CREATING AN EVIDENCE BASE FOR THE PROMOTION OF RESPECTFUL MATERNITY CARE

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Acknowledgements

Abstract

Introduction: Disrespectful and abusive behaviors during childbirth are fundamental violations of women's human rights. Additionally, these behaviors are increasingly being recognized for their role in deterring women from seeking skilled birth attendance at healthcare facilities, a practice widely agreed to be key to reducing maternal mortality. Despite convincing evidence of the harmful effects of disrespect and abuse during childbirth, there is very little evidence about which interventions successfully promote increases in respectful maternity care. The goals of this thesis are therefore threefold: 1) To identify risk factors for disrespect and abuse during childbirth and place them into a framework which takes into account the various sub-systems that impact the provision of respectful maternity care; 2) To develop an evidence base of interventions which have the potential to be successful in promoting respectful maternity care; and 3) To use the framework and catalogue of interventions identified to make recommendations for the Hansen Project on Maternal and Child Health, which aims to decrease the prevalence of disrespect and abuse at healthcare facilities in Ethiopia and Tanzania.

Methods: Risk factors and possible interventions were identified through an extensive structured literature review and key-informant interviews with public health practitioners and clinicians working in related fields.

Findings: Sixteen risk factors for disrespect and abuse are identified and categorized into a framework that includes four levels: Individual and Community, Provider, Facility, and National Systems. Twenty-two interventions are identified to address these risk factors and are categorized by the framework level that they affect and at which they would be implemented. Each intervention is described in detail and the evidence in support of its efficacy is summarized. Finally, taking into account local context and relevant risk factors and decision makers, recommendations of interventions are given for the Hansen Project on Maternal and Child Health.

Conclusions: The framework and catalogue of interventions developed in this thesis highlight the interconnectedness of actors and activities involved in the provision of respectful maternity care. Given the complexity of providing respectful care and the wide variety of stakeholders involved, no one intervention is likely to be efficacious on its own—coordination and synergy between levels and stakeholders will be required. The plethora of interventions indentified in this thesis demonstrates that disrespect and abuse is far from an incurable problem and that many potential solutions exist. It is sincerely hoped that this work will be useful as more groups begin engaging with the issue of respectful maternity care, and that the lessons and successes of the Hansen Project will provide additional guidance.

Introduction

Maternal mortality is defined as "the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes."[1] The Millennium Development Goals (MDGs) established by the United Nations in 2000 made improving maternal health an international priority. Specifically, MDG 5A is to reduce by three quarters, between 1990 and 2015, the maternal mortality ratio, measured in maternal deaths per 100,000 live births. However, progress towards this goal has been slow. Every day nearly 800 maternal deaths occur around the world, and 287,000 maternal deaths occurred in 2010. [2] Furthermore, between 1990 and 2010 the global maternal mortality ratio declined by only 3.1% per year—far from the annual decline of 5.5% that is needed in order to achieve MDG 5A.

Maternal mortality is a particularly tragic issue because it occurs almost entirely among poor and disenfranchised women (99 percent of maternal deaths occur in the developing world) and because it is almost always preventable. [2] The top causes of maternal death are hemorrhage, hypertensive disorders (eclampsia), sepsis, obstructed labor, and unsafe abortion.[3] Evidence from developed countries shows that these conditions are manageable and/or preventable if women have timely access to skilled healthcare providers working in healthcare facilities with adequate infrastructure and supplies.[3] Because the vast majority of obstetric complications leading to maternal death cannot be predicted and require urgent and immediate attention when they occur, there is widespread consensus that the most effective means of reducing maternal mortality is "the universal use of skilled birth attendants based in functioning healthcare facilities."[4] The majority of the global health community has adopted universal coverage of facility-based births as an intermediate goal for reducing maternal mortality. However, despite this global push for facility-based deliveries with skilled attendants, facility delivery rates in Sub-Saharan Africa remain below 50 percent, and fall well short of universal coverage in other regions, as well.[4]

For nearly two decades, the majority of interventions aimed at increasing rates of facility-based deliveries and decreasing maternal mortality have targeted barriers such as inadequate transportation, prohibitively high service costs, and lack of awareness of the benefits of facility-based deliveries. Recently, however, increased attention is being paid to reasons why women, who know fully the benefits of facility-based deliveries and who have the means to access a facility, continue to *choose* home births. Evidence from multiple countries in Sub-Saharan Africa shows that women would prefer to deliver in a facility but choose not to because of previous experiences (their own or a relative's/friend's) of inadequate, low quality, and/or disrespectful care in facilities.[4, 6, 7, 8, 9]

With increasing attention being paid to disrespectful and abusive care as a contributor to low facility utilization rates, in 2010 the USAID-commissioned TRAction Project released a landscape analysis on respectful maternity care.[10] The concept of respectful maternity care, however, is not new. The 1970s and 1980s in Brazil witnessed the inception and growth of the Humanization of Childbirth movement. This movement was one of the first organized efforts to promote respectful maternity care and focused on providing "humanized birth" that is fulfilling and empowering to women and their providers and which promotes the active participation and decision making of women in all aspects of their care.[11] The Humanization of Childbirth movement lost its spotlight in the late 1990s and early 2000s, however, many of the principles of the movement have been embodied in the concept of respectful care.

The TRAction report is both emblematic of and a driving force behind the renewed international attention being paid to respectful maternity care. In the report, authors Bowser and Hill describe the results of their extensive desktop review and interviews with expert informants on the topic of disrespect and abuse during childbirth. The results include a catalog of factors that impact the provision of respectful maternity care and the identification of seven categories of disrespect and abuse (see Table 1). In addition to the implications of disrespectful and abusive behaviors for skilled birth attendance at health facilities, these behaviors contribute to unnecessary suffering of women and are fundamental violations of women's human rights.[12]

Table 1: Seven Categories of Disrespect and Abuse, with examples. From Bowser and Hill, 2010.

Category	Example
Physical abuse	Slapping, pinching
Non-consented care	Absence of informed consent or patient communication, forced procedures
Non-confidential care	Lack of privacy (e.g. laboring in public) and/or confidentiality (e.g. disclosure of patient information)
Non-dignified care	Intentional humiliation, rough treatment, scolding, shouting, blaming, negative perceptions of care
Discrimination based on specific patient attributes	Discrimination based on race, ethnicity, age, language, HIV status, economic status, educational level, etc.
Abandonment of care	Women left alone during labor and birth, failure of providers to monitor women and intervene when needed
Detention in facilities	Detention of mother and/or baby in facility after delivery, usually due to failure to pay

Disrespectful and abusive behaviors during childbirth have been documented in both developed and developing countries all over the world, making this a truly global issue.[10] However, no accurate estimate of the prevalence of disrespect and abuse exists and, notably, there is also no operational definition of respectful maternity care—the concept is defined only in its absence. The promotion of respectful maternity care is a complex issue, and goes beyond relatively straightforward clinical quality improvement efforts to issues of health system governance, social justice, human rights, social norms, and empowering female decision making. Ensuring respectful maternity care therefore has enormous implications both for achieving MDG 5A and ensuring women's basic human rights.

Problem Statement

Despite the convincing evidence that disrespect and abuse during childbirth is violating women's human rights and negatively impacting the global goal of reducing maternal mortality, there is very little evidence about which interventions successfully promote increases in respectful maternity care and the health outcomes that result from improved care.

The goals of this thesis, therefore, are threefold. The first is to expand upon the TRAction report's documentation of risk factors for disrespect and abuse through an additional literature review and key informant interviews. After identifying the most relevant risk factors for disrespect and abuse, these risk factors will be organized into a framework which takes into account the various sub-systems that impact the provision of respectful maternity care (individual clients, providers, health facilities, and national systems). The aim of the framework is to enable the identification of risk factors applicable to any given context and to any individual's locus of control.

The second goal is to begin to develop an evidence base of interventions that have the potential to be successful in promoting respectful maternity care. To do this, interventions that have proven successful in a variety of geographic and technical areas will be identified and, using the framework developed in the first section, matched to the risk factor(s) that the intervention has the potential to address.

Finally, the framework and intervention package will be applied to a real example. The Hansen Project on Maternal and Child Heath, coordinated by the Women and Health Initiative at the Harvard School of Public Health, seeks to improve respectful maternity care in two vastly different settings: an urban hospital in Dar es Salaam, Tanzania and rural Primary Health Centers in Ethiopia. Each setting has different constraints, cultural norms, and contextual factors that will necessitate varied approaches. This

application exercise will demonstrate the usefulness of the framework in facilitating the identification of relevant risk factors and action points with the highest potential leverage. The interventions recommended in this thesis will be applied in the Hansen Project starting in mid-2013.

Methods

Two primary methods were used for this thesis: a structured literature review and semi-structured in-depth interviews. The literature review was conducted to identify factors that underlie, contribute to, or facilitate disrespect and abuse during delivery. Additionally, the literature review was used to identify interventions that have been implemented in a variety of geographic locations and technical fields that may be transferrable to the promotion of respectful maternity care. Both published, peer-reviewed literature and unpublished grey literature were reviewed. A list of peer-reviewed databases and journals searched and the search terms used can be found in Appendix A. Grey literature was reviewed from organizations identified through references in the peer-reviewed literature, in Bowser and Hill (2010), and through personal communication with members of the Women and Health Initiative and attendees of the Global Maternal Health Conference, held in Arusha, Tanzania in January 2013.

Interviews were conducted with experts in global maternal health, respectful care, and fistula care (due to the sensitive, stigmatized nature of the work), as well as with healthcare providers working in Tanzania and Ethiopia (see Table 2). The interview guides used for these interviews are available in Appendix B. The goal of the interviews was to hear first-hand about others' experiences of disrespect and abuse during childbirth and to elicit information on interventions under consideration for inclusion in this thesis.

Table 2: Key Informant Interviewees

Name	Organization	Title
Maggie Bangser	Women's Dignity World Lung Foundation	Founder and Executive Director Advisor
Charlotte Warren	Population Council	Associate for Reproductive Health Systems and Research
Dr. Mary Sando	Management and Development for Health	Maternal and Child Health Clinical Coordinator
Dr. Brenda D'Mello	Comprehensive Community-Based Rehabilitation Tanzania (CCBRT)	Technical Advisor to the European Union and CBM funded Maternal and Newborn Healthcare capacity building program
Dr. Mengistu Hailemariam	Ethiopian Federal Ministry of Health	Maternal Health Advisor
Dr. Delayehu Bekele	Saint Paul's Hospital Millennium Medical College, Addis Ababa, Ethiopia	Head of Obstetrics and Gynecology
Kate Ramsey	Averting Maternal Death and Disability (AMDD), Columbia Mailman School of Public Health	Senior Research Officer
Stephanie Kujawski	Averting Maternal Death and Disability (AMDD), Columbia Mailman School of Public Health	Program Officer

Framework for Promoting Respectful Maternity Care

In order to effectively direct interventions towards the promotion of respectful maternity care, the relevant underlying risk factors for disrespect and abuse must be identified and targeted. In their landscape analysis, Bowser and Hill identify a variety of factors that have been qualitatively and/or anecdotally linked to reports of disrespect and abuse during childbirth. Additional risk factors were identified through

the literature review and key-informant interviews. The aim of the framework developed here is to consolidate these risk factors for disrespect and abuse into a model that is intuitive and logical, and which can be used by public health practitioners and researchers to identify the underlying causes of disrespect and abuse in their particular setting so that effective interventions may be targeted to these issues. To create the framework, the factors identified by Bowser and Hill, the literature review, and those mentioned in key-informant interviews were placed into four categories: Individual and Community; Provider; Facility; and National Systems.

The framework is presented here as an ecological model of overlapping concentric circles to illustrate the dynamic interrelations between personal and systems-level factors that impact the delivery of respectful maternity care. The ecological systems theory was developed by Urie Bronfenbrenner in the 1970s as a framework for understanding child development.[13] Bronfenbrenner's ecological model was designed to illustrate that the entire ecological system in which growth occurs —including family, community, and society sub-systems—needs to be considered in order to understand the complex process of human development.

Similarly, the provision of respectful maternity care is a complex process that is affected by a variety of systems, including the national health system and policies, facility sub-systems, provider trainings and attitudes, and individual and community beliefs and behaviors. Each of these subsystems is complex in and of itself, and each is also influenced by the systems surrounding it. The formatting of the framework illustrates that there are four levels of the framework that are potential targets for interventions, while underscoring that that no level exists in isolation and that the entire context must be taken into consideration when selecting appropriate interventions for any given setting.
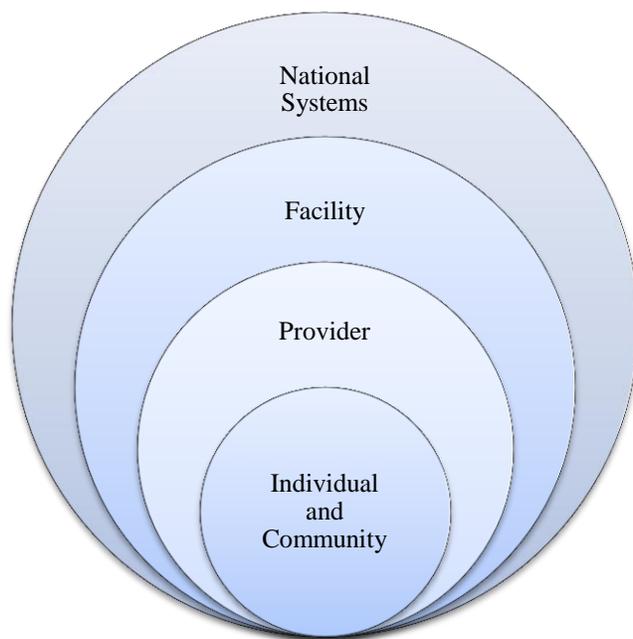
Figure 1: Framework of risk factors for disrespect and abuse during childbirth.

At the core of the framework are the individual and community. Within this category, there are four risk factors for disrespect and abuse:

1. **<u>Normalization of disrespect and abuse during childbirth</u>**. In some cases, women who have no experience with other health systems or facilities and who have never been introduced to the concepts of patient or human rights have normalized the occurrence of disrespect and abuse during facility-based childbirth.[10, 14] Because of this normalization, women are less likely to

have sufficient knowledge or to be empowered to speak up for themselves and demand better treatment. Observations in the Dominican Republic also indicate that this normalization may be passed down from generation to generation, thereby embedding the acceptance of disrespect and abuse in a community's culture and norms.[15] A study documenting the prevalence of disrespect and abuse in Kenya recorded a much higher prevalence through observation of deliveries than was reported by women in interviews immediately or several months after delivery, indicating that behaviors that an outsider would consider disrespect and abuse may have been normalized by the women who experience these behaviors.[16]

2. **Lack of community engagement and oversight.** Although public health facilities are often financed by taxes and other public fees, it is not uncommon for communities to feel that the facility is not there to serve them, that they have no control over the services provided, and that there is no way to air grievances or file appeals.[6, 14] Such disconnection and disengagement creates a sense of apathy and powerlessness that facilitate the continuing practice of disrespect and abuse.

3. **Financial barriers.** Lack of financial resources is a well-documented barrier to skilled birth utilization.[5] An inability to pay user fees has been shown to lead to detention of women and/or their newborns in healthcare facilities—sometimes for years.[17] Additionally, an inability to pay unofficial fees has been linked to abandonment. Qualitative evidence from Tanzania, for example, documents health workers demanding money for blood transfusions, and refusing to provide care until a patient provided the worker with a soda.[18]

4. **Lack of autonomy and empowerment.** Although there is little evidence that directly links autonomy and empowerment to respectful maternity care, Bowser and Hill present substantial evidence that autonomy and empowerment are linked to improved and safer choices for childbirth. As risk factors for disrespectful and abusive treatment, lack of autonomy and empowerment are intimately linked to normalization of disrespect and abuse and efforts to address one risk factor would likely benefit substantially from addressing the other.

The next level of the framework is the provider. Risk factors that act at this level include individual and internal factors (such as prejudices and training experiences), interactions with the health facility and national health system, and interactions with patient groups and communities. Specifically, the four factors of interest within this category are:

1. **Provider prejudice.** Providers may harbor prejudices based on a patient's age, ethnic group, language, religion, HIV status, educational status, socioeconomic status, and an array of other patient attributes.[79] Anecdotal evidence acquired by Bowser and Hill shows that prejudice can lead to discrimination and mistreatment substantial enough to be considered disrespect and abuse. A study of maternal health in urban settings found that poor urban women report rude, neglectful, and abusive care much more frequently than their wealthier counterparts,[19] and in Tanzania, HIV positive women are more likely to be spoken to disrespectfully due to provider stigma.[14]

2. **Provider distancing as a result of training.** Providers practice the behaviors that they see modeled during their training, and too often these behaviors are disrespectful and abusive.[21, 22, 23] Additionally, provider training may explicitly encourage distancing from the client and overemphasizing medical treatment at the expense of the interpersonal care, both of which may increase the chances of disrespectful and abusive provider practices.[15, 23, 24]

3. **Provider demoralization related to weak health systems, shortages of human resources, and lack of professional development opportunities.** In many developing countries, health facilities are chronically overcrowded and understaffed, while poorly managed supply chains leave facilities underequipped to provide even basic services. Furthermore, health workers are often under-paid and, particularly in rural areas, have little opportunity for career development and advancement. The resulting provider frustration and demoralization have been cited as a major contributor to negative and disrespectful provider attitudes and behaviors.[25, 78, 79] Burnout,

defined as "the exhaustion of physical or emotional strength as a result of prolonged stress or frustration", is associated with lower productivity, increased absenteeism, depersonalization of clients, and decreased motivation. People in occupations that work with the public, impoverished populations, and ill people, and whose work involves "extreme responsibility" with potentially severe consequences—a description that fits healthcare workers in stressed, developing healthcare systems all too well—are particularly at risk of burnout.[26, 27]

4. **Provider status and respect**. Anecdotal evidence from a range of countries suggests that low-level providers are more likely to suffer from insecurity and anxiety and subsequently mistreat their patients when they themselves are mistreated and disrespected by upper-level providers and facility management.[26] Furthermore, disrespectful behavior towards nurses or midwives from doctors and administrators undermines the teamwork necessary to have a well functioning and supportive work environment.[21]

The third level of the framework is the facility. Facility factors that impact the provision of respectful maternity care include aspects of management and supervision, facility administration, accountability mechanisms, and facility infrastructure. Specifically, these factors include:

1. **Lack of standards.** In most health facilities, standards for maternal care (where they exist) are focused on evidence-based clinical practices and pay little attention to standards of interpersonal care or the patient-provider relationship. Furthermore, even when clinical standards have been established they are frequently ignored or forgotten.[28]

2. **Lack of leadership and supervision for respectful maternity care**. In the absence of strong standards for respectful maternity care, weak leadership and supervision are particularly problematic. In some settings (as noted above in the provider training section), senior providers themselves may exercise poor leadership by modeling disrespectful care in their practice.[24] Additionally, weak supervision enables a facility environment in which providers cover for one another and feel immune to being held responsible for their actions.[26]

3. **Lack of accountability mechanisms**. Accountability mechanisms, such as complaint boxes, patient charters, or incident reports are designed to hold providers responsible for the quality of care they provide. These mechanisms are often lacking, however, and even where they do exist many clients may be unaware (particularly marginalized and illiterate women) and thus unable to assert their grievances, or too afraid of retaliation from health workers to use them.[7]

4. **Inadequate infrastructure, supplies, and human resources**. In addition to demoralizing healthcare providers, inadequate facility infrastructure, supplies, and human resources can materially contribute to disrespect and abuse.[9, 28] Many facilities are not built or equipped to handle the volume of patients that they do, making the maintenance of privacy, for example, inherently difficult. Overworked healthcare providers may find it logistically impossible to care for all their patients sufficiently and inevitably abandon someone in need.[29]

Finally, the fourth level of the framework is national systems, including health systems, laws, and policies. Components of this level set the stage for the provision of respectful maternity care and establish standards of accountability for facilities and providers to meet. The risk factors included in this category are:

1. **Lack of existence or enforcement of national laws and policies.** Disrespect and abuse are fundamental violations of ethical and human rights principles (see Table 3).[30] In their review, Bowser and Hill found that many national policies do not codify these principles and/or do not include policies to protect a woman's right to high-quality and respectful maternal care, despite the fact that many countries have made substantial human rights commitments. Furthermore, even where such policies exist, enforcement may be lacking. Without both policies and enforcement, providers and facilities cannot be held accountable by the national government for their actions. Human rights treaties impart three levels of obligations on signatories: to respect, protect, and fulfill. Significantly, rights violations can occur through both commission and omission.[31]

Therefore, failure of states to actively ensure the rights listed in Table 3 constitutes human rights violations by omission.

Table 3: Human Rights that are violated by disrespect and abuse during childbirth. From the White Ribbon Alliance Respectful Maternity Care Charter.[30]

Category of Disrespect and Abuse	Corresponding Right
Physical abuse	Freedom from harm and ill treatment
Non-consented care	Right to information, informed consent and refusal, and respect for choices and preferences, including the right to companionship of choice wherever possible
Non-confidential care	Confidentiality, privacy
Non-dignified care (including verbal abuse)	Dignity, respect
Discrimination based on specific attributes	Equality, freedom from discrimination, equitable care
Abandonment or denial of care	Right to timely healthcare and to the highest attainable level of health
Detention in facilities	Liberty, autonomy, self-determination, and freedom from coercion

2. **Lack of legal redress mechanisms**. This factor is tightly linked to the factor above—where policies and/or enforcement are lacking, an individual's right to redress may be nonexistent. Furthermore, this factor is closely linked to individual-level factors such as autonomy and empowerment; even where mechanisms for legal redress exist, if informed consent and informed patients are lacking, patients have no practical ability to seek redress.[32]

3. **Lack of leadership and governance for respectful maternity care.** As with all human rights policy issues, national leadership and governance is critical to enforce respectful maternity care standards and accountability to both national laws and policies and international conventions. Furthermore, respectful maternity care can be a sensitive issue, and the topic has the potential to alienate facility management and providers.[33] To elevate such an issue to the national dialogue requires strong leadership and a visible, respected champion of the cause.

4. **Professional association guidelines.** Most countries have a variety of professional organizations representing a broad range of professional cadres. These organizations maintain standards according to bioethical principles and human rights frameworks, and often have greater access to and better rapport with the providers they represent than other regulatory bodies.[10] In the absence of these organizations, it can be difficult to enforce compliance with these bioethical principles.

The relative weight and importance of each level of the framework depends upon the context. For example, in a country with a decentralized health system, providers and facilities may be able to make significant changes on their own accord, while in countries with a greater emphasis on top-down and centralized decision making, providers and facilities may have little power to exercise without the support of national policies. Similarly, in some health facilities providers may have significant autonomy in their practice and may be able to effect significant changes from their individual effort, while in others contexts facility standards and policies are strictly enforced and individual providers can do little on their own.

The goals of this framework are to make explicit the risk factors and sub-systems that may impact respectful maternity care and to highlight the interconnectedness of each level. The hope is that practitioners working in the field of respectful maternity care will use this framework to identify factors that are relevant and actionable in their particular context while simultaneously recognizing the constraints imposed *and* enablers afforded by other levels of the framework.

Interventions to Promote Respectful Maternity Care

In the previous section, a framework was developed to illustrate the factors and sub-systems that impact the provision of respectful maternity care. In this section, interventions with the potential to address each factor and level of the framework are presented. As noted previously, the choice of an ecological model for the framework was intended to illustrate that all sub-systems and factors therein are interrelated and that all combine to impact the delivery of respectful maternity care. Nevertheless, the interventions presented in this section aim to enable actors at each level of the framework to be proactive in creating change, given whatever context and resources that are present. Ideally, no one intervention presented below should be used in isolation—rather, by combining interventions that address the various sub-systems relevant to respectful maternity care, actors at multiple levels will be proactively engaged, increasing the chances for meaningful change.

The interventions described below have been culled from a wide variety of technical fields and geographic locations. To date, none of these interventions have been evaluated for their success in promoting respectful maternity care specifically, however, each was judged by the author to have the potential to contribute to reducing the prevalence of disrespect and abuse and promoting the provision of respectful care. The evidence available to support each intervention is presented below.

Interventions to Support Individuals and Communities

Community Monitoring Groups

Rationale: Community monitoring groups would address two risk factors of disrespect and abuse: lack of community engagement and oversight of local public health facilities, and the pervasive lack of any accountability mechanism at many facilities. Community monitoring groups have the potential to supply "constructive accountability," the aims of which are not to find fault but to develop "a dynamic of entitlement and obligation between people and their government" to ensure that health systems are functioning to the benefit of those they are intended to serve.[34]

Description: Community management and monitoring committees can take several forms, depending upon the local context. The key functions of such committees are to provide a bridge between the facility and community, to communicate the concerns of the community to health facilities, to communicate educational message from the health facility to the community, and to develop a local monitoring plan. An example of such a program can be found in India with the SAHAYOG organization.[35] SAHAYOG formed a grass-roots women's organization to develop local leaders who could take ownership over their health facilities. Local women's organizations were trained to monitor the local health budgets, the standards of their local facility, and maternal and child health outcomes at the local facility. SAHAYOG assisted the women's group in compiling the data they collected into reports and press briefings, and the women engaged yearly in a dialogue with officials from their local facility to present their findings and discuss potential quality improvement projects.

Evidence: The evidence in support of community monitoring groups is largely qualitative. The SAHAYOG project found that the women's groups created a strong voice for accountability and increased women's knowledge of their rights, thereby reducing information asymmetry. A CARE project in Nepal that implemented community management committees documented qualitative evidence of an increased demand for services due to increased community engagement with the facility, and reported that community members felt empowered and an increased sense of ownership due to the management committees.[36]

Community Values Clarification

Rationale: Values clarification is "the process of examining one's own values and moral reasoning" and has been done since the 1960s in a wide variety of fields.[37] The goal of a values clarification exercise is to engage in a process of self-examination to clarify and affirm beliefs on a certain subject so that

awareness and comfort in taking action are increased. The non-profit organization Ipas, which is focused on ensuring women's access to sexual health and abortion services, has used values clarification extensively to "promote increased support, advocacy, and provision of high-quality, woman-centered abortion care and sexual and reproductive rights" among communities, healthcare providers, administrators, and policymakers.[38] Although childbirth is not as stigmatized an issue as abortion, values clarification holds potential for promoting respectful maternity care by engaging communities to think about what respectful maternity care means to them and empowering them to act to ensure that these values are embodied in and acted upon at their local health facilities. Values clarification at the community level would thus address two risk factors: lack of community engagement with the health facility, and community and individual normalization of disrespect and abuse.

Description: Values clarification is a three-step process that involves: choosing a value (and understanding its consequences), prizing the value, and acting in accordance with the value. Ipas has designed a values clarification workshop curriculum built upon the principles of adult learning, which places an emphasis on self-reflection, small group work, and dialogue.[38] The Ipas toolkit includes detailed instructions for 14 activities; although these activities are specific to abortion values clarification, they could be modified to focus on values clarification surrounding respectful maternity care (and this has been done by the Population Council in Kenya).[33] Depending upon the context and funding, workshops can be held for several hours or several days and include 10-50 participants. At the community level, values clarification exercises should include members of the community monitoring group for the local facility (if established), local political and religious leaders, and influential women/ traditional birth attendants from the community.

Evidence: Ipas does not report results of values clarification workshops focused specifically on community members and leaders. However, workshops that included community members, providers, and policymakers in Nepal and South Africa showed promising results, although the level of evidence is not particularly strong. In Nepal, matched surveys from pre- and post-workshop indicate that participants displayed positive shifts in abortion rights attitudes, and providers reported increased comfort in providing abortion care.[38] In South Africa, qualitative and quantitative assessments were conducted on nearly 200 workshop attendees, although all information on initial attitudes and beliefs was collected retrospectively. Attendees reported increased personal awareness of their own feelings and increased compassion for women who undergo and providers who conduct abortions.[39] These findings are significant because research has consistently demonstrated that "beliefs and norms are associated with behavioral intention, which in turn is what best predicts behavior or performance." Thus, although no reliable behavioral measures were collected, there is reason to believe that changes in attitude may manifest in behavioral modification.[38]

Open Birth Days

Rationale: Despite high antenatal care utilization rates in many countries, qualitative evidence suggests that birth preparedness is often lacking and that it is not uncommon for women to arrive at facilities to deliver without an understanding of the process of registration and the progression through labor, delivery, and postnatal wards.[14] These processes, however, can be complicated and overwhelming for women, contributing to their emotional stress. If women are unaware of the quality of care that they should receive, they are unable to advocate for their rights to these services. Additionally, if women are unaware of the process they will be going through their behaviors may inadvertently increase the stress-levels and workloads of providers. Open Birth Days are an opportunity to assist patients in understanding the expectations that providers have of them and how to most effectively work with providers to ease the providers' jobs and enable them to provide respectful maternity care.[33]

Description: The concept of Open Birth Days has been proposed as a mechanism for women to become familiar with the facility at which they will deliver and to learn what they should expect during labor and delivery and the quality of care to which they are entitled.[33] The format that such an intervention would take would necessarily depend upon the staffing levels and layout of the facility. The Population Council

in Kenya has piloted Open Birth Days; at these facilities, a tent was set up outdoors and women were encouraged to come with their husbands to hear about the delivery process at the facility from staff members. When possible, women were also taken indoors to see the labor and delivery facilities and become familiar with what to expect when they come to deliver.

Evidence: The results of the Population Council pilot in Kenya have not yet been analyzed and published. However, preliminary evidence suggests both that women are excited to come and are showing up in good numbers, and that nurses like and support these sessions.[33]

Humanization of Childbirth Interventions: Patient Birth Companion/ Advocate, Ability to Choose Birthing Position, and Ability to Move During Labor

Rationale: As described previously, the Humanization of Childbirth movement sought to put women at the center of all care and decision making. To operationalize this goal, the movement supported a variety of interventions, including allowing women to choose a birth companion, allowing women to choose a birth position, and giving women the freedom to move around during delivery. Birth companions—often family members—provide emotional support to women during labor and delivery, making the entire process friendlier and less stressful. Additionally, in overcrowded facilities where the number of laboring women vastly outnumbers the capacity of providers to care for them, birth companions can provide food, water, enable the mother to move around as necessary, and advocate for the mother when she needs attention and medical care. Similarly, the ability to choose a birthing position and to move about during labor increases the comfort of women, shows respect for their cultural practices, and puts them at the center of the birthing experience. These interventions, therefore, would address the lack of empowerment risk factor.

Description: The mechanisms of the interventions themselves are quite simple and self-explanatory. In practice, however, they will require changes in facility policies, which could be brought about through Standards-Based Management and Recognition (SBM-R) (as discussed below under facility interventions), and slight upgrades to infrastructure (if necessary to accommodate different birthing positions).

A more complicated birth companion intervention is the institutionalization of doulas—nonclinical, trained childbirth assistants.[40] The role of a doula is to provide continuous support and care throughout the birthing process, to be an advocate for the woman, and to complement—not replace—clinical care. Care from doulas has been shown to lead to better birth outcomes and more satisfied patients, even when the doula is complementary to a relative or partner, indicating that allowing women to choose a birth companion *and* receive care from a doula would be beneficial.[41] Doulas can also play an important role in crowded facilities in which it is simply not possible for all women to have a birth companion. By assigning doulas to three or four beds in the labor ward, these women would have the benefit of a doula's support and advocacy without overwhelming the labor ward with too many extra people.

Evidence: The evidence in support of these interventions is often not disaggregated from larger humanization of childbirth programs, which typically include personnel training, communication activities, and improved health information systems.[11] Although the impact attributable to these selected interventions is difficult to determine, all three require very few resources or infrastructural changes to implement—any gain achieved by them, therefore, would be highly cost-effective. A study in Mozambique found that, when policies were modified to allow birth companions, the percentage of women who chose to have one increased from a baseline of zero percent to 34.2% during labor and 26.8% during delivery in the matter of one year, while the percentage of women choosing to deliver in a vertical position increased from zero percent to 29.5%.[42] Another humanization of childbirth intervention, carried out in Brazil in the 1990s and which allowed women freedom of movement, birth companions, and privacy curtains (in addition to staff trainings) found a substantial qualitative increase in patient satisfaction and a significant quantitative increase in monthly births at the facility (from 30 to 100 over three years).[11] Although this evidence is primarily anecdotal, it provides support for the position that these interventions are desired by women across a range of cultures.

Provider-Centered Interventions

Client-Oriented, Provider-Efficient Services (COPE)

Rationale: COPE is a clinical quality improvement methodology designed by EngenderHealth and Family Care International. The goal of COPE is to create provider involvement and ownership of the quality improvement process.[43] COPE is based on two assumptions—that recipients of care are autonomous clients and have a right to high-quality healthcare, and that healthcare staff want to perform their jobs well. The COPE framework embodies many of the principles of respectful care, and includes seven client's rights (information; access to services; informed choice; safe services; privacy, and confidentiality; dignity, comfort and expression of opinion; and continuity of care) and three staff needs (facilitative supervision and management; information training and development; and supplies, equipment, and infrastructure). COPE has been implemented in a wide variety of clinical settings and geographical locations and can be easily adapted to local needs. The overriding goal of COPE is to enable providers to take responsibility for ensuring that high-quality care is delivered and to be proactive in creating the changes needed to do so, rather than waiting on an external source or facility-led changes. By creating a sense of ability and capacity to effect change, COPE has the potential to reduce the provider demoralization risk factor.

Description: COPE consists of four tools: a series of ten self-assessment guides (one for each of the clients' rights and provider needs listed above), client interview guides, client-flow analysis, and an action plan. The process of self-assessment should be facilitated by a supervisor; the exercises in total require two to three days and should be repeated every three months. The tools enable providers to reflect on how care is currently delivered at their facility, to gain patient perspectives, and to objectively analyze the flow of patients through a facility (to assess waiting times, etc.). These measures are then compared to the standards established by the COPE framework, and an action plan is developed in collaboration with other providers to address any deficiencies. The action plan should consist of items that the providers themselves can take responsibility for enacting, with a focus on teamwork. The COPE cycle is a continuous feedback loop, with participants continually re-assessing client rights and provider needs and incorporating their findings into the next quality improvement cycle. Although the COPE framework is already focused on many components of respectful maternity care, the precise content of the self-assessment guides could be modified to ensure that all seven elements of disrespect and abuse are addressed.

Evidence: A longitudinal, quasi-experimental analysis of COPE for child health services was conducted in Kenya and Guinea in 1999-2000 with eight intervention and eight control sites.[44] For the analysis, a total of 167 interviews and 88 focus groups were conducted, along with 160 exit interviews of adults who had brought their children to the facility for care and 320 observations of visits. The results are very promising: staff at interventions sites were significantly more likely to conduct a thorough examination and provide appropriate counseling; to maintain auditory privacy (61% vs. 41%) and visual privacy (59% vs. 40%); and reported greater confidence and better relationships with supervisors and co-workers. Clients were more likely to be very satisfied with their visit (70% vs. 48%), and to say that waiting times were acceptable and that staff treated clients with privacy, confidentiality, and respect. The problems identified and addressed by providers were wide-ranging and included resolution of staff scheduling issues, instituting regular staff meetings, procuring supportive supervision, increased community outreach, and significant changes in staff attitudes and treatment of patients. These results emphasize that COPE is really an exercise in root cause analysis and provider empowerment.

Internal Ombudsmen

Rationale: The UN "Technical Guidance on the application of a human rights-based approach to the implementation of policies and programmes to reduce preventable maternal morbidity and mortality*"* states that a rights-based approach necessitates the "full-respect" of the rights of both the health system users (patients) and health workers.[32] As noted in the framework above, when health worker's rights

are violated and they are abused by their superiors and administrators, they are more likely to disrespect and/or abuse their patients. To ensure that provider's rights are respected, the Technical Guidance recommends the implementation of internal facility ombudsman.

Description: An ombudsman is an individual tasked with neutrally investigating complaints and mediating settlements. An internal facility ombudsman would be someone with whom health workers could officially log complaints about the working environment and co-workers without fear of retribution. The ombudsman would ensure that their complaints are adequately investigated and, if necessary, appropriate actions taken. Such a system would hold the facility accountable for the way in which its employees are treated.

Evidence: Ombudsmen were initially conceived of as mechanisms for citizens to make complaints against their government. Over the last 50 years, the number and location of ombudsmen has expanded greatly, and they are now found outside of government in both public and private institutions.[45] Most examples of hospital-based ombudsmen in the literature were focused on addressing patient, rather than provider, complaints, and this author found little quantitative evidence of the efficacy of internal ombudsmen in promoting health worker's human rights. Nevertheless, the generic ombudsmen model has been validated and widely accepted across a range of geographic locations and work environments, including universities and private companies, and there is no reason to believe that an internal facility ombudsmen, if truly an independent and neutral individual, would not live up to this legacy.

Values Clarification

Rationale: As described above under community and individual-focused interventions, values clarification is a process designed to engage in self-examination to clarify and affirm beliefs on a certain subject such that awareness and comfort in taking action are increased. When working with healthcare providers, the intention is to promote an understanding of self, including values and biases, so that providers can give the care that they themselves would like to receive. A values clarification exercise focused on healthcare providers would therefore address two risk factors for disrespect and abuse: provider distancing and provider prejudice.

Description: A values clarification exercise focused on providers would utilize essentially the same methodology described above under community/individual interventions. The Ipas toolkit could again be used, with alterations to address respectful maternity care instead of stigma. When selecting participants for the exercise, no providers should be placed in a group with their supervisors—this limits their honesty and ability to openly examine their beliefs and practices.[33]

Evidence: As noted above, Ipas reports results only for workshops that include a mix of participants. However, results from these workshops are promising, with highly significant proportions of participants reporting increased compassion, increased personal awareness, and changes in personal behavior.

Balint/ Peer-Support Groups

Rationale: Burnout, characterized by a persistent negative attitude towards work, exhaustion, distress, decreased motivation, and dysfunctional attitudes and behaviors, is a unique form of job stress that often leads to the depersonalization of clients.[46] There is evidence that healthcare workers experience higher levels of stress and psychological ill-health than other professionals, making them more susceptible to burnout and necessitating burnout interventions designed specifically for healthcare providers. A systematic review of studies from Europe, North America, and Asia found that two types of interventions are useful in preventing and addressing burnout amongst healthcare workers: person-directed (such as mindfulness training, as described below) and work-directed (such as colleague support and participatory problem solving).[27] The systematic review assessed the efficacy of the included studies using the Maslach Burnout Inventory (MBI), a validated 22-item survey for measuring burnout that consists of three subscales: emotional exhaustion, personal accomplishment, and depersonalization. The review concluded that person-directed interventions significantly reduced emotional exhaustion as well as lack of personal accomplishment, but not depersonalization. Work-directed interventions, however, reduced the

depersonalization subscale significantly and did not impact the other two scales. This seems to imply that a combination of the two types of interventions could reduce all three scales of the MBI, thereby decreasing provider burnout and demoralization *and* the impacts of this burnout on patient care. Thus, peer-support groups should be advocated for in conjunction with mindfulness training in order to maximize the benefit of both interventions.

Description: A Balint group is a group of six to ten physicians who meet regularly (weekly or bi-weekly) to present clinical cases in order to better understand the physician-patient relationship and promote patient-centered care.[47] This well-established model is just one example of a peer-support group; such groups are intended to be working, not therapeutic, groups that provide an opportunity for discussion and reflection with colleagues focused on work-stress and burnout. The aim of such groups is to provide an open space in which to collectively brainstorm stress-management techniques and methods for ensuring quality patient care and interactions, despite workplace stresses.[48] These groups have been implemented in a variety of formats. A study among nurses at a university hospital in Turkey formed support groups of twelve nurses and, over seven sessions, provided a background in coping mechanisms, basic communication skills, problem-solving methods, and practice using the problem-solving method to address stressful situations nurses encounter in the workplace.[49] Following these training sessions, nurses continued to meet regularly to discuss problems and stresses in the workplace and collectively brainstorm methods for handling such situations. A study in Sweden formed peer-support groups for nurses that met for ten weekly meetings, for two hours at a time.[48] The groups were managed by a group leader with three days of training in how to facilitate the group discussions, without intervening.

Evidence: A review of Balint group participants in Sweden found that regular participants reported more positive feelings about their work and their relationships with patients.[50] Although Balint group participants and non-participants described similar workloads, Balint participants reported higher satisfaction with management of work hours and workload, indicating that they may have developed coping strategies that improved their stress management. The Turkish study found a significant decrease in emotional exhaustion after the implementation of support groups and the Swedish study found a decrease in exhaustion, disengagement, depression, anxiety, and perceived quantitative demands at work. However, both the Turkish and Swedish studies found that these benefits disappeared after six to twelve months. Similarly, a systematic review of staff-support interventions (including formal and informal staff support groups) found some limited evidence that these groups reduced job-stress in health workers in the short term, but that any beneficial effects waned beyond one-month post-intervention when no refresher sessions were conducted.[51] However, the review found strong evidence that intensive, long-term inventions can reduce job stress and risk of burnout among a variety of healthcare workers. In total, the evidence suggests that peer-support groups have great potential for both preventing and mitigating burnout if the groups are conducted frequently and regularly over the long term.

Sensitization and Mindfulness Training

Rationale: Mindfulness practice "refers to the cultivation of conscious awareness and attention on a moment-to-moment basis" and in clinical practice serves as a stress-reduction and burnout reduction/prevention mechanism.[52] Successful practice of mindfulness may decrease provider demoralization, decrease provider distancing from clients by reducing provider burnout, and reduce the impact of providers' prejudices on the care they give.

Description: The concept of mindfulness is one that needs to be practiced to be understood. Training therefore typically involves an overview of the concept followed by simulated practice. An intervention with a facility admissions team involved three one-hour training sessions focused on the concepts of mindfulness, practice meditating, and practice maintaining attention in the present moment.[53] Similarly, a study designed to promote mindfulness and empathy amongst psychotherapists employed an introductory workshop with sessions on the concept of mindfulness, practice meditating, and practice with mindful breathing techniques. Additionally, a series of role-play exercises was used, with the participant alternating between the client and therapist.[52]

Evidence: As noted above, a systematic review of burnout prevention and treatment interventions found that person-directed interventions, such as mindfulness, significantly reduce burnout and the emotional exhaustion and feelings of a lack of personal accomplishment that accompany burnout.[27] The study involving the facility admissions team reported an increase in "family friendliness," which included supporting family involvement in care and valuing and respecting the cultural characteristics of the family. Notably, the gains were maintained at a six-month follow up. However, the study involved fewer than ten participants and the results are therefore susceptible to significant bias and lack of statistical power. The study with psychotherapists was also a small pilot study, and participants self-selected into the study making the generalizability of the results questionable. Nevertheless, participants reported increased empathy and compassion with the client's emotional experience and an increased awareness of their strengths and weaknesses as therapists. As with peer-support groups, it is vital that mindfulness training interventions promote the regular and frequent practice of mindfulness exercises in order to ensure that the benefits are sustained over the long term.

Visual Metaphors

Rationale: Visual metaphors are a form of sensitization training used by the United Kingdom Royal College of Nursing in their national campaign "Dignity at the Heart of Everything We Do," which was designed to prioritize dignified nursing care.[54] The goal of visual metaphors is to encourage nurses to view common examples of non-dignified care from an objective perspective in order to understand how patients are affected by these behaviors and reduce provider prejudice and distancing.

Description: The Dignity at the Heart of Everything We Do campaign created a support packet including a DVD and facilitator guide. The DVD showed non-healthcare scenes as examples of undignified treatment, including vignettes designed to elicit feelings of being inappropriately dressed, breaches of privacy, being ignored, being patronized, and being dependent. Following each vignette, an on-screen caption reads "How would you feel if you were treated like this?" to encourage providers to self-reflect and identify with the victim.

Evidence: The Royal College of Nursing commissioned an evaluation of the campaign in 2009 (one year after implementation). The evaluation was comprised of a multiple case-study design including 51 interviews and direct observation of the physical environment. A common theme that emerged from the interviews was that the visual metaphors challenged staff defensiveness about their practices and encouraged them to move beyond blame shifting to critically examine and discuss elements of their own practice that could be improved. Additionally, participants stated that the metaphors increased their awareness of the importance of auditory privacy and non-patronizing communication, and how they might be violating these rights in their own practice. Notably, the findings of the evaluation recommend that visual metaphors be targeted to care teams, instead of individuals, and note the importance of senior staff member support for the success of the intervention. No long term follow up of this campaign has been conducted so it remains unknown how long the effects of visual metaphors last and whether refresher exercises need to be done.

Role-Play Exercises

Rationale: Role-play exercises can be conducted in a variety of forms, but all are designed to encourage participants to see a different point of view than they typically do and to objectively assess common situations. In the promotion of respectful maternity care, the goal of role-play exercises would be for providers to gain an understanding of how disrespectful behaviors—stemming from prejudices and distancing from clients—are experienced by and negatively impact patients.

Description: A 2011 article on using role-play to teach providers communication skills describes three levels of exercises.[55] The most basic level involves a single demonstration role-play with a group of four to eight learners and one supervisor. Participants can take turns playing the patient, and after each "encounter" the group can debrief and discuss the behaviors displayed in the interaction. This level is recommended for beginner participants and facilitators, as group members are each able to take an active

role at some point without being put on the spot if they have little to contribute. The intermediate level involves dyad or triad role-play, in which learners pair up and practice simultaneously (if a third person is involved, he or she can provide feedback). Because the facilitator cannot be involved with all groups at once, the feedback received is typically less specific, making this a good approach if the skill being practiced is not too difficult or if the participants already have a base level of comfort. Finally, the advanced level involves a "hot seat" role-play in which one participant talks to a participant "patient" in front of the group. The authors note that this approach can result in "vivid learning" if done well, but also is the most anxiety producing for participants and requires the highest level of skill from the facilitator. Each of these methods could be tailored to include role-play of disrespectful behaviors, for example disclosing personal information or using harsh language.

Evidence: The same study described above under the mindfulness section also sought to determine the impact of an intermediate-level role play exercise on the family friendliness (supporting family involvement and valuing and respecting the cultural characteristics of the family) of facility admissions teams. Overall, the study found no effect of role-play on family friendliness, and in some instances negative changes were even documented.[53] This study demonstrates how context and content-specific role-play exercises are and the importance of well-trained facilitators. Any use of role-play interventions to promote respectful maternity care should carefully take into account the skill-level of facilitators available and the comfort level of participants with the role-play exercises to maximize the efficacy of the intervention and decrease the likelihood of negative backlash.

Facility-Focused Interventions

Humanization of Childbirth Interventions: Privacy Curtains and Name Tags

Rationale: As described previously, the Humanization of Childbirth movement sought to put women at the center of their care and empower their decision making. To operationalize this goal, the movement supported a variety of interventions focused on making facilities more comfortable and welcoming for women and a more supportive and less stressful work environments for providers. In particular, two interventions—privacy curtains and name tags—are relatively small changes that could be made at the facility level to mitigate the negative impact of poor facility infrastructure on the provision of respectful maternity care.

Description: One of the most obvious examples of disrespect during childbirth is the lack of privacy that comes from women laboring and delivering in open spaces. Hanging cloth curtains around beds to provide separation between individual beds and public spaces and hallways is a simple, fairly inexpensive mechanism to ensure the visual privacy of laboring/delivering women.

Once individual spaces have been set up for women, the addition of nametags to the bed or curtains will facilitate providers using a woman's name to address her, thereby increasing the level of dignified care provided. When providers use a woman's name to address her, the woman becomes humanized as an individual, not just another patient to deal with. This will provide an impetus for the provider to give more dignified care, and make the woman feel more at ease.

Evidence: As noted above, the evidence in support of these interventions is often not disaggregated from larger humanization of childbirth programs, which typically include personnel training, communication activities, and improved health information systems.[11] However, these interventions are relatively straightforward and inexpensive, therefore although the impact attributable to these two specific interventions is difficult to determine, any gain achieved by them should be highly cost effective. As mentioned above, humanization of childbirth interventions in a variety of countries have been documented to improve patient satisfaction, increase facility birth rates, and decrease maternal mortality. [11, 42]

Standards-Based Management and Recognition (SBM-R)

Rationale: Standards-Based Management and Recognition (SBM-R) is a quality improvement model developed by the organization Jhpiego. SBM-R is focused on management solutions to quality improvement and follows four basic steps: setting performance standards based on national or international standards, implementing the standards in a streamlined way, measuring progress, and rewarding achievement through recognition mechanisms.[56] SBM-R is similar to COPE in many ways and both are intended to be participatory processes. COPE, however, is best targeted to healthcare workers to engage them in making changes that are within their control, while SBM-R is best suited to being implemented amongst facility administration and human resource departments to develop facility management standards that facilitate the provision of respectful maternity care. Evidence shows that improving human resource management systems and processes can positively impact clinical indicators and the provision of quality care.[57]

Description: SBM-R starts by engaging unit managers in the process of defining detailed performance standards, ideally based on international or national guidelines. Managers then compare their unit's performance to these standards to identify performance gaps to target.[58] Next, these gaps are grouped into three categories—knowledge and skills, resources, and motivation—and specific interventions, including a timeline and individual responsibilities, are developed to address these gaps. Interventions are implemented by management teams and progress is continually monitored using agreed upon key indicators. SBM-R is one of the only quality improvement models that explicitly includes a recognition and rewards system for the achievement of benchmarks. This model has been implemented to focus on general facility management and specific content areas; although the process is well defined, the focus of the standards and interventions can be modified to fit program needs. Thus, the SBM-R model is amenable to focusing specifically on implementing management systems that promote the delivery of respectful care. In addition, SBM-R provides a mechanism for instituting new facility policies to allow for other interventions such as the installment of privacy curtains, allowing birth companions, and allowing women to choose their birth position.

Evidence: SBM-R has been implemented in several countries and focused on a variety of targets and performance measures.[56] Published evaluations are primarily internal with a pre-post design and most do not have a true comparison group. In all locations Jhpiego has assessed, SBM-R has led to increases in standards met from baseline to post-intervention. In Pakistan, where a control group was used in the evaluation, intervention groups participating in SBM-R achieved a significantly higher proportion of performance standards than controls did.[59] A review of quality improvement models founds that SBM-R is particularly applicable in settings with relatively low adoption and standardization of evidence-based procedures and when new services are being introduced. When focused on a few, targeted standards, it has also been demonstrated to be successful at improving specific aspects of service delivery.[58] This suggests that an SBM-R intervention focused on specific management goals to facilitate respectful care could be an effective mechanism for instituting standards and developing facility leadership.

Supportive Supervision

Rationale: Traditional models of supervision generally rely on external supervisors, usually from the district or regional health administration, to visit health facilities to assess the care being provided. Due to limited budgets and timeframes, these visits are typically short and focused on scrutinizing individual performance and the end results achieved, leading staff to perceive them as policing and blaming exercises.[60] Such supervision systems do not take into account external factors that affect an individual provider's ability to perform his or her work and, by focusing solely on past results instead of looking towards the future, fail to empower workers to improve work processes.

In contrast to traditional supervision systems, supportive or facilitative supervision is designed to emphasize mentoring, joint problem solving, record review, and observation of clinical practice. Supervisory visits from district or regional personnel typically last for several days instead of several hours so that the supervisor can observe the facility and workers as they naturally operate and dedicate

significant time to providing constructive feedback and engaging in joint problem-solving activities. Under such a system, supervisors provide a key link between facility management and staff by continuously updating management on progress being made and barriers that need to be addressed, thereby providing leadership for voicing staff concerns. If supervisors are trained in respectful maternity care principles and supervisory visits are designed to emphasize the review and facilitation of respectful care provision, supportive supervision can be a powerful mechanism for improving care on both the provider and facility levels.

Description: Supportive supervision is typically provided by district, regional, or national representatives who are responsible for overseeing facilities within a specific geographic region, however supervision can also be provided by intervention program staff or facility-based supervisors. Regardless, supervision should be systematic and routine, occurring at specified set intervals.[61] A program in Tanzania run by the World Lung Foundation utilizes supportive supervision in its quality improvement efforts.[22] Providers are trained in emergency obstetric care and then sent back to their health facilities. Supportive supervision by a trained specialist is then provided for two weeks in the health facility. The supervisor observes the provider from the moment a patient walks in the door to when they leave to provide live case management guidance and hands-on, practical mentoring on both the clinical and interpersonal aspects of care. After the initial two weeks, supportive supervision occurs at regular intervals for one week at a time; additionally, all facilities participate in weekly conference calls with program staff to check-in regarding progress and challenges. This is only one model for supportive supervision, and the finer details, including length of supervisory visits, could be altered based on context and funding. It has also been suggested that supervisory visits should include time for the supervisor to speak with clients after they are discharged to assess their satisfaction with the care experience.[22]

Evidence: Studies in several countries have found that supervision is one of the strongest predictors of staff satisfaction [62] and that supportive supervision can lead to significant decreases in the depersonalization subscale of the Maslach Burnout Inventory.[27] A systematic review of supervision interventions found moderate evidence that supervision leads to increases in provider performance, as measured by the percent of clinical criteria met.[63] An intervention in Georgia focused on vaccine delivery found that supportive supervision led to significant improvements in vaccine coverage; providers linked these changes qualitatively to the change from punishment to support, improved knowledge, and an increased sense of job responsibility.[64] Although the Tanzanian intervention mentioned above has not yet been assessed, qualitative evidence suggests that clinicians are very pleased with the program and believe that it is contributing to improvements in respectful maternity care delivery.[22]

Values Clarification

Rationale: As described above under community and individual-focused interventions, values clarification is a process designed to engage participants in self-examination to clarify and affirm beliefs on a certain subject such that awareness and comfort in taking action are increased. When working with health facility administration, the goal of the exercise is to engage participants not only in a process of self-understanding, but also a process of understanding what the true situation is in their facilities to create the motivation for change from the top.

Description and Evidence: The same intervention and results described above under community/individual and provider interventions apply.

Criterion-Based Audits

Rationale: Criterion-based audits have been defined as "a quality-improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and implementation of change." Criterion-based audits evaluate the processes and outcomes of care, and a key feature of these audits is that they are conducted serially to measure progress in outcomes.[65]

Description: Criterion-based audits begin by defining a set of standards that characterize appropriate care. Audit assistants (who are not necessarily medically-qualified) then compare case notes in patient

records against these standards to determine if the criteria are being met.[66] Once the comparison has been completed, the results are fed back to providers and facilities so that needed changes can be made. The clinical focus of standard criterion-based audits is perhaps not sufficient, however, for auditing respectful maternity care practices, as instances of disrespect and abuse may very likely not end up in patient medical records. Therefore, instead of reviewing records to compare to standards, respectful care auditors should conduct clinical observations of the care being provided to women during labor and delivery in order to document instances of disrespect and abuse on specific, criterion-based observation checklists.

Evidence: A review of criterion-based audit interventions to improve the quality of obstetric care found generally positive improvements in clinical outcomes and met standards.[65] Interventions that were the most successful included local stakeholders in the development of the criteria and fed the results back to practitioners in an interactive educational meeting rather than in writing. The review also found that providers are wary of criterion-based audits because they feel they will be unfairly blamed and punished for poor results. Criterion-based audits should therefore be conducted in the spirit of constructive accountability, which seeks not to impart blame but to "develop a dynamic of entitlement and obligation"[34] between women and the health system.

National Systems Interventions

Inclusion of Rights-Based Language and Accountability Mechanisms in Legislation

Rationale: As described in the framework, states have an obligation to respect, protect, and fulfill the human rights enshrined in treaties and conventions to which they are signatories (including those rights that protect against disrespect and abuse, see Table 3). The absence of national laws and policies that promote women's rights to respectful maternity care is a significant risk factor for disrespect and abuse. Furthermore, in the absence of appropriate laws and policies, providers and facilities cannot be held accountable for their actions—another risk factor for disrespect and abuse. Institutionalization of complaint procedures against facilities and providers can take many different forms, but the key is to ensure that the complaint system is transparent, independent, confidential, implemented consistently, and integrated into the relevant legal system.[67] Thus, the inclusion of language promoting the right to respectful maternity care and national accountability procedures in national legislation is a key step for governments to fulfill their legal rights obligations.

Description: The International Initiative on Maternal Mortality and Human Rights has published recommendations for the writing and introduction of rights-based legislation, including the importance of ensuring the meaningful participation of affected groups.[68] The White Ribbon Alliance (WRA) is also actively involved in advocacy efforts to promote the implementation of rights-based language in legislation and to strengthen accountability mechanisms in countries all over the world, including in Nepal where a Safe Motherhood bill is currently under review.[12] The exact form that these processes take is highly dependent upon the local culture and legal system. The White Ribbon Alliance provides open access advocacy tools on its website, including brochures, flyers, posters, and PowerPoint presentations aimed at advocacy, human rights, or clinical audiences. Given the highly technical legal issues involved, an intervention such as this would likely be well served by a partnership with an organization with extensive experience and success in this arena, such as the WRA.

Human Rights-Based National Maternal Health Plan

Rationale: National laws and policies protecting the rights of women to respectful maternity care are essential; however, as noted in the framework, the mere existence of national laws and policies does not ensure that they are followed and enforced. To reach this next level of commitment, a national maternal health plan is needed, as detailed by the United Nations Human Rights Council's (UNHRC) "Technical Guidance on the Application of a Human Rights Based Approach to the Implementation of Policies and Programmes for the Reduction of Preventable Maternal Mortality and Morbidity."

Description: The Technical Guidance, adopted in 2012, is the most technical and specific document ever adopted by the UNHRC on the issue of maternal health and provides actionable recommendations for policymakers to take in order to develop a rights-based National Maternal Health Plan.[69] The document aims to assist policymakers in the processes of planning and budgeting, monitoring and evaluating, and developing accountability mechanisms for rights-based maternal healthcare in their country. In order to move beyond declarative language and ensure implementation, the Technical Guidance emphasizes participation from all levels of the health system (communities, healthcare workers, administrators, policymakers, and donors) in the development of the plan and in bottom-up diagnostic exercises to ensure implementation is occurring as planned, and states that "a 'circle of accountability' must be integrated throughout all stages of planning and implementation, as well as monitoring in order to be transformative."[69] The National Maternal Health Plan advocated for in the Technical Guidance represents a broad, systemic change to national health systems. Although this may incorporate elements not traditionally thought of as impacting respectful maternity care (such as supply chain management), the value of this approach is that it places the rights of women, including rights to respectful maternity care (as detailed in Table 3), at the core of all maternal health planning at the national level, thereby assuring that respectful care is the standard that all policymakers, healthcare workers, and administrators are striving to meet.

Patient Charter/ Bill of Rights

Rationale: As detailed in the framework, disrespectful and abusive behaviors have been normalized amongst many individuals and communities, and a pervasive lack of women's empowerment and accountability mechanisms often means that, even if women do recognize that their care was disrespectful, they have no means by which to issue a complaint. Patient Charters and Bill of Rights are national standards to codify providers' and facilities' responsibilities to protect patients' human rights. When they are made public, they serve to increase awareness of patients' rights to respectful and dignified care (see Table 3) and provide a reference point for patients to issue complaints.

Description: If a country does not already have an existing Patient Charter/ Bill of Rights, one should be established (potentially in conjunction with the development of a Human Rights-Based National Maternal Health Plan, as detailed above). Once developed, Patient Charters or Bill of Rights should clearly and simply lay out the rights of all patients in appropriate language that can be understood by the local patient population. The Charter/ Bill of Rights should be posted largely and prominently in the health facility for all patients to see.

Improvement Collaboratives

Rationale: As described above under the COPE and SBM-R sections, quality improvement models have the potential to substantially decrease disrespect and abuse during childbirth. However, COPE and SBM-R are both focused on specific groups of health workers and facilities and do not contain explicit goals for scale-up. USAID's Health Care Improvement Collaborative model, however, is designed specifically to facilitate scale-up regionally or nationally and to achieve consistent application of quality improvement efforts.[70] Borrowing this component of Improvement Collaboratives and combining it with either COPE or SBM-R could therefore create an oversight mechanism and indirect governance for respectful maternity care at the regional and/or national level.

Description: Similarly to COPE and SBM-R, Improvement Collaboratives follow a "Plan-Do-Study-Act" cycle. Improvement Collaboratives are unique, however, in that they organize the quality improvement process across multiple sites, with support from the larger health system, to facilitate sharing of ideas and learning across teams to quicken the speed of improvement.[70] To begin a collaborative, an area of focus and relevant standards/goals are agreed upon, usually by the Ministry of Health or a regional body.[58] Representatives from participating facilities gather for a learning session to hear about the implementation package, goals, and methods, and site teams then develop their own plan to achieve these goals. Subsequent learning sessions are scheduled approximately monthly for participants to gather and share their successes and failures with other teams. All teams are required to monitor their

progress and report to the coordinating administrative body, and it is expected that a healthy level of friendly competition will develop to provide teams with extra motivation for implementing change. Typically, a benchmark is set to demarcate an acceptable level of success, and the collaborative continues until sites have met this benchmark and participants believe that change has been institutionalized (usually 9-18 months). If successful, collaboratives can also expand to additional sites. As with COPE and SBM-R, the focus of any Improvement Collaborative can be tailored to the specific program, making this methodology amenable to promoting respectful maternity care.

Evidence: An analysis of 27 collaboratives in 12 countries found that benchmarks of 80% performance levels were reached 87.4% of the time, and 90% performance levels were reached 72.6% of the time, regardless of the clinical area targeted or type of facilities that participated.[70] Additionally, Improvement Collaboratives' successes and ability to scale-up have been documented to stimulate further Ministry of Health buy-in, thereby building stability and further expanding the model.[58]

Integration of Human Rights and Respectful Care into Pre-Service Training

Rationale: It is very clear that the habits and values that healthcare workers form during their medical education and training impact the services they later provide.[21, 22, 78, 79] Most providers enter their professional training with good intentions and motivation to help others, but when instructors and mentors model disrespectful and abusive behaviors, these become the only practices that trainees learn. Although interventions can seek to lessen bad behaviors in a variety of ways, it would be preferable that providers enter their profession with respectful attitudes and practices that can simply be reinforced—rather than changed—through the interventions described above. Furthermore, anecdotal evidence suggests that increasingly, individuals are motivated to enter medical professions by the status and pay that accompany this work rather than by a desire to provide care to others, as evidenced by the extremely disrespectful behaviors of young workers who are "too new" to be burned out.[22] This trend only reinforces the need to provide appropriate training in and modeling of protection of human rights and respectful maternity care during pre-service medical training.

Description: Depending upon the country, training curricula may be set by the Ministry of Health at the national, regional, or district levels or another professional association. Changing the way that training is provided will necessarily involve working with these groups and will be therefore be dependent upon local context. Organizations such as the White Ribbon Alliance are currently involved in advocacy campaigns in many countries to incorporate respectful maternity care standards into all training curricula. Many WRA advocacy tools are freely available and provide excellent models for beginning a new advocacy campaign, or for linking with campaigns already working in any particular context.

Hansen Project on Maternal and Child Health Recommendations

Background

The Women and Health Initiative (W&HI) is a Dean's Flagship Initiative at the Harvard School of Public Health. One of the W&HI's core programs is the Hansen Project on Maternal and Child Health (hereafter referred to as the Hansen Project), supported by Katie Vogelheim and John Hansen. The Hansen Project is a multi-phase undertaking focused on preventing maternal deaths and mitigating the impact of mothers' deaths on their surviving children, with a particular focus in Ethiopia and Tanzania. Phase I of the Hansen Project is specifically focused on improving the quality of care and reducing the prevalence of disrespect and abuse during childbirth at a large, urban hospital in Dar es Salaam, Tanzania and in four rural Primary Health Care Units in the Amhara Region and Southern Nations, Nationalities, and Peoples Region (SNNPR) of Ethiopia. Baseline assessments of the prevalence and underlying contributors of disrespect and abuse at these facilities are being completed in the spring and summer of 2013; once baseline data has been collected, the W&HI will lead stakeholders in identifying interventions to promote respectful maternity care for each location.

This presents an ideal opportunity to test the framework and catalogue of interventions developed in this thesis and assess their usability and appropriateness. Key-informant interviews with clinicians and public health practitioners in Ethiopia and Tanzania were conducted to gain an understanding of the local context and determine which risk factors were most salient to each location. The information obtained through interviews was then used to select ten interventions to recommend for each country. The ultimate decision about which intervention(s) to pursue will be made by local stakeholders and communities.

Interventions for Tanzania

In collaboration with Management and Development for Health, a Tanzanian non-profit organization, the Hansen Project is working in Temeke District Hospital in Dar es Salaam, Tanzania. This large, urban hospital typically sees 60 to 80 births per day. Administrative and managerial responsibilities are split across a variety of stakeholders at Temeke, including District and Regional Ministry of Health officials, the Hospital Director, Medical Director, ward in-charges, and the hospital board, which includes powerful community representatives. Anecdotal evidence obtained from key informant interviews suggests that there are wide disparities in the quality of care between hospitals in Dar es Salaam; Temeke, which is located in a relatively poor region of the city, has fewer resources than some other hospitals and the quality of care provided is correspondingly lower.[14] Healthcare workers at Temeke (and in Tanzania generally) have extremely high workloads and often feel underappreciated and under paid.[14] Given this context, the following interventions are recommended for the Hansen project in Temeke District Hospital:

Individual and Community

1. **Community Values Clarification:** The Temeke hospital board is a key decision maker in budgeting and resources allocation issues, and this board includes several influential community members known as *diwanis*.[14] *Diwanis* are elected by their community to further the interests of the community and its members, and represent key linkages between the community and the hospital. In order to generate greater community oversight of Temeke District Hospital and to engage the community to create demand for respectful maternity services at Temeke, *diwanis* should be approached to participate in and facilitate community values clarification exercises.

2. **Open Birth Days:** Anecdotal evidence suggests that many women who deliver at Temeke District Hospital are unaware of their rights and have come to accept disrespectful and abusive behaviors as standard.[14] Additionally, the registration process at Temeke can be confusing and women are often unaware of how to prepare for their facility-based delivery. To counteract these two issues, Open Birth Days should be instituted at Temeke District Hospital. These could be held monthly or bi-monthly and should include instruction on how to prepare for delivery, when to come to the facility, who and what to bring, and what to expect during delivery. Such an intervention is expected to increase patients' comfort levels and empower them to ask for respectful maternity care; additionally, Open Birth Days could assist patients in understanding the expectations that providers have of them and how to most effectively work with providers to ease the providers' jobs and enable them to provide respectful care.

    Qualitative evidence suggests that many women bypass lower level health facilities to come directly to Temeke District Hospital to deliver, even when they have had a healthy pregnancy and are not experiencing complications, leading to substantial overcrowding at Temeke.[29] Indeed, a small fraction of women who deliver at Temeke have been referred.[14] Holding Open Birth Days at Temeke District Hospital is valuable, but would only benefit this small fraction of women. Therefore, additional Open Birth Days at feeder health facilities are also recommended. These would provide an opportunity for women to see the acceptability of delivery wards at their local health facility and encourage them to deliver there when appropriate. Additionally, general education provided at Open Birth Days on how to effectively work with providers would be applicable no matter where the woman eventually delivers.

3. **Humanization of Childbirth Interventions:** The labor and delivery wards at Temeke District Hospital are extremely overcrowded.[29] As a result, women are not allowed to bring a birth companion, and their ability to move about during labor and choose the birthing position that they are most comfortable with is limited. Due to space constraints, it is not practical to recommend that every woman be allowed a birth companion; instead, doulas should be present to provide care to zones of beds within the ward (preferably no more than three to four beds per doula). In addition to comforting patients, these doulas could enable them to move about as needed, provide food and water, and advocate for patients to receive the medical care they need from nurses and other clinicians. In order to gain provider acceptance, doulas should be promoted as a form of stress reduction for providers—this intervention would benefit providers as much as patients.

Provider

4. **Values Clarification:** As noted above, providers at Temeke District Hospital have high workloads and are stretched extremely thin. High levels of stress may contribute to disrespectful and abusive behaviors, but most providers entered their profession inspired by the motivation to provide care to others. Values Clarification exercises for providers allows them to reassess their values and motivations for the work that they do and reflect on the repercussions of their actions experienced by patients. Instituting change at Temeke is a complicated process due to the multiple levels of bureaucracy; values clarification, however, empowers providers to use their own personal beliefs to enact changes within their personal locus of control.

5. **Visual Metaphors:** In a facility as large and complex as Temeke District Hospital, blame shifting for disrespectful and abusive behaviors is easy and common. As described above, however, visual metaphors are useful tools for encouraging providers to move beyond blame shifting, to take responsibility for their actions, and to understand how their behaviors impact patients.

6. **Internal Ombudsmen:** Given the size and bureaucracy of Temeke District Hospital, it is difficult for providers to lodge complaints when their rights are violated and/or ensure that these complaints are addressed. An internal ombudsman could resolve this issue and ensure that providers' rights are being protected. However, in order to effect any change, the ombudsman would have to truly be a neutral, impartial, and non-political employee—anything less would likely have little impact, or even make the situation worse for providers. Given the strict requirements for the ombudsman, this intervention should not be undertaken until sufficient political will has been established and resources made available to ensure sustainability.

7. **Peer Support Groups:** Temeke District Hospital, as noted above, has an extremely high patient throughput and limited space and resources. As a result, providers work very long and stressful hours day in and day out, and burnout is reportedly high. Peer support groups would provide a valuable outlet for providers to discuss with their colleagues the stresses that they encounter and possible mechanisms to reduce this stress and improve their interactions with patients, thereby reducing provider burnout. Marketing these groups to providers should emphasize that these groups are intended to be a benefit, not another obligation or task for providers to complete.

8. **Mindfulness Training:** An important complement to peer support groups (as discussed previously) is mindfulness training. Together, these two interventions have been shown to reduce all three subscales of the Maslach Burnout Inventory. In the context of Temeke District Hospital, mindfulness training could be portrayed as prayer or mental touchstones that a provider is encouraged to return to at certain points during the day or whenever particularly stressed.

Facility

9. **Supportive Supervision:** The Tanzanian Ministry of Health and Social Welfare has developed a Supportive Supervision manual for the provision of HIV/AIDS-related services, and this document could provide a starting point for supportive supervision focused on respectful maternity care.[71] The Manual details the attributes and competencies that supportive

supervisors must possess and establishes a national system of supervision in which national teams supervise regional teams, who supervise district and council teams, who in turn supervise district hospitals. At lower level health facilities, supportive supervision is internal and conducted by the facility health management team. Principles of respectful maternity care could easily be integrated into this model, but larger changes to the model would also be beneficial. Currently, the model relies on short half-to-full day supervisory visits that are based around specific checklists. However, evidence suggests that checklists are too authoritative and that live case management or other interactive—and more time intensive—forms of supervision are better received and more effective.[72] Given the complex nature of respectful maternity care, it is therefore recommended that supervisory visits be extended to last for several days at a time and consist of live case management to actively engage providers in furthering their ability to provide respectful maternity care.

National Systems

10. **Improvement Collaboratives:** In 2010, the Tanzanian Ministry of Health and Social Welfare instituted Standards-Based Management and Recognition (SBM-R) in facilities to improve the quality of emergency obstetric care provision.[73] As previously mentioned, hospitals in Dar es Salaam provide vastly different levels of care quality. Although hospitals are working with different budgets and sets of resources, there is likely much that administrators can learn from the examples of other area hospitals. To address these inequities and improve the level of respectful maternity care provided at all city hospitals, it is recommended that an improvement collaborative be set up between hospitals to share successes and lessons learned from the facility-based SBM-R processes that are currently being undertaken. These processes will need to be modified slightly to explicitly include standards of respectful care.

Interventions for Ethiopia

In Ethiopia, the Hansen Project is working in collaboration with Last Ten Kilometers (L10K), an Ethiopian affiliate of John Snow Incorporated. The health facilities of interest in Ethiopia are four Primary Health Care Units (PHCU), each of which consists of five Health Posts and one Health Center, in Amhara and SNNPR Regions. PHCUs are the lowest level of the referral chain in Ethiopia and are designed to serve the needs of individual communities, with each Health Post expected to serve approximately 3-5,000 people and each Health Center designed to serve 15-20,000.[74] Ethiopia has extremely low rates of facility-based delivery (approximately 10% in 2011) [75] and, in contrast to Temeke District Hospital, a Health Center or Health Post may only have one delivery per day. Health Posts are staffed with Health Extension Workers, a trained, non-clinical cadre of frontline community-based workers, and Health Centers are staffed by nurses, midwives, and doctors.[76] Cultural and religious practices surrounding childbirth, including coffee ceremonies and the ritualistic burying of the placenta, are common and considered extremely important in Ethiopia, but are typically not permitted in health facilities.[78]

Individual and Community

1. **Community Monitoring Groups:** The extremely low rate of facility-based childbirth in Ethiopia is an indicator of the disconnectedness of communities from the health facilities that are designed to serve their needs. As noted above, one of the key functions of community monitoring groups is to serve as a bridge between the facility and community, creating accountability and facilitating two-way communication. The relatively small size of the health facilities involved in the Hansen Project in Ethiopia makes them well suited to working with community monitoring groups. By creating community ownership and oversight of the PHCUs, it is hoped that facility utilization rates would increase and community-facility relations would improve, as seen in the SAHAYOG example.

2. **Community Values Clarification:** Qualitative evidence suggests that women and communities are not aware of their rights as patients and are therefore not well positioned to advocate for themselves at health facilities.[78] The goal of a values clarification exercise is to engage participants in the process of clarifying their beliefs and create the impetus for them to act upon these beliefs to ensure that these values are embodied in their facilities. As with community monitoring groups, it is hoped that this activity would create greater linkages between communities and facilities, increase utilization rates, and encourage women and communities to advocate for their rights as patients.

3. **Open Birth Days:** The ultimate goal of Open Birth Days is to bring women to the facilities at which they would deliver to increase their comfort with the process and reduce any anxieties they might have. This intervention is particularly fitting in Ethiopia, given the extremely low facility utilization rates. Open Birth Days would be beneficial in physically bringing women to the facilities and giving them the opportunity to have their questions answered by health personnel. Additionally, this intervention would provide women a venue to give the facility and providers feedback on what they are looking for in a birthing space. For example, ritual coffee ceremonies are a cultural practice surrounding childbirth in Ethiopia. Open Birth Days could provide the means for women to communicate the importance of this ceremony to providers and facilities so that physical spaces and procedural policies could be adjusted to allow for the practice.

4. **Humanization of Childbirth Interventions:** Most women in Ethiopia would prefer that their husband or other close family member is present during labor and delivery.[78] The Health Posts and Health Centers in the Hansen Project have sufficient space to permit each woman to bring a birth companion. Although this practice was recently made universally permitted across Ethiopia, many providers and/or facilities have not yet begun to allow such practices; ensuring that this policy is enforced would increase the comfort of women and decrease the likelihood that health providers would show disrespect during delivery.[78] Additionally, allowing women the ability to move about as desired during labor and choose their birthing position would make facility-based deliveries more culturally-acceptable. Acceptability could be increased even further by showing support for and enabling cultural practices such as coffee ceremonies, as described above.

Provider

5. **Values Clarification:** Anecdotal evidence suggests that healthcare workers in Ethiopia are unmotivated and demoralized by poor pay and often have no knowledge of or training in medical ethics.[78] Values clarification exercises could help to reinforce the initial values that motivated healthcare workers to choose their profession, and remind them of how their actions impact patients. Although in-service values clarification should not be viewed as a substitute for instituting medical ethics education into pre-service training (see below), it could raise awareness of the importance and applications of ethical principles in providers who have missed this initial training.

6. **COPE:** PHCUs in Ethiopia, particularly in rural areas, are often understaffed and underequipped, and their staff are overworked.[78] COPE is a process designed to maximize staff efficacy to create positive changes with the resources that are available to them. The strong, central governance of the Ethiopian health system may create a tendency for healthcare workers and facilities to wait for instructions and supplies from higher levels; the goal of COPE is discourage this passivity and inspire providers to effect meaningful change at the local level. Many PHCUs in Ethiopia, and all that are involved in the Hansen Project, are already engaged in Participatory Community Based Quality Improvement (PCQI) processes under the facilitation of L10K. Although the PCQI process is similar in many ways to COPE, the specific COPE tools (which should be modified to focus on respectful maternity care, as noted above) could be integrated into the process to encourage the very active participation of healthcare workers, in addition to facility management.

Facility

7. **Humanization of Childbirth Interventions:** Many health facilities in Ethiopia are not welcoming or accommodating for patients and do not physically facilitate the provision of respectful maternity care.[78] Simple interventions, such as the addition of privacy curtains, can promote respectful care both by ensuring patient privacy and confidentiality and by making acceptable the presence of family members(s) as birth companions. Organizations such as Pathfinder International have begun developing Women-Centered Facilities in some regions of Ethiopia.[78] Although this project is in the early stages and has not yet been evaluated, these facilities may serve as a good model for how to institute simple, facility-based humanization of childbirth interventions for the Hansen Project.

8. **Supportive Supervision:** Supportive supervision is designed to emphasize mentoring and joint problem solving to empower the supervisee to make meaningful changes in their practice. For providers in small, rural health facilities in Ethiopia, supportive supervision would also allow them to continue developing their clinical skills—a potentially significant incentive that could increase motivation and satisfaction. National Supportive Supervision guidelines exist for Ethiopia, but the extent to which they are implemented varies by location.[78] The guidelines rely heavily on short visits and checklists—two practices associated more with traditional supervision methods than supportive supervision. For the purposes of the Hansen Project, these guidelines could be expanded upon to lengthen the duration of supervisory visits, include a specific focus on respectful maternity care, and add live case management activities to supplement checklists.

National Systems

9. **Integration of Respectful Care Principles into Pre-Service Training:** As mentioned above, education in medical ethics and human rights is often missing in pre-service training in Ethiopia.[78] Because of this, providers may not even be aware that they are providing sub-optimal care, particularly regarding issues such as privacy and confidentiality. Although interventions such as supportive supervision and values clarification can teach providers these concepts once they are working, it would be preferable to have such education occur before providers are deployed to their posts to that no gaps in ethical and rights-based care occur. The Federal Ministry of Health has the authority to require that these principles be included in pre-service training, and it should do so for all cadres of health workers, from Health Extension Workers to specialized physicians.

10. **Human Rights-based National Maternal Health Plan:** As previously mentioned, Ethiopia has a strong national government and national policies are set from the top. However, Regional governments and health systems are responsible for implementing and enforcing these policies. Although human rights and respectful maternity care are included in the relevant and necessary policy documents, the bottleneck to providing these services occurs at the implementation stage.[78] A Human Rights-Based National Maternal Health Plan, as detailed by the UN Technical Guidance, is designed specifically to bridge this implementation gap. The Technical Guidance emphasizes participation from all levels of the health system in the development of the plan and in bottom-up diagnostic exercises to ensure implementation is occurring as planned. The Ethiopian Federal Ministry of Health should engage in such a process with Regional and District-level officials to ensure that their well-intentioned policies are achieving their maximum benefit.

Conclusions

There is little doubt that giving birth in a clean, well-equipped, and adequately staffed health facility reduces the risk of maternal mortality and morbidity.[1, 2] However, despite years of public health programming promoting such behavior, facility-based childbirth rates remain low in many countries.

Traditional explanations for this, including lack of access to facilities or lack of knowledge about the benefits of facility-based birth, are insufficient to explain these low rates. Indeed, there is evidence that women who have the means to access care *and* believe that facility-based deliveries are safest for their health and their child's health are still delivering at home.[4, 8] Increasingly, such reluctance to deliver at a health facility is being linked to disrespectful and abusive provider behaviors during facility-based childbirth. A woman's own past experiences may discourage her from seeking care in the future; additionally, evidence shows that neighbors and communities share experiences of healthcare facilities with each other, and that the poor experience of one person deters their neighbors from seeking care at that facility.[77] The provision of disrespectful and abusive care to one woman therefore has the potential to deter whole communities from seeking maternity services at a facility.

Despite the convincing evidence that disrespect and abuse during childbirth is violating women's human rights and negatively impacting the global push for universal facility-based childbirth, there is very little evidence about which interventions successfully promote increases in respectful maternity care. In this thesis, a framework of risk factors for disrespect and abuse was developed with the goal of helping public health practitioners and clinicians conceptualize the issue for their specific context. The framework categorized risk factors into four levels by their method of action: Individual and Community, Provider, Facility, and National Systems. The boundaries between these levels are nebulous, as each level is a sub-system within the larger healthcare provision system and all levels necessarily interact with and impact each other. The relative weight and importance of each level of the framework depends upon the context to which it is being applied; the goals for the framework are to highlight this interconnectedness and facilitate the identification of factors that are relevant and actionable in any particular context.

To begin to develop an evidence base for the promotion of respectful maternity care, a catalogue of interventions with demonstrated or purported efficacy and with the potential to improve the provision of respectful care was developed, and each intervention was categorized into this new framework. Because respectful maternity care is an issue not constrained by clinical specialty, geographic location, facility type, type of provider, or patient type, interventions from a wide range of disciplines and geographic locations were considered. Similar to the interrelated nature of the framework, many of the interventions identified were complementary and/or overlapping; in some cases, the implementation of one might preclude the need for another, while in others the efficacy of one is likely to be much greater if a second intervention is co-implemented. Given the complexity of providing respectful maternity care and the wide variety of stakeholders involved, no one intervention is likely to be efficacious on its own—coordination and synergy between levels and stakeholders will be required.

Finally, the framework was applied to develop recommendations for the work of the Hansen Project for Maternal and Child Health in Tanzania and Ethiopia. The contexts in which the Hansen Project is operating in these two countries—including the populations served, facility infrastructure, facility commodities, staff training and expertise, and national systems—are vastly different, with different risk factors for disrespect and abuse being prominent in each setting. As a result, there were many differences in the interventions that were deemed to be essential and likely to succeed in each setting. Notably, however, some interventions were recommended for both countries, underscoring that respectful maternity care is a universal issue with some common, underlying factors regardless of context. This exercise was conducted to demonstrate the utility of the framework and catalogue of interventions developed, and will be implemented by the Hansen Project in mid-2013.

Although there is little evidence to date linking any of these interventions with a reduction in disrespectful and abusive behaviors during childbirth, the plethora of interventions identified in this thesis demonstrates that disrespect and abuse is far from an incurable problem and that many potential solutions exist. It is sincerely hoped that this work will be useful as more groups begin engaging with the issue of respectful maternity care, and that the lessons and successes of the Hansen Project will provide additional guidance.

References

1. World Health Organization. Health Statistics and Health Information Systems. http://www.who.int/healthinfo/statistics/indmaternalmortality/en/index.html, accessed March 21, 2013

2. World Health Organization. (May 2012) Maternal Mortality Factsheet. http://www.who.int/mediacentre/factsheets/fs348/en/index.html, accessed March 21, 2013

3. Ronsmans, C., Graham, W. (2006) Maternal Mortality: who, when, where, why. *The Lancet*, 368: 1189-1200.

4. Kruk, M., Paczkowski, M., Mbaruku, G., de Pinho, H., Galea, S. (2009) Women's preferences for place of delivery in rural Tanzania: A population-based discrete choice experiment. *American Journal of Public Health*, 99(9): 1666-1672.

5. Thaddeus, S., Maine, D. (1994) Too far to walk: maternal mortality in context. *Sm. Sci. Med.*, 38(8): 1091-1110.

6. Mamdani, M., Bangser, M. (2004) Poor People's Experiences of Health Services in Tanzania: A literature review. *Reproductive Health Matters*, 12(24): 138-153.

7. "We have no choice." Facility-based childbirth: The perceptions and experiences of Tanzanian women, health workers, and Traditional Birth Attendants. (2009) CARE International in Tanzania and Women's Dignity.

8. Kruk, M., Paczkowski, M., Tegegn, A., Tessema, F., Hadley, C., Asefa, M., Galea, S. (2010) Women's preferences for obstetric care in rural Ethiopia: a population-based discrete choice experiment in a region with low rates of facility delivery. *J Epidemiol Community Health*, 64: 984-988.

9. Shiferaw, S., Spigt, M., Godefrooij, M., Melkamu, Y., Tekie, M. (2013) Why do women prefer home births in Ethiopia? *BMC Pregnancy and Childbirth*, 13(5).

10. Bowser, D., Hill, K. (2010) Exploring evidence for disrespect and abuse in facility-based childbirth: Report of a landscape analysis. USAID TRAction Project.

11. Misago, C., Kendall, C., Freitas, P., Haneda, K., Silveira, D., Onuki, D., Mori, T., Sadamori, T., Umenai, T. (2001) From 'culture of dehumanization of childbirth' to 'childbirth as a transformative experience': changes in five municipalities in northeast Brazil. *International Journal of Gynecology and Obstetrics*, 75: S67-72.

12. White Ribbon Alliance. http://www.whiteribbonalliance.org/index.cfm/the-issues/respectful-maternity-care/. Accessed February 12, 2013.

13. Bronfenbrenner, U. (1979) Towards an experimental ecology of human development. *The American Psychologist*, 32(9): 513-530.

14. Dr. Mary Sando, personal communication (March 27, 2013).

15. Miller, S., Tejada, A., Murgueytio, P., Diaz, J., Dabash, R., Putney, P., Bjegovic, S., Caraballo, G. (2002) Strategic Assessment of Reproductive Health in the Dominican Republic. *Population Council*, New York, New York.

16. Warren, C., Abuya, T., Ndwiga, C., Njuki, R. (2012). Findings from Kenya: Barriers to skilled birth attendance: Disrespect and abuse during health facility deliveries. *International Journal of Gynecology & Obstetrics, 119S3: S161–S260.*

17. Center for Reproductive Rights & Federation of Women Lawyers—Kenya (2007) Failure to Deliver: Violations of Women's Human Rights in Kenyan Health Facilities. Printed in the United States.

18. Bangser, M., Mehta, M., Singer, J., Daly, C., Kamugumya, C., Mwangomale, A. (2011) Childbirth experiences of women with obstetric fistula in Tanzania and Uganda and their implications for fistula program development. *International Urogynecological Journal*, 22: 91-98.

19. Matthews, Z., Channon, A., Neal, S., Osrin, D., Madise, N., Stones, W. (2010) Examining the 'Urban Advantage' in maternal health care in developing countries. *PLoS Medicine*, 7(9).

20. Godfery Mbaruku, personal communication with Kathleen McDonald (January 18, 2013).
21. Leape, L. L., Shore, M. F., Dienstag, J. L., Mayer, R. J., Edgman-Levitan, S., Meyer, G. S., Healy, G. B. (2012) A Culture of Respect, Part 1: The Nature and Causes of Disrespectful Behavior by Physicians. *Academic Medicine*, 87(7): 845-852.
22. Maggie Bangser, personal communication (March 18, 2013).
23. Jewkes, R., Abrahams, N., Mvo, Z. (1998) Why do nurses abuse patients? Reflections from South African obstetric services. *Social Sciences and Medicine* 47(11): 1781-1795.
24. d'Oliveira, A., Diniz, S., Schraiber, L. (2002) Violence against women in health-care institutions: an emerging problem. *The Lancet*, 359: 1681-85.
25. Center for Reproductive Rights (2008). Broken Promises: Human Rights, Accountability, and Maternal Deaths in Nigeria.
26. Leape, L. L., Shore, M. F., Dienstag, J. L., Mayer, R. J., Edgman-Levitan, S., Meyer, G. S., Healy, G. B. (2012) A Culture of Respect, Part 2: Creating a Culture of Respect. *Academic Medicine*, 87(7): 853-858.
27. Marine, A., Ruotsalainen, J. H., Serra, C., Verbeek, J. H. (2009) Preventing occupational stress in healthcare workers. *The Cochrane Library*, Issue 1.
28. Miller, S., Cordero, M., Coleman, A. L., Figueroa, J., Brito-Anderson, S., Dabagh, R., Calderon, V., Caceres, F., Fernandez, A. J., Nunez, M. (2003) Quality of care in institutional deliveries: the paradox of the Dominican Republic. *International Journal of Gynecology and Obstetrics*, 82: 89-103.
29. Brenda D'Mello, personal communication (April 5, 2013).
30. Respectful Maternity Care Advisory Council, White Ribbon Alliance for Safe Motherhood. (2011). *Respectful maternity care: the universal rights of childbearing women*. Washington, DC: WRA. Retrieved February 12, 2013.
31. Fathalla, M. F. (2006) Human Rights aspects of safe motherhood. *Best Practice and Research Clinical Obstetrics and Gynecology*, 20(3): 409-419.
32. U.N. General Assembly. Human Rights Council. Report of the Office of the United Nations High Commissioner for Human Rights on its Twentieth Session. Technical guidance on the application of a human rights-based approach to the implementation of policies and programmes to reduce preventable maternal morbidity and mortality. (A/HRC/21/22). 2 July 2012. (Mimeo)
33. Charlotte Warren, personal communication (March 29, 2013).
34. Freedman, L.P. (2003) Human rights, constructive accountability, and maternal mortality in the Dominican Republic: a commentary. *International Journal of Gynecology and Obstetrics,* 82: 111-114.
35. Dasgupta, J. "Participation of Informed Users in Monitoring Quality of Care." Arusha International Conference Center, Arusha, Tanzania. January 17, 2013. Conference Presentation.
36. CARE (2011) Governance and Health case study: Linking Governance and Empowerment to Improved Maternal and Newborn Health Services in Nepal.
37. Turner, K. L., Page, K. C. (2008) Abortion attitude transformation: A values clarification toolkit for global audiences. Chapel Hill, NC, Ipas.
38. Turner, K. L., Hyman, A. G., Gabriel, M. C. (2008) Clarifying Values and Transforming Attitudes to improve access to second trimester abortion. *Reproductive Health Matters*, 16(31 Supplement): 108-116.
39. Mitchell, E. M. H., Trueman, K., Gabriel, M., Bickers Bock, L. B. (2005) Building Alliances from Ambivalence: evaluation of abortion values clarification workshops with stakeholders in South Africa. *African Journal of Reproductive Health*, 9(3): 89-99.
40. Ballen, L. E., Fulcher, A. J. (2006) Nurses and Doulas: Complementary roles to provide optimal maternity care. *JOGNN*, 35: 304-311.
41. Hodnett, E. D., Gates, S., Hofmeyr, G. J., & Sakala, C. (2003). Continuous support for women during childbirth. *The Cochrane Database of Systematic Reviews*, Issue 3.

42. Reis, V. (2012) Humanizing Childbirth in Mozambique. *International Journal of Gynecology and Obstetrics*, 119S3(S161-S260): I308.
43. EngenderHealth Client-Oriented, Provider-Efficient Services. http://www.engenderhealth.org/our-work/improving-quality/cope.php. Accessed February 10, 2013.
44. Bradley, J. (2002) COPE® for child health in Kenya and Guinea: An analysis of service quality. New York: EngenderHealth.
45. Abedin, N. (2011) Conceptual and functional diversity of the ombudsmen institution: A classification. *Administration and Society*, 43(8): 896-929.
46. Felton, J. (1998) Burnout as a clinical entity—its importance in health care workers. *Occupational Medicine*, 48(4): 237-250.
47. American Balint Society. http://americanbalintsociety.org/content.aspx?page_id=22&club_id=445043&module_id=123029 accessed March 5, 2013.
48. Peterson, U., Bergstrom, G., Samuelsson, M., Asberg, M., Nygren, A. (2008) Reflecting peer-support groups in the prevention of stress and burnout: randomized controlled trial. *Journal of Advanced Nursing*, 63(5): 506-516.
49. Günüşen, N. P., Üstün, B. (2010) An RCT of coping and support groups to reduce burnout among nurses. *International Nursing Review*, 57: 485-492.
50. Kjelmand, D., Holstrom, I., Rosenqvist, U. (2004) Balint training makes GPs thrive better in their job. *Patient Education and Counseling*, 55(2):230-235.
51. Van Wyk, B. E., Pillay-Van Wyk, V. (2010) Preventative staff-support interventions for health workers. *Cochrane Database of Systematic Reviews*, Issue 3.
52. Andersson, L., King, R., Lalande, L. (2010) Dialogical mindfulness in supervision role-play. *Counseling and Psychotherapy Research*, 10(4): 287-294.
53. Singh, N. N., Wechsler, H. A., Curtis, W. J., Sabaawi, M., Myers, R. E., Singh, S. D. (2002) Effects of role-play and mindfulness training on enhancing the family friendliness of the admissions treatment team process. *Journal of Emotional and Behavioral Disorders*, 10(2): 90-98.
54. Baillie, L., Gallagher, A. (2012) Raising awareness of patient dignity. *Nursing Standard*, 27(5):44-49.
55. Jackson, V., Back, A. (2011) Teaching communication skills using role-play: an experience-based guide for educators. *Journal of Palliative Medicine*, 14(6).
56. Necochea, E., Bossemeyer, D. (2005). Standards-Based Management and Recognition, a Field Guide. A practical approach for improving the performance and quality of health services. Published by Jhpiego. Available at: http://www.jhpiego.org/files/SBMR%20FieldGuide.pdf. Accessed February 10, 2013.
57. Crigler L, Boucar M, Wittcoff A, Isenhower W, Wuliji T. 2011. Aligning and Clarifying Health Worker Tasks to Improve Maternal Care in Niger: The Tahoua Region Human Resources Quality Improvement Collaborative. Technical Report. Published by the USAID Health Care Improvement Project. Bethesda, MD: University Research Co., LLC (URC).
58. Tawfik, Y., Segall, M., Necochea, E., Jacobs, T. (2010) Finding Common Ground: Harmonizing the Application of Different Quality Improvement Models in Maternal, Newborn, and Child Health Programs. Technical Report. Published by the USAID Health Care Improvement Project. Bethesda, MD: University Research Co., LLC (URC).
59. Katende, C., Akram, N., Plotkin, M., Saleem, W., Charurat, E. Y., Saeed, N. (2008) Improving Family Planning the Private Sector: Effectiveness of a Quality Improvement Intervention on Clinical Performance. Baltimore: Jhpiego.
60. Salem, B. B., Beattie, K. J. (1996) Facilitative Supervision: A vital link to quality reproductive health service delivery. *AVSC Working Paper*, No. 10.

61. Mogasale, V., Wi, T. C., Das, A., Kane, S., Singh, A. K., George, B., Steen, R. (2010) Quality assurance and quality improvement using supportive supervision in a large-scale STI intervention with sex workers, men who have sex with men/transgenders and injecting-drug users in India. *Sex Transm Infect*, 86(Supplement 1): 83-88.

62. McAuliffe E, Daly M, Kamwendo F, Masanja H, Sidat M, et al. (2013) The Critical Role of Supervision in Retaining Staff in Obstetric Services: A Three Country Study. *PLoS ONE* 8(3).

63. Bosch-Capblanch, X., Liaqat, S., Garner, P. (2011) Managerial supervision to improve primary health care in low- and middle-income countries. *Cochrane Database of Systematic Reviews*, Issue 9.

64. Djibuti, M., Gotsadze, G., Zoidze, A., Mataradze, G., Esmail, L., Kohler, J. (2009) The role of supportive supervision on immunization program outcome—a randomized field trial from Georgia. *BMC International Health and Human Rights*, 9(Suppl 1): S1-S11.

65. Kongnyuy, E. J., Uthman, O. A. (2009) Use of criterion-based clinical audit to improve the quality of obstetric care: A systematic review. *Acta Obstetricia et Gynecologica*, 88: 873-881.

66. Graham, W., Wagaarachchi, P., Penney, G., McCaw-Binns, A., Antwi, K. Y., Hall, M. H. (2000) Criteria for clinical audit of the quality of hospital-based obstetric care in developing countries. *Bulletin of the World Health Organization*, 78(5).

67. Diesfeld, K. (2003) Patients' rights and complaints procedures: international perspectives. *International Journal of Therapy and Rehabilitation,* 10(11).

68. Stoffregen, M., Andion, X., Dasgupta, J., Frisancho, A., Mutunga, A. (2010) Human Rights-based approaches to maternal mortality reduction efforts. International Initiative on Maternal Mortality and Human Rights.

69. Yamin, A. E. (2013) Applying human rights to maternal health: UN Technical Guidance on rights-based approaches. *International Journal of Gynecology and Obstetrics*, http://dx.doi.org/10.1016/j.ijgo.2013.01.002.

70. Franco, L. M., Marquez, L., Ethier, K., Balsara, Z., Isenhower, W. (2009) Results of Collaborative Improvement: Effects on Health Outcomes and Compliance with Evidence-based Standards in 27 Applications in 12 Countries. Collaborative Evaluation Series. Published by the USAID Health Care Improvement Project. Bethesda, MD: University Research Co., LLC (URC).

71. United Republic of Tanzania Ministry of Health and Social Welfare. (March 2010) A Manual for Comprehensive Supportive Supervision and Mentoring on HIV and AIDS Health Services.

72. Bosch-Capblanch, X., Garner, P. (2008) Systematic Review: Primary health care supervision in developing countries. *Tropical Medicine and International Health*, 13(3): 369-383.

73. United Republic of Tanzania Ministry of Health and Social Welfare. (October 2010) Standards-Based Management and Recognition for Improving Quality of Maternal and Newborn Care: Quality Improvement Standards for Hospitals: Assessment Tool.

74. Ethiopia Federal Ministry of Health http://moh.gov.et/

75. Ethiopia Central Statistical Agency and ICF International. 2012. 2011 Ethiopia Demographic and Health Survey: Key Findings. Calverton, Maryland, USA: CSA and ICF International.

76. Sebhatu, A. (2008) Ethiopian Health Extension Program. Partners in Population and Development Africa Regional Office. http://www.ppdafrica.org/docs/ethiopiahep.pdf

77. Leonard, K., Adelman, S., Essam, T. (2009) Idle chatter or learning? Evidence of social learning about clinicians and the health system from rural Tanzania. *Social Science and Medicine,* 69:183-190.

78. Dr. Mengistu Hailemariam, personal communication (April 10, 2013).

79. Dr. Delayehu Bekele, personal communication (April 9, 2013).

Appendix A: Literature Review Methods

Databases searched

1. PubMed
2. Embase
3. Ebsco

Individual Journals Searched

1. International Journal of Nursing Practice
2. Journal of Clinical Nursing
3. Journal of Advanced Nursing
4. International Nursing Review
5. Journal of Nursing Management
6. Nursing and Health Sciences
7. Research in Nursing and Health

Search Terms Used

1. humanized childbirth
2. supportive supervision
3. caring behavior
4. quality improvement
5. fistula stigma
6. HIV/AIDS stigma
7. sensitization training
8. role play
9. universal rights of childbearing women
10. caring for the carers
11. respectful care
12. disrespect and abuse
13. dignified care
14. expert patient

Appendix B: Interview Guides

General Guide

Thank you so much for agreeing to talk with me today! As (Kathleen/ Ana/ Mary Nell) may have mentioned, I am working on my masters thesis, which is focused on respectful maternity care. Specifically, I am working to identify factors that contribute to disrespect and abuse in a variety of settings. I am also doing a literature review of interventions that have been tested for other outcomes that might be transferable to promoting respectful maternity care and that could be used in the W&HI Hansen Project in Ethiopia and Tanzania.

1. To get started, could you tell me about the work that you have done or are currently doing (in Tanzania/in Ethiopia/related to respectful maternity care)? *Prompt: location of work, role/ title, time in position*

2. Who typically cares for women during labor and delivery? Prompt for midwife vs. nurse vs. physician, etc.

3. Can you talk me through the process that women would go through when they come to a facility to deliver? Prompt: registration, rules, who's allowed/not, etc.

4. During this work, have you ever witnessed or heard about instances of disrespect and/or abuse during childbirth?

5. If so, what exactly did this D&A consist of? *Prompt: 7 categories of D&A: Physical abuse, non-consented care, non-confidential care, non-dignified care, discrimination, abandonment, detention*

6. What cadres of health workers were involved in these incidences?

7. In your experience, how common or rare are events such as these?

8. How, if at all, does incidence of disrespect and abuse differ by level of health facility or type of health worker?

9. In your opinion, what factors led to or enabled this disrespect and abuse to occur? *Prompt: patient characteristics (age, ethnicity, education, lack of companion, etc), community characteristics (norms), provider characteristics (prejudice, job dissatisfaction, stress, lack of time, etc), facility factors (poor management, lack of standards, lack of accountability, lack of supervision), policy factors (guidelines, laws, accountability, etc).*

10. Have you ever worked on an intervention aimed towards reducing these types of incidences? (IF YES, SKIP TO QUESTION 12)

11. If you became involved in such an effort, what strategies would you attempt and why?

12. What types of activities did these interventions involve? *Prompt for specifics, ask if they'll share any written materials*

13. How successful or unsuccessful were the activities, and what contributed to this success?

14. What, if anything, would you change if you were to try this again?

15. How transferrable, if at all, do you believe this intervention would be to a new setting?

16. What training and resources were required to implement this intervention?

17. *If experience is in Tanzania or Ethiopia:* In your opinion, what levels of the health system are most critical to engage for the success of an intervention? *Prompt for various levels (national, district, hospital, provider, community*

     a.   How successful, if at all, could an intervention in Tanzania/Ethiopia be if primarily targeted facility management instead?

     b.   Provider and/or patient attitudes?

Fistula Provider-Specific Guide

Thank you so much for agreeing to talk with me today! As (Kathleen/ Ana/ Mary Nell) may have mentioned, I am working on my masters thesis, which is focused on respectful maternity care. Specifically, I am working to identify factors that contribute to disrespect and abuse in a variety of settings. I am also doing a literature review of interventions that have been tested for other outcomes that might be transferable to promoting respectful maternity care and that could be used in the W&HI Hansen Project in Ethiopia and Tanzania.

1. To get started, could you tell me about the work that you have done or are currently doing (in Tanzania/in Ethiopia/related to fistula)? *Prompt: location of work (country, office/ health facility), role/ title, time in position*

2. In my thesis research, I have seen that provider burnout/ compassion fatigue due to training and work conditions is often cited as a cause of disrespectful and abusive behaviors, as is provider prejudice. In your work regarding fistula, how, if at all, are these issues significant?

3. What work, if any, have you done toward addressing these issues? *Prompt: role play exercises, provider sensitization training, etc*

4. What types of activities did these interventions involve? *Prompt for specifics, ask if they'll share any written materials*

5. How successful or unsuccessful were the activities, and what contributed to this success or failure?

6. What, if anything, would you change if you were to try this again?

7. How transferrable, if at all, do you believe this intervention would be to another setting?

8. What training and resources were required to implement this intervention?

9. Another common theme in the respectful maternity care literature is patient empowerment and community engagement. How, if at all, is this significant for the work you do on fistula?

10. What work, if any, have you done toward addressing this issue? *Prompt: patient charter, companion, etc*

11. What types of activities did these interventions involve? *Prompt for specifics, ask if they'll share any written materials*

12. How successful or unsuccessful were the activities, and what contributed to this success or failure?

13. What, if anything, would you change if you were to try this again?

14. How transferrable, if at all, do you believe this intervention would be to a new setting?

15. What training and resources were required to implement this intervention?

Appendix C: Complete Bibliography

Abedin, N. (2011) Conceptual and functional diversity of the ombudsmen institution: A classification. *Administration and Society*, 43(8): 896-929.

American Balint Society. http://americanbalintsociety.org/content.aspx?page_id=22&club_id=445043&module_id=123029 accessed March 5, 2013.

Andersson, L., King, R., Lalande, L. (2010) Dialogical mindfulness in supervision role-play. *Counseling and Psychotherapy Research*, 10(4): 287-294.

Baillie, L., Gallagher, A. (2012) Raising awareness of patient dignity. *Nursing Standard*, 27(5):44-49.

Ballen, L. E., Fulcher, A. J. (2006) Nurses and Doulas: Complementary roles to provide optimal maternity care. *JOGNN*, 35: 304-311.

Bangser, M. (2006) Obstetric fistula and stigma. *The Lancet,* 367: 535-36

Bangser, M., Mehta, M., Singer, J., Daly, C., Kamugumya, C., Mwangomale, A. (2011) Childbirth experiences of women with obstetric fistula in Tanzania and Uganda and their implications for fistula program development. *International Urogynecological Journal*, 22: 91-98.

Barbey, A., Faisel, A. J., Myeya, J., Stavrau, V., Steward, J., Zimicki, S. (2001) Dinajpur SafeMother Initiative Final Evaluation Report. Published by CARE. Available at: http://webtest.dhaka.net/care/publication/Publication_6871971.pdf

Behruzi, R., Hatem, M., Fraser, W., Goulet, L., Masako, I., Misago, C. (2010) Facilitators and barriers in the humanization of childbirth practice in Japan. *BMC Pregnancy and Childbirth*, 10(25).

Behruzi, R., Hatem, M., Goulet, L. Fraser, W., Leduc, N., Misago, C. (2010) Humanized birth in high risk pregnancy: barriers and facilitating factors. *Med Health Care and Philos*, 13: 49-58.

Behruzi, R., Hatem, M., Goulet, L., Frazer, W. (2011) The facilitating factors and barriers encountered in the adoption of a humanized birth care approach in a highly specialized university affiliated hospital. *BMC Women's Health*, 11: 53.

Blum, C., Hickman, C., Parcells, D., Locsin, R. (2010) Teaching Caring Nursing to RN-BSN Students Using Simulation Technology. *International Journal for Human Caring*, 14(2).

Bosch-Capblanch, X., Garner, P. (2008) Systematic Review: Primary health care supervision in developing countries. *Tropical Medicine and International Health*, 13(3): 369-383.

Bosch-Capblanch, X., Liaqat, S., Garner, P. (2011) Managerial supervision to improve primary health care in low- and middle-income countries. *Cochrane Database of Systematic Reviews*, Issue 9.

Bosch, M., van der Weijden, T., Wensing, M., Grol, R. (2007) Tailoring quality improvement interventions to identified barriers: a multiple case analysis. *Journal of Evaluation in Clinical Practice,* 13: 161-168.

Bowser, D., Hill, K. (2010) Exploring evidence for disrespect and abuse in facility-based childbirth: Report of a landscape analysis. USAID TRAction Project.

Bradley, J. (2002) COPE® for child health in Kenya and Guinea: An analysis of service quality. New York: EngenderHealth.

Bronfenbrenner, U. (1979) Towards an experimental ecology of human development. *The American Psychologist*, 32(9): 513-530.

CARE (2011) Governance and Health case study: Linking Governance and Empowerment to Improved Maternal and Newborn Health Services in Nepal.

Carolan, M., Hodnette, E. (2007) "With Woman" philosophy: examining the evidence, answering the questions. *Nursing Inquiry*, 14(2): 140-152.

Center for Reproductive Rights (2008). Broken Promises: Human Rights, Accountability, and Maternal Deaths in Nigeria.

Center for Reproductive Rights & Federation of Women Lawyers—Kenya (2007) Failure to Deliver: Violations of Women's Human Rights in Kenyan Health Facilities. Printed in the United States.

Cheraghi-Sohi, S., Bower, P. (2008) Can the feedback of patient assessments, brief training, or their combination, improve the interpersonal skills of primary care physicians? A systematic review. *BMC Health Services Research*, 8(179).

Crigler L, Boucar M, Wittcoff A, Isenhower W, Wuliji T. 2011. Aligning and Clarifying Health Worker Tasks to Improve Maternal Care in Niger: The Tahoua Region Human Resources Quality Improvement Collaborative. Technical Report. Published by the USAID Health Care Improvement Project. Bethesda, MD: University Research Co., LLC (URC).

d'Oliveira, A., Diniz, S., Schraiber, L. (2002) Violence against women in health-care institutions: an emerging problem. *The Lancet*, 359: 1681-85.

Dao, B. (2012) Respectful Maternity Care: A Clinician's Perspective. *International Journal of Gynecology & Obstetrics,* 119S3: S161–S260.

Dasgupta, J. "Participation of Informed Users in Monitoring Quality of Care." Arusha International Conference Center, Arusha, Tanzania. January 17, 2013. Conference Presentation.

Davenport, A. (2007) Voices from the Village: Improving Lives through CARE's Sexual and Reproductive Health Programs. The FEMME Project in Peru: Partnerships for improved health. Published by CARE. Available at: http://www.care.org/careswork/whatwedo/health/downloads/vftv_peru.pdf

Dieleman, M., Biemba, G., Mphuka, S., Sichinga-Sichali, K., Sissolak, D., van der Kwaak, A., van der Wilt, G. (2007) 'We are also dying like any other people, we are also people': Perceptions of the impact of HIV/AIDS on health workers in two districts in Zambia. *Health Policy and Planning*, 22:139-148.

Dieleman, M., Bwete, V., Maniple, E., Bakker, M., Namaganda, G., Odaga, J., van der Wilt, G. (2007) 'I believe the staff have reduced their closeness to patients': an exploratory study of the impact of HIV/AIDS on staff in four rural hospitals in Uganda. *BMC Health Services Research*, 7(205).

Diesfeld, K. (2003) Patients' rights and complaints procedures: international perspectives. *International Journal of Therapy and Rehabilitation,* 10(11).

Djibuti, M., Gotsadze, G., Zoidze, A., Mataradze, G., Esmail, L., Kohler, J. (2009) The role of supportive supervision on immunization program outcome—a randomized field trial from Georgia. *BMC International Health and Human Rights*, 9(Suppl 1): S1-S11.

EngenderHealth Client-Oriented, Provider-Efficient Services. http://www.engenderhealth.org/our-work/improving-quality/cope.php. Accessed February 10, 2013.

Ethiopia Central Statistical Agency and ICF International. 2012. 2011 Ethiopia Demographic and Health Survey: Key Findings. Calverton, Maryland, USA: CSA and ICF International.

Ethiopia Federal Ministry of Health http://moh.gov.et/

Fathalla, M. F. (2006) Human Rights aspects of safe motherhood. *Best Practice and Research Clinical Obstetrics and Gynecology*, 20(3): 409-419.

Felton, J. (1998) Burnout as a clinical entity—its importance in health care workers. *Occupational Medicine*, 48(4): 237-250.

Franco, L. M., Marquez, L., Ethier, K., Balsara, Z., Isenhower, W. (2009) Results of Collaborative Improvement: Effects on Health Outcomes and Compliance with Evidence-based Standards in 27 Applications in 12 Countries. Collaborative Evaluation Series. Published by the USAID Health Care Improvement Project. Bethesda, MD: University Research Co., LLC (URC).

Franco, L. M., Marquez, L. (2011) Effectiveness of collaborative improvement: evidence from 27 applications in 12 less-developed and middle-income countries. *BMJ Qual Saf*, 20: 658-665.

Freedman, L.P. (2003) Human rights, constructive accountability, and maternal mortality in the Dominican Republic: a commentary. *International Journal of Gynecology and Obstetrics,* 82: 111-114.

Graham, W., Wagaarachchi, P., Penney, G., McCaw-Binns, A., Antwi, K. Y., Hall, M. H. (2000) Criteria for clinical audit of the quality of hospital-based obstetric care in developing countries. *Bulletin of the World Health Organization*, 78(5).

Günüşen, N. P., Üstün, B. (2010) An RCT of coping and support groups to reduce burnout among nurses. *International Nursing Review*, 57: 485-492.

Harvey, G. (2005) Quality Improvement and evidence-based practice: As one or at odds in the effort to promote better health care? *Worldviews on Evidence-Based Nursing*, Second Quarter.

Hodnett, E. D., Gates, S., Hofmeyr, G. J., & Sakala, C. (2003). Continuous support for women during childbirth. *The Cochrane Database of Systematic Reviews*, Issue 3.

Horsman, J., Sheeran, P. (1995) Health care workers and HIV/AIDS: A critical review of the literature. *Social Sciences and Medicine*, 41(11): 1535-1567.

Hunter, L. (2002) Being with Woman: A Guiding Concept for the Care of Laboring Women. JOGNN, 31:650-657.

Hyrkas, K., Koivula, M., Lehti, K., Paunonen-Ilmonen, M. (2003) Nurse managers' conceptions of quality management as promoted by peer supervision. *Journal of Nursing Management*, 11: 48-58.

Ivers, N., Jamtvedt, G., Flottorp, S., Young, J., Odgaard-Jensen, J., French, S., O'Brien, M.A., Johansen, M., Grimshaw, J., Oxman, A. (2012) Audit and feedback: effects on professional practice and healthcare outcomes. *Cochrane Database of Systematic Reviews*, Issue 6.

Jackson, V., Back, A. (2011) Teaching communication skills using role-play: an experience-based guide for educators. *Journal of Palliative Medicine*, 14(6).

Jewkes, R., Abrahams, N., Mvo, Z. (1998) Why do nurses abuse patients? Reflections from South African obstetric services. *Social Sciences and Medicine,* 47(11): 1781-1795.

Kaplan, H., Brady, P., Dritz, M., Hooper, D., Linam, W., Froehle, C., Margolis, P. (2010) The influence of context on quality improvement success in health care: a systematic review of the literature. *The Milbank Quarterly*, 88(4):500-559.

Katende, C., Akram, N., Plotkin, M., Saleem, W., Charurat, E. Y., Saeed, N. (2008) Improving Family Planning the Private Sector: Effectiveness of a Quality Improvement Intervention on Clinical Performance. Baltimore: Jhpiego.

Kayongo, M., Esquiche, E., Luna, M., Frias, G., Vega-Centeno, L., Bailey, P. (2006) Strengthening emergency obstetric care in Ayacucho, Peru. *International Journal of Gynecology and Obstetrics*, 92:299-307.

Kjelmand, D., Holstrom, I., Rosenqvist, U. (2004) Balint training makes GPs thrive better in their job. *Patient Education and Counseling*, 55(2):230-235.

Kongnyuy, E. J., Uthman, O. A. (2009) Use of criterion-based clinical audit to improve the quality of obstetric care: A systematic review. *Acta Obstetricia et Gynecologica*, 88: 873-881.

Kruk, M., Paczkowski, M., Mbaruku, G., de Pinho, H., Galea, S. (2009) Women's preferences for place of delivery in rural Tanzania: A population-based discrete choice experiment. *American Journal of Public Health*, 99(9): 1666-1672.

Kruk, M., Paczkowski, M., Tegegn, A., Tessema, F., Hadley, C., Asefa, M., Galea, S. (2010) Women's preferences for obstetric care in rural Ethiopia: a population-based discrete choice experiment in a region with low rates of facility delivery. *J Epidemiol Community Health*, 64: 984-988.

Leape, L. L., Shore, M. F., Dienstag, J. L., Mayer, R. J., Edgman-Levitan, S., Meyer, G. S., Healy, G. B. (2012) A Culture of Respect, Part 1: The Nature and Causes of Disrespectful Behavior by Physicians. *Academic Medicine*, 87(7): 845-852.

Leape, L. L., Shore, M. F., Dienstag, J. L., Mayer, R. J., Edgman-Levitan, S., Meyer, G. S., Healy, G. B. (2012) A Culture of Respect, Part 2: Creating a Culture of Respect. *Academic Medicine*, 87(7): 853-858.

Leonard, K., Adelman, S., Essam, T. (2009) Idle chatter or learning? Evidence of social learning about clinicians and the health system from rural Tanzania. *Social Science and Medicine*, 69: 183-190.

Majumdar, B., Browne, G., Roberts, J., Carpio, B. (2004) Effects of cultural sensitivity training on health care provider attitudes and patient outcomes. *Journal of Nursing Scholarship*, 36(2): 161-166.

Mamdani, M., Bangser, M. (2004) Poor People's Experiences of Health Services in Tanzania: A literature review. *Reproductive Health Matters*, 12(24): 138-153.

Marine, A., Ruotsalainen, J. H., Serra, C., Verbeek, J. H. (2009) Preventing occupational stress in healthcare workers. *The Cochrane Library*, Issue 1.

Matthews, Z., Channon, A., Neal, S., Osrin, D., Madise, N., Stones, W. (2010) Examining the 'Urban Advantage' in maternal health care in developing countries. *PLoS Medicine*, 7(9).

McAuliffe E, Daly M, Kamwendo F, Masanja H, Sidat M, et al. (2013) The Critical Role of Supervision in Retaining Staff in Obstetric Services: A Three Country Study. *PLoS ONE* 8(3).

Miller, S., Cordero, M., Coleman, A. L., Figueroa, J., Brito-Anderson, S., Dabagh, R., Calderon, V., Caceres, F., Fernandez, A. J., Nunez, M. (2003) Quality of care in institutional deliveries: the paradox of the Dominican Republic. *International Journal of Gynecology and Obstetrics*, 82: 89-103.

Miller, S., Tejada, A., Murgueytio, P., Diaz, J., Dabash, R., Putney, P., Bjegovic, S., Caraballo, G. (2002) Strategic Assessment of Reproductive Health in the Dominican Republic. Population Council, New York, New York.

Misago, C., Kendall, C., Freitas, P., Haneda, K., Silveira, D., Onuki, D., Mori, T., Sadamori, T., Umenai, T. (2001) From 'culture of dehumanization of childbirth' to 'childbirth as a transformative experience': changes in five municipalities in northeast Brazil. *International Journal of Gynecology and Obstetrics*, 75: S67-72.

Mitchell, E. M. H., Trueman, K., Gabriel, M., Bickers Bock, L. B. (2005) Building Alliances from Ambivalence: evaluation of abortion values clarification workshops with stakeholders in South Africa. *African Journal of Reproductive Health*, 9(3): 89-99.

Mogasale, V., Wi, T. C., Das, A., Kane, S., Singh, A. K., George, B., Steen, R. (2010) Quality assurance and quality improvement using supportive supervision in a large-scale STI intervention with sex workers, men who have sex with men/transgenders and injecting-drug users in India. *Sex Transm Infect*, 86(Supplement 1): 83-88.

Mony, P. "Improving quality of maternal and neonatal health care in primary health centres: Design and implementation of an on-site, nurse mentoring program in Karnataka state, India." Arusha International Conference Center, Arusha, Tanzania. January 15, 2013. Conference Presentation.

Necochea, E., Bossemeyer, D. (2005). Standards-Based Management and Recognition, a Field Guide. A practical approach for improving the performance and quality of health services. Published by Jhpiego. Available at: http://www.jhpiego.org/files/SBMR%20FieldGuide.pdf. Accessed February 10, 2013.

Nzinga, J., Ntoburi, S., Wagai, J., Mbindyo, P., Mbaabu, L., Migiro, S., Wamae, A., Irimu G., English, M. (2009) Implementation experience during an eighteen month intervention to improve pediatric and newborn care in Kenyan district hospitals. *Implementation Science*, 4(45).

Peterson, U., Bergstrom, G., Samuelsson, M., Asberg, M., Nygren, A. (2008) Reflecting peer-support groups in the prevention of stress and burnout: randomized controlled trial. *Journal of Advanced Nursing*, 63(5): 506-516.

Preston-Shoot, M. (2001) A Triumph of Hope over Experience? Modernizing accountability: The case of complaints procedures in community care. *Social Policy and Administration*, 35(6): 701-715.

Records, K., Wilson, B. (2011) Reflections on meeting women's childbirth expectations. JOGNN, 40:394-398.

Reis, C., Heisler, M., Amowitz, L. L., Moreland, R. S., Mafeni, J. O., Anyamele, C., Iacopina, V. (2005) Discriminatory attitudes and practices by health workers toward patients with HIV/AIDS in Nigeria. *PLoS Medicine*, 2(8).

Reis, V. (2012) Humanizing Childbirth in Mozambique. *International Journal of Gynecology and Obstetrics*, 119S3(S161-S260): I308.

Respectful Maternity Care Advisory Council, White Ribbon Alliance for Safe Motherhood. (2011). *Respectful maternity care: the universal rights of childbearing women*. Washington, DC: WRA. Retrieved February 12, 2013.

Ronsmans, C., Graham, W. (2006) Maternal Mortality: who, when, where, why. *The Lancet*, 368: 1189-1200.

Salem, B. B., Beattie, K. J. (1996) Facilitative Supervision: A vital link to quality reproductive health service delivery. *AVSC Working Paper*, No. 10.

Sebhatu, A. (2008) Ethiopian Health Extension Program. Partners in Population and Development Africa Regional Office. http://www.ppdafrica.org/docs/ethiopiahep.pdf

Shiferaw, S., Spigt, M., Godefrooij, M., Melkamu, Y., Tekie, M. (2013) Why do women prefer home births in Ethiopia? *BMC Pregnancy and Childbirth*, 13(5).

Singh, N. N., Wechsler, H. A., Curtis, W. J., Sabaawi, M., Myers, R. E., Singh, S. D. (2002) Effects of role-play and mindfulness training on enhancing the family friendliness of the admissions treatment team process. *Journal of Emotional and Behavioral Disorders*, 10(2): 90-98.

Stoffregen, M., Andion, X., Dasgupta, J., Frisancho, A., Mutunga, A. (2010) Human Rights-based approaches to maternal mortality reduction efforts. International Initiative on Maternal Mortality and Human Rights.

Tawfik, Y., Segall, M., Necochea, E., Jacobs, T. (2010) Finding Common Ground: Harmonizing the Application of Different Quality Improvement Models in Maternal, Newborn, and Child Health Programs. Technical Report. Published by the USAID Health Care Improvement Project. Bethesda, MD: University Research Co., LLC (URC).

Teutsch, C. (2003) Patient Doctor Communication. *Medical Clinics of North America*, 87: 1115-1145.

Thompson, J. B. (2004) A human rights framework for midwifery care. *J Midwifery Womens Health*, 49: 175-181.

Thaddeus, S., Maine, D. (1994) Too far to walk: maternal mortality in context. *Sm. Sci. Med.*, 38(8): 1091-1110.

Turner, K. L., Hyman, A. G., Gabriel, M. C. (2008) Clarifying Values and Transforming Attitudes to improve access to second trimester abortion. *Reproductive Health Matters*, 16(31 Supplement): 108-116.

Turner, K. L., Page, K. C. (2008) Abortion attitude transformation: A values clarification toolkit for global audiences. Chapel Hill, NC, Ipas.

U.N. General Assembly. Human Rights Council. Report of the Office of the United Nations High Commissioner for Human Rights on its Twentieth Session. Technical guidance on the application of a human rights-based approach to the implementation of policies and programmes to reduce preventable maternal morbidity and mortality. (A/HRC/21/22). 2 July 2012. (Mimeo)

U. N. General Assembly. Human Rights Council. Report of the Office of the United Nations High Commissioner for Human Rights on its Fourteenth Session. Preventable maternal mortality and morbidity and human rights. (A/HRC/14/39). 16 April 2010. (Mimeo)

United Republic of Tanzania Ministry of Health and Social Welfare. (March 2010) A Manual for Comprehensive Supportive Supervision and Mentoring on HIV and AIDS Health Services.

United Republic of Tanzania Ministry of Health and Social Welfare. (October 2010) Standards-Based Management and Recognition for Improving Quality of Maternal and Newborn Care: Quality Improvement Standards for Hospitals: Assessment Tool.

USAID Health Care Improvement Project. (2008) The Improvement Collaborative: An Approach to Rapidly Improve Health Care and Scale Up Quality Services. Published by the USAID Health Care Improvement Project. Bethesda, MD: University Research Co., LLC (URC).

Van Wyk, B. E., Pillay-Van Wyk, V. (2010) Preventative staff-support interventions for health workers. *Cochrane Database of Systematic Reviews*, Issue 3.

Wagner, M. (2001) Fish can't see water: the need to humanize birth. *International Journal of Gynecology and Obstetrics*, 75: S25-37.

Warren, C., Abuya, T., Ndwiga, C., Njuki, R. (2012). Findings from Kenya: Barriers to skilled birth attendance: Disrespect and abuse during health facility deliveries. *International Journal of Gynecology & Obstetrics*, 119S3: S161–S260.

"We have no choice." Facility-based childbirth: The perceptions and experiences of Tanzanian women, health workers, and Traditional Birth Attendants. (2009) CARE International in Tanzania and Women's Dignity.

White Ribbon Alliance. http://www.whiteribbonalliance.org/index.cfm/the-issues/respectful-maternity-care/. Accessed February 12, 2013.

Wolf, Z., Giardino, E., Osborne, P., Ambrose, M. (1994) Dimensions of nurse caring. *Image J Nurse Sch*, 26(2): 107-111.

World Health Organization. (May 2012) Maternal Mortality Factsheet. http://www.who.int/mediacentre/factsheets/fs348/en/index.html, accessed March 21, 2013

World Health Organization. Health Statistics and Health Information Systems. http://www.who.int/healthinfo/statistics/indmaternalmortality/en/index.html, accessed March 21, 2013

Wu, S., Li, L., Wu, Z., Liang, L., Cao, H., Yan, Z., Li, J. (2008) A brief HIV stigma reduction intervention for service providers in China. *AIDS Patient Care and STDs*, 22(6).

Yamin, A. E. (2013) Applying human rights to maternal health: UN Technical Guidance on rights-based approaches. *International Journal of Gynecology and Obstetrics*, http://dx.doi.org/10.1016/j.ijgo.2013.01.002.

Yiu, J. W., Mak, W. W. S., Ho, W. S., Chui, Y. Y (2010) Effectiveness of a knowledge-contact program in improving nursing students' attitudes and emotional competence in serving people living with HIV/AIDS. *Social Science and Medicine*, 71:38-44.

Zinnen, V., Paul, E., Mwisongo, A., Nyato, D., Robert, A. (2012) Motivation of human resources for health: a case study at rural district level in Tanzania. *International Journal of Health Planning and Management*, 27: 237-247.