Ministry of Public Health

Deputy Minister Office for Health Care Services Provision

Reproductive, Maternal, Newborn, child and Adolescent Health Directorate

RESPECTFUL MATERNITY CARE ORIENTATION PACKAGE
For Community Health Worker

Facilitator Guide

April 2017
FORWARD

In its on-going quest to improve the health status of its people and in line with the quality and equity improving agenda, Ministry of Public Health (MoPH) in Afghanistan has continued to strengthen health service delivery across the entire continuum of health care and ensure a respectful and caring health workforce.

According to existing evidence in Afghanistan and worldwide, Respectful Maternity Care (RMC) is known to be the most neglected area of health care services. To address this gap, MOPH prioritized RMC and adapted the RMC orientation package beside other interventions, with technical and financial support of USAID funded HEMAYAT project and other partners.

The MOPH renews its commitment to improving RMC within the continuum of care from community to facility level. It is my considered view that, with enough level of commitment and support from the MOPH and all stakeholders, promoting and institutionalizing RMC will improve the health status and will significantly contribute in reduction of preventable maternal and newborn mortality in the country.

I would like to take this opportunity to extend appreciation to RMC technical working group, Reproductive Maternal, Newborn, Child and Adolescent Health Directorate, Community Based Health Care Department, Health Promotion Department, partners and professional associations who have actively participated in the preparation of the RMC orientation package.

Sincerely,

Dr. Feda Mohammad Paikan
Deputy Minister for Health Care Services Provision
Ministry of Public Health
Kabul, Afghanistan
ACKNOWLEDGMENTS:

The Ministry of Public Health (MoPH) of the Islamic Republic of Afghanistan is committed to increase quality skilled birth attendance to at least 60% and to enhance access to reproductive health services by 2020.

The Ministry of Public Health considers Respectful Maternal Care (RMC) as an essential component of “Quality Maternal and Newborn Health Services” and a priority to increase facility birth and ensure effective implementation of women’s rights in health services. Despite overall advances in maternal health outcomes, ensuring women have skilled and respectful care during delivery remains a challenge. Mistreatment in childbirth is a major barrier to women accessing facility-based care. It is critical for the MoPH in Afghanistan to consider how it can prevent such mistreatment, and better meet women’s socio-cultural, emotional and psychological needs as part of broader efforts to provide better quality care.

The RMC orientation package has been adapted by the RMC working group under the leadership of Reproductive, Maternal, Newborn, child and Adolescent Health Directorate (RMNCAHD), with technical and financial support of USAID-funded HEMAYAT project in close collaboration with the Community Based Health Care and Health Promotion Departments. The work was a collaborative effort of technical stakeholders who assured that both facility and community based RMC packages are adapted and aligned with Afghanistan context.

I would like to thank RMNCAHD for taking the lead of this initiative and the RMC working group members, namely; Health promotion and Community Based Health Care directorates, AMA, AFSOG, WRA, AKDN and HEMAYAT project for their continued support and provision of technical inputs throughout the RMC package’s adaptation process.

I am sure that RMNCAHD and its development partners will ensure that efforts to ensure RMC are prioritized during facility-based maternity care services. This ultimately results in increased quality of care and contributes to reducing maternal and newborn deaths in the country.

Sincerely yours,

Dr. Zelaikha Anwari
Director of Reproductive, Maternal, Newborn, child and Adolescent Health Directorate
Ministry of Public Health
Table of Contents

ACKNOWLEDGMENTS: ........................................................................................................................................ ii
ABBREVIATIONS AND ACRONYMS .................................................................................................................. 1
INTRODUCTION ..................................................................................................................................................... 2
  Respectful Maternity Care (RMC) .................................................................................................................... 3
  Why focus on preventing mistreatment during childbirth? ............................................................................ 3
About the Resource Package ............................................................................................................................... 3
How should respectful maternity care training be implemented? .................................................................. 4
Workshops are designed to be offered as follows: ............................................................................................ 4
What is included in the Resource Package? ........................................................................................................ 4
Who should use this Resource Package? ........................................................................................................... 5
Who should use the community facilitator’s guide? ........................................................................................... 5
Tips for facilitators .............................................................................................................................................. 5
WORKSHOP INTRODUCTION ............................................................................................................................ 8
SESSION 1 ........................................................................................................................................................ 8
  Overview of maternal health ............................................................................................................................. 8
SESSION 2 ........................................................................................................................................................ 12
  Barriers to accessing or receiving quality maternal health care services ..................................................... 12
SESSION 3 ........................................................................................................................................................ 16
  Health service charter to promote accountability ............................................................................................ 16
SESSION 4 ........................................................................................................................................................ 20
  Role of families and communities in promotion of RMC ............................................................................. 20
Appendices ......................................................................................................................................................... 22
  Appendix 1: Community TOTs Workshop Schedule .................................................................................... 22
  Appendix 2: Maternity Open Day .................................................................................................................... 23
  Appendix 3: WRA Charter on Universal Rights of Childbearing Women .................................................... 23
  Appendix 4: Monthly monitoring data form for community health workers (CHWs) ................................. 25
  Annex 5: MEDIATION AS AN ALTERNATIVE DISPUTE RESOLUTION MECHANISM ......................... 26
  Annex 6: Member of Respectful Maternity Care Orientation Package Working Group ............................... 33
References ......................................................................................................................................................... 34
###ABBREVIATIONS AND ACRONYMS

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AAAQ</td>
<td>Available, Accessible, Acceptable and of Good Quality</td>
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<td>ADR</td>
<td>Alternative Dispute Resolution</td>
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<td>ANC</td>
<td>Antenatal Care</td>
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<td>CHWS</td>
<td>Community Health Workers</td>
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<td>CPD</td>
<td>Continuous Professional Development</td>
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<td>QI</td>
<td>Quality Improvement</td>
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<td>FIGO</td>
<td>The International Federation of Gynecology and Obstetrics</td>
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<td>HMIS</td>
<td>Health Management Information System</td>
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<td>IDI</td>
<td>In Depth Interview</td>
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<td>ICM</td>
<td>International Confederation of Midwives</td>
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<td>MDG</td>
<td>Millennium Development Goal</td>
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<td>MMR</td>
<td>Maternal Mortality Ratio</td>
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<td>MNH</td>
<td>Maternal and Neonatal Health</td>
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<td>MOPH</td>
<td>Ministry of Public Health</td>
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<td>PNC</td>
<td>Postnatal care</td>
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<td>PPT</td>
<td>PowerPoint</td>
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<td>RMC</td>
<td>Respectful Maternity Care</td>
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<td>SBA</td>
<td>Skilled Birth Attendance</td>
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<td>SRH</td>
<td>Sexual and Reproductive Health</td>
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<td>TOTs</td>
<td>Trainers of Trainers</td>
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<td>WRA</td>
<td>White Ribbon Alliance</td>
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<td>VE</td>
<td>Vaginal Examination</td>
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<td>ANDS</td>
<td>Afghanistan National Development Strategy</td>
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<td>BPHS</td>
<td>Basic Package of Health Services</td>
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<td>EPHS</td>
<td>Essential Package of Health Services</td>
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<td>EVAW</td>
<td>Elimination of Violence Against Women</td>
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<td>NAPWA</td>
<td>National Action Plan for Women Affairs</td>
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<tr>
<td>FHAG</td>
<td>Family Health Action Group</td>
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<td>VCAT</td>
<td>Values Clarification and Attitude Transformation</td>
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INTRODUCTION

Pregnancy, childbirth, and their consequences are still the leading causes of death, disease, and disability among women of reproductive age in developing countries. Nearly 275,000 maternal deaths due to treatable conditions during pregnancy and childbirth occurred globally in 2011. Almost all of these took place in developing countries. A key strategy to address high maternal and newborn morbidity and mortality is to increase the proportion of quality skilled birth attendants to at least 60% and enhanced access to reproductive health services (Call to action 2015).

The health sector of Afghanistan, with strong support from various donors and development partners, has made remarkable progress in improving the health status of the population, particularly in access, coverage, and quality of health service. However; still financial and geographical barriers to accessing skilled care, as well as the poor quality of care in maternity units are considered huge challenges.

A little understood component of the poor quality of care experienced by women during facility-based childbirth is the mistreatment behavior of health care providers and other facility staff. Acknowledgment of these behaviors by policymakers, program staff, civil society groups, and community members indicates the problem is widespread.

Progress toward achieving MDG 5 has been slow because improvements require overcoming financial and geographical barriers to accessing skilled care, as well as the poor quality of care in maternity units.

In a landscape analysis conducted in 2010, these behaviors were categorized into seven manifestations:

- Physical abuse
- Non-consented care
- Non-confidential care
- Non-dignified care
- Discrimination
- Abandonment of care
- Detention in facilities

Numerous factors contribute to this experience, which are grouped into:

- Individual and community-level factors
- Normalizing mistreatment
- Lack of legal and ethical foundations to address mistreatment
- Lack of leadership in this area
- Lack of standards and accountability
- Provider prejudice due to lack of training and resources

The interventions aimed to improve accountability of health providers at all levels of the health care system: policy, health program managers, facility or provider and community levels. This Resource Package is based on the most effective interventions, and provides practical, low cost, and easily adaptable strategies for facilities to improve respectful maternity care (RMC).

Respectful Maternity Care (RMC)

RMC refers to the humane and dignified treatment of a childbearing woman throughout her pregnancy, birth, and the period following childbirth. It respects her rights and choices through supportive communication, actions, and attitudes. Because mistreatment and environments degrade the quality of maternity care, identifying and addressing mistreatment is an important component of cultivating RMC in health facilities.

The Resource Package is designed to support facilitators to train health facility managers, health care providers, and practitioners to confront mistreatment during facility-based maternity care services and to promote respectful maternity care.

Gender-sensitive and respectful care and treatment ultimately improves health outcomes and brings the positive impacts listed in below items.

a. Quality of care and patient safety

b. Clients’ preference to consult with health professionals and use health facilities

c. Satisfaction and reputation of health care providers

Why focus on preventing mistreatment during childbirth?

However, there is no specific data from surveys on mistreatment in Afghanistan, but the Afghanistan Health survey (AHS 2013) reveals the following reasons for not seeking care:

About 11% of women responded the reason for not seeking care because of unfriendly staff of health facilities, as well as around 6% of them stated that the service hours were not convenient for them. More than 3% of them were not seeking care due to religious beliefs.

In 2014 a qualitative research on human elements and contextual factors affecting the quality of care women receive in Afghan maternity hospitals was conducted, main facts highlighted in the study are:

- Politeness and good behavior is more important than professional skills and knowledge to women seeking maternity care services
- Prior to professional lessons, health care providers should learn about ethics
- Women are neglected and abused verbally and physically
- Delivery happened in the corridors of the hospitals without any attendant.
- Many women and babies are discharged after delivery without postnatal observation.

Health care providers also reported that high patient numbers, long hours and lack of shift systems affects the quality service delivery.

About the Resource Package

This resource is designed to be used by RMC trainers, and others who organize or facilitate RMC training workshops for community based health care providers; including Community Health Workers (CHW), Family Health Action Group (FHAG) members, society leaders. It provides experienced
facilitators with the background information, materials, instructions, and tips necessary to effectively deliver a package of interventions to promote respectful care in the provision of reproductive, maternal, and newborn health services at community level.

This Resource Package includes activities and materials that advance a specific agenda: to promote increased support, advocacy, and provision of high-quality, woman-centered maternity care. These changes are not likely to occur immediately after one workshop; they may be incremental. It takes a hands-on approach to empower service providers, community health workers, communities, and policymakers with the knowledge and skills to tackle mistreatment during childbirth.

How should respectful maternity care training be implemented?
Although it is strongly recommended to integrate RMC orientation package’s content, activities and exercises into trainings, technical updates, workshops, meetings and continuous professional development sessions on maternal and newborn care; the package maybe used for separate RMC workshops as well.

Workshops are designed to be offered as follows:
Community-based workshop (Two days): for community health workers (CHWs) or volunteers, society leaders, Community Health Supervisors (CHS), and Family Health Action Group (FHAG) members. The content can be delivered in a one-day workshop and includes information on the rights and obligations of women who give birth in facilities and of service providers.

What is included in the Resource Package?
1. **Facilitator’s guide (for community-based workshops):** This manual is designed to be used by facilitators to promote respectful maternity care at a community level. The manual can target to educate a variety of stakeholders in community settings (i.e., Community Health Workers, Family Health Action Group (FHAG) members, society leaders, etc.). It highlights key practical points to enable participants to act as resource persons regarding the rights and obligations of childbearing women, and as advocates of respectful maternity care including how to conduct an alternative dispute resolution mechanism.

2. **Participant’s guide:** This is a teaching aid for CHWs and other community-level resource persons to conduct community sensitization meetings or training workshops for general community members. The content and language used in the flipchart is simple and pictorial. Handouts are available for participants to take home as resources.

3. **PowerPoint slides:** All the key information is summarized in power point presentation which can be projected during the training program to the audience.

4. **Tools:** These offer guidance for conducting or organizing evidence-based interventions that promote respectful maternity care. These tools support:
   - Maternity Open Days: A day set aside by a health facility that permits community members to visit the maternity ward and interact with maternity staff in order to demystify myths and misconceptions surrounding facility-based services.
   - Alternative Dispute Resolution: Mediation is a cost-effective conflict resolution mechanism that brings clients or relatives affected by mistreatment and the perpetrators together to discuss and resolve issues without the need for formal legal measures.
• “Caring for the Carers” counseling sessions: Counseling sessions for service providers and other staff working in maternity units/wards, or the facility as whole, help them cope with work-related psychological stress or trauma, which is a major driver of mistreatment.

Who should use this Resource Package?
This Resource Package is designed to be adaptable for a variety of stakeholders in different settings that include: community health workers, members of family health action groups, community members, community groups, maternal health program implementers and society leaders. Childbirth beliefs and behaviors tend to be context-specific and are founded on a myriad of social, cultural, professional and political factors. The activities in this Resource Package may be adapted to different social contexts.

Who should use the community facilitator’s guide?
Reproductive health trainers, health care managers, supervisors or anyone responsible for training. Community-level workers or volunteers, society leaders and FHAG members can use the “Respectful Maternity Care community based facilitator’s guide.”
This document highlights key practical points that can be used by community-level resource persons and advocates in promoting women and families’ understanding of their rights and obligations regarding dignified childbirth. It is specifically designed to help community members to proactively engage with health providers, health managers, and policy makers in promoting respectful maternity care. However, facilitators should be very familiar with all of the components of the Resource Package.

Tips for facilitators
Characteristics of effective training
This Resource Package is designed on adult learning principles for a learner-centered, interactive training approach. Facilitators are encouraged to model the concepts and skills needed for effective training, including group facilitation, coaching, and non-judgmental conduct. All effective training courses or workshops should take into consideration the following:

• Trainers and participants should understand the purpose of the training
• Trainers and participants should understand the objectives of the workshop
• Training methods should enable participants to achieve the objectives of the training
• Training should build on participants’ existing skills and experience
• Use open-ended questions that begin “how”, “what”, “when”, and “why” to invite discussion and feedback
• New knowledge and skills should be presented in a meaningful and relative context
• Use a variety of training methods to meet the needs of different learning styles
• Create opportunities for participants to apply new knowledge and skills
• Provide constructive feedback for participants on their performance
• Ensure enough time for participants to meet the objectives of the training
• Trainers should solicit and accept feedback from participants and use this feedback to make improvements in the training
REMEMBER: Effective training techniques keep participants engaged in the learning process, help trainers to assess how the training is being received, and help trainers adjust the training process as needed. (Appendix 1)

**Participant selection:**
Facilitators are encouraged to carefully consider how participants’ backgrounds and characteristics will affect the experience and the effectiveness of the workshop. It is important for participants to feel safe and comfortable engaging in an honest examination and exploration of their beliefs, opinions and attitudes, and to remain open to change. Whenever possible, we recommend assessing participants’ knowledge, attitudes and practices with regard to respectful maternity care in advance to aid in participant selection and workshop design.

It is the responsibility of the facilitator to create and maintain an open learning environment. Different viewpoints about childbirth and the issue of mistreatment are valid, inevitable and will contribute to the richness of group discussion. There are benefits and risks to mixing participants with different personal and professional backgrounds, experiences of supporting women in the community and viewpoints about women’s rights and choice of where to give birth. In different circumstances, a more diverse group can increase the amount of facilitation needed.

The optimum facilitator-to-participant ratio is 1:7.

**Important workshop materials include:**
- PPT presentations and projector
- Flipchart paper
- Markers
- Cards/sticky notes
- Masking tape
- Note books and pens
- Reference materials

**Teaching methods:**
As with any training event, workshops should utilize adult learning principles. The following are commonly used teaching methods:
- Interactive presentations
- Expressive activities (role play, songs, skits, artwork, games)
- Large and small group discussions
- Individual and group work
- Simulations
- Hypothetical and real case studies
- Personal journals and interviews
- Sensitivity and listening techniques
• Self-analysis worksheets

Additional background content:

We recommend background sessions on topics related to respectful and dignified maternity care. These may include:

• Data on maternal and newborn mortality and morbidity on global, regional and, national scales
• Context-specific data on the proportion of women who attend antenatal services, facility based health care services and childbirth, and postnatal care services where available.
• Context-specific data on manifestation of mistreatment
• Context-specific data on the drivers of mistreatment from service provision surveys, WHO, or other relevant sources
• Relevant context-specific data on the magnitude and prevalence of mistreatment (If available).

Community Workshop Introduction:

Overall workshop objectives

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

• Outline the current status of maternal health in relation to respectful maternity care
• Discuss rights-based approaches related to RMC
• Discuss selected strategies that reduce mistreatment
• Discuss the role of the community in promoting respectful maternity care
• Demonstrate knowledge and use of alternative dispute resolution mechanism
• Develop action plans to support the implementation of RMC interventions at the community level.
WORKSHOP INTRODUCTION

**Learning objectives**
By the end of the session the participants will be able to:
1. Articulate their hopes and concerns about the workshop and about the topic of mistreatment.

**Training materials**
- Index cards or paper
- Sticky note pads
- Pens or pencils
- Flipchart easel and paper

**Session length**
15 Minutes
- 5 minutes for writing on cards/papers
- 5 minutes to discuss in pairs
- 5 minutes to discuss responses

**Participants’ Expectations and Group Norms:**
This is an introductory activity that can be completed as an icebreaker at the beginning of a workshop. This activity helps participants identify their expectations and/or concerns and discomforts regarding the workshop. The same can be used at the end of the workshop to assess whether their expectations have been met as a result of the training.

Participants will state/write:
- Their expectation(s) for this workshop
- What they hope to accomplish during the workshop
- What they hope to accomplish by the end of this workshop
- Any suggestions on the group norms during the workshop

**SESSION 1**
**Overview of maternal health**
## Learning objectives

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

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

## Training materials

- Flipchart paper, markers, masking tape, sheets of paper or cards
- PPT presentation
- Chart of the global status on maternal health
- Reference materials on country’s/region’s status on maternal health.

## Session length

30 Minutes

## Facilitator’s instructions:

- Introduce the session using a brainstorming activity.
- Ask the participants to define or to explain the terms “respectful maternal care” and “maternal health”.
- Write down all the responses on the flip chart.
- Summarize them and provide the correct definition using the PowerPoint presentation.
- Ask participants if they know of women who choose to deliver at home in their areas; ask for any recent (last 1 year) home deliveries.
- Ask participants to indicate the difference, in the terms of numbers, between those who deliver in health facilities and those who deliver at home; allow them to give reasons for answers provided.
- Summarize the responses on reasons mentioned and tell the participants that the workshop focuses on promoting respectful maternity care during health services including childbirth.
- Use the PowerPoint presentation to discuss barriers to receiving quality maternal health care.

## Content:

### Respectful Maternity Care Concept:

RMC involves respect for women’s basic human rights including: respect for women’s autonomy,
dignity, feelings, choices, and preferences, including companionship during maternity care

**Definition of Maternal Health:**
Maternal health refers to the health of women during pregnancy, childbirth and the first few days and weeks after childbirth. While motherhood is often a positive, fulfilling experience, far too many women associate it with suffering, ill-health, and even death.

Nearly 275,000 maternal deaths due to treatable conditions during pregnancy and childbirth occurred globally in 2011. Most of them die because they had no access to skilled maternity care for either normal or complicated childbirth (WHO et al., 2012).

About 800 women die from preventable pregnancy or childbirth related complications around the world every day. Almost all maternal deaths (9 out of 10 women) occur in developing countries.

Most maternal deaths are avoidable, as the health care solutions to prevent or manage complications are well known. All pregnant women need access to quality antenatal care, skilled care during childbirth, and care and support in the weeks after childbirth. They also need access to fully functioning emergency care when complications occur. It is critical that all births are attended by skilled health professionals who can provide competent life-saving interventions. Interventions need to focus on improving the quality of care. One key component of quality care is respectful maternity care (RMC).

**Who is a skilled health professional?**
A skilled health professional includes doctor, midwife, nurse—who has been educated and trained and has the skills required to manage:

- Normal, uncomplicated pregnancies
- Childbirth
- The immediate postnatal period
- Identification, management and referral of complications in women
- Identification, management and referral of complications in newborns

**Barriers to accessing/receiving quality maternal health care:**

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2 WRA, 2011. Respectful Maternity Care Brochure, Respectful Maternity Care: http://whiteribbonalliance.org/campaigns/respectfulmaternity-care/


4 Trends in maternal mortality 1990 to 2013 WHO 2014


6 WHO-ICM-FIGO Joint Statement 2004 NB “Midwife” definition

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• Perceived or real negative provider attitudes
• Poor quality of care reported in facilities during childbirth, including mistreatment by health providers and facility staff
• Inadequate provision of the absolute minimum maternity care services
• Low levels of provider competency, skills and poor management of facilities
• Poor facility infrastructure, e.g. water, electricity, equipment, drugs, and supplies
• Cost of services (especially in private health facilities)
• Cultural beliefs, stigma and the perception of both clients and providers on various health conditions and services
• Gender and the decision-making process
• Awareness of availability of services
• Actual availability, physical and social accessibility of services
• Poor access to facilities due to weak road network and other communication network
• Lack of available emergency transport

In addition to geographic, financial and cultural barriers, seven categories of mistreatment have been identified: physical abuse, non-consented care, non-confidential care, non-dignified care, discrimination, abandonment of care, and detention in facilities or demand for payment.7

Brainstorming activity:
If a woman wants to squat during childbirth, what happens in the facility?
What happens to a woman’s placenta in the facility near you?

7Bowser and Hill 2010 Exploring evidence for mistreatment in facility based childbirth: Report of a Landscape Analysis Bethesda, MD: USAID TRAction Project, University Research Corporation, LLC, and Harvard School of Public Health
SESSION 2

Barriers to accessing or receiving quality maternal health care services

Learning objectives

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

1. Describe the seven categories of mistreatment during facility-based childbirth.
2. Explain the drivers of mistreatment during facility-based childbirth.
3. Discuss communities’ role in promoting respectful and dignified childbirth.

Training materials

- Flipchart paper, markers, masking tape, sheets of paper or cards
- Handouts from WRA/universal rights of childbearing women (Appendix 3)
- Community brochure example (appendix 4)

Session length

60 Minutes

Facilitator’s instructions:

- Introduce the session by informing the participants that mistreatment is a common experience in many contexts e.g., transport, industry, public offices.
- Invite the participants to give any personal experiences they may have had both in their social life and health care setting that they considered disrespectful or inhumane. The facilitator may also give his/her own personal experience.
- Explain that mistreatment affects the individual at a personal level and their future behavior in terms of seeking the services/recommending services to others.
- Use the lecture method and PowerPoint presentations and/or flipchart to deliver the session content.
- Involve the participants through questions and answers as appropriate throughout the presentations.

Content:

Introduction

We know that having access to good skilled care from a health professional can make the difference between a pregnant woman’s life and death. However, many women do not give birth with professional assistance. There is evidence that mistreatment during facility based childbirth deters women from seeking help when they are in labor.
Categories of mistreatment

1. **Non-dignified care:**
   Communities perceive non-dignified care as:
   - Use of harsh words that suggest rudeness and disrespect
   - Lack of assistance in carrying their baby to the postnatal ward after delivery
   - Providers reprimanding the client if she calls for help
   - Cleaners and other subordinate staff without midwifery skills assisting in delivery
   - When women are asked to undress in front of all other women in the labor wards with no gowns provided
   - Sharing beds with other women

2. **Non-confidential care**
   Many people perceive non-confidential care as:
   - Examination, delivery and treatment that require undressing without curtains or partitions
   - Consultation conducted without privacy and
   - Group counseling and discussions where women are required to give their personal information in public.

3. **Non-consented care**
   - Lack of information and/or explanation of the treatment and procedures that are required.
   This includes physical examination, vaginal examination, tubal ligation or taking of medication if the client or her relative is in a position to make sound judgment at the time.

4. **Physical abuse**
   - Both men and women feel that slapping, pushing and pinching is abusive.

5. **Abandonment of care/ Neglect**
   Communities perceive their women have been abandoned when:
   - Providers ignore the clients or fail to attend to the clients on time
   - Providers lock themselves in offices and do not respond to calls for assistance
   - There is no skilled personnel available and women have to wait a long time for services such as Cesarean section
   - Where there is no assistance until complications develop
   - Women are left to deliver alone
   - Women in severe pain are not given pain relief
• Women end up giving birth on benches in admission rooms waiting for help.

6. **Discrimination**
Community members feel that women who are at an increased risk of discrimination are those that:
• Have five or more children
• Forget to carry or lack the antenatal clinic card
• Are poor
• Are young women (teenage mothers)
• Are living with HIV or Hepatitis

7. **Detention**
Although in many countries detaining women in hospital for lack of funds to pay for treatment is illegal, reports indicate that women are still detained and are subjected to abusive treatment such as:
• Working in the facilities (washing utensils, toilets and washroom)
• Provision of beds for the baby only and none for the mother
• Separation from their infants in which mothers are only allowed to breastfeed their babies at fixed times in the nursery

**Drivers of mistreatment**
The drivers of mistreatment can be defined as the reasons that might explain why mistreatment during childbirth occurs (but should not be used as excuses) and helps communities and health systems work out ways to resolve the issues.

**Policy factors**
• Gap between maternal and newborn health policy and practice
• Poor community participation in policy process
• Lack of awareness of patient and provider rights (obligations)
• Poor funding for maternal and child health care services

**Health system factors**
• Inadequate infrastructure e.g., lack of beds, curtains and drugs, water and electricity and other supplies at the facilities.
• Poor supervision and management of facilities; providers miss duties and grave misconduct goes without punishment
• Poor payment and high workload of providers; work related stress and burnout may lead the provider to vent out on the mothers and partners during childbirth
- Poor human resource management of existing staff High cost of reproductive health services forces women to deliver at facilities of poorer quality where women are prone to abuse and disrespect
- Inadequate communication and linkages between the health facility management, providers and community members on issues related to facility-based childbirth.
- Weak implementation of standards and quality of care guidelines.

**Community-level factors**
- Lack of a clear understanding of legal mechanisms by communities
- Perception among community members that legal mechanisms and processes are expensive
- The abusive practices are viewed as part of the process of ensuring the safety of the mother and baby
- Communities prefer to seek services from providers of the same ethnic group due to socialization and culture
- Limited opportunities for communities to seek redress if women are unhappy with the treatment they received
- Imbalanced power dynamics (Informal payment)

**Personal factors**
- Gender imbalance in many communities, in which the man is the overall decision maker for choice of both the service provider and facility for childbirth, which may make women more likely to experience mistreatment
- Inadequate knowledge of individual and communities' rights to quality care during facility-based childbirth; inability to defend or demand rightful treatment.
- Traditional beliefs, practices, customs and taboos make it difficult to discuss the issues around childbirth either with the health facility staff or any form of authority at the community level

**FIGURE 1: DRIVERS (ROOT CAUSES) OF MISTREATMENT**

<table>
<thead>
<tr>
<th>WHAT DRIVES MISTREATMENT?</th>
<th>At policy and governance levels:</th>
<th>At health facility and provider levels</th>
<th>At the community level:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Non-realization of international conventions</td>
<td>Lack of understanding of clients’ rights</td>
<td>Imbalanced power dynamics</td>
</tr>
<tr>
<td></td>
<td>Complacency of policymakers</td>
<td>Inadequate infrastructure leading to poor working environment</td>
<td>Overly complex mechanism for victims who seek redress</td>
</tr>
<tr>
<td></td>
<td>Insufficient funding for maternal health care</td>
<td>Staff shortages leading to high stress</td>
<td>Lack of understanding of women’s health Rights</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Poor supervision</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Lack of professional support</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Weak implementation of standards and quality of care guidelines</td>
<td></td>
</tr>
</tbody>
</table>

At all levels of care: Normalisation of mistreatment coupled with no, or weak, accountability mechanisms
SESSION 3
Health service charter to promote accountability

Learning objectives
By the end of the session the participants will be able to:
1. State the elements of the health service charter.
2. Explain the clients’ health rights.
3. Discuss the clients’ obligations.
4. Discuss Maternity Open Days.

Training materials
Flipchart paper, markers, masking tape, sheets of paper or cards

Session length
30 Minutes

Facilitator’s instructions
- Divide the participants into groups of five each. Provide the participants with a flipchart and felt pen.
- Ask the participants to write down what they consider to be their rights and obligations in health care.
- In plenary, ask the groups to present their deliberations.
- During presentations, invite the rest of the participants to review the points. Then, provide them the correct answers.
- Use a guided illustrative lecture to discuss the service charter, client / client rights and obligations in the service charter.
- End the session with question and answers on their rights and obligations.

Content:

A service charter
A service charter is a simple public document which briefly and clearly states the standard and quality of service that any client can expect from an organization within the context of its services. The charter is guided by the organizations’ vision, mission, values, culture and ethical policies.
Where they exist, a Ministry of Public Health’s (MoPH) service charter usually outlines:
- Responsibilities or commitments of the MoPH
- Responsibilities of service providers
- Clients’ rights and obligations

MoPH Responsibilities/Commitments
Ministries of health are committed to achieve goals for delivering health services:
• Equitable distribution of health services
• Timely provision of health care services
• Provision of quality services
• Clients’ rights to information
• Courtesy and respect to clients
• Non-discrimination to clients
• Confidentiality of a client’s information
• Privacy of client’s care and treatment
• Avoiding any corrupt practices and preferential treatment of clients
• Establishing client care centers in all facilities
• Conducting regular client surveys and publishing reports.

**Responsibilities of health service providers**

Examples of health service providers’ responsibilities:
• Promotion of healthy lifestyles
• Regulation of provision of health services
• Prevention of diseases
• Protection of the public against harm
• Coordination and provision of health services
• Clients/patients on arrival at hospital served speedily and handled with respect
• Respond to enquiries, and correspondence promptly
• Acknowledge technical and complex enquiries within stipulated timelines
• Provide accessible and timely services to all
• Attend to clients or patients within stipulated timelines.

**Clients’ Rights**

All clients have the right to:
• Optimum care by qualified health care providers
• Accurate information
• Timely service
• Choice of health care provider and service
• Protection from harm or injury within health care facility
• Privacy and confidentiality
• Be treated courteously and with dignity
• Continuity of care
• Personal/own opinion and to be heard
• Emergency treatment in any facility of choice
• Dignified death, preservation and disposal
• Participate in the planning and management of health care service

Clients’ Obligations
Obligations are things you must do for moral or legal reasons for your own benefit or others in the society:

• Engage in healthy lifestyle
• Seek treatment promptly
• Seek information on illness and treatment
• Comply with treatment and medical instructions
• Be courteous and respective to health care providers
• Help to combat corruption by reporting any corrupt practices and refrain from seeking preferential treatment
• Enquire about the related costs of treatment and/or rehabilitation and to agree on the mode of payment.
• Care for health records in his or her possession
• Respect the rights of other patients and health care providers
• Provide health care providers with relevant and accurate information for diagnosis, treatment, rehabilitation or counseling purposes
• Protect and conserve health facilities
• Participate in the management of health care services
• Fostering partnership in service delivery

An example of how to foster partnership is outlined below

Maternity Open Days
Many community members do not understand the events and procedures associated with facility-based childbirth. Lack of understanding leads to mistrust between care provider’s community members. It leads to fear of MISTREATMENT, myths, and misconceptions about the procedures required assisting women during childbirth. These negatively influence their decisions to seek care at a health facility.

Why the Maternity Open Days?

Maternity Open Days provide an opportunity for pregnant women and their families to interact with health care providers and visit the maternity unit to help quell any fears they may have about giving birth in a facility.

Maternity Open Days provide an opportunity to understand how communities and health facility staff can work out how to support each other and see how some challenges can be overcome. For example, if a facility does not have a good electricity system, the community may contribute to purchase a generator.

Maternity Open Days aim to:
• Promote mutual understanding, accountability and respect among community members and service providers
• Improve knowledge and demystify procedures during maternity care services such as Antenatal check-up, childbirth and the immediate postnatal period.

How to hold a Maternity Open Day?
This activity is usually conducted jointly with the health facility management, a community focal person and the CHWs. The following needs to be done;
Summary of how to hold a Maternity Open Day (Annex 2 TOR for maternity open day):
• Agree on a date for the open day with health facility managers and community leaders
• Send invitations through the existing community information systems
• Invite pregnant and interested women and their families to visit the maternity unit
• Arrange simple refreshments to be made available (if possible)
• Before the maternity unit tour, explain about care and procedures during labor and delivery including the layout of the maternity unit. Describe the quality of care that clients can expect. Allow for discussion to dispel any misconceptions/rumors
• Explain the rights that maternity clients have, and their obligations to the provider and facility
• Allow groups of 5–8 community members to tour at time to avoid congestion Note: you must not disrupt care of any women currently attending the maternity unit
• Maintain privacy and confidentiality for mothers in labor
• After the tour, midwives and other health providers engage the community members with a question-and-answer session on:
  o Were their expectations met during the tour?
  o Clarify any other queries they may have.
  o Ask community members for recommendations, i.e., what contributions can the community members make toward improving the maternity unit for both the providers and the clients?
• Encourage facility-based childbirth and male involvement/birth companions during pregnancy labor and delivery. Remind pregnant women about birth and complication readiness plans
• Other curative or preventive health services may be integrated into the day’s activities, e.g., minor treatment of childhood illnesses, screening for cancer of the cervix or prostate.

Group Activity: Planning Maternity Open Days
How will we engage the community members and the facility managers to implement Maternity Open Days in our facilities?
What challenges might we face and how shall we overcome them?
SESSION 4
Role of families and communities in promotion of RMC

Learning objectives

By the end of the session the participants will be able to:
• Outline community members’ role in promoting respectful maternity care.
• State the community structures available for dealing with incidents of mistreatment.
• Demonstrate knowledge on identifying incidents of mistreatment at the community level.

Training materials
• Flipchart paper
• Markers
• Masking tape
• Sheets of paper or cards

Session length
60 Minutes

Facilitator’s instructions

• Introduce the session by asking the participants to brainstorm on what they consider to be their role in promoting RMC
• Use a PowerPoint presentation to deliver the session content
• End the session with a group discussion on how to strengthen the existing community structures to respond to reports of mistreatment incidents effectively

Content

Community’s Role in Promoting RMC

Community members’ role in promoting RMC includes:
• Address barriers preventing RMC such as (cultural barriers, misconception, inadequate knowledge, financial barrier etc.)
• Recognizing their right to quality care during childbirth in health facilities. Rights are entitlements that every human being possesses and is allowed to enjoy simply by virtue of being a human being
• Sensitize members on MISTREATMENT during maternity care which is a violation of women’s basic rights.
• Educate and sensitizes the community on RMC
• Advocate for support of maternal health at all levels.
• Promote and maintain behavior change communication (BCC) in the community.
• Involve men in RMC and planning.
• Monitor and evaluate RMC services offered by facilities
• Proactively pursue information and education on good health practices including childbirth
• Respectfully demand good client care during all kinds of services provided in health facilities including childbirth

Resolve mistreatment by:
• Report mistreatment incidents as well as refer clients for professional counseling support- know who to report to and the counselor in your locality
• Encourage women that have experienced mistreatment during childbirth to speak out and seek redress through mediation, counseling or other available resources
• Offer psycho-socio support to women and their families who experience mistreatment during childbirth
• Establish or strengthen a clear linkage between the community and facilities to address mistreatment
• Discuss mediation as an ADR.
• Mobilize community resources (money, material and human) to support initiatives that promote respectful and dignified childbirth such as legal and maternal health advocates, community members / volunteers to work as mediators etc.

Community Level Structures for dealing with mistreatment:
Community members should be made aware of their rights and obligations to improve their response to mistreatment. They should also be sensitized on the existing structures through which to claim their rights by reporting incidents of mistreatment.

These structures include:
• Community Health Workers (CHWs): These are volunteers trained by the MOPH to offer basic health care and refer community members to formal health care services as appropriate.
• Family Health Action Groups (FHAG):
  • Health Shura
  • CBHC officer
  • CHSs
  • Health facility management committees
  • Religious leaders
  • Local administration (Chiefs, village and society leaders )
  • Community development council
  • Hospital management board

Group Discussion

1. Divide the participants into groups of 5 preferably from the same community unit/locality.
2. Ask participants to identify the local community structures that they can use to channel complaints on mistreatment incidents from community members. Ask participants to discuss how the existing structures can be strengthened to respond effective to community reports on mistreatment incidents.
3. Allow the participants to report this in plenary and guide the discussion on the best
# Appendices

## Appendix 1: Community TOTs Workshop Schedule

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Facilitator</th>
</tr>
</thead>
<tbody>
<tr>
<td>08:30</td>
<td>Participant Registration, Opening and Introductions</td>
<td>Community/Project Staff</td>
</tr>
<tr>
<td>08:45</td>
<td>• Workshop objectives</td>
<td></td>
</tr>
<tr>
<td>09:00</td>
<td>• Over view of maternal health</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Categories of mistreatment during childbirth childbirth</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• overview of Gender; Human Rights and Law</td>
<td></td>
</tr>
<tr>
<td>08:45-09:00</td>
<td>Tea Break</td>
<td></td>
</tr>
<tr>
<td>10:45</td>
<td>Dealing with Mistreatment</td>
<td></td>
</tr>
<tr>
<td>01:00</td>
<td>Lunch</td>
<td></td>
</tr>
<tr>
<td>02:00</td>
<td>• Mediation as alternative dispute resolution</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Role play demonstration on conducting mediation</td>
<td></td>
</tr>
<tr>
<td>02:00</td>
<td>• Community monitoring and data management in RMC, RMC- Action Plans</td>
<td></td>
</tr>
<tr>
<td>04.30</td>
<td>Departure</td>
<td></td>
</tr>
</tbody>
</table>
Appendix 2: Maternity Open Day

Maternity Open Day: Clarifying misconceptions about childbirths

What is Maternity Open Day?

Maternity Open Days provide an opportunity for pregnant women and their families to interact with health care providers and visit the maternity unit to demystify birthing practices and mitigate any fears regarding childbirth in a facility.

WHY MATERNITY OPEN DAYS?

Fear of mistreatment and misconceptions about the procedures required to assist women during childbirth negatively influence their decisions to seek care at a health facility. This approach brings together women, their families and providers to enable pregnant women to understand what happens in a maternity unit. Misunderstandings, myths and misconceptions of the birthing process were indicated in the baseline findings:

- Some clinical aspects of labor, delivery and postnatal care will be existed that perceived as disrespectful by men and women
- The consequences of this result in fear of clinical procedures. Providers may also lack empathy and perceive women as being uncooperative

This intervention is part of the respectful maternity care (RMC) Resource Package developed by the partners of the other countries and focuses on policy, health system and community levels. The package includes the most effective interventions, and provides practical, low cost, and easily adaptable strategies for facilities and communities to reduce mistreatment during childbirth. RMC refers to the humane and dignified treatment of a childbearing woman throughout her pregnancy, birth, and the postnatal period.

OBJECTIVES

Maternity Open Days are designed to:

- Promote mutual understanding between community members and service providers
- Improve knowledge and demystify procedures during labor, childbirth and the immediate postnatal period

Women and their families will attend maternity open days across the 2-3 study sites. Open days are introducing through pilot project in one province as a part of routine activities to strengthen facility and community linkages:

- Maternity unit tours during ANC visits also will be introduced in targeted facilities.
- Increase in the number of men accompanying their partners.
- Providers now recognize the importance of linking more closely with the communities.
HOW TO HOLD A MATERNITY OPEN DAY?

1. Discussion with RMC taskforce of MoPH/RMNCAHD at central level and PPHCC or RH subcommittee of relevant province PPHD
2. Agree on a suitable date for the open day with health facility managers/in charges and community leaders
3. Send invitations through the existing community information/communication systems
4. Invite pregnant women and their families to visit the maternity unit in order to share information on labor and delivery procedures
5. Arrange simple refreshments to be made available (if possible)
6. Offer screening for other diseases (cervical, breast and prostate cancer) to encourage attendance
7. Invite community leaders (provincial council female and male representatives, religious affairs department representative including Mullah Imam, directorate of women affairs (DoWA) representative, directorate of education representative including principle, headmaster and a teacher of girls high school, health committee (shura-e-sehi), CHS and 2 CHWs, civil society representative, media representative, professional associations representative from targeted province, 3 pregnant women and their families) and health providers to speak about care and treatment in the maternity unit. Allow for discussion to try and dispel any misconceptions or rumors.
8. During the maternity unit tour, ensure that privacy and confidentiality of mothers in labor are maintained.
9. Exhibition and introducing the existed instruments/equipment's and supply of health facility: delivery table, incubators, sterilizer, oxytocin, Methergin, Magnesium sulfate, contraceptive pills, condoms, Depo Provera, IUD, ferrous sulfate
10. Following a tour of the maternity units, midwives and other health care providers engage with community members through a question and answer session about what women should expect when they come to give birth in the maternity units.

Expected Outcome:

- Community members have embraced the Maternity Open Days
- There are more cordial relationships between providers and community members
- Helps to clarify myths and misconceptions associated with facility delivery
- Improved community’s participation, particularly men, in the welfare of clients and staff within the maternity unit
- Maternity Open Days integrate other services to encourage participation e.g., health talks, and screening for breast, prostate and cervical cancer
Appendix 3: WRA Charter on Universal Rights of Childbearing Women

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

1. Every woman has the right to be free from harm and ill treatment. No one can physically abuse you.

2. Every woman has the right to information, informed consent and refusal, and respect for her choices and preferences, including companionship during maternity care. No one can force you or do things to you without your knowledge and consent.

3. Every woman has the right to privacy and confidentiality. No one can expose you or your personal information.

4. Every woman has the right to be treated with dignity and respect. No one can humiliate or verbally abuse you.

5. Every woman has the right to equality, freedom from discrimination, and equitable care. No one can discriminate because of something they do not like about you.

6. Every woman has the right to healthcare and to the highest attainable level of health. No one can prevent you from getting the maternity care you need.

7. Every woman has the right to liberty, autonomy, self-determination, and freedom from coercion. No one can detain you or your baby without legal authority.

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

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

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

RESPECTFUL MATERNITY CARE: THE UNIVERSAL RIGHTS OF CHILDBEARING WOMEN

For more information visit: www.whiteribbonalliance.org/respectfulcare
Appendix 4: Monthly monitoring data form for community health workers (CHWs)

Promoting dignified care to women during childbirth

Name of CHW ................................................................. Phone number ........................................
Year .................................................... Month ......................... Facility ........................................ Community unit .........................

<table>
<thead>
<tr>
<th>IINDICATORS FOR COMMUNITY LEVEL</th>
<th>No. of females</th>
<th>No. of males</th>
<th>Total number</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. COMMUNITY-MEMBERS’ TRAINING</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. No. of community dialogue days conducted to promote respectful childbirth this month.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. No. of community members trained on promoting respectful childbirth during community dialogue days this month.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. No. of community members actively involved in community activities to deal with MISTREATMENT during this month (e.g., society leaders, community legal watchdogs).</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. No. of mistreatment cases reported by community members to health facility management committees during this month.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. No. of mistreatment cases resolved through mediation by community members and facility management or staff participation during this month.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>f. No. of mistreatment cases referred for counseling and mediation during this month.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>g. No. of women referred or escorted from the community for facility-based childbirth during this month.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. MALE INVOLVEMENT IN BIRTH PLANNING</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. No. of male forums conducted to promote respectful childbirth this month.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. No. of male partners trained on birth preparedness this month.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. No. of male partners willing and involved in birth planning this month.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. No. of male partners accompanying their partners/wives for ANC services this month.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. No. of male partners accompanying their partners/wives for delivery services this month.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>f. No. of male partners accompanying their partners/wives for postnatal cares services this month</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>g. No. of men championing rights and obligations to respectful childbirth this month</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
3. YOUTH INVOLVEMENT IN PROMOTING DIGNIFIED CHILDBIRTH

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td>No. of youth forums conducted this month to promote respectful childbirth.</td>
<td></td>
</tr>
<tr>
<td>b.</td>
<td>No. of youths sensitized on promoting respectful childbirth during this month.</td>
<td></td>
</tr>
<tr>
<td>c.</td>
<td>No. of youths willing and involved in promoting respectful childbirth during this month.</td>
<td></td>
</tr>
</tbody>
</table>

4. WOMEN'S GROUP INVOLVEMENT IN PROMOTING DIGNIFIED CHILDBIRTH

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td>No. of women's group forums conducted to promote respectful childbirth this month</td>
<td></td>
</tr>
<tr>
<td>b.</td>
<td>No. of women sensitized on promoting respectful childbirth through women groups this month</td>
<td></td>
</tr>
<tr>
<td>c.</td>
<td>No. of women's groups championing rights to and obligations for respectful childbirth this month</td>
<td></td>
</tr>
</tbody>
</table>

Any comments
................................................................................................................................................
................................................................................................................................................
................................................................................................................................................
................................................................................................................................................

CHW contact........................................
Telephone........................................
Signature ........................................
Date ........................................
Annex 5: MEDIATION AS AN ALTERNATIVE DISPUTE RESOLUTION MECHANISM

**Required Learning:**

You will learn how to improve accountability by holding individuals responsible for acts of mistreatment. This session equips participants with knowledge and skills of how to use the alternative dispute resolution mechanism through mediation to resolve or seek redress for acts of mistreatment. The participants are also expected to adapt ADR to compliment other mechanisms used to demand accountability among health workers within the health care setting.

**Alternative Dispute Resolution (ADR) Mechanism:**

ADR is a process of resolving disputes by using methods other than conventional litigation (i.e., Shura-e-Sehee, hospital management board, Family Health Action Groups and so on. It is the act or process of mediating between parties, to effect an agreement or reconciliation

**Definition of Mediation, A Mediator, And the Mediator’s Role**

**Mediation:**

Mediation is a process whereby an independent and impartial third party facilitates the negotiation process between disputing parties. The third party, the mediator, is not a decision maker- like a judge or a magistrate. Decisions are made by the parties themselves with facilitation from the mediator. Mediators need to be specially trained. A mediator is a convener, an educator, a guardian of the mediation process, and an independent and impartial intervener.

The role of the mediator is to:

- Assess the degree of conflict
- Expand access to relevant resources that enable the parties to make informed decisions
- Test the reality of each party’s assumptions and engage the parties to gain new perspective on their own positions
- Serve as a neutral facilitator for negotiation and enhance communication between disputing parties
- Educate the parties on the negotiation process and ensure that the process is upheld and not abused

Childbirth is a stressful yet joyous moment for the mother, family, and the service provider. However, sometimes the mother, spouse or relatives may feel that some of the events occurring around the labor and delivery process are not well handled. Incidents of mistreatment should be discussed and the responsible parties held accountable in order to resolve the issue and prevent it from happening again. Mediation is a recommended method to address incidents of mistreatment and to promote respectful and dignified care during childbirth. The mediation process is voluntary and may be terminated at any time by any party or the mediator.

The advantages of mediation for patients/relatives include that mediation:

---

• Is faster than a court process
• Is less confrontational or adversarial
• Encourages creativity for solutions
• Improves communication between parties
• Results in more durable solutions
• Is less costly
• Is flexible
• Is less formal
• Is party-controlled/driven
• Is confidential
• Satisfying to the parties

Mediation can follow the following structure:

Stage 1 – Introduction and opening statement (setting the climate)
Stage 2 – Narration or presentation by the parties (storytelling)
Stage 3 – Determining interests
Stage 4 – Setting out issues
Stage 5 – Brainstorming options
Stage 6 – Selecting durable solution
Stage 7 – Closure

The seven stages each involve unique steps:

Stage One – Introduction
• Introduction of mediator and parties
• Disclosure of mediator’s qualifications
• Congratulating parties for choosing mediation
• Establishing and maintain trust and confidence
• Explanation of the mediation process/ground rules
• Disclaimer of bias and neutrality of mediator
• Signing confidentiality agreement (If exists)

Stage Two – Presentation by the parties
• Parties provide perspective of dispute without interruption:
  ✓ Gives party’s opportunity to vent or express their anger and emotions
  ✓ Helps mediator to understand the parties and their interests
  ✓ Helps mediator to identify obstacles to resolutions
  ✓ Opportunity for parties to hear each other directly and get the other’s perspective
• The mediator acts as an active listener and asks questions for clarification
Stage Three – Determining interests

- Mediator summarizes, clarifies, and confirms the interests of the disputants
- Parties confirm the accuracy of the mediator's understanding of the disputants
- Mediator may encourage parties to address each other directly, ask and answer questions, clarify misunderstandings, and offer acknowledgments

Stage Four – Setting out issues

- Mediator helps disputants develop a list of issues:
  - Objective is to help disputants focus on the specific items that must be resolved
  - All issues that need to be resolved must be identified
- Mediator frames issues in a manner that promotes problem-solving:
  - Exemplifies use of neutral language

Stage Five – Brainstorming options

- Mediator encourages the disputants to generate options
- Mediator encourages disputants to select familiar and creative options
- Mediator and parties explore and discuss the pros and cons of each option
- Mediator guides parties to focus on the problems and not on each other or the past
- Mediator should only make suggestions of options if there is certainty that he or she has no personal bias in the situation
- Ideally, a workable option should originate from the parties themselves

Stage Six, seven– Selecting Durable Options and Closure

- Mediator facilitates negotiations between the parties
- Mediator helps the parties pick realistic and viable options for resolution
- The mediation will hopefully result in agreement
- If no agreement, the mediator acknowledges progress and explores alternative solutions

Disadvantages and Challenges of Mediation

Disadvantages:

- Nonbinding unless party’s consent
- Proceedings have the potential to go on indefinitely
- Goodwill is necessary
- Unsuitable when parties need urgent protection (e.g., sexual assault)
- Unsuitable where there is inequality of bargaining power (e.g., a manager and supervisee)
- No precedents are created (a precedent is a rule established in a previous legal case that is either binding on or persuasive). This implies that in mediation the way a case is resolved cannot be used as a basis for resolving another case
Challenges of mediation:
- Lack of trust among participants and poor communication
- The meeting of parties involved in mediation may be difficult or uncomfortable
- Parties may believe that there is a better way of resolving their disputes
- Parties who come into the mediation with a set definition of their problem

ACTIVITY - Role Play 1: USING MEDIATION TO RESOLVE AN INCIDENT OF PHYSICAL ABUSE

Participant Roles:
Health Provider: The provider is a midwife at the local health center who is accused of slapping a woman during childbirth in her facility.

Mrs. Parwin: Mrs. Parwin, 21 years old, is a first-time mother who delivered at a hospital two months ago. She is accompanied by her husband, a sister, and her mother-in-law to seek redress for being slapped during the birth of her baby in the health facility.

The mediator: The mediator is a 50-year-old respected elder who is trained in mediation and is also the chairperson of the Shura-e-Sehee.

Situation:
Mrs. Parwin is 21 years old, a first-time mother who came to the hospital for maternity care services. During the second stage of labor she was asked to "Bear Down" or push, but she was "Uncooperative" and the health provider slapped her. Mrs. Parwin thinks she was mishandled during childbirth and reported the incident to the head of the maternity unit. But she was told that she should just forget about the issue. Mrs. Parwin was unsatisfied with the response and was aware that she has a right to seek redress. She sought help from the Community Health Worker, Family Health Action Group and Community Health Supervisor to resolve the incident. The Community Health Worker advised Mrs. Parwin of an alternative dispute resolution mechanism (mediation) and also assisted her in informing the facility management of her desire to seek redress through mediation. The facility management verified the facts of the incident and informed the provider involved in the incident of Mrs. Parwin’s wishes. The provider agreed to a mediator and the date for mediation. The provider, Mrs. Parwin, and her relatives came for the mediation session.

Focus of the Role Play:
The focus of the role play is the interaction between the midwife, Mrs. Parwin, her relatives, and the mediator.

The mediator should follow the mediation stages described above to perform the session;
- Stage 1 – Introduction and the mediator’s opening statement (setting the climate)
- Stage 2 – Narration or presentation by the parties (storytelling)
- Stage 3 – Determining interests
- Stage 4 – Setting out issues
- Stage 5 – Brainstorming options
- Stage 6 – Selecting sustainable solutions
Stage 7 - Closure

**Discussion Questions:**

1. How did the mediator approach Mrs. Parwin, her relatives, and the provider?
2. Did the mediator give the parties enough information about the role of a mediator? About the process of mediation? About maintaining confidentiality? About their right to be heard equally?
3. How did the provider and Mrs. Parwin respond to the mediator?
4. How did the mediator demonstrate objectivity, no coercion, and control of the discussions during interactions between Mrs. Parwin and the provider? And during the interactions with Mrs. Parwin relatives?
5. Were the mediator’s explanations and communication effective in resolving the incident?
## Annex6: Member of Respectful Maternity Care Orientation Package Working Group

<table>
<thead>
<tr>
<th>#</th>
<th>Name</th>
<th>Title</th>
<th>Organization</th>
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<tbody>
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<td>1</td>
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</table>
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