

policy

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RESPECTFUL MATERNITY CARE

*A Nigeria-focused Health
Workers' Training Guide*

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ABBREVIATIONS

ADR	alternative dispute resolution
ANC	antenatal care
CHEWs	community health extension workers
CQI	continuous quality improvement
D&A	disrespect and abuse
FMOH	Federal Ministry of Health
HCP	healthcare providers
HFMC/B	health facility management committees, or boards
HRBA	human rights-based approach
IEC	information, education, and communication
MCH	maternal and child health
MDAs	ministries, departments, and agencies
MDG	Millennium Development Goal
MMR	maternal mortality ratio
M&E	monitoring and evaluation
NDHS	Nigerian Demographic and Health Survey
RMC	respectful maternity care
SBA	skilled birth attendants
SRH	sexual and reproductive health
VCAT	values clarification and attitude transformation
WRA	White Ribbon Alliance
WRAN	White Ribbon Alliance Nigeria

INTRODUCTION TO DIGNITY IN CHILDBIRTH – NIGERIA

Pregnancy, childbirth, and their consequences remain the leading causes of death, disease, and disability among women of reproductive age in developing countries. Nearly 275,000 maternal deaths related to treatable conditions during pregnancy and childbirth occurred globally in 2011. Almost all of these deaths took place in developing countries (Lozano et al., 2011). Maternal mortality is highest in sub-Saharan Africa, where the maternal mortality ratio (MMR) is one hundred times greater than in developed regions. Nigeria, situated in West Africa, is one of the countries that contributes significantly to the overall number of maternal deaths, with an estimated 50,000–55,000 deaths occurring annually.

Progress on MDG 5 has been slow because improvements require overcoming financial and geographical barriers to accessing skilled care, as well as the poor quality of care in maternity units. A little-understood component of the poor quality of care experienced by women during facility-based childbirth is the disrespectful and abusive (D&A) behaviour healthcare providers and other facility staff.

Acknowledgement of these behaviours by policymakers, programme staff, civil society groups, and community members indicates the problem is widespread. In a landscape analysis conducted in 2010, these behaviours were placed in seven categories: physical abuse, non-consented care, non-confidential care, non-dignified care, discrimination, abandonment of care, and detention in facilities (Bowser and Hill, 2010). Numerous factors contribute to this experience, which Bowser and Hill group as follows:

- Individual and community-level factors
- Normalising D&A
- Lack of legal and ethical foundations to address D&A
- Lack of leadership
- Lack of standards and accountability
- Provider prejudice, due to poor training and lack of resources

This guide is designed to support communities and, specifically, healthcare providers in confronting D&A during facility-based childbirth and promoting dignity in evidence-based maternity care. This guide has been adapted from the generic guide produced by the Population Council to reflect the Nigerian context and the specific needs of healthcare workers at primary, state, and federal levels in the country.

The adaptation process was undertaken using a mixed methods approach that combined document review, consultative meetings with stakeholders, focus group or individual discussions, and site visits of primary and tertiary institutions during November and December 2014. Based on a comparison with the generic Population Council guide, sections of the manual were adopted, deleted, or revised to more accurately represent the needs expressed in Nigeria. Most significantly, initial assessments revealed that a willingness to adopt respectful maternity care (RMC) principles and actions was impeded by lack of upgraded knowledge or skills in the workforce. This led to the alignment of the human-rights base of RMC with current evidence-based practice support in the revised manual.

The draft guide was then taken and field-tested in February on a group of more than 40 providers. The training took place over a five-day period in North-Central Nigeria, inclusive of theory and clinical practice/outreach and led by the WRA project consultant and state-level RMC champion. The providers completing the training also evaluated the tools and content for contextual applicability. The field testing of the guide also served the dual purpose of developing the first cohort of RMC facility champions in a training of the trainers model. In order to successfully complete the training, providers were asked to engage with traditional rulers (e.g., village rulers or chieftains) to sensitise them to RMC concepts and to fully develop a community-based RMC implementation strategy and working plan. The recommended revisions to the draft guide were then incorporated into a final document.

The guide is also informed by a baseline study undertaken by the White Ribbon Alliance Nigeria (WRAN) during June and July of 2014. Since 2003, the WRAN has worked to improve overall maternal and child health (MCH) mortality in Nigeria. One of the WRAN's greatest successes was the adoption of RMC as a federal policy by the Federal Ministry of Health's (FMOH) National Health Council in August 2013. FMOH adopted a draft charter on the institutionalisation of RMC as a strategy to promote the reproductive rights of women in Nigeria. This includes the right to quality maternity health services. In institutionalising the RMC charter, the federal government aims to raise awareness about the fundamental rights of women while receiving care in any health facility. This is one more step towards regaining the trust of women and communities who will, in turn, increasingly use health facilities that provide skilled attendance during labour/delivery and during the postpartum period.

In line with multi-pronged global strategies to improve the understanding of basic concepts of RMC, the WRAN, FMOH, and other partners have modified the original WRA RMC charter for use in Nigeria. The Nigerian RMC charter states that the following should be goals for healthcare workers:

1. Make it easier for pregnant women and mothers to feel safe and comfortable.
2. Help them make informed decisions by discussing aspects of their healthcare.
3. Provide privacy and confidentiality at all times.
4. Promote her dignity.
5. Provide the same standard of care to all.
6. Provide quality maternal healthcare at all levels because it is her right and not a privilege.
7. Provide services to all pregnant women and report concern to the relevant authorities.

The Nigerian RMC charter further highlights key words and messages to communicate RMC concepts in simple language to the provider and community. The key message of the revised charter is as follows: "We value and respect the dignity and freedom of our pregnant women and mothers." The key words and phrases aimed at the community and providers include 'safety and comfort,' 'informed decisions,' 'privacy and confidentiality,' 'dignity,' 'standard,' 'quality,' and 'rights/privilege for all women.'

Health workers are central to efforts to improve RMC. The latest research suggests that one-off trainings do not significantly improve RMC and that ongoing engagement of health workers is likely to provide better results. As such, this guide is designed to support health facility managers and providers at all levels of the system to confront disrespect and abuse during facility-based childbirth and to promote and deliver respectful maternity care. Evidenced-based clinical care realities are presented in a practical manner to encourage healthcare workers to find their own implementation solutions. Components of community/social accountability are also integrated into the materials to increase the probability that core concepts of RMC's human rights-based approach will be maintained long after the trainings have been completed.

The combined partnership and focus of the FMOH and WRAN will enhance efforts to make RMC an accepted standard of care for women in Nigeria. Hopefully, this domesticated guide will provide a locally useful tool for multiple stakeholders in pre-service, in-service, and advocacy to advance Nigeria's motto of "Unity and Faith, Peace and Progress."

WHY IS DIGNITY IN CHILDBIRTH IMPORTANT?

Dignity in childbirth is a global issue and findings from the baseline study in Kenya have been widely disseminated. Results from a baseline qualitative survey in six primary care health centres in Nigeria's Kwara state were used to assess the local situation. The survey was conducted with both women and healthcare providers to discover barriers to achieving dignity in childbirth. All seven categories of D&A were found. Illustrative statements from survey respondents are summarised below:

- Physical abuse: Beatings by healthcare workers were normalised and justified as being “for the good of the baby.”
- Abandonment of care: “My baby was almost out before anyone helped me—I may as well stay at home.”
- Verbal abuse: “Am I the one that impregnated you?”
- Non-consented care: “All women have episiotomy with their first child.”

Additional contributions to reported D&A includes

- Non-consented care
- Lack of individualised assessment and care plans; group health education modality most-often used
- Physical structure and facility layout often prohibit confidential care and the presence of a companion in labour
- Detention in health facilities when patients are unable to meet charges often results in women delivering in mission homes or with a traditional birth attendant
- Infrastructural issues, including poor roads, unreliable power sources and water supply, and limited access to sanitation facilities
- Staff shortages, resulting in chronic overwork, fatigue, and poor attitudes from healthcare workers
- Facilities that lack the full range of supplies necessary to provide basic obstetrical care

WHO SHOULD USE THE FACILITATORS' GUIDE?

Everyone can use the dignity in childbirth facilitators' guide. Facilitators may choose use the contents for a standalone dignity in childbirth workshop, or they may incorporate select activities for 1–2 hour training updates. Incorporation into monthly facility seminars may be most effective for ongoing knowledge transfer in much of Nigeria. Trainers are encouraged to further adapt the exercises and/or include other exercises. Once a core team of facilitators exists at the county, district, or regional level, incorporation of content into other meetings, workshops, or continuing professional development sessions can begin. Be sure to allow sufficient time for discussion or role plays.

FACILITATORS' GUIDE

The guide includes sessions and activities designed to fully engage participants in a set of interventions to promote dignity in childbirth. Strategies are founded on values clarification and attitude transformation (VCAT) training. Promoting respectful care is a process, so the interventions are designed to move participants through the VCAT theoretical framework, which begins with individual motivation to change based on new knowledge, a deep sense of self-understanding, and openness.

Supportive management, supervision, and follow-up of trainees at all levels of health service provision are required to ensure favorable results. The interventions are interconnected and include

- Improving knowledge of health rights and laws
- Providing psychosocial support for work-related stress through 'caring for the carers'
- Implementing maternity open days
- Refocusing on work ethics and strengthening professionalism
- Improving (or developing) systems for reporting and documentation of rights violations
- Implementing conflict resolution mechanisms to deal with incidents of D&A
- Creating rights and legal campaigns at the national, regional, and community levels

The guide provides facilitators with multiple discussion boxes, including brainstorming prompts, case studies, and "Knowing Nigeria" sections designed to stimulate discussion. Any of the "Knowing Nigeria" boxes may be adapted for role plays or brainstorming sessions to increase audience participation. Because strong oral traditions influence Nigerian education, facilitators are encouraged to follow pre-workshop content familiarisation sessions with relevant stories, activities, and discussions that reinforce content, rather than PowerPoint presentations.

Participant Selection

Facilitators must consider how participants' backgrounds will affect their experiences, as well as the effectiveness of the sessions and overall workshop. There are both benefits and risks to mixing participants with different backgrounds and views on women's rights and birth choices. In the Nigerian context, a more diverse group will increase the required degree of facilitation, with consistent reminders that the purpose of the workshop is not to 'shame and blame.'

Workshop Materials

Some workshop materials may be required for use throughout all sessions, including

- PowerPoint presentations and projector
- Flipchart paper
- Markers
- Cards/post-it notes
- Masking tape
- Notebooks and pens
- Reference materials such as blank parto-graph and copies of the code of conduct

Teaching Methods

- Interactive presentations
- Large and small group discussions
- Individual and group work

- Hypothetical and real case studies
- Sensitivity and listening techniques
- Expressive activities (role plays, songs, skits)
- Games
- Simulations

As a trainer, be prepared to utilise your full range of creative efforts. Power outages of varying lengths are frequent, and you may not be able to rely upon PowerPoint.

WORKSHOP INTRODUCTION

Overall Workshop Objectives

By the end of the workshop, participants will be able to

- Outline the current status of maternal and neonatal health in relation to respectful care
- Discuss key RMC concepts, terminology, and legal and rights-based approaches related to dignity in childbirth
- Demonstrate knowledge and use of VCAT theory and practice
- Discuss select evidence-based strategies that reduce D&A
- Discuss participants' role in promoting RMC
- Develop personalised action plans to support the implementation of RMC interventions at various levels of health (e.g., policy, programme, regional/state, facility and community levels)

Participants' Expectations and Group Norms

This introductory activity can be completed as an icebreaker to begin a workshop or day session, and can be revisited at the end as a form of evaluation. The activity helps participants identify their expectations and/or concerns, as well as their discomforts regarding the workshop. Similarly, its use at the end of the workshop can assess whether expectations were met as a result of the training. Finally, the activity allows facilitators to identify additional participant expectations and address concerns about workshop topic and contents.

Introductory Session Objectives

"A friend is someone you share the path with." ~ African proverb

By the end of this activity, participants will be able to

1. Know each other and begin the process of establishing trusting relationships within the group
2. Articulate their hopes and concerns about the workshop, particularly the topic of disrespect and abuse

Begin the workshop with a motivational icebreaker activity to help participants warm up for the remainder of the sessions. For example, you may use the "names and adjectives game," where participants are asked to think of an adjective that describes their current feelings or their personality. The adjective must start with the same letter as their name. For instance: "I'm Hajera and I'm happy," or "I'm Luther and I'm lucid." As they say these, they can also mime an action that describes the adjective. In some cultures, an activity in which men and women touch or shake hands would not be appropriate.

Time: 15 minutes

Facilitator Instructions

Write the following statements on a flip chart or ask participants to write them on post-it notes:

- My expectation for this workshop is ...
- During the workshop, I hope that I will be able to ...
- By the end of this workshop, I hope that I ...

Introduce the activity as an opportunity to discuss what participants hope to gain from the workshop or the day's sessions, and ask about their concerns or discomforts regarding the issues that will be discussed.

1. After all willing participants have contributed, add your own expectations and hopes for the workshop that have NOT already been mentioned. Ask for one or two overall comments about the entire list (not any one person's response).
2. Acknowledge that you will do your best to meet the group's expectations. Explain which objectives meet certain expectations and those that may go beyond the scope of the workshop.
3. Record any items beyond the scope of the workshop under an 'Out to Pasture' heading. Use a flipchart or writing board if appropriate. Assure participants that you will discuss how they might meet these expectations in other ways outside of the workshop.
4. Solicit and discuss any outstanding questions, comments, or concerns from the participants.
5. End the session by asking participants to state group norms for the workshop. Write them on a flipchart and post it on the wall.
6. Address housekeeping issues, such as location of facilities and refreshment breaks.

SESSION 1: OVERVIEW OF MATERNAL HEALTH

Learning Objectives

By the end of the session, participants will be able to

1. Briefly discuss the concept of RMC
2. Outline the current status of maternal and newborn health globally, regionally, and locally
3. Discuss factors that contribute to maternity mortality and morbidity
4. Discuss the evidence for D&A during facility-based childbirth

Time: 45 Minutes

Facilitator Instructions

- Ask participants to define or explain the term “maternal health.”
- Ask participants for the current status of facility-based deliveries at their respective facilities, and how their facility performs against current maternal health targets—e.g., antenatal care (ANC) visits, skilled birth attendants (SBAs), post-natal care, etc.
- Ask participants to offer potential reasons for why the targets remain generally low in their facilities.
- End the session by stating that, among all the reasons mentioned, the workshop focuses on promoting dignified care during childbirth. If this was not already mentioned among the reasons given for low numbers of SBAs (which is highly unlikely), add it to the list.

Content

Respectful maternity care concept: RMC encompasses respect for women’s basic human rights and includes respect for their autonomy, dignity, feelings, choices, and preferences, including companionship during maternity care (WRA, 2011).

Definition of maternal health: Maternal health refers to the health of women during pregnancy, childbirth, and the postpartum period. While motherhood is often a positive and fulfilling experience, far too many women associate it with suffering, ill-health, and even death (WHO et al., 2012).

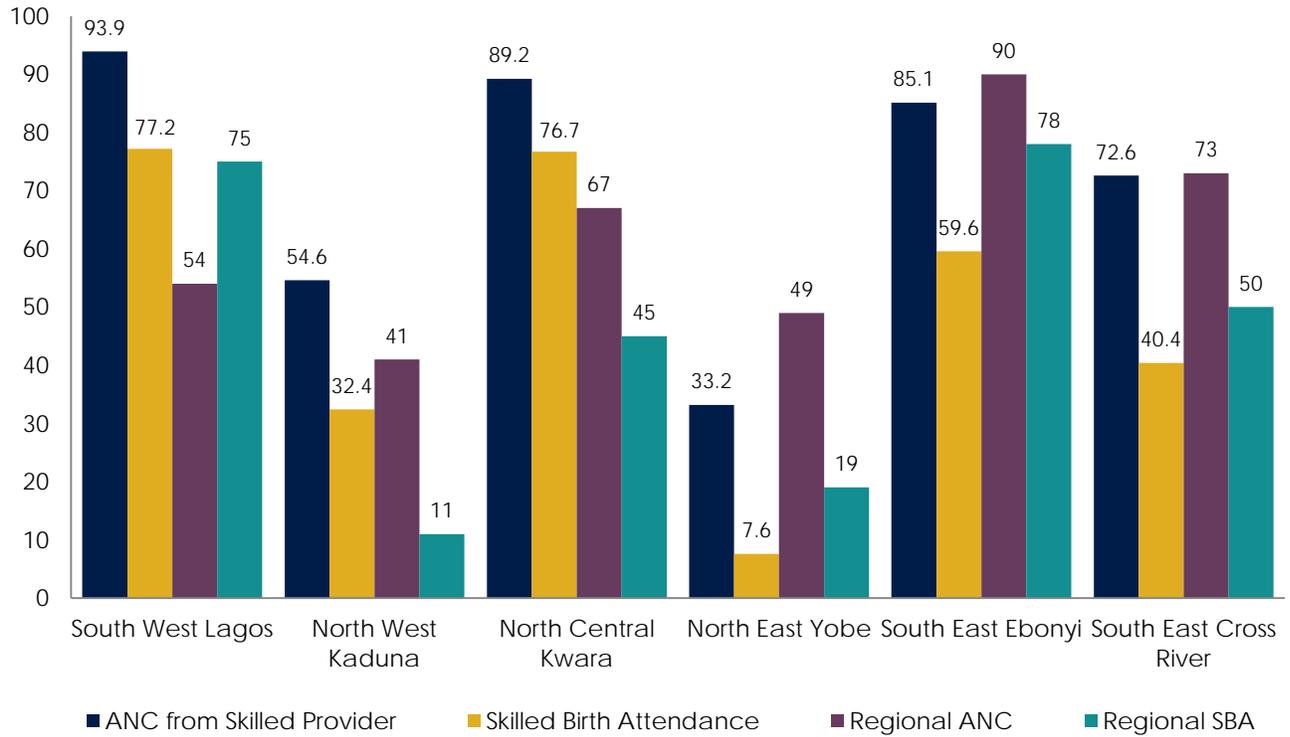
Major direct causes of maternal morbidity and mortality: The major causes of maternal morbidity and mortality include hemorrhage, infection/sepsis, pre-eclampsia/eclampsia, unsafe abortion, and obstructed labour/ruptured uterus (Lale Say et al., 2014).

Overview of Maternal Health

Globally, up to 287,000 women die each year during pregnancy and childbirth. Most die as a result of their lack of access to skilled care, routine checkups, and emergency obstetric care. However, since 1990, some countries in Asia and northern Africa have more than halved their maternal mortality rates (WHO et al., 2012).

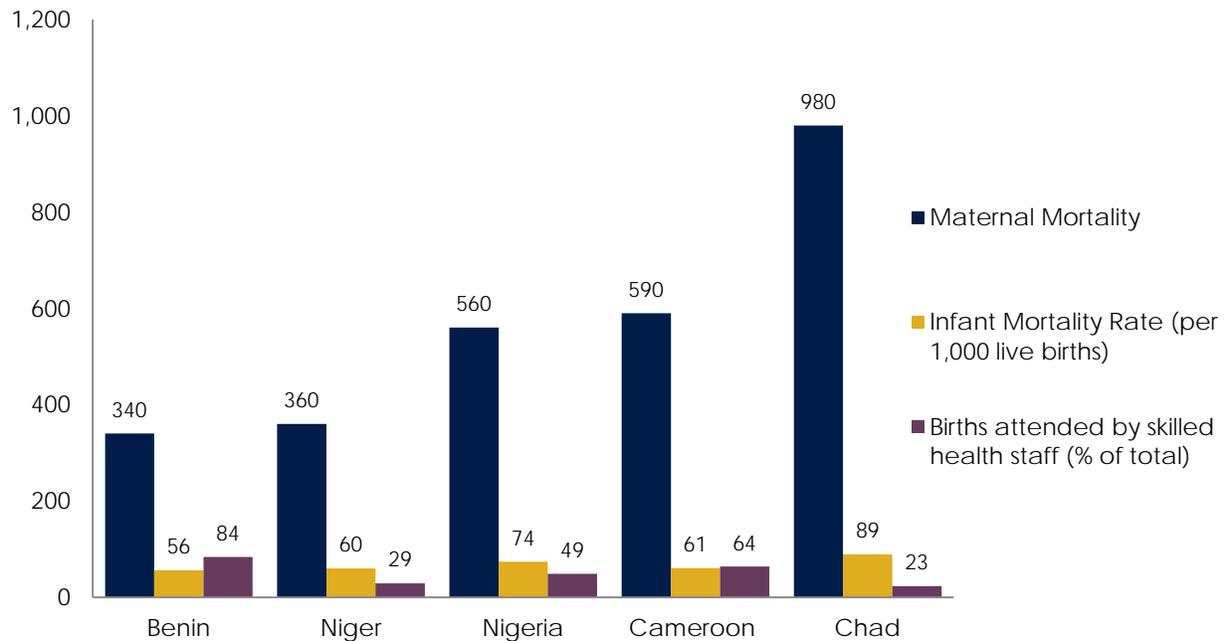
The MMR in developing countries is 240 per 100,000 live births, versus 16 per 100,000 live births in developed countries. According to the Nigerian Demographic and Health Survey (NDHS) 2013, the country’s MMR of 576 per 100,000 births is not significantly different that that found in the 2008 NDHS. There are also notable regional and state-level differences in the use of services to reduce the MMR.

Figure 1: Regional and State-level Comparison of Skilled Antenatal Care and Skilled Birth Attendants



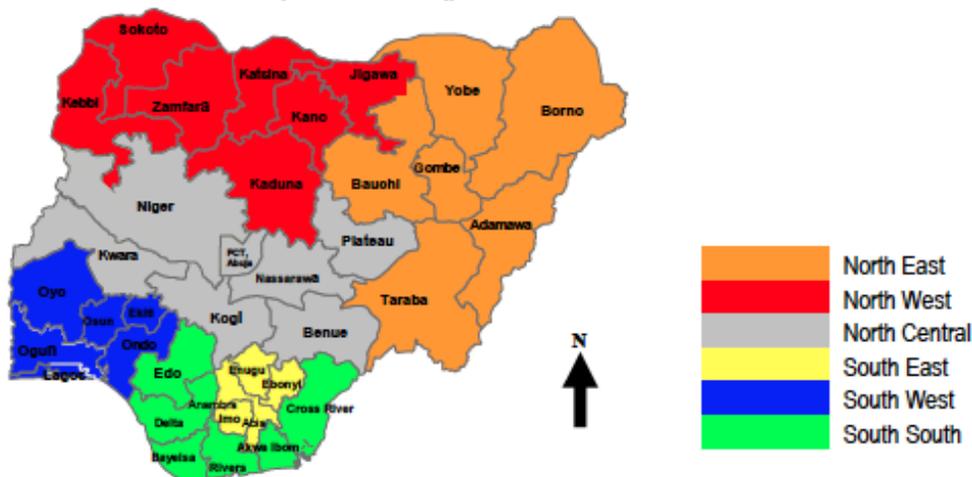
About 800 women die from preventable pregnancy- or childbirth-related complications every day in developing countries. More than half of these deaths occur in sub-Saharan Africa, and approximately one-third occur in South Asia (WHO, 2012 and WHO, 2014). Maternal death accounts for 32 percent of all deaths for Nigerian women ages 15–49, an average of 50,000–60,000 annually.

Figure 2: Nigeria and Its Neighbours—A Glance at MNCH Indicators



To avoid excess maternal deaths, all women require access to quality ANC, skilled care during childbirth, care and support in the weeks after childbirth, and access to fully functioning emergency obstetric care. It is critical for skilled health professionals to be present at birth to provide competent life-saving interventions. The Midwife Service Scheme, introduced in 2009, is an FMOH effort aimed at increasing the use of SBAs by deploying midwives to hard-to-reach and underserved rural areas. However, further interventions are necessary to improve the *quality* of care. One key component of high-quality maternal, child, and neonatal health services is respectful maternity care.

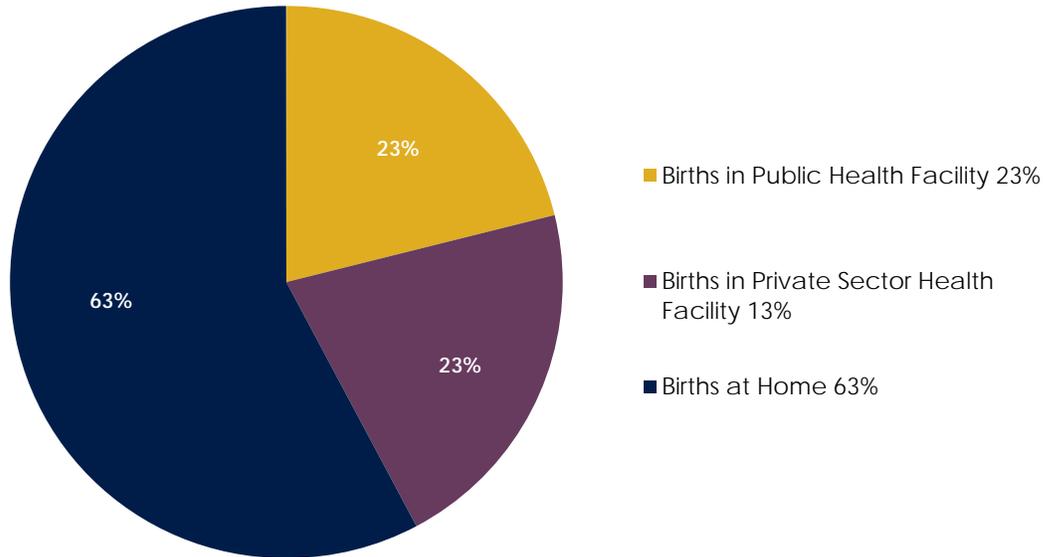
Figure 3: Geopolitical Map of Nigeria's Zoning



Nigeria's large land mass and population, and its economic situation and culture, pose myriad challenges to ensuring access to high-quality maternal healthcare. The vast majority of births still take place outside

of healthcare facilities for multiple reasons. In many cases, culture impedes the ability of women to make decisions related to their healthcare. One suggestion is to encourage women to obtain global consent or permission from their partner or family to seek care from the onset of pregnancy through the postpartum period. This may mitigate one of the three primary barriers to facility delivery.

Figure 4: Women’s Choice of Place of Birth NDHS 2013



Additional barriers to accessing or receiving care include

- Real or perceived negative provider attitudes
- Poor quality of care reported in facilities during childbirth, including D&A from health providers and facility staff
- Failure to provide minimum standards of obstetric care
- Limited provider competency and skills, and lack of supportive supervision
- Poor facility infrastructure, including water, electricity, equipment, drugs, and supplies
- Prohibitive cost of services and poverty
- Stigma and cultural perception of both clients and providers related to various health conditions and services
- Gender limitations to decision making
- Medicalisation (Johanson et al., 2013) of childbirth, in which the natural process of childbirth and its associated problems or challenges are defined and treated as medical conditions, and become the subject of medical study, diagnosis, prevention, or treatment. Pregnancy, labour, and delivery are normal processes and about 90 percent of births will have no complications
- Lack of awareness or recognition of danger signs
- Lack of awareness of service availability
- Inadequate mix of services, including availability and physical and social accessibility

- Poor access to facilities due to inadequate road and communications networks
- Lack of available emergency transport, so families must often provide their own transportation to access the next level of care

Table 1: Drivers of Disrespect and Abuse

What Drives Disrespect and Abuse in Nigeria?		
At policy and governance levels <ul style="list-style-type: none"> • Non-realisation of international conventions, despite Nigeria's signatory status to most • Lack of transparency and accountability for policymakers • Insufficient funding for maternal healthcare • Insufficient reporting and/or monitoring and evaluation of services 	At health facility and provider levels <ul style="list-style-type: none"> • Limited understanding of clients' rights • Inadequate infrastructure leading to poor working environment • Staff shortages leading to high stress and poor quality of care • Lack of basic knowledge and inappropriate task-shifting—i.e., community health extension workers (CHEWS) delivering in PHCs • Poor supervision • Lack of professional support • Lack of standards and quality-of-care guidelines 	At the community level <ul style="list-style-type: none"> • Sociocultural factors • Imbalanced gender power dynamics • Healthcare providers seen as authority figures • Limited understanding of women's health rights • Illiteracy • Misinformation and lack of information • Non-prioritisation of healthcare needs

In addition to geographic, financial, and cultural barriers, seven categories of disrespect and abuse have been identified: physical abuse, non-consented care, non-confidential care, non-dignified care, discrimination, abandonment of care, and detention in facilities or demand for payment (Bowser and Hill, 2010).

Table 2: Categories of Disrespect and Abuse, with Illustrative Statements

Categories of Disrespect and Abuse	Comparative Statements from WRAN Baseline Study
Physical abuse	"They beat us for the good of the baby."
Non-consented care	"In the olden days when our mothers used to give birth at home, they never used to have episiotomies and did not have their private parts stitched after childbirth. Why is it so common for health facility births these days?"
Non-confidential care	
Non-dignified care	"Am I the one that impregnated you?" "When you were having sex and enjoying it, did you not know it will lead to this?"
Discrimination	
Abandonment of care	"My baby was almost out before anyone helped me—I may as well stay at home."
Detention in facilities	

Optional: Role Play 1: Communicating a Woman's Right to Dignified Childbirth

Directions

The group will self-select one participant to take a few minutes to read the background information provided below and prepare. The observers should read the same information so they can participate in the large group discussions that follow.

The purpose of the role play is to provide an opportunity for participants to appreciate the importance of good communication when talking to women about available healthcare and their sexual and reproductive rights.

Participant roles

Provider: The provider is an experienced healthcare worker at a primary healthcare centre, who also has good communication skills.

Antenatal care clinic: ALL others

Situation: The women are at an antenatal care clinic. Some are interested in learning more about the care available at the health centre because a relative or neighbor delivered there. Everyone present knows someone who has died as a result of childbirth. One of the providers working in the facility has a reputation in the community for 'shouting at women all the time.' Many are nervous about health facility delivery because the majority of women in the community deliver at home.

Focus of the role play: *The focus should be on the interaction between the midwife and the women. The midwife should*

- Be friendly and reassuring
- Describe the role of the midwife
- Briefly explain the range of services available for women, and how families can be involved in decisions about care
- Encourage the women to ask questions and take time to address them
- Discuss a woman's right to a companion for facility-based visits during her pregnancy and childbirth
- Discuss safe motherhood and women's right to safe, respectful healthcare

The mothers at the clinic should ask questions and express their concerns until the midwife has provided them with adequate information about the midwife's role, their rights as women, and the care available at the health centre.

Discussion questions: *The trainer/facilitator should use the following questions to facilitate discussion after the role play:*

1. How did the midwife approach the clinic teaching?
2. Did the midwife give enough information about her role? About the health centre? About a woman's right to safe motherhood? About her right to have a birth companion?

Brainstorming

"Sincerely, we don't monitor labour properly because we don't have enough staff." -Healthcare workers at primary and secondary levels

How do statements/realities such as this impact overall maternal health in your facility?

3. How did the women respond to the midwife?
4. What did the midwife do to demonstrate emotional support and reassurance during the group's interaction?
5. Were the midwife's explanations and reassurance effective? Why or why not?

SESSION 2: HUMAN RIGHTS AND LAW

“Speak softly and carry a big stick; you will go far.” ~ West African proverb

Learning Objectives

By the end of the session, participants will be able to

- Define ‘human rights’
- State the origin and characteristics of human rights
- Discuss a human rights-based approach to reproductive health
- Discuss human rights instruments for RMC

Time: 1 Hour

Facilitator Instructions

1. Ask participants to brainstorm meanings for ‘human rights.’ Allow several responses and provide the correct definition as needed.
2. Discuss the origin and characteristics of human rights.
3. Interactively discuss the legal background of a human rights-based approach to reproductive health.
4. Facilitate a brainstorming session on the definition of ‘reproductive health’ and ‘reproductive rights.’ Write participants’ responses on a flipchart and discuss each one. Use a PowerPoint presentation to provide the correct definitions of these terms.
5. Discuss examples of human rights and limitations to human rights-based approaches to reproductive health

Content

Definition of ‘human rights’: Human rights are those rights that every human being possesses and is entitled to enjoy simply by virtue of being a human being (*United Nations General Assembly, 1948*).

Limitations

Origin and characteristics of human rights: Human rights are founded on religious, philosophical, and legal principles. Most religions promote the concept of equal and fair treatment of all human beings. The principle of equality, dignity, and non-discrimination form the philosophical basis of human rights (*United Nations General Assembly, 1948*).

The following are characteristics of human rights:

- Internationally guaranteed
- Legally protected
- Focused on the dignity of human beings
- Protective of individuals and groups
- Obligatory for both state and non-state actors
- Cannot be waived or taken away

- Equal and interdependent
- Universal

Legal Background of Human Rights

(Adapted from definitions of SRHR in the ICPD and Beijing Platforms of Actions 2005)

United Nations Charter, 1945

- Act as the foundation of human rights legal instruments
- Reaffirm faith in fundamental human rights, worthy of the human person and their dignity
- Encourage and promote respect for human rights
- Based on principles of equality and non-discrimination

Universal Declaration of Human Rights (UDHR), 1948

- An international bill of human rights, adopted by the UN General Assembly
- Based on the philosophy of equality, dignity, and non-discrimination
- Sets the direction for subsequent work in human rights
- Serves as a yardstick to measure respect and compliance for human rights

International human rights instruments

- Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)
- International Covenant on Economic, Social and Cultural Rights (ICESCR)
- Convention on the Elimination of All Forms of Racial Discrimination (CERD)
- International Covenant on Civil and Political Rights (ICCPR)
- Convention Against Torture and Other Inhuman, Cruel and Degrading Treatment (CAT)
- Convention on the Rights of the Child (CRC)

Examples of African regional human rights instruments

- African Charter on Human and Peoples' Rights (African Charter)
- Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol)
- African Charter on the Rights and Welfare of the Child (Children's Charter)

Examples of Human Rights

The concepts of human rights and rights of law are dynamic. Although a range of fundamental human rights has already been legally recognised, nothing precludes existing rights from being interpreted more broadly or additional rights being accepted. As a result, human rights are a powerful tool for promoting social justice and dignity. Some of the human rights guaranteed in the main international human rights treaties include

- Non-discrimination
- Life
- Bodily integrity
- Privacy
- Freedom of thought
- Liberty and security
- Freedom of expression
- The choice to marry and have a family
- Enjoyment of the highest standard of physical and mental health
- The choice of whether, when, and how many children to have
- Prohibition of arbitrary arrest, detention, and exile
- Due process in criminal trials
- Self-determination

- Education
- Information

Limitations of Human Rights

Rights are not absolute. Under certain conditions, limitations can be imposed by the state on the exercise and realisation of certain rights. This ensures respect for the rights of others and the maintenance of public order, health, morals, and national security.

Human Rights-based Approach to Reproductive Health

Definition of reproductive health: Complete physical, mental, and social well-being in all matters related to the reproductive system, including a satisfying and safe sex life, the capacity to have children, and the freedom to decide if, when, and how often to do so.

Reproductive rights: The rights of couples and individuals to decide freely, and to responsibly number and space their children; to have the information, education, and means to do so; and to attain the highest standards of sexual and reproductive health and make decisions about reproduction free of discrimination, coercion, and violence.

Rights-based Approach to Reproductive Health

In general, a human rights-based approach includes accountability, participation, transparency, empowerment, and non-discrimination, and identifies entitlements as the core of human rights.

- A human rights-based approach (HRBA) is founded on the principles of peace, justice, freedom, development, and sustainability.
- HRBA also focuses on accountability and identifying those responsible for human rights realisation (duty bearers), as well as those whose capacities to meet their responsibilities must be strengthened (claim holders).
- HRBA empowers beneficiaries to develop a self-sustaining process of change, eliminating dependency on foreign agents for reform or development

Human Rights in Nigeria

The National Human Rights Commission was established by the National Human Rights Commission Act, 1995, in compliance with Nigeria's status as a UN member.

The Commission

- Helps to create a supportive environment for the promotion, protection, and enforcement of human rights
- Provides avenues for public information
- Promotes research and dialogue to raise awareness about human rights issues

According to the constitution of the Federal Republic of Nigeria, Chapter VI, the following fundamental human rights are ensured to all Nigerians:

- Life
- Dignity of the human person
- Personal liberty

- Fair hearing
- Private and family life
- Freedom of thought, conscience, and religion
- Freedom of expression and the press
- Peaceful assembly and association
- Freedom of movement

The *goal of a HRBA* is to take a closer long-term look at power relationships that put women at risk for harm.

A human rights-based approach to maternal and newborn child health analyses the root causes of maternal mortality rates, both internal and external to the healthcare system, with a view to the intersections of poverty, gender inequality, and structural challenges.

Brainstorming

A newly delivered mother cannot pay her facility bill. She is sent home to find the naira to pay while the baby is kept in the facility. Is this a human rights violation? Why or why not?

SESSION 3: PROMOTING RESPECTFUL AND DIGNIFIED CARE DURING CHILDBIRTH

“When there is a mountain in your path, do not sit down at its foot and cry, get up and climb it.” ~ Zimbabwean proverb

Learning Objectives

By the end of this session, participants will be able to

- Explain the meanings of ‘respectful’, ‘dignified,’ ‘disrespect,’ and ‘abuse’
- Discuss the categories of D&A during childbirth
- Discuss factors leading to D&A
- State legal definitions for the categories of D&A and for the corresponding Universal Rights of Childbearing Women, and list examples and standards of care

Time: 1 Hour

Facilitator Instructions

1. Introduce the session by informing participants that D&A is a common experience in several contexts, including the transport industry, public offices, etc.
2. Invite participants to recount any personal experiences, both in their social life and in a healthcare setting, that they considered disrespectful or inhumane. The facilitator may also offer his/her own personal experiences.
3. Explain that D&A affects the individual at a personhood level, as well as his/her future behaviour in seeking services or recommending services to others.

Optional Audio-visual Component

WHO Reproductive Health Library: “Labour companionship: Every woman’s choice”

Recommended use: up to six minutes, 25 seconds (6:25) for Session 3; minutes 6:26–14:30 may be used in later sessions to discuss community engagement processes

Film guide discussion questions: What elements of RMC were brought up in the film? What are your thoughts? What is the reality in your facility?

apps.who.int/rhl/videos/en

<http://youtu.be/hJ2mWJat5IU?list=PL68EE6D503647EA2F>

Suggested audio-visual alternatives: “Birth is a Dream” photo essay film series

Content

Context: Disrespect and abuse (D&A) globally and regionally

The notion of safe motherhood must be expanded beyond the prevention of morbidity or mortality to encompass respect for women’s basic human rights, including their autonomy, dignity, feelings, choices, and preferences (inclusive of companionship during maternity care) (Jolivet, 2011).

During childbirth, providers should be caring, empathetic, supportive, and trustworthy, and should contribute to confidence and empowerment. They should also be gentle and respectful, and communicate effectively to enable informed decision making. However, this may not be the case for most women.

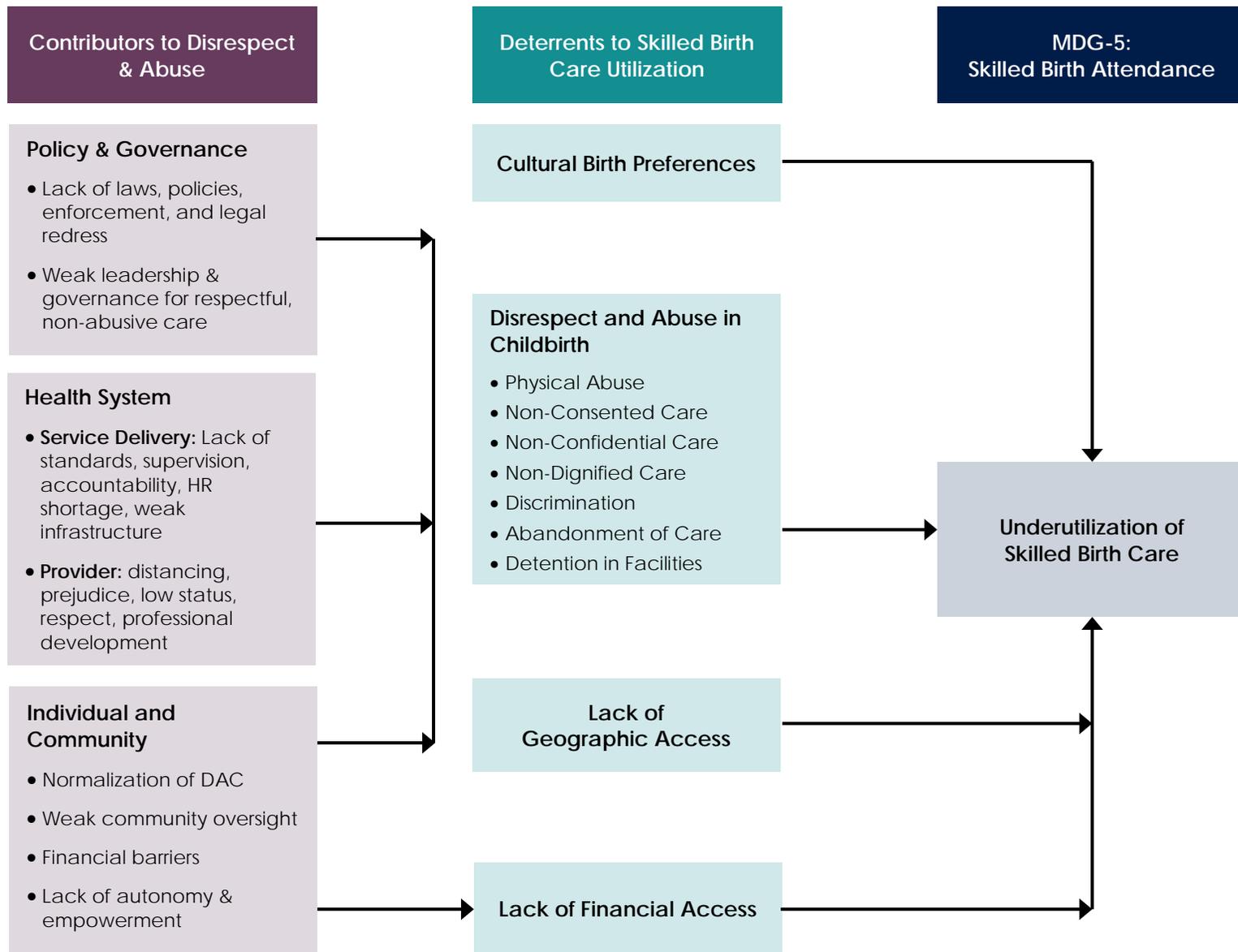
Definitions of terms

1. 'Dignified' means having or showing dignity—i.e., the quality of being worthy of honor or respect.
2. 'Respect' is a specific feeling of regard for the actual qualities of the one respected (e.g., "I have great respect for her judgment"). Specific ethics of respect are of fundamental importance in different cultures, beliefs, and professions.
3. 'Undignified' means lacking dignity or value for someone.
4. 'Disrespect' means rude conduct, and is usually considered to indicate a lack of respect.

Disrespect and abuse in childbirth

Based on a comprehensive review of research conducted by Bowser and Hill in 2010, seven categories of disrespect and abuse in childbirth have been identified. These include physical abuse, non-consented care, non-confidential care, non-dignified care, discrimination based on specific patient attributes, abandonment of care, and detention in facilities. Manifestations of D&A often fall into more than one category, so the categories are not intended to be mutually exclusive; rather, they should be seen as overlapping along a continuum.

Figure 5: Landscape Analysis of Disrespect and Abuse (Bowser and Hill, 2010)



The Universal Rights of Childbearing Women

To align the seven categories of D&A with international rights instruments suitable to address them, the White Ribbon Alliance (WRA) and its partners developed a charter on the universal rights of childbearing women. This charter aims to address disrespect and abuse of women seeking maternity care and to provide a platform for improving RMC through the following (White Ribbon Alliance, 2011):

- Raising awareness for including childbearing women in the guarantees of human rights recognised in internationally adopted United Nations and other multinational declarations, conventions, and covenants
- Highlighting the connection between human rights and implementation activities relevant to maternity care
- Increasing the capacity of maternal health advocates to participate in human rights processes and champion RMC
- Aligning a sense of entitlement to high-quality maternity care among childbearing women with international human rights standards
- Providing a basis of accountability for communities and the maternal care system
- Demonstrating the legitimate place of maternal health rights within the broader context of human rights

The WRA charter (see Appendix 3) identifies seven universal childbearing rights. Healthcare providers are duty-bound to offer maternity care services that adhere to these rights to improve the quality of maternity care. The WRA charter has been adapted for Nigeria (see Appendix 3) to simplify the messages delivered to clients. The adaptation also identifies the following key words and phrases for all tenets of the original RMC charter, for easy recall even in a low-literacy setting:

1. Safety and comfort
2. Informed decisions
3. Privacy and confidentiality
4. Dignity
5. Standard care
6. Quality is a right and a privilege
7. Service for all pregnant women

Knowing Nigeria—Exploring concepts of privacy

Is a client's privacy or confidentiality compromised when

- Breasts are exposed during breastfeeding?
- Gathering of medical history takes place alongside another client due to space constraints?
- Cleaners are present during procedures?
- She is not covered by draping after a vaginal exam?

"We value respect, dignity, and freedom of our pregnant women and mothers!"

SESSION 4: PROFESSIONAL ETHICS

“In the moment of crisis, the wise build bridges and the foolish build dams.” ~ Nigerian proverb

Learning Objectives

By the end of the session, participants will be able to

1. Define ‘healthcare ethics,’ ‘code of conduct,’ ‘etiquette,’ ‘scope of practice,’ and ‘professional associations’
2. Discuss the principles of ethics
3. Explain the common themes in the set of ethics that promote dignified care and respect
4. Describe the role and responsibilities of regulatory bodies and professional associations in promoting dignified and respectful care
5. Discuss ethical issues surrounding childbirth

Time 1 Hour, 30 Minutes

Facilitator Instructions

1. This module provides learners with insight into potential conflicts between personal and professional ethics during provision of care.
2. Present definitions for ‘ethics,’ ‘code of conduct,’ ‘etiquette,’ and ‘scope of practice.’ Discuss these terms in relation to RMC terms. Key terms/definitions are bolded for focus below.
3. Briefly introduce the Nigerian Nursing and Midwifery Council and the Nigerian Medical and Dental Council, summarising the roles and responsibilities of professional associations and regulatory bodies in promoting respectful and dignified childbirth.
4. Conduct a group activity to stimulate differentiation between ethics and etiquette in professional practice. This is also an opportunity for participants to personally interact with others to gain insight on ethics in the provision of maternity care.
5. End the session by emphasising medical professional ethics to inform ethical decisions in maternal healthcare.

Content

Definition of ‘ethics’: Ethics involve a systematic examination of moral life and seek to provide sound justification for the moral decisions and actions of people. The word *ethics* can also refer to philosophical inquiry in examining ‘right from wrong’ and ‘good from bad’.

Codes of ethics: A **code of ethics** makes public the professional *values of healthcare providers*, as well as the values of professional education and practice. Each provider has a personal value system influenced by his or her upbringing, culture, religious and political beliefs, education, and life experiences. Ethical decision making considers values that are important to other individuals, as well as the reasons for their importance.

Roles and Responsibilities of Regulatory Bodies

The Nursing and Midwifery Council of Nigeria and the Nigerian Medical and Dental Council are parastatals of the Federal Government of Nigeria, and function as

- Regulatory bodies charged with public protection through licensure and support for continuous professional development
- Legal entities
- Administrative structures
- Corporate and statutory bodies charged with performing specific functions, including disciplinary functions

These councils' mission on behalf of the Nigerian government is to ensure the delivery of safe and effective nursing, midwifery, and medical care to the public through quality education and best practices.

The councils have established guidance documents, including codes of conduct and scopes of practice, to further guide professional practice. A review of these codes shows that the foundations of dignity in childbirth practice exist within professional standards.

By definition, a **scope of practice defines the responsibilities of the provider as well as the legal boundaries of practice**. It defines what health professionals can be held **accountable** for in the course of practice. The scope differs from one profession to another and stipulates the **practice boundaries** and the linkages between professions.

Code of Conduct for Nigerian Nurses and Midwives Sampler

The professional nurse and the healthcare consumer

The Nurse must

1. Provide care to all members of the public without prejudice to their age, ethnicity, race, nationality, gender, political inclination
2. Uphold the health consumers' rights as provided in the constitution
3. Ensure that the client/patient of legal age 18 years and above gives informed consent for nursing intervention; in case the health consumer is under aged, the next of kin or the parents can give the informed consent on his behalf
4. Keep information and records of the client confidential except in consultation with other members of the health team to come up with suitable intervention strategies, or in compliance with a court ruling, or for protecting the consumer and the public from danger
5. Avoid negligence, malpractice, and assault while providing care to the client/patient
6. Relate with a consumer in a professional manner only
7. Not take bribes or gifts that can influence you to give preferential treatment
8. Consider the views, culture, and beliefs of the client/patient and his family in the design and implementation of his care/treatment regimen
9. Know that all clients/patients have a right to receive information about their condition
10. Be sensitive to the needs of clients/patients and respect the wishes of those who refuse or are unable to receive information about their condition
11. Provide information that is accurate, truthful, and presented in such a way as to make it easily understood

12. Respect clients' and patient's autonomy, their right to decide whether or not to undergo any healthcare intervention, even where refusal may result in harm or death to themselves or a fetus unless a court of law orders to the contrary
13. Presume that every patient is legally competent unless otherwise assessed by a suitable qualified practitioner
14. Know that the principles of obtaining consent apply equally to those people who have a mental illness
15. Ensure that when clients and patients are detained under statutory powers, you know the circumstances and safeguards needed
16. Provide care in emergencies where treatment is necessary to preserve life without clients'/patients' consent if they are unable to give it, provided that you can demonstrate that you are acting in their best interests

Ethical principles

Ethical principles guide moral decision making and action, and assist in the formation of moral judgment in professional practice. Ethical principles important to medical practice include

- **Beneficence (obligation to do good) and non-maleficence (obligation to avoid doing harm):** Applying these principles to medical practice can pose problems for providers. Avoidance of deliberate harm and injury to others, however, is something within an individual's capacity and resources. Failure to uphold this principle can be interpreted as grossly unethical, regardless of context.
- **Justice:** The principle of formal justice states that *equals should be treated equally and that those who are unequal should be treated differently according to their needs*. Clients with greater healthcare needs (such as maternal complications and chronic illness) require more attention.
- **Autonomy:** The ethical principle of autonomy claims that individuals should be permitted personal liberty to determine their own actions, according to plans that they have chosen. During labour, women must be informed of the services available to them, at which point they can choose to opt in or out. Birthing preferences are the woman's choice, and the provider must respect individuals as self-determined choosers. To respect a mother's choices is to acknowledge autonomy stemming from personal values and beliefs, as well as preferred cultural practices.

Knowing Nigeria—Brainstorming

2008 NDHS data is comparable to 2013 reports that place estimates of violent occurrences at 28 percent. Do you think that this impacts the acceptance of violent incidents in maternity care?

"Sometimes they beat us for the good of the baby."

Role of health professional associations

A health professional association or body is not a profit-making entity. Professional associations may have the following functions:

1. Represent the interests of a profession and, in essence, serve as that profession's public voice at national and international levels.
2. Protect the profession by guiding the terms and conditions of employment.
3. Ensure that the public receives the highest possible standard of care by maintaining and enforcing training and practice standards, and ethical approaches to professional practice.
4. Influence national and local health policy development to improve healthcare standards and ensure equitable access to high-quality, cost-effective services.

Health profession regulatory bodies and professional associations are partners in raising quality standards for RMC.

The Nigerian Medical and Dental Council Code of Medical Ethics in Nigeria: Rights and responsibilities of Members of the Medical and Dental Professions

Clinic Etiquette

In order to ensure the most constructive relationship between the practitioner and the patient, practitioners

- Should provide privacy to their patients
- Should offer explanation to patients on fees and charges for service
- Must always give unconditional positive regard to their patients and express appropriate empathy for their condition
- Must at all times show appropriate courtesy to patient

The following acts constitute Professional Negligence

- Failure to obtain the consent of patients informed or otherwise for procedures before proceeding with any surgical or other procedures or course of treatment when such a consent was necessary
- Failure to refer a patient in good time when such a referral or transfer was necessary
- Failure to see a patient as often as his medical condition warrants or to make proper notes of the practitioner observations and prescribed treatment during such visits, or to communicate with the patient or his relations as may be necessary with regards to any developments progress or prognosis in the patients' condition

SESSION 5: VALUES CLARIFICATION AND ATTITUDE TRANSFORMATION (VCAT)

"If you do not cry out you will die unheard." ~ African proverb

Learning Objectives

By the end of this session, participants will be able to

- Explain the meaning of 'values,' 'value clarifications,' and 'attitude transformation'
- Identify the values that inform their current beliefs and attitudes about childbirth and midwifery practice
- Distinguish between assumptions, myths, cultures, and facts surrounding D&A in childbirth
- Demonstrate separation of personal beliefs from their professional roles and responsibilities in advocating for respectful and dignified care during childbirth
- Discuss their behavioural intentions concerning provision of respectful care during childbirth consistent with their chosen, affirmed values
- Briefly discuss behaviour transformation
- Discuss psychological debriefing or care for providers as an option to support them in dealing with negative behaviours and work-related stress

Time: 2 Hours 15 Minutes

- Discuss using PowerPoint presentations: 45 minutes
- Crossing the line: 45 minutes (Activity 1)
- Life-saving skills: 45 minutes (Activity 2)

Facilitator Instructions

The process of *values clarification* relies on a skilled facilitator who can create a safe, comfortable space and assist participants in using rational thinking and emotional awareness to examine personal belief systems and behaviour patterns; using thoughtful reflection and honest self-examination to identify and analyze issues for which their values may conflict; and specifying actions that are consistent with their clarified value(s).

Introduce the session.

1. Engage participants with a short question and answer session on how attitudes and values affect maternity care services.
2. Use PowerPoint presentations to briefly discuss 'values,' 'values clarification,' and steps in attitude transformation.
3. Focus on interactive discussion in this session to complement exercises and activities.
4. Encourage participants to reflect on their values as service providers and to consider means of reducing D&A.

Content

Introduction to values clarification for D&A during childbirth

- Our values are a fundamental part of our lives and have an effect on our behaviour, both personally and professionally. Our choices and actions result from informed, reasoned thoughts and feelings influenced by our values (Navran, 2010).
- Values are closely related to and affected by our beliefs, ideals, and knowledge, and can affect our attitudes and behaviours.
- Values define that which is right versus wrong when deciding where to expend time and energy.
- Values are generally persistent and assume a pattern in our lives.

What is values clarification?

'Values clarification' is the process of assessing the effect of personal values on decision making. It determines the outcome of an action. In other words, someone's personality can be determined by examining what he or she does (International Encyclopedia of Unified Science). Given the central role of values in our lives, it is important to understand how values form and how they affect our decision making and behaviour. "Valuing occurs when the head and heart ... unite in the direction of action" (Dewey et al., 2008) .

Attitudes and beliefs

An *attitude* is a favorable or unfavorable evaluation or view of a person, place, thing, or event. A *belief* is a thought that is held and deeply trusted. Beliefs tend to be buried deep within the subconscious and trigger automatic reactions and behaviours. We seldom question beliefs, but hold them as truths (Fishbein and Raven, 1962).

- Our beliefs shape our attitudes—how we think about and act towards particular people and ideas. They are so ingrained that we may be unaware of them until confronted with a situation that challenges them.
- Everyone has a right to her or his own beliefs. However, healthcare providers have a professional obligation to provide care in a respectful and nonjudgmental manner. Awareness of personal beliefs and their effect on others—both positively and negatively—can help.

The values, attitudes, and beliefs of healthcare workers often intersect with accepted norms in hospital culture. This can also clash with the application of evidence-based patient care practices. Recognition of this intersection of value systems is crucial for improvements in care. The influence of organisational culture on the quality of maternity care and on RMC has been demonstrated in the literature and is commonly accepted..

Important factors affecting practice in a health unit include

- Time pressures
- Procedural imperatives
- Professional conflicts

The following short exercise is a simple one for personal reflection or discussion.

Hospital culture or personal value statements

- “The behaviour was bad but it wasn’t as bad as it could be.”
- “It could be worse.”
- “Other patients have had it worse.”
- “Too much work with too few people, so why try?”
- “It won’t change anything anyway.”
- “We have always done it this way.”
- “I am the expert, not the patient.”
- “I had to suffer/endure/put up with it; now it’s their turn.”
- “At least they aren’t/the baby isn’t ...”
- “People support one another in this facility.”
- “We work as a team.”

Childbirth brings up many private, emotional, and sensitive issues in Nigeria. The table below outlines some that are generally considered sensitive, and that should be approached with an underlying awareness of one’s own values, beliefs, and attitudes.

- Hidden contraception use/family planning
- Gravida and parity: it is normative to provide an inaccurate number of pregnancies due to concern about perceived threat to current pregnancy
- Partner or family history—i.e., polygamy issues with sexually transmitted infections
- Male providers
- Abortions, either spontaneous or therapeutic
- Maternal age
- Highly active antiretroviral therapy/HIV status
- Child marriages, especially a married girl child
- Female genital cutting

Our communication of our beliefs and attitudes (both verbal and non-verbal) is an important aspect of client interactions. Every interaction between healthcare providers and a pregnant woman and her family has a potential impact on

- Choice of facility-based childbirth or future fertility intentions
- Willingness to trust and share personal information and concerns
- Ability to listen to and retain important information
- Capacity to make decisions that accurately reflect the woman’s situation, needs, and concerns
- Commitment to adopt new health-related behaviours
- Future health-seeking behaviour

Nigerian communication techniques that may be considered 'good' or 'acceptable'	Nigerian communication techniques that may be considered 'bad' or disrespectful
Greeting with respect Respect for age in titles of address Taking time to establish a rapport Greeting with 'madam,' 'my friend,' 'Mama Na,' etc. Smiling and nodding frequently	Raised eyebrows Gesticulating Pointing finger at someone Failing to use official titles or forms of address

BRAINSTORMING: How do you react when someone inadvertently disrespects your personal values? When a patient is suspected of not telling the truth? How does this affect your values? How does it affect your attitudes?

Process of values clarification

1. **Choosing:** A value must be chosen freely from among alternatives, with an understanding of both positive and negative consequences of that choice.
2. **Prizing:** A chosen value must be associated with some level of satisfaction and affirmation, as well as confidence in the value.
3. **Acting:** A freely chosen, affirmed value must translate into action. Ideally, the action will lead to some positive outcome and be done repeatedly.

Knowing Nigeria: Culturally aware RMC tribal considerations

Consider what is acceptable for you or your tribe. What about for the woman in your care? What may cause inadvertent offense? What should you know more about to provide culturally relevant care?

- a. Greeting
- b. Forms of address
- c. Customs
- d. Physical space issues
- e. Consider labour, as well as antenatal and postpartum goals
- f. Breastfeeding
- g. Food
- h. Dress

Learning Objectives of VCAT Activities

By the end of the session, participants will be able to

1. Understand how D&A in childbirth affects peoples' diverse views
2. Identify and examine the role of external influences—such as family and social norms, religious beliefs, and age or life stage—on the formation of values about midwifery and facility-based childbirth
3. Explain how their values have changed over time, in response to new knowledge and experiences
4. Articulate any conflicts between the social norms to which they were raised, trained, or oriented, and their current values; how are values conflicts resolved?

Activity 1: Crossing the Line Exercise (Exhale, 2005)

Timeline: 40 Minutes

Facilitator Preparation

If possible, clear a large area of the room to allow participants to move around, and place the line in the middle of this area using masking tape. If not possible, use the room itself as the 'line,' asking participants to cross to one side or another as needed.

Review the statements below, and adapt them if needed. Read those statements, selected in advance, that best apply to the participants. The ending statement should be one that all participants can identify with, such as the last one in the handout below.

Instructions

1. Ask all participants to stand on one side of the line or room.
2. Explain that you will read a series of statements. Participants should step entirely across the line when a statement applies to their beliefs or experiences.
3. Remind participants that there is no 'in between,' so they must stand on one side of the line or the other. There are no right or wrong answers.
4. Ask participants to refrain from speaking during the exercise unless they need clarification or do not understand the statement that is read.
5. Stand at one end of the line and give an easy practice statement, such as "*Cross the line if you had fruit for breakfast this morning.*"
6. Once some people have crossed the line, give participants an opportunity to observe who crossed and who did not. Invite participants to notice how it feels to be where they are.
7. Ask someone who crossed the line to briefly explain their response to the statement. Then ask the same of someone who stayed put. If only one person did or did not cross the line, ask them how it feels.
8. Invite all participants move back to one side of the line.
9. Repeat these steps for several statements about respectful maternity care. Select the statements that best apply to the participants.
10. After the statements are read, ask participants to take their seats. Discuss the experience. Discussion questions may include
11. How did you feel about the activity?
12. What did you learn about your own and others' views on respectful maternity care?
13. Were there times when you felt tempted to move with the majority of the group?
14. Did you move or not? How did that feel?
15. What did you learn from this activity?
16. What does this activity teach us about the stigma surrounding respectful maternity care?
17. How might normalisation of D&A affect women's emotional experience and health-seeking behaviour with future childbirth? How would it affect their family members?

18. How might normalisation of D&A impact the experience of health workers and providers in promoting respectful maternity care?
19. Debrief on the last statement in particular. If everyone in the group crossed the line, discuss this commonality. If some remained, discuss how different views affect people's work on respectful maternity care and the broader issues of skilled birth attendance.
20. Solicit and discuss any outstanding questions, comments, or concerns from participants. Briefly discuss how our beliefs are transferred to clients as a normalcy. Also stress how double standards can affect practice and attitude. How can we start to value our weaknesses and work towards improving service delivery? Keep in mind that the exercise can create disagreement, especially if participants feel they were justified in saving the mother and/or the baby, and did their best in the circumstances.

Crossing the Line Statements

Cross the line if

- At some point in your professional life, you witnessed or heard a mother in labour being shouted or jeered at by a colleague
- You have ever witnessed an event and evaluated the degree of disrespectful behaviour—for example, “This is not good, but it is not as bad as ...”
- You have been asked to keep a secret about a colleague you witnessed pinching or slapping a mother in a labour ward
- You have ever heard a colleague or family member speak in a derogatory manner about a woman's actions during childbirth—e.g., crying, screaming, etc.
- At some point in your life, you shouted to help a woman in labour
- You were ever told to cover up a report of abuse by a colleague or the in-charge of the unit
- You have ever stifled (subdued) your feelings about a mother screaming while in labour
- You ever avoided the issue of childbirth abuse at your workplace to keep safe or avoid conflict
- You believe all women deserve access to safe, high-quality maternal healthcare

Activity 2: Lifesaving Choices

Time: 45 Minutes

Facilitator Instructions

This session will help participants address underlying attitudes, values, and assumptions that affect childbirth choices. Please read the scenario and ask participants to quietly deliberate in small groups for 10 minutes to choose whose life to save. Each group will then present its findings to the larger group. Allow ample time for disclosure and discussion. Participants may choose not to participate.

Scenario: You have supplies/staff to admit only two patients, all of whom are halfway through their labour process (or 5 centimeters dilatation). The others will need to transfer to a facility two hours away via personal transport. Here is the list of women. Which patients will you choose?

1. Petty trader; 26 years old; third child; second wife; HIV-positive; Fulani
2. Wife of the imam; 44 years old; mother of six
3. Jehovah's witness; 22 years old; history of severe post-partum hemorrhage and anemia; Yoruba

4. Physician; 30 years old; first baby; Igbo
5. Primary school-educated; 15 years old; pregnant with second child; Hausa

You will have 10 minutes to decide. Which patients will you eliminate? Why?

Content

The family and social groups in which we grew up often play an important role in shaping the core values that inform our beliefs. Social groups may include immediate and extended family; racial, ethnic, or cultural group; heritage; and socioeconomic group. These external influences may often play subconscious roles and operate in the background of our beliefs and interactions. At different points in our lives, and for different reasons, we may challenge these beliefs and underlying values. We can respond to new knowledge and practice by reflecting on the source of our core values, how they influence our present beliefs about midwifery or childbirth, and how they have changed over time.

Behaviour transformation

Behaviour transformation is a self-directed process that starts with

- Aspiring to achieve the desired behaviour as a result of self-reflection
- Understanding what the change means in your life, including life purpose and goals
- Taking personal responsibility (and the ability to take personal, social, and professional responsibility)
- Self-behaviour coaching through affirmation—words charged with power, conviction, and faith and repeated several times a day or while undertaking a task or procedure

A Note on Psychological Debriefing

Conducting psychological debriefing sessions for providers

Caring for providers or providing psychological debriefing sessions is an approach that enables groups and individuals to deal with work-related stress. Providers are exposed to traumatic events that create sadness, overwhelm coping skills, and may result in poor behaviour. Psychological debriefing occurs when a group of providers meets to discuss experiences, impressions, and thoughts related to an event, to prevent adverse reactions and reduce unnecessary psychological after-effects.

Why psychological debriefing?

- Mobilise resources within and outside the group to increase solidarity, group support, and cohesion.
- Decrease the sense of uniqueness or abnormality of reactions to increase normalcy.
- Promote cognitive organisation through clear understanding of both events and reactions.
- Promote an outlet for reactions and feelings.
- Prepare individuals for experiences related to trauma or critical incidents.
- Identify avenues for further assistance if required—e.g., medication, legal redress, or counseling.

All caregivers are at risk for psychological stress, based on the realities of the maternal health workplace in both low- and high-income settings. High patient volume, poor support, and leadership and structural challenges contribute to compassion fatigue, emotional fatigue, and burnout, all of which may drive D&A.

Knowing Nigeria—Brainstorming

Currently, there is no precedent in most of the Nigerian context for psychological debriefing. How can we implement this 'caring for caregivers' strategy as a component of routine support services for providers and staff in our respective work areas? Should we implement it?

SESSION 6: SERVICOM ACCOUNTABILITY FOR FACILITY-BASED CHILDBIRTH

“Do unto others, as you would have them do unto you.” ~ Proverb

Objectives

By the end of the session, participants should be able to

1. Define the service charter tool SERVICOM, created to ensure a rights-based approach to maternal healthcare
2. Discuss the four guiding principles and the basic structure of SERVICOM
3. Briefly discuss the core functions and responsibilities of the Federal Ministry of Health, state ministries of health, and local governments
4. Discuss the responsibilities of patients/clients and health providers in the service charter
5. Demonstrate knowledge of the application (or adaptation) of a human rights-based approach to service provision through SERVICOM to promote dignity in childbirth

Time: 1 Hour

Facilitator Instructions

- Ask participants to brainstorm the meanings of ‘mutual accountability’ and SERVICOM
- Ask participants to state examples of customers’ obligations. Discuss the roles and responsibilities of providers in the service charter.
- End the session with a question and answer session to summarise the topic.

Content

What is mutual accountability? Mutual accountability involves teams or parties being accountable and transparent in service delivery or business cooperation. It is critical in improving quality and achieving better results. The partners involved in health service delivery usually include governments, implementing partners, health managers, providers, clients, and the community (Mutual Accountability for Development Results¹).

What is a charter? A charter is a formal document that outlines standards, core functions, and organisational rules of conduct and governance. It grants certain rights, powers, and functions to an organisation, but also includes obligations to (and rights of) customers.

Do you recognise this symbol? What is it?



What is SERVICOM?

SERVICOM is an acronym for Service Compact with all Nigerians. It is a social contract between the Federal Government of Nigeria and its people.

In June 2003, former President Olusegun Obasanjo declared that Nigerians had felt shortchanged by the quality of their public services for too long. After subsequent review and input, SERVICOM was born.

What are the SERVICOM principles?

1. Affirmation of service to the Nigerian nation
2. Conviction that Nigeria can only realise its full potential if its citizens receive prompt and efficient services from the state
3. Consideration of the need (and the right) of all Nigerians to enjoy social and economic advancement
4. Dedication to delivering timely, fair, honest, effective, and transparent services, to which citizens are entitled

SERVICOM charters 101

1. Exists to outline day-to-day management and implementation
2. A SERVICOM unit is present in all ministries, departments, and agencies/units of government (MDAs/MDUs) throughout the federation
3. Each MDA is required to produce a SERVICOM charter
4. A national coordinator monitors the performance of MDAs/MDUs in the country
5. Regular evaluation and ratings of service delivery level are conducted to measure excellence
6. Sanctions and penalties may be given to MDAs/MDUs
7. The SERVICOM team of inspectors may pose as regular or unusual customers to provoke reactions and test your patience
8. Conducts spot checks on security gatemen and receptions for politeness/courtesy

The SERVICOM unit in an MDA is headed by a deputy director, who serves as the nodal officer and head of the unit. The nodal officer reports directly to the minister through the permanent secretary without any departmental mediation in the ministry. In the case of the extra-ministerial department or parastatal, the nodal officer is to report directly to the chief executive.

SERVICOM's golden rule is to "Serve others like you would want to be served."

The SERVICOM health service charter is a statement of intent to clients and customers, and defines the health ministry's core functions, services offered, commitments, and obligations, as well as the customer's rights and obligations and mechanisms for complaint and redress for dissatisfied customers. It is guided by the FMOH vision, mission, and mandate.

Core functions of the Federal Ministry of Health (or other equivalent body) may include (Ministry of Health Service Charter, 2007)

- Formulation and implementation of health and sanitation policies
- Provision and promotion of preventive, curative, and rehabilitative health services

- Quarantine administration for disease outbreak

State ministries of health and local government responsibilities and commitments

These entities are committed to achieving the following goals for service delivery to clients:

- Equitable distribution of health services
- Timely provision of healthcare services
- Provision of high-quality services
- Customers' right to information
- Courtesy and respect for, and nondiscrimination against, customers
- Privacy and confidentiality of a client's health information
- Avoidance of corrupt practices and preferential treatment of clients

All customers have the right to

- Optimum care by qualified health providers
- Accurate information
- Timely service
- Protection from harm or injury within a healthcare facility
- Privacy and confidentiality
- Courteous treatment
- Dignified treatment
- Continuity of care
- Have their personal opinion be heard
- Emergency treatment in any facility of choice
- Participate in the planning and management of their own healthcare services

Brainstorming/Discussion

What similarities do you notice between a customer's rights and the RMC charter/principles?

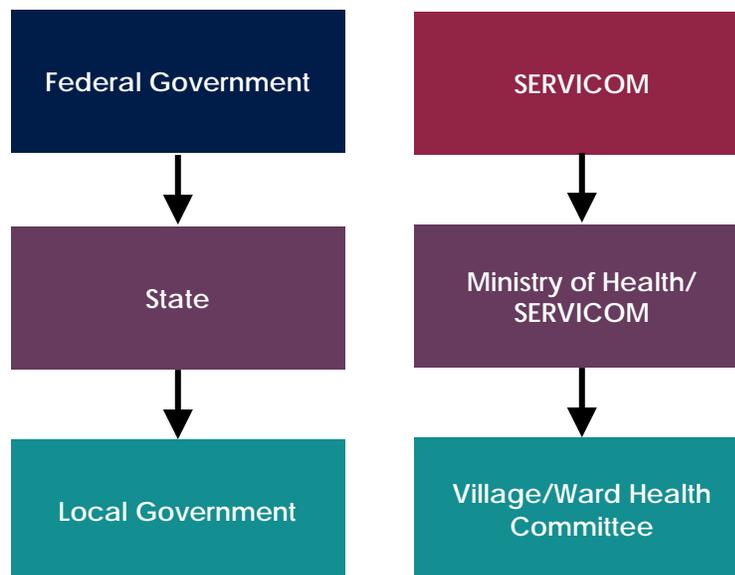
Customers' obligations

Obligations are things a patient must do for moral or legal reasons, for their own benefit or that of others in society.

- Engage in a healthy lifestyle.
- Seek treatment promptly.
- Seek information on illness and treatment.
- Comply with treatment and medical instructions.
- Be courteous and respectful to health providers.

- Help to combat corruption: report any corrupt practices and refrain from seeking preferential treatment.
- Inquire about the costs of treatment and/or rehabilitation and agree on the mode of payment.
- Care for health records in his or her possession
- Respect the rights of other patients and healthcare providers.
- Provide healthcare providers with relevant and accurate information for diagnosis, treatment, rehabilitation, or counseling purposes.
- Protect and conserve health facilities.
- Participate in the management of healthcare services.
- Foster partnership in service delivery.

Figure 6: SERVICOM Reporting Structure



SESSION 7: HEALTH FACILITY MANAGEMENT AND QUALITY IMPROVEMENT MECHANISMS

“If spider webs unite they can tie up an elephant.” ~ Proverb

Learning Objectives

By the end of this session, participants should be able to

1. Describe the term ‘continuous quality improvement’ (CQI)
2. Discuss CQI in relation to dignified maternity care
3. Determine the roles of CQI teams in promoting respectful and dignified care
4. Discuss ways to strengthen CQI in maternity units

Time: 1 Hour

Facilitator Instructions

- Begin the session by brainstorming definitions for ‘quality of care’ and ‘continuous improvement.’
- Discuss quality care initiatives and how they relate to respectful maternal care. Use the PowerPoint presentation to review the content.
- Ask participants to review their facility using the following questions: How could quality improvements teams include respectful care as an area of focus? How could community members’ views be incorporated into facility monitoring teams? Allow 10 minutes for discussion and report to plenary.
- Facilitator may use photos of facilities in the area to allow participants to assess current structures and make recommendations for quality improvements using the ‘3 R’s’ (review, rethink, revise the room). Facilitator should encourage participants to think of no-cost or low-cost options for improvements to care.
- End the session by summarising potential solutions for strengthening facility quality from participants’ responses, and explain that these could be included in the action plans that the participants will develop at the end of the workshop.

Content

Health facility management committees (HFMCs) or health facility management boards (HFMBs) may be established through national or state legislative frameworks, although few are currently operational in Nigeria. There is state- and federal-level interest in adding these boards to the management structure, although there are no policies or procedures to guide the composition or structure. As a new addition to the health systems management process, the development of these boards would be an ongoing process. It is theorised that community representatives on these bodies would represent community interests in the management of health facilities. Examples of effective community management and input are seen in certain primary healthcare facilities that have been built by and operated within the communities they serve.

Proposed role of the health management committees in promoting dignified and respectful care during childbirth

1. Advise the facility and the community on matters related to the promotion of respectful health services.
2. Represent and articulate community interests on matters pertaining to health in local development forums.
3. Facilitate a feedback process for the community pertaining to operations and management of the health facility.
4. Mobilise community resources towards the development of health services in the area.

Definition of continuous quality improvement: CQI includes efforts to make changes leading to better patient outcomes (health), better system performance (care), and better professional development, as well as addressing improved access to care (WHO, 2005).

Quality of care includes the following elements:

- **Availability:** functioning public health and healthcare facilities, goods, services, and programmes in sufficient quantity
- **Accessibility:** non-discrimination, physical accessibility, economic accessibility (affordability), and information accessibility
- **Acceptability:** respectful of medical ethics and culturally appropriate, sensitive to age and gender
- **Quality:** scientifically and medically effective

Healthcare services, including care during childbirth, must be available, accessible, acceptable, and of good quality (AAAQ). RMC is one of the components addressed by the (AAAQ) framework described above (Cottingham et al., 2010).

Activity 1: 3 A's and a Q

Timeline: 20 Minutes

Facilitator Preparation

This activity is intended to get participants to think about the interface between hospital culture and client care. Write 'quality,' 'available,' 'accessible,' and 'acceptable' on a flipchart or pieces of paper. Read each of the following statements aloud and have participants individually decide which category the statements fall into. Pick one or two statements and facilitate discussion among small groups of participants who made the same choice. Discuss reasons for decision making.

1. "People support one another in this unit."
2. "We have enough staff to handle the workload."
3. "When a lot of work needs to be done quickly, we work together as a team to get the work done."
4. "In this unit, people treat each other with respect."
5. "Staff in this unit work longer hours than is best for patient care."
6. "Staff feel like their mistakes are held against them."

7. “Mistakes have led to positive changes here.”
8. “It is just by chance that more serious mistakes don’t happen around here.”
9. “When an event is reported, it feels like the person is being written up, not the problem.”
10. “We work in ‘crisis mode,’ trying to do too much, too quickly.”
11. “Units in this facility work well together to provide the best care for patients.”
12. “Shift changes are problematic for patients in this facility.”

Introduction to CQI in childbirth:

In labour and childbirth, CQI includes woman-centred care, or healthcare that respects the values, culture, choices, and preferences of a woman and her family, within the context of promoting optimal health outcomes. Woman-centredness is designed to promote satisfaction with the maternity care experience and improve wellbeing for women, newborns, their families, and healthcare professionals. It is an essential component of healthcare quality improvement.

Woman-centred care

1. Accepts each woman’s knowledge and feelings regarding her personhood, and respects her ability to identify her own needs and those of her baby
2. Recognises the importance of ensuring optimal maternal and newborn health outcomes
3. Is ‘holistic’ in addressing the needs engendered by a woman’s physiology, psychology, ethnicity, socioeconomic circumstances, sexual orientation, culture, religion, and level of education
4. Recognises women as predominant caregivers and strives to support them in managing the challenges they face in accessing healthcare
5. Facilitates links to childbirth information and education, enabling women to ask questions and make informed choices about who provides care, where it is given, and what form it takes
6. Recognises women’s rights to self-determination in terms of choice of caregiver and birth support, including decisions about the role that family members or significant others will play during pregnancy, labour, birth, and postnatal periods
7. Offers continuity of care so women are able to form trusting relationships with those who support them, and promotes collaboration with care providers to ensure smooth transitions from one level of care to another
8. Focuses on women’s unique needs, expectations, and aspirations, rather than the needs of institutions or professions involved
9. Ensures women are equal partners in the planning and delivery of maternity care

At the end of this section, please ask each participant to grade his or her work area/unit on patient D&A.

Grading: Excellent/ Very good/ Acceptable/ Poor/ Failing

** Facilitation note: Dependent on group composition, cohesion, and time constraints, discussion may be facilitated to disclose why the assigned grades were given. **

Write a maternal or childbirth quality improvement goal for your facility: A goal should be SMART (see below) and consider what you want to accomplish.

Short

Measurable

Achievable

Realistic

Time-measured

The roles of CQI in promoting respectful and dignified care during facility-based childbirth

Monitoring teams can gather data and information on provider and client perspectives of RMC, using such tools as the following:

- a. **Maternity care provider discussion guide (Appendix):** A guide for soliciting providers' perspectives on caring behaviours and the feasibility of performing them. The quality improvement team will track progress on individual and facility work plans to promote a good working environment that enhances caring behaviours.
- b. **Maternity client exit interview guide (Appendix):** An interview guide for exploring clients' perspectives on provider caring behaviours and recent birth experiences.

If facility resources are limited, consider the '3 R's' for providing RMC: reorder, rethink, revise the room.

How can we re-evaluate and use differently the space that we have in order to provide RMC? What items in the space are no longer needed or not useful?

SESSION 8: MEDIATION

“Home affairs are not talked about on the public square.” ~ African proverb

Objective

By the end of the session, participants should be able to

1. Describe and discuss examples of community-level mediation, conciliation, arbitration, and negotiation, as well as community-level alternative dispute resolution (ADR) mechanisms available in the local context
2. Describe and discuss the healthcare facility as a community with specific needs for mediation amongst providers
3. Define the characteristics and role of a mediator
4. Explain the ADR or mediation process
5. Discuss advantages and disadvantages of ADR mechanisms

Time: 1 Hour, 30 Minutes

Facilitator Instructions

- Introduce the session by asking participants to define ‘mediator’ and ‘mediation.’
- Allow participants to share their experiences of situations where mediation has been used.
- Use an interactive lecture to discuss the role of mediation and the stages of the process.
- Utilise group discussion sections to facilitate workable solutions for dealing with provider-related conflict surrounding D&A.
- End the session by restating that ADR offers guidance and a mechanism to resolve incidents of D&A within the healthcare setting. It compliments other tools used to demand accountability among health workers.

Content

Definition of alternative dispute resolution mechanism: ADR is the use of traditional or community justice systems in resolving conflict between parties. This system of dispute resolution is rooted deeply in Nigerian society and tradition. The normalisation of mediation processes began to shift with the urbanisation of the population; prior to this, mediation was seen as a way to maintain cultural norms (Rhodes-Vivour, n.d.). ADR has been found effective in resolving conflict resulting from D&A.

Definition of mediation: Mediation is a process whereby an independent and impartial third party facilitates negotiation between disputing parties. Any decisions about the resolution are made by the parties themselves, with facilitation from the mediator.

Definition of a Mediator, and the Mediator’s Role: A mediator is a convener, an educator, a guardian of the mediation process, and an independent and impartial intervener. A mediator’s role is often based on authority and a respected role in the community.

Mediator's role

- Conflict assessor: understand as much of the conflict as possible
- Impartial convener: maintain neutral involvement in facilitating the negotiation
- Communications officer: enhance communication between the disputing parties
- Resource expander: assist parties with information needed to make informed decisions

Mediation process in promoting respectful and dignified care during childbirth

1. The mother and her partner or relatives may feel that some of the events occurring around the labour and delivery process are not well handled.

Example: Explanations and informed consent were not given before procedures, especially in emergencies such as post-partum hemorrhage.

2. Providers may have differing viewpoints about what constitutes provision of RMC, and disputes may arise in the unit.

Example: A birth companion at bedside when other patients are present, or a provider who intervenes/speaks up against a colleague violating one of the RMC standards

Incidents of D&A should be discussed and the responsible parties held accountable to resolve the issue and prevent it from happening again. The mediation process is voluntary and may be terminated at any time by any party or the mediator.

The advantages of mediation for patients, relatives, and providers include the following:

- Faster than a court process
- Less confrontational or adversarial ('face-saving')
- Encourages creative solutions
- Improves communication between parties
- Less costly and less formal
- Flexible

Knowing Nigeria

The Citizens Mediation Centre, a legal entity serving the mediation needs of the indigent, was established in Lagos in 1999. The centre provides free alternative dispute resolution. The Multi-Door Courthouse is located in the High Court in Abuja, Kano, and Lagos. The court system feels mediation is a worthwhile option for resolving disputes in Nigeria.

Mediation can incorporate the following stages:

Stage one: Introduction

- Introduction of mediator and parties
- Disclosure of mediator's qualifications
- Establish and maintain trust and confidence
- Explanation of the mediation process and ground rules
- Disclaimer of bias and neutrality of mediator

Stage two: Presentation by the parties

- Parties provide their perspectives on the dispute without interruption
 - Parties have the opportunity to vent or express anger and/or other emotions
 - Helps mediator understand the parties' motivations and interests
 - Helps mediator identify obstacles to resolutions
 - Opportunity for parties to hear each other's perspectives directly
- The mediator is an active listener and asks questions for clarification

Stage three: Determining interests

- Mediator summarises, clarifies, and confirms the interests of the parties, as well as his/her understanding of the dispute
- At this point, the mediator may encourage parties to address each other directly, ask and answer questions, clarify misunderstandings, and offer acknowledgments

Stage four: Identifying issues

- Mediator asks disputants to develop a list of issues
 - Objective is to help disputants focus on specific items that must be resolved
 - All issues needing resolution must be identified
- Mediator frames issues in a manner that promotes problem-solving
 - Use of neutral language

Stage five: Brainstorming options

- Mediator encourages disputants to brainstorm both familiar and creative options
- Explore and discuss pros and cons for each option
- Mediator instructs disputants to focus on the problems, not on each other or the past
- Mediator facilitates negotiation between parties
- Mediator helps parties pick realistic and viable options for resolution
- Hopefully, the mediation will result in agreement
- If no agreement, mediator acknowledges progress and explores alternative solutions

Disadvantages and Challenges of Mediation

Disadvantages

- Non-binding unless parties consent
- Potential for endless proceedings
- Need for goodwill
- Unsuitable where there is inequality of bargaining power (e.g., a manager and supervisee)

Challenges of mediation

- Lack of trust among participants and poor communication
- Meeting of parties may be difficult or uncomfortable

Application of mediation in disrespect and abuse during childbirth

Once a case is identified through a complaint and the parties choose to resolve it through mediation, mediators should verify facts from both reports and the parties' accounts.

Mediators may include

- The in-charge official at a facility, members of a facility management team, or CQI committee members
- Society or community leaders
- Representatives of professional associations or bodies
- Hospital management teams

Words of Wisdom from a History of Nigerian Mediation

"The elder is always right; the younger has no alternative but to accept the words of the elder."

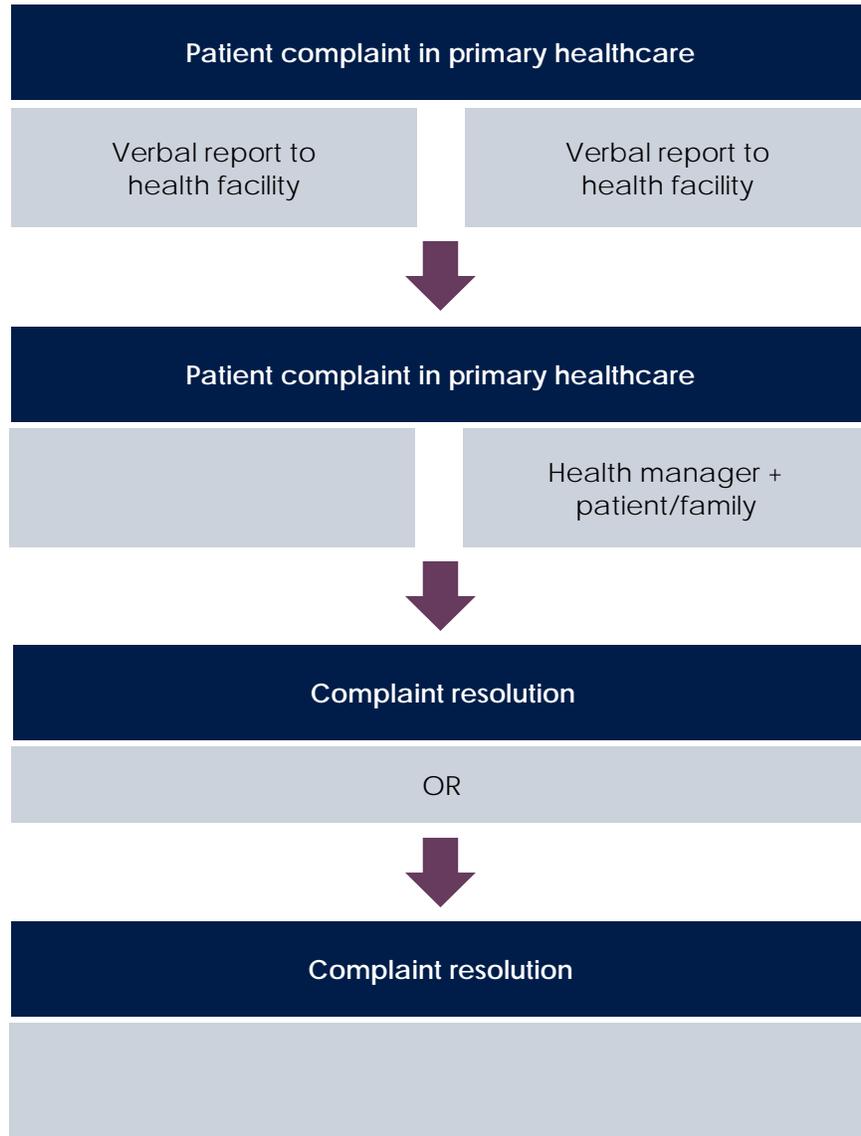
Group Discussion

How does the power dynamic illustrated in this quotation affect the mediation process in Nigeria?

How does the dynamic between senior and junior medical staff affect resolution of D&A cases? What about the relationships between nurses or midwives and physicians?

The figure below illustrates a 'normal' community-based reporting mechanism for incidents at the primary healthcare level.

Figure 7: Community-based mechanisms for reporting complaints



Group discussion questions

Does a similar pattern exist in our facility? What positive and/or negative traits are associated with this reporting mechanism for mediation?

When reflecting on your facility, how do you feel you could incorporate mediation within a healthcare setting? What about at the federal or state levels?

Optional Role Play 1: The Mediation Process for Resolving an Incidence of Physical Abuse

Directions

Three participants should represent a skilled provider, a woman, and a mediator for this role play. They should take a few minutes to prepare by reading the background information provided below. The observers in the group should do the same reading so they can participate in the small group discussion following the role play. The purpose of the exercise is to provide an opportunity for participants to appreciate the role of mediation and the mediation process as an alternative dispute resolution mechanism for dealing with D&A and promoting accountability in reproductive rights.

Participant roles

Provider: The provider is a midwife at the local health centre who is accused of slapping a woman during facility-based childbirth.

Madame Ogun: Madame Ogun, 21 years old, is a *primigravida* (first-time mother) who gave birth at KaKoi hospital two months ago. She is accompanied by her husband, a sister, and her mother-in-law to seek redress for being slapped during the birth of her baby in the health facility.

The mediator: The mediator is a 50-year-old respected elder.

Situation

During the second stage of her labour, Madame Ogun was asked to bear down but was uncooperative and the provider (midwife) slapped her. Madame Ogun thinks her childbirth was mishandled and reported the incident to the unit in-charge, but the facility in-charge advised her to just forget about the issue. Madame Ogun was not satisfied with this response and knew of her right to seek redress. She sought help from the community legal aid to resolve the incident. The legal aid advised Madame Ogun to use an alternative dispute resolution mechanism (mediation) and assisted her in informing the facility management of her desire to seek redress. The facility management verified the facts of the incident and informed the provider of Madame Ogun's wishes. The provider agreed to use mediator and the date for mediation was set. The provider, Madame Ogun, and her relatives were present.

Focus of the role play

The focus is the interaction between the midwife, Madame Ogun, her relatives, and the mediator. The mediator should observe all stages (refer to the alternative dispute resolution protocol job aid) to perform the session.

The facilitator should use the following questions to stimulate discussion after the role play:

1. How did the mediator approach Madame Ogun, her relatives, and the provider?
2. Did the mediator provide the parties enough information about his or her role, the mediation process, maintaining confidentiality, and their rights to be heard equally?
3. How did the provider and Madame Ogun respond to the mediator?
4. How did the mediator demonstrate his or her objectivity, non-coercion, and control of discussions between Madame Ogun and the provider? How about during the interactions with Madame Ogun's relatives?
5. Were the mediator's explanations and communications effective in resolving the incident?

SESSION 9: THE COMMUNITY'S ROLE IN PROMOTING RESPECTFUL FACILITY-BASED CHILDBIRTH

By the end of the session, participants should be able to

1. Outline community members' roles in promoting RMC
2. Demonstrate techniques for strengthening community-facility links, as well as methods for dealing with D&A at the community level
3. Discuss the role of individual members of the facility community or the community at large in promoting RMC
4. Discuss family open days as an approach for improving mutual understanding, accountability, and respect among community members and service providers

Facilitator Instructions

- Introduce the session by asking participants to brainstorm their role as members of the facility community and the community at large in promoting RMC
- Discuss family open days and the use of birthing companions as interventions to promote mutual accountability between providers, health managers, and community members

Audio-visual

WHO Reproductive Health Library: "Labour companionship: Every woman's choice"

Recommended use: start at six minutes, 26 seconds (6:26), to 14 minutes, 30 seconds (14:30); use to discuss community engagement processes

Film guide discussion questions: What do you think? How could this work in your facility or the facility in your community?

Session Content

The community's role in promoting respectful maternity care

Community members play a role in promoting RMC, including identification of barriers that prevent women from receiving respectful care during childbirth in health facilities. Barriers include

- Inadequate knowledge of labour and delivery procedures
- Failure of providers and facilities to fulfil their obligations and respect patients' rights
- Cultural beliefs and practices
- Myths and misconceptions
- Financial barriers (encourage birth planning and a complication readiness plan)

Community members should

- Recognise their right to quality care during childbirth in health facilities and proactively pursue information and education on good health practices, including childbirth
- Respectfully demand good customer care during all services provided in health facilities, including childbirth

- Encourage women who have experienced D&A during childbirth to speak out and seek redress through mediation, counseling, or other available avenues
- Offer psychosocial support to women and their birth partners or families who experienced D&A during childbirth
- Establish and/or strengthen a clear linkage between the community and facilities to address D&A
- Mobilise community resources (financial, material, and human) to support initiatives promoting respectful and dignified childbirth

Knowing Nigeria—Brainstorming

Large or small group discussion

Healthcare workers belong to both their external communities and those within healthcare facilities. How does the community and culture of the healthcare facility impact provision of RMC? How can we strengthen accountability links between community and facility for RMC?

Community-level structures for dealing with D&A

Community members should be aware of structures that exist to help them claim their rights and report incidents of D&A. These include

- **Community Health Extension Workers:** Volunteers trained to offer basic healthcare and refer community members to formal healthcare services as appropriate
- **Health managers:** In charge of health facilities
- **Ward development committees/community development associations:** Include community members who represent community interests and have authority to hold facilities accountable for high-quality health services.
- **Local administration, women's groups, and faith-based organisations:** Chiefs and village and society leaders charged with linking their communities to other formal governments in dealing with social issues, including health and community welfare

The community's role in promoting RMC becomes more challenging when women are referred upwards through the system, from primary healthcare centres to the district level, and higher to tertiary care centres. These levels of care operate under different mechanisms of facility control, from local governments to the FMOH; this impacts the community's ability to remain engaged with accountability mechanisms.

Family Open Days: A System of Mutual Accountability

Why family open days?

Family open days provide an opportunity for pregnant women and their families to interact with healthcare providers and visit the facility to dispel any fears they or their families may have about facility-based childbirth.

Family open days aim to

5. Promote mutual understanding, accountability, and respect among community members and service providers
6. Improve knowledge and demystify procedures during labour, childbirth, and the immediate postnatal period
7. Encourage facility-based childbirth and the involvement of males and/or birth companions during pregnancy, labour, and delivery
8. Provide reminders about birth and complication readiness plans, including early financial planning for emergencies such as mothers' savings and loans programmes
9. Potentially provide services or education for curative or preventive health services that may be integrated into the day's activities—e.g., minor treatment of childhood illnesses, immunisations, family planning education, or screening for cancer of the cervix to form a complete community-outreach package

How to hold a family open day

- Agree on a date with health facility managers and community leaders, or institute a standard day for open visitation (for example, every 15th day of the month).
- Send invitations through existing community information systems, including social mobilisers, town hall meetings, radio, and faith-based organisations.
- Post information at the health facility or discuss at ANC educational visits.
- Before the facility visit, explain about care and procedures during labour, delivery, and postpartum, including the layout of the maternity unit. Allow for discussion to dispel any misconceptions or rumors.
- Arrange for community members to tour the facility, avoiding congestion.

Note: you must maintain privacy and confidentiality for women in the maternity unit and avoid disrupting care.

- After the tour, health providers and RMC champions can engage community members with a question and answer session. Suggested topics include
 - Were expectations met during the tour?
 - Clarification of any other information
 - Ask community members for recommendations—i.e., what contributions can they make towards improving the maternity unit, for both providers and clients?

Family open days may also foster community engagement, as tours do not have to be led by a health worker. A community member may be trained to lead tours and to refer medical questions back to health workers. This may also increase the sustainability of open days and provide a workable solution to staff shortages, which impact feasibility of holding these events.

Group discussion activity on family/maternity open days

Given challenges related to staffing shortages and high patient flow, how do we encourage a flexible approach to family/maternity open days? What happens when only one nurse is on duty, or we are in a place where deliveries are guided by CHEWs?

SESSION 10: MONITORING AND DATA MANAGEMENT

Objectives

By the end of the session, participants should be able to

- Discuss the purpose of record-keeping and reports
- Describe management issues relevant to record-keeping.
- Demonstrate the ability to complete and maintain records related to RMC
- Discuss criteria for gauging the provision of RMC services
- Briefly discuss monitoring and evaluation (M&E) for RMC

Time: 45 Minutes

Facilitator Instructions

- Introduce the session by asking participants to define the terms ‘data’ and ‘monitoring.’
- Allow participants five minutes to discuss various monitoring tools for maternal and child health, including personal health records, partographs, and antenatal files.
- Clarify for participants the tools used in reporting.

Group Activity

Introduce the monitoring tools for each level of service

Place participants in groups according to the level of service—e.g., health managers, facility or ward in-charges, facility staff, and community members.

Explain that each group will review the monitoring tools and discuss the following:

- Using the tool: why, how, who, and when
- Recording the source: register minutes, exit interviews, suggestion boxes, etc.
- Ensuring and using high-quality data
- Reporting: frequency, and to whom
- Mode of reporting and feedback: hand delivery, email, phone
- Use of data to ensure dignified childbirth

Definitions

Record-keeping: Recording and retention of information to facilitate future planning and reference.

Reports: Filling out and compiling specific information/data for use at certain levels of planning.

Importance of record-keeping and reporting in promoting respectful and dignified care

- A key planning tool in care at the ward/health facility level
- Information collected and kept for decision making in management and supervision activities
- Accurate, clear, complete, and relevant information for client records

- Commonly used records and forms based on use reviewed regularly

M&E criteria for gauging respectful and dignified care

Includes the following:

Facility-controlled factors

- Appropriate information, education, and communications (IEC) materials, including RMC client brochures and a service charter on clients' rights displayed or made available
- Provision of privacy (both audio and visual): Rooms, curtains/screens, doors, and labels indicating procedures
- Availability of minimum supplies for basic care
- Support for ongoing education of healthcare providers in evidence-based practices

Client-controlled factors

- Clients and families engaged in care and expecting accountability from healthcare providers
- Client ownership of birth experiences: i.e., stating labour and birth preferences
- No reported physical abuse
- No reports of any form of discrimination
- No reported non-consented care
- No reported use of inappropriate language
- Clients report maintenance of privacy and confidentiality of information during their care
- Clients/families feel empowered to report negligent care from providers

Provider-controlled factors

- Commitment to lifelong learning for current evidence-based practices
- Appropriate use of tools for antenatal care and labour monitoring
- Appropriate documentation throughout antenatal care (antenatal file), labour (partogram), and postpartum (narrative notes)
- Chart audits

Partograph use as RMC monitoring tool

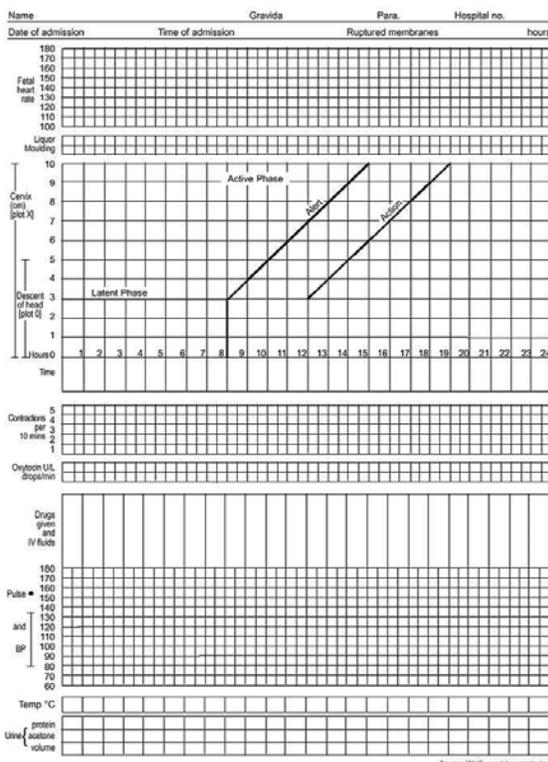
In accordance with WHO guidelines and international best practice standards, the FMOH and state ministries of health support the use of the partograph. The partograph was designed for use in labour monitoring to identify and intervene early during problematic labours. Its use has been well-documented and it is considered both easy to use and time- and life-saving.

Partograph evaluation shows several ways that it can be used to monitor uptake of RMC standards of care.

RMC Standard	Partograph Monitoring of RMC Standard
The woman is protected from physical harm or ill treatment	Were vital signs and fetal heart tones taken and recorded? Was the contraction pattern assessed? Were these done according to stage of labour?
The woman's right to information, informed consent, and choice is protected	Did the woman consent to vaginal exams?
Confidentiality/privacy	Is the woman's file kept in a secure place? Is information shared only with providers who directly care for the client?
The woman is treated with dignity and respect	Is the woman allowed to move about in labour? Can she assume her birth position of choice?
The woman receives equitable care, free of discrimination	Were fluids provided during labour? Was the woman's obstetrical history recorded?
The woman is never left without care	Were evaluations completed in a timely fashion, in accordance with standards of care?

The use of the partograph as an RMC tool may particularly interest overburdened providers and settings experiencing staff shortages, especially those that do not want to adopt another monitoring tool. When assessing RMC standards, additional information can be obtained from other sources of patient information, such as narrative notes.

ANNEX 2: Partograph



RMC spot check
 Analyzing the partograph: which sections are specific to RMC practice?

Brainstorming/discussion activity

How can you make RMC monitoring a part of everyday routines in your facility?

Other means of verification and data monitoring for RMC

- Client exit interviews
- Supervision reports (internal or external)
- Periodic surveys of clients and staff
- Bi-monthly or quarterly data reports that may include facility and community monitoring

SESSION 11: CLINICAL EXPERIENCE

“Wealth diminishes with usage; learning increases with use.” ~ Nigerian proverb

Learning Objectives

By the end of the session, participants will be able to

1. Discuss the evidence in support of clinical practice RMC, including episiotomy, food and fluids in labour, and positioning during labour/birth
2. Identify acts of inclusion or negligence that result in D&A, or identify acts of inclusion that promote RMC, as they observe the seven categories of D&A
3. Identify any conditions that could be dehumanising for clients and relatives
4. Participate in debriefing session

Time: 4–6 Hours

Facilitator’s Instructions to Participants

- Briefly introduce RMC-related controversies in obstetric care, allowing room for discussion and demonstration of techniques.
- Please allow adequate time for facility introductions.
- Each group should carry a copy of the introduction/permission letter.
- The clinical objectives and checklist will be discussed in the session, prior to deployment to clinical site (may be done the day before visit).
- *** In order to fully engage, participants in the RMC clinical observation workshop are asked to refrain from intervening in procedures unless the observed client is in danger. Please be mindful of your status as guests present with the permission of the client and the provider.*
- After the visit, allow groups time to discuss, analyse, and debrief on the clinical experience.
- Use the groups’ findings to reinforce observed positive behaviours.
- For any observed acts that resulted in D&A, discuss how these can be overcome.
- Allow participants to reflect on their experience and personal practice to identify areas that require strengthening to promote RMC.
- End the session by asking participants to share their ideas for strengthening the areas identified.

Clinical Overview: Evidence-based Practice and RMC

Implementation of RMC challenges practice in such a way that impacts the entire maternal health system in Nigeria and throughout much of sub-Saharan Africa.

Several routine clinical care issues are called into question during the implementation of RMC standards. The following specific WRA charter items are particularly affected:

2. Information, informed consent, and refusal and respect for a woman’s choices, including companionship: *Informed decisions (Nigeria charter)*
5. Equal freedom from discrimination and equitable care: *Standard care (Nigeria charter)*

6. Healthcare provision to facilitate the highest attainable level of health: *Quality maternal healthcare is a right and not a privilege (Nigeria charter)*
7. Liberty, autonomy, self-determination, and freedom from coercion

Point of reflection

Maternal health evidence-based practice, or obstetrical tradition with impact on provision of RMC information, equity, and freedom of choice?

- Routine episiotomy (especially in primiparous clients)
- Restriction of food and fluids in labour
- Positioning in labour

Episiotomy

A Cochrane review in 2012 found that the use of restrictive episiotomy is highly beneficial compared to routine episiotomy (Cochrane Database of Systemic Reviews, 2010). In eight trials with over 5,000 participants, women were found to have fewer complications or severe vaginal or perineal trauma. Supportive techniques to slow down the delivery of the birth of the head allow the perineum to stretch slowly and reduce perineal trauma. Primary (FIGO Safe Motherhood and Newborn Health (SMNH) Committee, 2012) indications for episiotomy include

1. Suspected macrosomia based on current and past obstetrical history
2. Breech presentation
3. Decreased length of second stage of labour, if fetal distress (defined by auscultation of fetal heart tones) is present

Food and fluids in labour

There is a great deal of concern within the medical community regarding the allowance of food and fluids in labour. Reasons stated in opposition include

1. Concern that traditional medicines might be introduced into the birth process and health facility
2. Concern that the woman might require operative delivery

Another Cochrane study highlighted the historical context of food and fluid restrictions, based upon general anesthesia work in the 1940s that found an increased risk of stomach contents entering the lungs. Since then, however, obstetrical anesthesia has changed considerably, with better general anesthetic techniques and greater use of regional anesthesia. These advances, along with reports by women that restrictions were unpleasant, have prompted research to reexamine these restrictions. In addition, poor nutritional balance may be associated with longer and more painful labour, and fasting does not guarantee an empty stomach or less acidity.

Positioning in labour and delivery

Restrictions on labour and delivery positioning have contributed to reluctance among women to attend a facility for skilled birth attendance. This is supported by a baseline study conducted in Nigeria that found that women prefer to give birth while kneeling or in the squatting position; this is generally not allowed by providers in health facilities. There is no Nigerian federal, state, or local policy or procedure that disallows this practice, so it is more attributable to discomfort on the part of the provider.

A 25-year-old tailor said, “The lithotomy position favored in health facilities is an inconvenient position for me and I have had 5 children, all born kneeling down at home, and I have never had course to regret the kneeling position whenever I put to bed.”

Another Cochrane study on labour positioning found that women who gave birth on their backs were more likely to require both assisted delivery and surgical opening of the birth outlet (Cochrane Database of Systemic Reviews, 2012). The supine position also reduces utero-placental blood flow and can contribute to fetal distress.

Historical artifacts and information, both from around the world and in the Nigerian tradition, support upright positions for labour and delivery. However, most providers are uncomfortable with positions outside of lithotomy.

Large or small group discussion/reflection questions

- Is RMC human rights-based or evidence-based? Or, are the two inseparable?
- What choices do we offer women in labour?
- Do we discuss risk/benefit ratios?
- Do providers make suggestions for the comfort of the mother or themselves?
- Are we more comfortable with evidence or tradition?
- Most providers today are not comfortable with alternative labour positioning because they were not taught the practice, even though evidence supports it. How can we change this?

Clinical observation tool for review with participants after interactive lecture/discussion

SESSION 12: TRANSLATING EVIDENCE INTO ACTION: IMPLEMENTATION ACTION PLANS

“Greatness and beauty do not belong to the gods alone.” ~ Nigerian proverb

Learning Objectives

By the end of the session, participants will be able to

- Develop personal and facility action plans to assist with RMC evaluation in their facilities
- Discuss both barriers to and facilitation of RMC implementation at community, facility, local, and federal levels

Facilitator’s Instructions to Participants

Healthcare workers are provided with a baseline evidence-based implementation and evaluation tool for use and adaptation in the Appendix.

The tool is designed to guide RMC implementation at the facility level, and is based on the seven standard RMC principles. Participants should review and critique the tool for use in their respective facilities. The tool is divided into chart, audit, and observational sections and can be used as an ongoing assessment for progress towards RMC implementation.

If the group of trainees is diverse, each smaller group of participants will develop action plans. These plans should address D&A at the personal, ward, unit, and/or facility level, as well as at various levels of health management.

All groups’ action plans will be twofold. First, they should initiate or strengthen the tested interventions discussed during the RMC workshop. Second, they should orient or update other providers in each participant’s respective workstation through mentorship and supervision.

Action Plans on Intervention Implementation

Ask participants to write what they need to implement each standard or intervention component.

- The intervention component (refer to course content and add another context-specific intervention that may arise during the workshop)
- What needs to be done? By whom? By when?
- What resources are needed?

Evaluation

- What evidence indicates progress?
- How and when will evidence be gathered?

Allow participants to work in groups and share work plans with the plenary for discussion and input from others. Individual work plans will not be shared, but will serve as a personal commitment towards behaviour change.

Action Plans on Updating or Training Staff

Ask each participant to orient others back in their facility

1. Using a mentorship approach, offer feedback to all providers in the health facility, especially those in the maternity unit (including support staff such as clerks, cleaners, and guards). All facility staff should be familiar with the RMC concept, as well as proven interventions for dealing with D&A.
2. Evaluate knowledge gained by asking questions
3. Once the staff is oriented, recommend formation or utilisation of implementation action plans as created above.

REFERENCES

- Ajzen, I. 1985. "From Intentions to Actions: A Theory of Planned Behaviour." Pp. 11–39 in *Action-Control: From Cognition to Behaviour*, edited by Kuhl, J. and J. Beckman. Heidelberg, Germany: Springer-Verlag.
- Ajzen, I. 1991. "The Theory of Planned Behavior." *Organizational Behavior and Human Decision Processes*, 50(2): 179–211.
- Allport, G. 1961. *Pattern and Growth in Personality*. New York: Holt, Rinehart and Winston.
- Armitage, C. and J. Christian. 2004. "From Attitudes to Behavior: Basic and Applied Research on the Theory of Planned Behavior." *Current Psychology* 22(3): 187–195.
- Bhattacharya, S. and Constantinides, G.M. 2005. *Theory of valuation* (2nd ed.). Hackensack, NJ: World Scientific.
- Bhutta, Z.A., M. Chopra, H. Axelson, P. Berman, T. Boerma, et al. 2010. "Countdown to 2015 Decade Report (2000–10): Taking Stock of Maternal, Newborn, and Child Survival." *Lancet* 375(9730): 2032–2044.
- Bowser, D. and K. Hill. 2010. *Exploring Evidence for Disrespect and Abuse in Facility-Based Childbirth: Report of a Landscape Analysis*. Bethesda, MD: USAID-TRAction Project, University Research Corporation, LLC, Harvard School of Public Health.
- Carroli, G. and L. Mignini. 2009. "Episotomy for Vaginal Birth." *Cochrane Database of Systemic Reviews*. Doi: 10.1002/14651858.CD000081.pub2.
- Cottingham, J., E. Kismodi, A.M. Hilber, O. Lincetto, M. Stahlhofer, et al. 2010. "Using Human Rights for Sexual and Reproductive Health: Improving Legal and Regulatory Frameworks." *Bulletin of the World Health Organization* 88: 551–555.
- Exhale. 2005. *Teaching Support: A Guide for Training Staff in After-Abortion Emotional Support*. Oakland, CA: Exhale.
- FIGO Safe Motherhood and Newborn Health (SMNH) Committee. 2012. "Management of Second stage labor." *International Journal of Gynecology Obstetrics* 119: 111–116.
- Fishbein, M. and B.H. Raven. 1962. "The AB Scales: An Operational Definition of Belief and Attitude." *Human Relations* 15(1): 35–44.
- Gupta, J.K., G.J. Hofmeyr, and M. Shehmar. 2012. "Position in the Second Stage of Labor for Women Without Epidural Anesthesia." *Cochrane Database of Systemic Reviews* 5: 1–89.
- International Community of Women Living with HIV/AIDS (ICW). 2005. *Sexual and Reproductive Health and Rights Briefing*. London: ICW International Support Office. Retrieved from <http://www.icw.org/files/SRHrights.pdf>.
- Ipas. 2011. "Abortion Attitude Transformation: A Values Clarification Toolkit for Global Audiences." Chapel Hill, NC: Ipas.
- Jhpiego. 2009. "Clinical Training Skills (CTS) for Health Care Providers." Baltimore: Jhpiego.

Johanson, R., Newburn, M. and Macfarlane, A. 2013. "Has the medicalization of childbirth gone too far?" *BMJ*, 324(7342): 892–895.

Jolivet, R. 2011. *Respectful Maternity Care: The Universal Rights of Childbearing Women* (Full charter). Washington, DC: Health Policy Project. Available at <http://www.healthpolicyproject.com/index.cfm?ID=publications&get=pubID&pubID=46>.

Karel, M. J., J. Powell, and M.D. Cantor. 2004. "Using a Values Discussion Guide to Facilitate Communication in Advance Care Planning." *Patient Education & Counseling* 55(1): 22–31.

Kinnier, R.T. 1986. "Development of a Values Conflict Resolution Assessment." *Journal of Counseling Psychology* 34(1): 31–37.

Kinnier, R.T. 1995. "A Reconceptualization of Values Clarification: Values Conflict Resolution." *Journal of Counseling & Development* 74(1): 18–24.

Lim, J.J., J. Childs, and K. Gonsalves. 2000. "Critical Incident Stress Management." *AAOHN Journal* 48(10): 487–497.

Lozano, R., H. Wang, K.J. Foreman, J.K. Rajaratnam, M. Naghavi, et al. 2011. "Progress Towards Millenium Development Goals 4 and 5 on Maternal and Child Mortality: An Updated Systematic Analysis." *Lancet* 378(9797): 1139–1165.

Medical and Dental Council of Nigeria. n.d. Medical and Dental Council of Nigeria website. Available at <http://www.mdcn.gov.ng/>.

Moore, C. 1996. *The Mediation Process: Practical Strategies for Resolving Conflict*. San Francisco: Jossey-Bass Publishers.

Navran, F.J. 2010. "Defining Values, Morals, and Ethics." Palm Coast, FL: Navran Associates. Available at <http://www.navran.com/article-values-morals-ethics.html>.

Nigerian National Secretariat and White Ribbon Alliance. *Kwara State Respectful Maternity Care Baseline Assessment Report*. Abuja, Nigeria: Federal Ministry of Health.

Nursing Council of Kenya. 2012. *Code of Ethics and Conduct for Nurses in Kenya (2nd Edition)*. Nairobi: Nursing Council of Kenya.

Penn-Kekana L., B. McPake, and J. Parkhurst. 2007. "Improving Maternal Health: Getting what Works to Happen." *Reproductive Health Matters* 15(30): 28–37.

Prata, N., C. Ejembi, A. Fraser, O. Shittu, and M. Minkler. 2012. "Community Mobilization to Reduce Postpartum Hemorrhage in Home Births in Northern Nigeria." *Social Science & Medicine* 74(8): 1288–1296.

Rhodes-Vivour, A.O. n.d. "Mediation (A 'Face Saving Device') – The Nigerian Perspective." United Kingdom. Available at <http://www.drvtlawplace.com/media/MEDIATION-FACESAVING-%20DEVICE.pdf>.

Say, L., D. Chou, A. Gemmill, O. Tunçalp, A. Moller, et al. 2014. "Global Causes of Maternal Death: A WHO Systematic Analysis." *The Lancet Global Health* 2(6): e323–e333.

United Nations Economic and Social Council. n.d. “Mutual Accountability for Development Cooperation Results: Where Next?” Background study for the 2012 Development Cooperation Forum. Available at [http://www.un.org/en/ecosoc/newfunct/pdf/dcf_mutual_accountability_busan_study\(29jun\).pdf](http://www.un.org/en/ecosoc/newfunct/pdf/dcf_mutual_accountability_busan_study(29jun).pdf).

Warren, C., R. Njuki, T. Abuya, C. Ndwiga, G. Maingi, et al. 2013. “Study Protocol for Promoting Respectful Maternity Care Initiative to Assess, Measure and Design Interventions to Reduce Disrespect and Abuse During Childbirth in Kenya.” *BMC Pregnancy and Childbirth* 13(21).

WHO. 2005. *Preparing a Health Care Workforce for the 21st Century: The Challenge of Chronic Conditions*. Geneva, Switzerland: WHO.

WHO, UNICEF, UNFPA, and The World Bank. 2012. *Trends in Maternal Mortality: 1990 to 2010: WHO, UNICEF, UNFPA and The World Bank Estimates*. Geneva, Switzerland: Department of Reproductive Health and Research, World Health Organization.

WHO, UNICEF, UNFPA, The World Bank, and United Nations Population Division. 2014. *Trends in Maternal Mortality: 1990 to 2013 Estimates by WHO, UNICEF, UNFPA, The World Bank and United Nations Population Division*. Geneva, Switzerland: Department of Reproductive Health and Research, World Health Organization.

White Ribbon Alliance. 2011. “Respectful Maternity Care” (brochure). Washington, DC: White Ribbon Alliance. Available at <http://whiteribbonalliance.org/campaigns/respectful-maternity-care/>.

Yamin, A.E. 2013. “From Ideals to Tools: Applying Human Rights to Maternal Health.” *PLOS Medicine* 10(11): e1001546.

APPENDIX 1: THREE-DAY TRAINING SCHEDULE FOR PROVIDERS

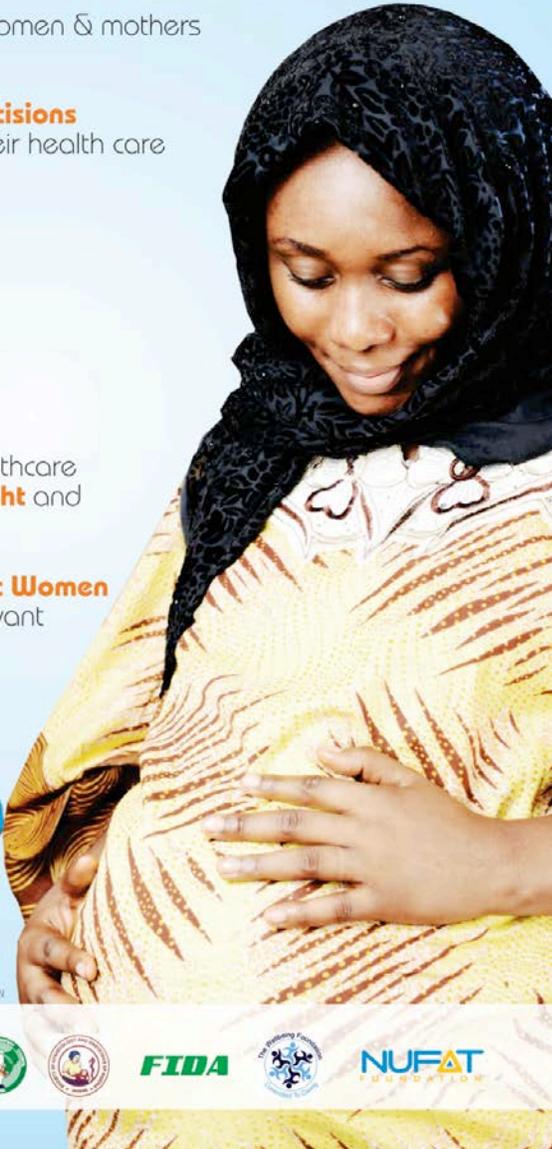
Day 1	Day 2	Day 3
<ul style="list-style-type: none"> Participant expectations and norms Workshop objectives RMC concept and tool kit Workshop logistics 	Recap Understanding self (concept) <ul style="list-style-type: none"> Improving accountability for RMC Group work 	Recap <ul style="list-style-type: none"> Clinical evidence to support RMC Partograph as an RMC monitoring tool
<ul style="list-style-type: none"> Overview of the project Overview of maternal and neonatal health 	Continuous quality improvement/monitoring	Clinical practice <ul style="list-style-type: none"> Introduce clinical objectives
Tea/coffee break	Tea/coffee Break	Break
Understanding health rights and law	Addressing providers and clients rights: SERVICOM	Clinical practice
Promoting respectful maternity care (RMC)	Professional ethics and code of conduct	Clinical practice
Values clarification and attitude transformation (VCAT) in RMC	Role of professional associations in RMC <ul style="list-style-type: none"> Group work on ethics and professionalism 	Clinical practice
Lunch	Lunch	Lunch
Group work: VCAT exercises <ul style="list-style-type: none"> Crossing the line Lifesaving choices 	Alternative dispute resolution mechanism: mediation in RMC <ul style="list-style-type: none"> Conducting mediation 	<ul style="list-style-type: none"> Review of clinical experience Workshop evaluation and closure

APPENDIX 2: TEMPLATE FOR ORGANISING THE RMC WORKSHOP

Logistics (should be conducted at least 1–2 months prior)				
Task	Person Assigned	Date Due	Done	Comments
Ensure that the training venue has been appropriately selected and confirmed (classroom and clinical), and that it is adequate to create a positive learning climate, conduct planned activities, and meet course objectives				
Ensure that all participants have been invited (include information on travel reimbursement, per diem, lodging facilities, etc.)				
Ensure that all necessary facilitators and consultants have been arranged				
Ensure management of logistics, including dietary needs, travel and transportation, lodging, and per diem				
Materials				
Ensure that supplies are in place for projection of AV materials (extension cords, power supply, surge protector)				
Ensure that the necessary training materials are prepared in time <ul style="list-style-type: none"> • Facilitator materials • Participant materials • Training supplies • Reference documents 				
Shortly before the workshop				
Review any assessments of training or learning needs				
Review course materials and adapt if necessary				
Reconfirm clinical training site arrangements				
Meet with trainers to coordinate roles and responsibilities, if necessary				
Ensure that training manuals and reference or source materials are available				
Prepare certificates for statements of qualification or participation				

(Sullivan et al., 2009)

APPENDIX 3: THE NIGERIAN WRA CHARTER (Session 2)



HEALTH WORKERS GUIDE TO RESPECTFUL MATERNITY CARE

Health Workers, Let's

- 1 Make it easier for pregnant women & mothers feel **Safe** and **Comfortable**
- 2 Help them make **Informed Decisions** by discussing all aspects of their health care
- 3 Provide **Privacy** and **Confidentiality** at all times
- 4 Promote their **Dignity**
- 5 Provide the same **Standard** of care to all
- 6 Provide **Quality** maternal healthcare at all levels because it is her **Right** and not a **Privilege**.
- 7 Provide service to **All Pregnant Women** and report concern to the relevant authorities

we value
respect **dignity**
& **freedom**
of our Pregnant Women
& Mothers

ADOPTED FROM RESPECTFUL MATERNITY CARE: THE UNIVERSAL RIGHTS OF CHILD BEARING WOMEN

FEDERAL MINISTRY OF HEALTH THE WHITE RIBBON ALLIANCE HEALTH WORKERS' UNION FIDA NUFAT FOUNDATION

WHITE RIBBON ALLIANCE: #143, ADEMOLE ADOCHUNBO CRESCENT WUSE II, ABUJA, NIGERIA

In seeking and receiving maternity care before, during and after childbirth:

1 ARTICLE I
EVERY WOMAN HAS THE RIGHT TO BE FREE FROM HARM AND ILL TREATMENT
 NO ONE CAN PHYSICALLY ABUSE YOU

2 ARTICLE II
EVERY WOMAN HAS THE RIGHT TO INFORMATION, INFORMED CONSENT AND REFUSAL, AND RESPECT FOR HER CHOICES AND PREFERENCES, INCLUDING COMPANIONSHIP DURING MATERNITY CARE
 NO ONE CAN FORCE YOU OR DO THINGS TO YOU WITHOUT YOUR KNOWLEDGE AND CONSENT

3 ARTICLE III
EVERY WOMAN HAS THE RIGHT TO PRIVACY AND CONFIDENTIALITY
 NO ONE CAN EXPOSE YOU OR YOUR PERSONAL INFORMATION

4 ARTICLE IV
EVERY WOMAN HAS THE RIGHT TO BE TREATED WITH DIGNITY AND RESPECT
 NO ONE CAN HUMILIATE OR VERBALLY ABUSE YOU

All rights are grounded in established international human rights instruments, including the Universal Declaration of Human Rights; the Universal Declaration on Bioethics and Human Rights; the International Covenant on Economic, Social and Cultural Rights; the International Covenant on Civil and Political Rights; the Convention on the Elimination of All Forms of Discrimination Against Women; the Declaration of the Elimination of Violence Against Women; the Report of the Office of the United Nations High Commissioner for Human Rights on preventable maternal mortality and morbidity and human rights; and the United Nations Fourth World Conference on Women, Beijing. National instruments are also referenced if they make specific mention of childbearing women.

Safe Motherhood is more than the prevention of death and disability...It is respect for every woman's humanity, feelings, choices, and preferences.

RESPECTFUL MATERNITY CARE: THE UNIVERSAL RIGHTS OF CHILDBEARING WOMEN



5 ARTICLE V
EVERY WOMAN HAS THE RIGHT TO EQUALITY, FREEDOM FROM DISCRIMINATION, AND EQUITABLE CARE
 NO ONE CAN DISCRIMINATE BECAUSE OF SOMETHING THEY DO NOT LIKE ABOUT YOU

6 ARTICLE VI
EVERY WOMAN HAS THE RIGHT TO HEALTHCARE AND TO THE HIGHEST ATTAINABLE LEVEL OF HEALTH
 NO ONE CAN PREVENT YOU FROM GETTING THE MATERNITY CARE YOU NEED

7 ARTICLE VII
EVERY WOMAN HAS THE RIGHT TO LIBERTY, AUTONOMY, SELF-DETERMINATION, AND FREEDOM FROM COERCION
 NO ONE CAN DETAIN YOU OR YOUR BABY WITHOUT LEGAL AUTHORITY

Disrespect and abuse during maternity care are a violation of women's basic human rights.



For more information visit: www.whiteribbonalliance.org/respectfulcare

APPENDIX 4: THINKING ABOUT MY VALUES WORKSHEET

(Session 5 optional exercise)

Instructions

Please think carefully about the following questions and answer honestly, according to your personal experiences. Indicate a yes or no response in the column provided. Additional space is provided for clarification and discussion as needed. Please keep your written responses brief. You will only be asked to share the responses you feel comfortable discussing with others.

Questions for Reflection	Yes	No	Description/Explanation
Part A: Family and Social Groups			
Did the family who raised you discuss specific beliefs or values regarding child birth?			
Did you experience any personal or family events that changed your beliefs or values about child birth and maternity care services?			
Do your family's values about maternity care services reflect the values commonly held by your family's racial or ethnic group, cultural heritage or nation?			
Do you think the socioeconomic situation you were brought up in influences your values about maternity care services?			
Is your present socioeconomic situation and/or level of professional education and practice different from that of the family who raised you?			
Part B: Religion and Spirituality			
Have you held the same spiritual/religious beliefs since childhood?			<p>If yes, what they are:</p> <p>If no, describe how they have changed:</p>
Do your personal spiritual/religious beliefs relate to your views on maternity care services?			
<p>Do your current values about any of the following topics conflict with your spiritual/religious beliefs and ability to provide maternity care in any way? Check all that apply.</p> <ul style="list-style-type: none"> Parity of the mother Marriage/partnership relationship Level of formal education Advanced maternal age–mother too old Adolescent–mother too young Mother poor Mother physically or mentally challenged 			

Questions for Reflection	Yes	No	Description/Explanation
Part A: Family and Social Groups			
Do you consciously refer to your spiritual/religious beliefs when you are making an important life decision or caring for clients?			Sometimes Not usually
Do you think your age affects your perspective when offering maternity care services?			How?
Which one social group has had the greatest influence on your current values related to maternity care services?			Racial/ethnic Family Friends Religious/spiritual Lecturers/tutors Professional colleagues

Questions for self-reflection (do not answer)

Describe a time when you felt challenged by a life event or circumstance that called for an action not supported by your religious/spiritual beliefs. How were you able to reconcile this action with your beliefs?

(Ipas, 2011)

APPENDIX 5: MATERNITY CARE PROVIDERS INTERVIEW GUIDE

(Session 10)

In your own opinion, how has the value clarification and attitude transformation training affected provision of maternity care services and the healthcare providers in the maternity unit? Please explain your answers.

In our own opinion, what would you say about the following caring behaviours in this maternity unit/facility in the past one month?	Improved	Not improved	Not applicable/ not observed	Additional comments
Privacy				
Confidentiality				
Use of dignified tone/language				
Obtaining consent for procedures during care				
Explanation of procedures about care and ward operations to clients and their relatives				
Allowing birth companions during labour and delivery/postpartum				
Availability of water, clean environment, warm labour room				
Availability of meals and hot or cold drinks for clients				
Availability and adequacy of linen for use by clients and their newborns				
Availability of commodities and supplies for labour delivery				If not improved, which supplies are missing?
Timely response/action to clients' needs when required for support in labour or postpartum				
Timely response/action to clients' needs when required for referral or advanced care				
Has RMC been discussed by colleagues in the facility?				
Has RMC been discussed by clients coming from antenatal clinic?				
In your own opinion, what would you say about service providers' working conditions in the last one month?				
What would you say about the challenges or successes experienced in relation to providing RMC?				

Probe for what has improved and how it has improved (or not improved), in terms of support for RMC—from facility managers, professions associations, and community members—on the topics of maternity open days, caring for carers, teamwork, etc.

APPENDIX 6: MATERNITY CLIENT EXIT INTERVIEW (Session 10)

Facility _____

Date _____ Month _____ Year _____

Instructions

1. Introduce yourself to the client.
2. Explain to the client the purpose of the interview.
3. Reassure the client of confidentiality and privacy during the interview.

Introduction

My name is _____ I am going to ask you a few questions about the services you received in this facility. This interview is voluntary. Any information you provide will be treated with confidentiality. Your responses and your name will not appear in any report(s). Should you choose not to participate, provision of services to you in this or any other healthcare facility will not be affected. Please feel free to ask any questions or for clarification, and feel free to decline participation in the interview.

Questions	Yes	No	Sometimes	n/a	Additional Comments
1. Were you allowed to come with a birth companion who stayed with you during the birth of this baby?					
2. Did the provider(s) explain all the procedures to be carried out for you during labour, delivery, and after the birth of this baby?					
3. Did the service provider physically examine you a. Immediately after delivery b. Within 6 hrs in the ward					
4. Was privacy offered during examination and childbirth?					
5. Did the service provider explain the results of your health examination? Did any service provider tell you when you should return for another visit? Specify which services.					

Questions	Yes	No	Sometimes	n/a	Additional Comments
6. Do you feel you were offered adequate care a) On admission? b) During labour and delivery? c) After delivery?					
7. Did you feel that the providers who attended to you used appropriate/friendly language?					
8. Do you feel that the service providers responded in a timely fashion when you called for help?					
9. Did the service provider leave you alone when you felt you needed his/her for support/help during labour and delivery at any time?					
10. In summary, would you say you were satisfied with the services you received in this facility?					
11. Would you recommend this facility to a friend?					
12. Do you have any suggestions on areas that can be improved?					

Condition of mother: Stable or not stable. On which day after delivery were you discharged?

1st day (within 24 hrs)

2nd day

3rd day and beyond

Condition of baby: Stable or not stable

I appreciate your time and participation. Best wishes to you and your family.

APPENDIX 7: FAMILY OPEN DAYS

Promoting dignified care to women during childbirth through facility community partnerships

Health facility name: _____

Facility in-charge: _____

Phone number: _____

Date/year/month: _____

Family Open Days	No. of Females	No. of Males	Total No.
Number of maternity open days in the facility conducted during this month			
If no family open day was conducted, please expand			
Number of pregnant women attending family open days during this month			
Number of non-pregnant women attending family open days this month			
Number of male partners/companions attending family open days during this month			
Number of youth ages 10-25 attending family open days during this month			

Was family open day facilitated by

- Health worker
- Community member

Were other services offered during family open day?

- Health talks (which topic?)
- Facility tour

Please give your recommendations for future family open days.

Signature: _____

Date: _____

Telephone: _____

APPENDIX 8: TRANSLATING EVIDENCE INTO ACTION: IMPLEMENTATION ACTION PLANS

(Session 12 form for healthcare workers/facilities)

Monitoring Respectful Maternity Care

Unit-based Assessment

RMC monitoring and implementation after baseline RMC training is to be conducted in two phases. Phase one entails a random facility chart audit based upon the number of deliveries in the selected site. Phase two entails direct unit observation.

Instructions to assessor: Please introduce yourself and explain the purpose of this evaluation to staff and potential clients impacted by the assessment. Use the checklist format provided to record observations.

- Initial assessment
- First assessment
- Second assessment
- Third assessment
- Other

Name of assessor: _____

Affiliation: _____

Facility being assessed: _____

Contact person: _____

Standards of care for respectful maternity care

1. The woman is protected from physical harm or ill treatment
2. The woman's right to information, informed consent, and choice/preference is protected
3. Confidentiality and privacy is protected
4. The woman is treated with dignity and respect
5. The woman receives equitable care free of discrimination
6. The woman is never left without care
7. The woman is never detained or confined against her will

Respectful Maternity Care Chart Audit	Yes	No	Observation/comment
The woman's right to information, informed consent, and choice is protected (2)			
Is a patient consent form on file? Or, is a progress note indicating consent available?			
Confidentiality/privacy (3)			
Are curtains or screens in use?			
Is the client's name posted in view?			
The woman is treated with dignity and respect (4)			
Is the patient's name recorded on file?			
The woman is protected from physical harm or ill treatment (1)			
Is a partogram or client narrative in use?			
Is the last menstrual period or estimated due date recorded?			
Is the medical history recorded?			
Is the OB history recorded?			
Are allergies recorded?			
Was food or fluid given?			
Is information recorded about status of membranes?			
The woman is never left without care (6)			
Were vital signs recorded? (Blood pressure, temperature, pulse every 4 hours)			
Was fetal heart tone recorded every 30 minutes?			
Was the contraction pattern assessed?			
Were evaluations done in a timely fashion as per standards of care?			
The woman is never detained or confined against her will (7)			
Baring discharge for medical complications, was the woman released from the facility in a timely fashion? (i.e., 24–48 hours after vaginal delivery or 72–96 hours after operative delivery)			
<p><i>Respectful Maternity Care Clinical Practice Checklist</i> Ward-based Observations for RMC Monitoring</p>			

Respectful Maternity Care Chart Audit		Yes	No	Observation/comment
Interpersonal interaction with care providers				
1.	Healthcare providers introduce themselves to clients			
2.	History-taking or subsequent interview of admitted mothers is done in private area			
3.	Physical examinations at any stage of labour or post-natally are fully explained in calm, supportive tones of voice			
4.	Families at bedside assisting in labour ward and/or postnatal care/companionship encouraged			
5.	Is there any use of physical restraint?			
6.	Updates on progress given to client			
7.	Explanations of ongoing procedures are given (including examinations or injections)			
8.	Use of routine episiotomy			
9.	Women allowed to move freely in labour suite			
10.	Position of choice allowed for delivery			
11.	Evidence of allowance of food and fluid in unit			
General facility observations				
12.	Proper infection prevention practices, such as hand washing and use of infection control material			
13.	Use of delivery register and other data management tools such as partogram			
14.	High level of cleanliness of the ward/unit/facility			
15.	Public display of a service charter and general ward information			
16.	Condition of ward areas—e.g., is there privacy and confidentiality as evidenced by client screens, curtains, partitions, use of fabrics?			
17.	Responsiveness to clients' request for help			
18.	Positive and professional provider working relationships with colleagues, patients, relatives, and/or community members; women are spoken to in kindly manner			
Recommendations based upon assessment standards (note item and standard number 1–7)				

APPENDIX 9: CLINICAL PRACTICE CHECKLIST

Sample verbal consent

Good day, my name is I am here as a participant in a workshop designed to promote respectful maternity care. I would like to obtain your permission to observe your medical care. You have the right to say no to my request, and this refusal will in no way affect the care that you receive here today. Thank you for considering my request. Do you consent to my observation?

Clinical observation checklist

Please indicate with an X in the appropriate box your evaluation of the observed behaviour. Does the behaviour promote respectful maternity care?

Respectful Maternity Care Clinical Practice Checklist

	Yes	No	Additional comments/ observations
Interpersonal interaction with care providers			
History-taking or subsequent interview of admitted mothers			
Physical examinations at any stage of labour or post-natally			
Families at bedside assisting in labour ward			
Families at bedside assisting in postnatal care			
Initiation of immediate breastfeeding			
Explanations of ongoing procedures such as			
a) Examinations			
b) Injections			
c) Use of routine episiotomy			
Are women allowed to move freely in labour suite?			
Evidence of allowance of food and fluid in unit			
General facility observations			
Proper infection prevention practices			
Use of delivery register and other data management tools			
High level of cleanliness of the ward/unit/facility			
Public display of a service charter and general ward information			
Condition of ward areas—e.g., is there privacy and confidentiality as evidenced by client screens, curtains, partitions, use of fabrics?			
Family involvement in client care procedures			
Positive, professional provider working relationships with colleagues, patients, relatives, and/or community members			

	Yes	No	Additional comments/ observations
<p>Review the design of the unit that you are placed in. How could you rearrange the facility to provide standard RMC if challenges have been noted in clinical observation? List three things that could be changed.</p> <p>1.</p>			
<p>2.</p>			
<p>3.</p>			

Additional comments or observations from experience

APPENDIX 10: TRANSLATING EVIDENCE INTO ACTION: IMPLEMENTATION ACTION PLANS (Session 12)

Facility/Organisation: _____

Telephone contact: _____

Email address: _____

Statement of Goal and Objectives

Goal:

Objectives:

What needs to be done?

By whom?

By when?

What resources are required? (physical, financial, supportive)

Evaluation

What evidence indicates progress?

How and when will evidence be gathered?

APPENDIX 11: LIST OF CONSULTATION WORKSHOP PARTICIPANTS

White Ribbon Alliance for Safe Motherhood, Nigeria

Consultative Meeting for RMC Domestication Manual

Name	Organisation
Adegoke, Dr Dawodu	Federal Ministry of Health
Ahmadu, Dr S. K.	Ipas
Asala, Christy	Switch Media
Ayoola, Modupe	Nigerian Nursing & Midwifery Council
Fasehun, dr Luther-King	The Wellbeing Foundation Africa
Hardtman, Pandora	White Ribbon Alliance, independent MNCH consultant
Ibanga, Imoh	International Federation of Female Lawyers Nigeria
Ibraye, Tonte	White Ribbon Alliance Nigeria
Kera, Dr Hajara	Ahmadu Bello University Teaching Hospital
Liman, Dr Idris M.	Nigeria Medical Association
Momah, Dr P.N	White Ribbon Alliance Nigeria board member
Nnadozie, Helen	Nigerian Association of Nurse and Midwives
Okeke, Bridget	Ipas
Olaogun, Dr Oluwadamilola	White Ribbon Alliance Nigeria project manager
Omar, Dr Nafsah Wali	Subsidy Reinvestment and Empowerment Project, Maternal and Child Health
Saka, Dr Asiat A.	Kwara State Primary Health Care Development Agency
Sule, Gladys O.	Traffina Foundation for Community Health
Sule, Saadat	Liverpool School of Tropical Medicine Nigeria
Temitope, Akinola Eytayo	Leah Charity Foundation
Tumsah , Dr Fatima	Pathfinder International

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