United Republic of Tanzania

Ministry of Health and Social Welfare

Respectful Maternity Care Workshop

Meeting Report

Courtyard Hotel, Dar es Salaam, Tanzania

USAID FROM THE AMERICAN PEOPLE

Maternal and Child Survival Program

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Abbreviations

AAPH	Africa Academy for Public Health
AMDD	Averting Maternal Death and Disability
CCBRT	Comprehensive Community-Based Rehabilitation
CHMT	Council Health Management Team
CFU	Client Follow-Up
CHW	Community Health Worker
D&A	Disrespect and Abuse
DHMT	District Health Management Team
EGPAF	Elizabeth Glaser Pediatric AIDS Foundation
EPMM	Ending Preventable Maternal Mortality
GBV	Gender-Based Violence
JHU	Johns Hopkins University
IHI	Ifakara Health Institute
M&E	Monitoring and Evaluation
MCSP	Maternal and Child Survival Program
MDG	Millennium Development Goal
MDH	Management and Development for Health
MHTF	Maternal Health Task Force
MNCH	Maternal, Newborn, and Child Health
MNH	Maternal and Newborn Health
MOH	Ministry of Health
MOHSW	Ministry of Health and Social Welfare
NGO	Non-Governmental Organization
OBD	Open Birth Day
PRINMAT	Private Nursing and Midwifery Association of Tanzania
PSE	Pre-Service Education
QI	Quality Improvement
QOC	Quality of Care
RHMT	Regional Health Management Team
RMC	Respectful Maternity Care
RMNCH	Reproductive, Maternal, Newborn, and Child Health
SBM-R	Standards-Based Management and Recognition

TAMA	Tanzania Midwife Association
TANNA	Tanzania National Nursing Association
USAID	U.S. Agency for International Development
WHO	World Health Organization
WRA	White Ribbon Alliance
WRATz	World Ribbon Alliance Tanzania Charter

Background

Although Tanzania has achieved Millennium Development Goal (MDG) 4, the burden of newborn deaths remains high and prioritizing newborn survival is a priority of the Ministry of Health and Social Welfare (MOHSW). However, progress toward MDG 5 has been slower and the percentage of women who deliver in a facility has stagnated at or below 51% for more than 20 years. The slow decline in maternal and newborn mortality is linked to various issues including low utilization of and inadequate quality of maternity services. The MOHSW has highlighted the need to "improve access to quality health services …" for mothers, newborns, and children.[1] Respectful maternity care (RMC) is considered an essential component of quality maternal and newborn health services, and disrespect and abuse (D&A) during childbirth is known to be a significant barrier to increasing facility-based births, as well as a breach of rights-based approaches to care. Even the 49% of Tanzanian women who avail facility childbirth services may experience various forms of D&A including verbal abuse, neglect (abandonment of care), discrimination, non-confidential care, and detention in facilities.(Kruk et al.; McMahon et al.; Sando et al.) With support from the United States Agency for International Development (USAID), and in collaboration with the MOHSW, the Maternal and Child Survival Program/Tanzania (MCSP/TZ) called a meeting of stakeholders to review the available evidence related to RMC and D&A in Tanzania and the region. The stakeholders examined approaches that could best address D&A in the East African region to inform the development of a strategy relevant to the Tanzania context that will enable provision of RMC in maternity services.

The **specific objectives** of the meetings were as follows:

1. Review outcomes and experiences from existing RMC research and program experience in Tanzania and from selected East African countries
2. Review significant contextual variables that influence RMC program effectiveness
3. Discuss and build consensus on promising evidence-informed RMC approaches in the context of MCSP/TZ maternal and newborn health (MNH) quality-of-care (QOC) programming (drawing from national and global initiatives) and possibly leverage the national RBF program.

Agenda and Participants

Participants included representatives from the MOHSW, USAID (Tanzania Mission and Headquarters), MCSP including representatives from the Tanzania, Ethiopia, Kenya and Rwanda field offices, as well as MCSP Headquarters. Other participants included: Africa Academy for Public Health (AAPH), EngenderHealth, Elizabeth Glaser Pediatric AIDS Foundation (EGPAF), Tanzania National Nursing Association (TANNA), the Private Nurses Midwives Association of Tanzania (PRINMAT), Management and Development for Health (MDH), the Tanzania Midwives Association (TAMA), Comprehensive Community Based Rehabilitation (CCBRT), Ifakara Health Institute (IHI), Averting Maternal Death and Disability Program (AMDD)/Columbia University – USA, World Lung Foundation, World Ribbon Alliance Tanzania Charter (WRATz), Johns Hopkins University (JHU) – USA, Maternal Health Task Force (MHTF), Korogwe District Hospital, Sumbawanga Regional Hospital, Population Council – Kenya, including representatives from research institutes, professional associations and non-governmental organizations (NGOs) working in the field of RMC in Tanzania.

Appendixes 1 and 2 contain a detailed agenda and a list of participants, respectively.

All PowerPoint presentations are available on request.

[1] MOHSW 2014 The Sharpened One Plan.

Welcome, Meeting Objectives and Introductions

The meeting was opened by **Dr. Dunstan Bishanga**, MCSP/TZ Chief of Party, who welcomed participants from Tanzania, the US, and other East African countries including Ethiopia, Kenya and Rwanda. **Dr. Raz Stevenson**, Senior Maternal Child Health Advisor, Health Office, USAID Tanzania, thanked the MOHSW for its engagement and talked about the need for strategic approaches to ensuring that health facilities/services are accountable to the communities they serve—social accountability—ensuring that women and their families have a voice in the quality of services. Dr. Stevenson noted that the time is right for the Ministry to ensure that women's voices have some "teeth," or reciprocity, by addressing the barriers noted in Tanzanian research on D&A. This can include review of standards and curricula, and identification of areas for improvement based on insights and discussions from workshop participants over the coming days.

Ms. Amalberga Kasangala, Chief Nursing Officer, MOHSW, represented the Ministry in officiating the RMC workshop.

Tanzania MOHSW's Vision of Improving Quality of Care with a Focus on RMC

Dr. Grace Mallya presented the MOHSW's vision for improving QOC with a focus on RMC. She noted Tanzania's successes such as achieving MDG 4 and drafting of the One Plan II, which includes RMC and gender-based violence (GBV), while highlighting areas that merit more attention in order to reduce maternal and neonatal mortality. Dr. Mallya emphasized that D&A and poor QOC are significant barriers to care-seeking for delivery, and that there are opportunities for improving quality of services at all levels:

- Policy: reinforcing the client charter and advocating for changes to policy and/or law;
- Facility: reorganization of facility to ensure privacy and confidentiality, and provision of motivational incentives for maternity staff;
- Provider: value clarification, attitudes and norms change, as well as client provider interactions;
- Community: sensitized to demand their rights; and
- Finally, she suggested the way forward is to conduct advocacy at regional and district levels to restructure facilities to accommodate RMC practices by establishing quality improvement (QI) teams, liaising with pre-service education (PSE) and encouraging community involvement.

Opportunities for Improving Quality of Services

- **Policy level:**
  - Reinforcing the client charter
  - Advocating for policy and/or law change
- **Facility level:**
  - Reorganization of facility to ensure privacy and confidentiality
  - Motivational incentives for maternity staff
- **Provider level:**
  - Value clarification, attitude, and norms change
  - Client/provider interactions
- **Community level:**
  - Sensitized to demand their rights

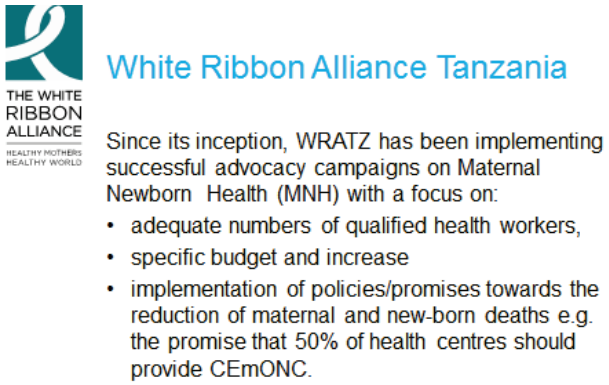
Addressing RMC within MCSP

Dr. Bishanga shared MCSP's programmatic goal—to increase access and coverage of quality reproductive, maternal, newborn, and child health (RMNCH) services by contributing to the scale-up and rollout of high-impact interventions to reduce maternal, newborn, and child mortality in line with the One Plan II (MOHSW 2016–2020). This will include: increasing coverage of high-impact interventions; incorporating gender-sensitive and respectful services; improving measurement; reducing unmet family planning needs; and strengthening community-based interventions. Keeping in mind the household-to-hospital continuum of care, MCSP plans interventions at the national, facility, and community levels. MCSP has a broad

implementation platform across facilities and regions with a focus on Kagera and Mara regions. Constraints that need to be considered before and during implementation of RMC activities include timeline and budget, and a need to ensure they are context specific.

Addressing RMC in Tanzania–WRATz Engagement

Rose Mlay presented on WRATz, which was launched as a national alliance in 2004, and has more than 3,500 members including 108 member organizations, and focal persons in each region of Tanzania. The alliance's philosophy is "Respectful maternity care is a universal human right that is due to every childbearing woman in every health system." The Charter for Universal Rights of Childbearing Women was developed from a landscape review by Diana Bowser and Kathleen Hill that identified seven D&A domains.



A new WRA video summarizing progress in advocating for RMC was shared: https://www.youtube.com/watch?v=SO3kQhZwk44&list=PLlpvwXkLP8h5LZWSsNQkCtpsK2CQn6kl0&index=3

WRA objectives for the promotion of RMC:

- Set standards for RMC and global endorsement of a RMC rights framework.
- Implement country-led advocacy campaigns to increase accountability and improve service delivery.
- Foster multi-sector coordination to harmonize efforts and collaboration.

WRA has five key approaches to address RMC that provide a useful framework for country-level activities:

1. Promoting the right to RMC
2. Mobilizing communities to demand RMC
3. Integrating RMC into training and standards for providers
4. Supporting providers to deliver RMC
5. Incorporating RMC in national legislation and health policy

What does it take to Promote RMC in the Existing Care System?

Dr. Brenda D'Mello presented on behalf of CCBRT, an NGO supporting the MOHSW to implement maternal, newborn, and child health (MNCH) services, and shared the organization's experience of integrating RMC into capacity-building activities of selected health facilities supported by the program in the Dar es Salaam region. The team utilized Jhpiego's Standards-Based Management and Recognition (SBM-R®) tools for results-based assessments with the understanding that not having standards/having standards, but not knowing them/using the wrong standards contributes to inadequate quality of services. Dr. D'Mello consistently reiterated the importance of training, mentoring, coaching, and assessing quality through the use

of SBM-R. CCBRT further used quarterly regional stakeholder meetings to assess progress toward evidence-based standards, develop action plans for follow-up, share best practices and lessons learned, and undertake peer-to-peer problem-solving. Many sites are now scoring at or above 85%. One major gap in SBM-R is an absence of conversation on "what you should not do." Simple examples of QI highlighted by D'Mello include a requirement that providers greet clients and that facilities invest in curtains (for privacy). SBM-R results have improved from 9% to 78% (October 2014). Dr. D'Mello suggested "changing hearts" among providers by having women who have been victims of D&A testify about their experiences at in-service trainings (thereby allowing trainings to become an avenue for advocacy rather than for punitive measures). Champions were recognized and there is a "no shame, no blame" approach in use. The wards are bulging with a 33.79% increase in facility deliveries. Challenges include increased volume of patients vs. unrealistic budgets and human resource shortages at high-volume comprehensive EOC sites. She concluded by emphasizing that supporting staff to deal with the high workload is key, and investing in comprehensive capacity-building that includes a focus on RMC is preferable to a vertical RMC program.

RMC Program Development in Tanzania: Lessons from Implementation Research

Kate Ramsey and Godfrey Mbaruku of IHI and AMDD reported on their USAID-TRAction-funded implementation research effort (Staha Project), which is being conducted in two districts, Korogwe and Muheza, in Tanga region. The study is quasi-experimental, with Korogwe assigned to intervention and Muheza assigned to comparison, and includes eight health facilities, two hospitals, five health centers, and one high-volume dispensary across the two districts. The presenters discussed the objectives, timeframe, design, and implementation of their research. The research objectives included: developing and validating tools for assessing D&A; determining the manifestations, types, correlates, and prevalence of D&A in childbirth; exploring potential drivers of D&A; and designing, implementing, monitoring, and evaluating the impact of interventions to reduce D&A.

A tool was developed and validated to capture prevalence of D&A, which was used for the baseline and endline assessments. The baseline research, which also included qualitative methods, found a reported prevalence of any D&A of between 19–28%, depending on whether women were interviewed immediately upon discharge or six to eight weeks postpartum. The implementation research was guided by Damschroeder et al.'s Consolidated Framework for Implementation Research, and the presenters highly recommended the incorporation of conceptual frameworks in the design of any RMC implementation research in Tanzania or elsewhere. Regular implementation tracking was designed to assess progress and included routine client exit surveys and qualitative interviews.

The Staha Project's intervention included local adaptation and activation of the national Client Service Charter complemented by regular support to a QI team in Korogwe's district hospital, which focused on identifying and overcoming obstacles to achieving RMC. This was developed based on a series of consultations with stakeholders at management, facility, and community levels in Korogwe district. Program monitoring results are encouraging and the client exit surveys demonstrate an improvement in women's ratings of QOC, including domains of respectful care, over the course of the intervention. The patient exit survey results were also an intervention as they shifted priorities and made providers feel responsible for making changes.

The two presenters highlighted the importance of a local "adaptation process" of the national charter as part of the intervention. For the project, local adaptation involved a systematic dialogue between representatives of the district health system and communities in the two districts. Korogwe was the first district to adapt the

national charter to reflect local needs and concerns. The final document, approved by local authorities, is centered on the value of mutual respect and consensus on key rights and responsibilities for patients and providers to ensure respectful care. Although agreed during the adaptation process, upon dissemination, one of the most controversial parts of the Charter was found to be the right to refuse treatment.

The project endline data collection is currently under way and final findings will be forthcoming.

Preliminary findings from qualitative analysis include:

- Leadership and facility readiness was an important element in the success; some leaders emerged later in the process highlighting the need for continual engagement.
- Health care providers are mostly committed and felt that many of the changes improved their working environment and described some level of peer accountability.
- The process of engaging and facilitating discussion through the adaptation process was sometimes uncomfortable, but integral to success.
- Communities are keen to engage—women's reports are a monitoring tool; however, many interventions can address rights and needs of patients and providers and "light mechanisms" can allow time for relationship building.

Based on this success, facility staff are reporting increased numbers of women using facility childbirth services in the study districts, which is resulting in new challenges inherent to maintaining quality in the face of higher demand for services.

MHTF/MDH RMC Experience and Research in Tanzania

Dr. David Sando of MDH presented on the results and approaches from a second implementation research study. The research study was conducted in the Temeke District of the Dar es Salaam region. The project (called Uzazi Bora Project) was designed to assess the types and prevalence of D&A and factors associated with D&A. The study was conducted over a one-year (2013–2014) period. At baseline, 2,000 clients were interviewed in two sessions; 3–6 hours postnatal and 4–6 weeks later. Results of this published study are shown in the tables below (with the authors' permission):

Table 1. Client Reports of D&A

Type of D&A	Baseline Exit N=2,000	Baseline CFU* N=70	Evaluation CFU Overall N=149	Evaluation CFU OBD** N=28	Evaluation CFU Non-OBD N=121
Any type of D&A	14.6%	77.1%	19.5%	14.3%	20.7%
Physical abuse	4.5%	51.4%	1.3%	0%	1.7%
Non-consented care	0.3%	5.7%	0.7%	0%	0.7%
Non-confidential care	1.7%	51.4%	1.3%	0%	1.7
Lack of privacy	1.9%	51.4%	4.7%	3.6	5.0%
Non-dignified care	6.3%	52.9%	4.7%	3.6%	5.0%
Abandonment	7.7%	50.0%	14.8%	14.3%	14.9%
Detention	0.2	1.4%	1.3%	0%	1.7%

*Client follow-up.
**Open birth day.

Table 2. Client Reports of Lack of Information

Lack of information about:	Baseline Exit N=1,799	Baseline CFU N=69	Evaluation CFU N=149
Ward environment	77%	74%	66%
Time of meals and what to eat	98%	100%	69%
Findings of general examination	89%	100%	72%
Findings of vaginal examination	65%	99%	55%
Progress of labor	79%	88%	55%
Movement during labor	97%	99%	83%
When to breastfeed the baby	92%	100%	68%

To address the findings from the baseline, two interventions were selected:

1. RMC Workshop
2. Open Birth Days (OBDs)

Results of the interventions were positive: OBDs allowed for close interactions between providers and clients and allowed clients to see providers as "good collaborators." Providers have better understanding of clients and more empathy:

- 100% of providers said that the RMC Workshop changed the way they think about their clients.
- 75% said that the RMC Workshop improved their interpersonal relationships with clients.

Summary

- Results from the pilot are encouraging, but more work remains!
  - Nearly 20% of clients still reporting some D&A
  - Providers are more satisfied than at baseline, but still have concerns about infrastructure and human resources.
- Combined with increased dialogue, OBDs and RMC workshop have shown promising results
  - A more rigorous evaluation is needed

A theory of change was developed and the impact of the study shows that changes in knowledge, attitudes, and communication across all levels of the health facility have led to individual and institutional commitments to people-centered care.

In summary, the IHI/AMDD and MDH/MHTF implementation research demonstrates that D&A is an obvious problem within health facility settings in Tanzania. These results are reinforced by a qualitative study by McMahon et al. exploring experience of disrespectful and abusive maternity care in Tanzania's Morogoro region (see **Table 3**). The IHI/AMDD baseline results highlight the variation in prevalence measures depending on the specific measurement method, with observation yielding the highest prevalence measures, followed by client home-based interviews after discharge (intermediate), followed by client exit interviews at the time of discharge (lowest prevalence measure.) Results from these pilot studies in Tanzania are encouraging, but more work remains to validate feasible measurement approaches that can be integrated into routine programming and to understand key drivers and feasible sustainable approaches for reducing D&A and achieving RMC at broader scale in Tanzania.

Table 3. Domains of D&A across Tanzania-Based Studies

Prevalent Types of Mistreatment in Tanzania (*WHO "2nd order theme"*)	Prevalence of quantitative studies (Kruk et al. 2014; Sando et al. 2014). Qualitative studies: McMahon et al. 2014
Verbal abuse	Kruk et al. 13.2%; Sando et al. 4.3%; Spangler *qualitative*
Physical abuse	Kruk et al. 5.08%; Sando et al. 4.55%
Neglect	Kruk et al. 15.5%; McMahon et al. *qualitative*; Spangler *qualitative*
Lack of supportive care	McMahon et al. *qualitative*; Spangler *qualitative*
Poor communication	McMahon et al. *qualitative*; Spangler *qualitative*
Denial or lack of birth companion	McMahon et al. *qualitative*
Discrimination	Sando et al. 20%—documented higher discrimination among non-HIV-positive than HIV-positive women; Spangler *qualitative*
Non-consented "care"	Kruk et al. 0.17%; Sando et al. 0.26% (self-report); 82% (observation–vaginal exams)
Non-confidential care	Kruk et al. 6.16%; Spangler *qualitative*
Lack of privacy	Kruk et al. 6.16%;
Detention, bribe	Kruk et al. 3.39% (bribe); Sando et al. 91.54% (obs); Spangler *qualitative*

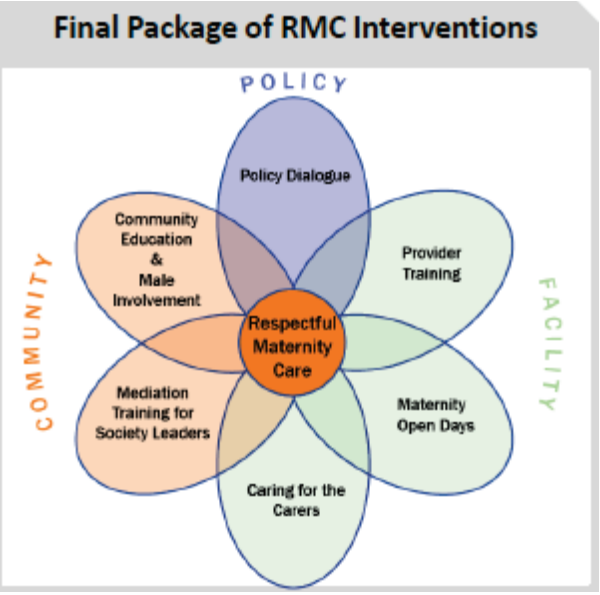
The sections below explore research findings from Kenya and highlights from the evolving global literature on this topic.

USAID-Supported RMC Implementation Research in Tanzania and Beyond

Neal Brandes from USAID Washington discussed some of the key documents and initiatives guiding USAID's focus on implementation research, namely Fixsen's Core Implementation Components (2009). While there is enough evidence in the literature to make it clear that D&A exists, we need to ask – "Have we documented the pieces that we think are influencing change? Have we started with a meaningful and informative theory of change? In all the research conducted, there are common findings about implementation, but different models are likely to work, and how do we test or document these different models? How can we be more systematic about documenting the process and applying change more quickly? How do we plan for scale-up in this area? What can we draw from ongoing work including in other technical areas?"

Brandes highlighted that in Tanzania there is an HIV/AIDS platform, as well as an expansion of both Results-Based Financing and Big Results Now platforms—learning from these endeavors could inform efforts to foster RMC if programmatic and intellectual linkages are made. "How do we infuse a culture of learning and continuous adaptation and how do we engage researchers so that we have real-time feedback?" USAID has a research team at Muhimbili, working with the Ministry Task Force, focused on embedding research into the process of implementation. Brandes concluded by highlighting that while different models to address D&A exist, any intervention must incorporate systematic documentation to learn a) contextual factors that mediate implementation and b) to explore how the stakeholders respond to the intervention through adaptation and adoption.

RMC in Kenya–the Heshima Project



Charity Ndwiga and Timothy Abuya presented on the Heshima Project, implemented by Pop Council with USAID funding through URC TRAction Project, which set out to: 1) Specify types and prevalence of D&A; 2) Develop and validate tools for assessing D&A; 3) Identify potential drivers of D&A; 4) Design, implement, and evaluate an intervention to reduce D&A in the areas of labor and delivery, and postnatal care within 48 hours at the facility; and 5) Generate lessons for replication and scale-up. The presentation focused on the RMC program experience and lessons learned from implementation research in Kenya. The intervention comprised a set of activities at policy, health facility, and community levels in 13 study sites. There has been progress and improvement since the start of the research in 2011 to 2104, resulting in an overall reduction of women who reported feeling humiliated or disrespected at any time from 21.1% (N 641) at baseline to 13.2% (N 728) at endline. In this study, D&A drivers were identified from the national, facility, and community levels. At policy and governance levels, issues like policy at the national level to support RMC, complacency of policymakers in dealing with D&A, and insufficient funding for maternal health care were identified; at facility level, the problem of informal payment for services or bribes, inadequate infrastructure leading to poor working environment as well as staff shortages leading to high stress come out clearly. At community level, lack of understanding of women's health rights and overly complex mechanisms of victims who seek redress for D&A were identified, among others. The intervention focused on the above three areas. At the policy level, the project promoted increased visibility of RMC as a rights-based approach; an RMC resource package was developed for all levels of care; and incorporation of RMC into a national Maternal Health Bill. The implementation process included a continuous process of consultation with key stakeholders and tracking prevalence of reported D&A during labor and delivery.

Key recommendations from the Heshima Project:

- Participatory process in design and development of interventions generates trust and ownership of intervention thus enabling implementation process.
- Continuous policy and advocacy dialogue–the Ministry of Health (MOH), civil society, regulatory and professional bodies–should be instituted as a means to allay fear, mitigate negativity, and curb any blaming and shaming.
- A multi-disciplinary project steering committee developed (as a means to find others working in maternal health and to avoid making others engaged in this issue feel neglected or question the program's legitimacy). The committee provides guidance and ensures project legitimacy at both national and sub-national levels.
- Data on prevalence of D&A should be accessible, clean, and well maintained, as well as provide evidence for action and need for change.
- Training and engaging media and champions enhance advocacy and visibility of RMC and D&A at all levels.

- Positive relationships between community networks must be created in order to foster an enabling environment for promoting RMC.
- External actors provided a balanced external perspective that promoted RMC.
- Adaptation of RMC into various policy guidelines and training materials for policy is necessary to position RMC as a key component within MNH. To this end, the RMC Learning Resource Package (facility, community) was developed and is in use for training.

The project developed important elements of an intervention package; rights-based approaches to service delivery, community-facility participation, psychological debrief for caregivers due to stress-related work (caring for the carers), and improvement of facility management and governance. Contextual influences included: policy and political influence in Kenya context; devolution of power from national to county management teams, the free maternity care mandate, and resource constraints.

Rose Mlay and Sheena Currie moderated a brief session on participant insights and reflections. Critical issues raised during the discussion included: need for indicators to improve accountability, changing "the heart" of the provider, the role of professional associations, advocating for mutual respect between clients and providers via, for example, OBDs, involving private health care facilities, and using/operationalizing the Client Charter as part of standard practice.

Building Momentum for RMC

Mary Ellen Stanton, USAID Maternal Health Team Lead

Comments and Thoughts on Framing the Issues

- There is a reluctance to be direct in using words like abuse.
- There are important structural issues that contribute to RMC "Wicked Problems or Wicked People"– these are situations that set us up for conflict. Digging out what we need to do at institutional levels will help at individual levels.
- Paying attention to inter-personal issues, as well as over medicalization. It's a decision on how to frame the issue about whether you bring over medicalization into the RMC discourse (e.g., inappropriate induction of labor or cesarean section, etc.). There are situations where there are too many medically unindicated cesarean sections and a lack of informed choice.
- RMC should not be relegated to a "soft issue" in maternal health, resulting in less attention paid to RMC than to "hard" clinical interventions like emergency obstetric care or postpartum uterotonics. Compassion and respect are somehow often perceived as having less inherent value than clinical interventions and we need to change this view via framing.

Thoughts on Challenges in Building Momentum

In taking this on, the lessons learned on **what didn't work** will be very important. Lynn Freedman (AMDD) has said that we risk engendering a sense of complacency and potentially negative unintended consequences if we propose small and reductionist solutions to this vast, complex problem. Despite our fervor, there will be apathy, distrust, cynicism and pushback. In Arusha a few years ago, there was tremendous pushback by providers after a panel on D&A because the providers asserted that they themselves are victims of abuse.

The World Health Organization (WHO) is gathering information on the issues around human resources and the challenges of the work environment, infrastructure, and gender-related issues. Also of note, when WHO

conducted the large global study on GBV they brought in people who are working with GBV and did *advocacy-based* health programming before they did *evidence-based* programming.

Working with WHO on Linking RMC to Global Initiatives (Ending Preventable Maternal Mortality [EPMM])

Rima Jolivet of MHTF shared an overview of a strategy for EPMM recently finalized by WHO and stakeholders. EPMM outlines a framework for the next 15 years with human rights at its center—RMC is a rights-based issue, as well as an issue of quality of care. Key elements of EPMM relevant for RMC include:

- Empower women through participatory accountability mechanisms, and enhance the status of women as providers and receivers of health care.
- Educate women, including midwives, about their RMC rights and empower them to demand it.
- Provide education and resources including mechanisms for redress.
- Conduct values clarification.
- Study factors that lead to unequal treatment and D&A based on specific attributes.
- Health sector systems must include both the hardware and the software (including ensuring mechanisms for participation and community engagement and prioritizing respectful care norms and values).

Conceptualizing RMC and D&A for Program Action: WHO Systematic Typology of Mistreatment of Women in Childbirth in Health Facilities, WHO Maternal and Newborn QOC Framework

Kathleen Hill, MCSP Maternal Health Team Lead, presented on the importance for maternal health stakeholders to consider both sides of the RMC/D&A coin in addressing D&A and promoting RMC in a particular context. Ideally, stakeholders engaged in maternal health advocacy, policy, and program efforts can find ways to hold both sides of the coin as they frame the issues for local and global audiences. It is important to consider that the absence of mistreatment (e.g., no yelling or verbal abuse) may not equate with respectful and dignified care (e.g., compassionate emotional support).

D&A Side of the Coin

A systematic review of mistreatment of women during childbirth in health facilities has just been published (Bohren et al.). The Mixed Methods Systematic Review of Mistreatment (2015) reviewed 65 studies that met pre-defined criteria. Approximately two-thirds of the reviewed articles were published after the 2010 USAID-funded Landscape Analysis of Disrespect and Abuse in Childbirth (Bowser and Hill.)

The systematic review defines a "typology of mistreatment during childbirth" that identifies seven "third-order themes" of mistreatment, including:

- Physical abuse
- Sexual abuse
- Verbal abuse
- Stigma and discrimination
- Failure to meet professional standards of care
    - Lack of consent and confidentiality

- Neglect/abandonment

- Poor rapport between women and providers
  - Ineffective communication; lack of supportive care; loss of autonomy

- Health system conditions and constraints

The majority of studies published to date continue to be qualitative and descriptive with limited measures of prevalence or evaluation of interventions to reduce D&A. Only three of the 65 studies included in the systematic review are quantitative studies that include a measure of prevalence of D&A (Kruk, Sando, Okafor.) Only two quantitative studies have ever been published to our knowledge of the results of an intervention to reduce D&A in childbirth (Sando, Abuya in press).

Both quantitative studies of an intervention to reduce D&A demonstrated impact and have been presented at this meeting (Sando et al; Abuya et al.) A publication of the Staha Project intervention to reduce D&A is anticipated in the coming year once endline data have been collected and analyzed.

The explosion of evidence about mistreatment (or D&A) in facility childbirth has contributed greatly to a growing public acknowledgement of the problem of mistreatment (D&A) of women in facility childbirth. However, despite clear evidence of widespread mistreatment of women in childbirth, challenges remain for achieving consensus around a clear operational definition of mistreatment and its key elements, as well as feasible measurement approaches that can be incorporated into broader maternal health programming to address mistreatment of women. More research is needed to: 1) test and validate routine measures of D&A and RMC that can be used to measure prevalence and support implementation efforts; 2) deepen understanding of common key drivers of mistreatment in specific contexts; and 3) generate stronger evidence about feasible and sustainable multifaceted approaches for reducing mistreatment within the context of maternal health programs operating at scale.

RMC Side of the Coin

RMC is a key element of QOC for pregnant and postpartum women around the time of childbirth. Many QI initiatives have addressed RMC as a central component of QOC. The recent publication of WHO's "Quality of care for pregnant women and newborns—the WHO vision" has helped to position RMC as a central element of quality of maternal and newborn care (Tunçalp et al.). WHO's QOC framework for MNH includes eight domains, three of which are directly relevant to RMC, including (see Figure 1):

1. Effective and responsive communication:
   - [Women] experience effective interactions with staff who demonstrate communication skills.
   - Clear and accurate information exchange
2. Care provided with respect and dignity:
   - Privacy and confidentiality are respected
   - No woman or newborn subjected to mistreatment
3. Emotional support:
   - Companion of choice
   - Emotional support

Following an expert consultation in Geneva in April 2015, to review the WHO QOC MNH framework, the WHO is further refining a set of standards, quality statements, and indicators for each of the eight framework domains. This work should help to inform ongoing global and country policy, and program and advocacy efforts to promote RMC and decrease D&A during childbirth.

Working in collaboration with country and global partners, the USAID-funded MCSP has an important opportunity to strengthen RMC and reduce D&A as a central element of maternal health programming in MCSP-supported countries.

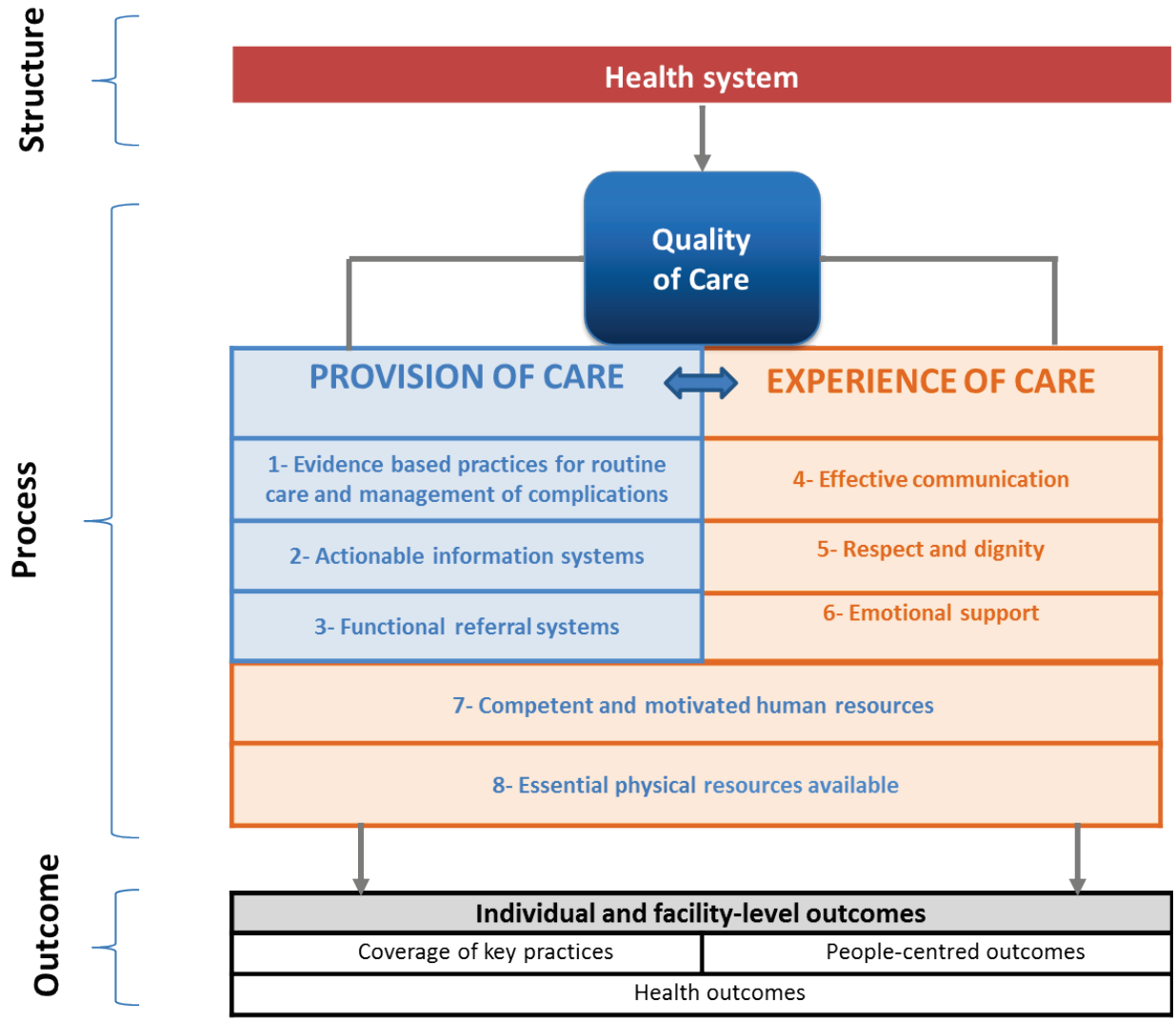
MCSP has defined two overarching goals to guide its ongoing work to promote RMC and reduce D&A in MCSP-supported countries:

1. To promote RMC as an integral element of high-quality, comprehensive, effective, safe, and people-centered maternal and newborn care
2. To support contextual approaches for reducing locally prevalent types of D&A (mistreatment) with emphasis on local participatory design and program learning

Depending on the country context, country workplans, and funding resources, MCSP will collaborate with country partners on one or more of the following activities to support robust design and implementation of D&A reduction approaches:

- Assess prevalent types of D&A in local contexts using a mixture of measurement approaches when feasible to triangulate results (observation; client questionnaires (exit and/or follow-up home-based); provider interviews, etc.).
- Define **measurable goals** focused on achieving specific priority RMC outcomes and/or reducing specific locally prevalent types of D&A (i.e., unpack RMC and D&A for programming and measurement).
- Engage local stakeholders (community, facility, and health system) to analyze drivers of measured D&A in the local context, supplemented by a review of the relevant literature (published and gray).
- Develop and co-design promising program approaches or "solutions" (all system levels) with national, regional, and local stakeholders to achieve RMC goals and reduce locally prevalent prioritized types of D&A.
- Iteratively test and refine program approaches ("solutions") with commitment to continuous program learning.
- Contribute to development, testing, and validation of measures of RMC and D&A that can be feasibly integrated into routine maternal health programming to gauge program progress, inform continuous learning, and evaluate program impact (preferably as part of broader maternal health programs rather than as stand-alone RMC/D&A interventions).

Figure 1. WHO QOC Framework for Maternal and Newborn Health (Tuncalp et al.)



Day 1 Group Work and Presentations

Workshop participants divided into small groups to analyze drivers and potential solutions for addressing selected types of D&A from the following perspectives:

- Group 1: Village Community Leader and members
- Group 2: Facility Staff
- Group 3: Regional/District Health Management Teams (DHMTs)
- Group 4: National Policy Leaders

A fifth group was considered for priority areas of RMC/D&A research.

A summary handout **mapping prevalent forms of mistreatment** per Tanzania research (4, 12, 15) and corresponding WHO QOC dimensions related to experience of care was distributed to groups to guide their group work (see **Appendix 3**).

Groups were asked to choose three categories of mistreatment in facility childbirth reported in the Tanzania (and/or global) literature and to consider key drivers and opportunities for addressing the selected types of mistreatment from the perspective of their assigned group (e.g., community members, facility providers, district manager).

Three types of mistreatment	Why does this mistreatment occur? Five most important drivers from your group stakeholders' perspective	Opportunities for addressing the mistreatment in Tanzania

The main types of mistreatment selected by groups to consider as part of the exercise were: lack of birth companion (four groups), lack of privacy (three groups), verbal abuse (two groups), and neglect and abandonment (three groups). The groups considered these across the continuum of care and from different dimensions, for example, the c**ommunity leader** clearly reflected the beneficiaries' concerns including the lack of accountability; the facility group discussed reasons why mistreatment has become "normalized" in many facilities, and Groups 3 and 4 explored how health system issues, including infrastructure, HRH, and organization of care, impact the ability to provide RMC. **See Appendix 4 for notes of group work discussion for groups 1–4.**

A key message from participants was: "We have a client service charter—let's use it."

RMC Research Group

The research group began by acknowledging the growing support, recognition, and academic interest in RMC and as reflected by the growing literature on the topic (including prevalence data from a few publications).

The research group considered several interventions to promote RMC and reduce D&A that merit further research in terms of effectiveness and/or feasibility. The first intervention discussed was presence of a birth companion—the perceived feasibility, or non-feasibility, of having birth companions (Hofmeyer vs. Pitchforth) was discussed with respect to infrastructure and cultural barriers in many settings. Another intervention was related to Maternity Open Days, which should include husbands and partners. A third intervention (approach) was ensuring that RMC is well-addressed in PSE, which includes the importance of training students in clinical sites that model quality respectful care and offering refresher trainings for lecturers. The research group discussed the need to engage with advocacy organizations such as WRATz, but also acknowledged that it can be challenging for programs and researchers if they align themselves too much with organization that are focused on advocacy.

The group highlighted avenues for program learning and future research, including:

- The importance of testing and validating questions that can be incorporated into questionnaires or observational activities and that can measure prevalence and explore drivers of distinct types of D&A in a specific context. It was suggested that "We should strive to identify questions that can be incorporated into nationally representative surveys and can also be used for programmatic evaluations."
- Potentially undertaking a case study with a "positive deviant"—identifying a facility that we know has a high load of clients and yet manages to provide RMC could be very informative–what are the

characteristics that make these facilities successful and how can we harness and translate knowledge from these facilities to other settings?

- Incorporating program learning into any intervention in order to clearly outline components (both core and peripheral components) of the intervention and to track how an intervention performed in relation to stated aims outlined at the outset. This could help the broader RMC/D&A community appreciate how programs need to be adapted or modified in the course of addressing a complex, protracted, and delicate problem.
- Pursuing preliminary efforts to foster buy-in (complemented by research)—to increase stakeholder buy-in at community, facility, district, and national levels.

Day 2

The day started with a summary of Day 1 sessions and participants' reflections on Day 1.

Ideas for key messages included:

- RMC has great support in Tanzania and globally
- There is a lot of existing evidence, both qualitative and quantitative
- Operationalizing the Tanzanian Client Service Charter is a priority
- A mutually respectful relationship is vital between the health care provider and clients (must go both ways)
- Involvement of multiple stakeholders is needed to address RMC, including the private sector
- Continuous support to health care providers and health facilities is key—we must care for the carers if we want to reduce D&A (supportive supervision, onsite mentoring and coaching)
- Need to have better links between health facilities and communities
- Community awareness and engagement, including male involvement
- Measurement—routine monitoring— of RMC and D&A must be agreed for inclusion
- A theory of change is important for addressing D&A—must understand key manifestations of D&A and drivers of these manifestations in the local context and the mechanisms through which interventions to address D&A function
- Need to re-emphasize human rights-based approaches to care

Group work

Participants were then divided into four groups building on the work from Day 1 with a goal to formulate priorities and action for RMC in Tanzania based on best available evidence and lessons learned (see **Appendix 3).** The groups were given scenarios and asked to design and implement a program to reduce D&A in facility childbirth. Each group selected a D&A driver and goal and then selected a program approach and system level at which they would implement an intervention (including key stakeholders with whom they would engage). Some groups developed indicators to monitor a data source and suggestions for the frequency of measurement.

Details of Day 2 group work are available on request.

Closing Remarks

Mary Ellen Stanton expressed her appreciation to the group for their energetic and passionate participation. She closed the day's discussions by expressing her own excitement about the many good ideas for action that were raised during discussions, but that will require some sifting.

Dunstan Bishanga made closing remarks during which he gave a few hints on the way forward for the project, such as synthesizing all the contents and inputs shared in the workshop report. Strategies should be well-defined, and MCSP will ensure that its implementation plans are communicated to key stakeholders, while also continuing with internal discussions and with MOHSW to disseminate plans to the broader community. MCSP will take these discussions to the various technical working groups (Safe Motherhood and Community Health Worker (CHW) technical working groups), with which MCSP staff are involved. MCSP will work closely with WRATz in order to share lessons with others:

- Make sure MCSP can complement and synergize existing platforms.
- Involve civil society organizations and associations to operationalize RMC.
- Establish a forum to continue to update each other at the country level, perhaps led by WRATz.
- Establish an RMC subcommittee—WRATz, IHI, and MHTF—and see how MCSP can be involved.

The Chief Nursing Officer with Tanzania's MOHSW acknowledged all participants for their full participation and assured the group that the MOHSW is ready to work with RMC partners.

Meeting Summary Points and Recommendations

- Important progress has been made in understanding and addressing common forms of mistreatment of women during facility-based childbirth services in Tanzania and the East Africa region over the last 3 years:
    - Four quantitative studies have tested measurement methods (observation, client questionnaires) to establish prevalence measures of mistreatment (Nigeria, Kenya, and two studies in Tanzania).
    - Three implementation research studies (two USAID-supported) have developed and assessed interventions to reduce D&A, shedding important light on promising RMC/D&A approaches (two from Tanzania, one published and one pending; and one from Kenya, pending publication).
    - **Many** qualitative studies have been published in the last five years further illuminating common forms of D&A, and in some cases building understanding of key drivers of D&A in specific contexts.
    - Publication in 2015 of a mixed-methods systematic review that includes a typology of mistreatment with seven third-order themes, 16 second-order themes, and 39 third-order themes (Bohren et al.).
- Important advocacy and policy gains have been made at the global and country levels, including publication of the WHO statement on prevention and elimination of disrespect and abuse during facility-based childbirth (2014) and endorsement of a national RMC charter by the Nigeria National Health Council.
- Promising approaches to reduce D&A and promote RMC agreed upon by meeting participants include:
    - Approaches that break down barriers between providers and clients (e.g., regular facilitated community-facility dialogue; QI teams that engage in continuous work to improve people-centered care with facility and community members; and maternity open days)

    - Local participatory approaches focused on iterative and attention to locally devised priorities
    - "Caring for the Carer" (psychologic support for health workers)
    - Strategic advocacy efforts to create a favorable policy and leadership environment
    - Promoting mutual accountability: rights and responsibilities of health care providers and clients
    - Continuous QI focused on overcoming critical barriers and regular measurement (with consideration of community and facility team members)
    - Strengthening local health systems to overcome structural barriers (lack of commodities, lack of basic infrastructure)
    - Possibly efforts focused on professional ethics and regulation (requires further testing)
- Further research is needed on local participatory implementation design and processes that can be adapted and sustained locally to reduce D&A and sustain RMC—with a focus on iterative learning and adaptation
- Further testing of promising low-cost interventions (e.g., Open Maternity Days, Birth Companions, Caring for Carers) is needed as part of program learning to establish effectiveness and feasibility in low-resource settings
- Further program and implementation learning is needed to clarify relative contributions and synergies of cross-system, multifaceted approaches to promote RMC and reduce D&A (e.g., national advocacy and guidelines; regulation of providers; training and supervision; community accountability approaches; service delivery QI and local health system strengthening approaches, facility scorecards, etc.)
- Further consensus is needed on the most useful construction of D&A "typologies" and operational definitions for specific purposes, including for prevalence measurement and for RMC/D&A program implementation
- Further consensus is needed on RMC and D&A terminology for specific audiences and purposes, including advocacy, policy, and programming, as well as terminology related to both mistreatment (or D&A) and RMC (or compassionate, dignified, humanized, or people-centered care)

Next Steps Agreed to by MCSP and the MOHSW in Tanzania

- MCSP will finalize an RMC concept note to guide RMC program implementation and learning in project areas, leveraging key learning generated during the meeting.
- MCSP will seek opportunities for strengthening RMC knowledge and skills in PSE curricula.
- MCSP will promote inclusion of RMC/D&A awareness, knowledge, and skills as part of in-service continuous capacity-building in MCSP MNCH programming.
- Project strategies should be defined and refined before implementation.
- MCSP has a unique opportunity and will use findings and learning from RMC implementation research done in Tanzania (Staha Project, Uzazi Bora project) and in neighboring Kenya to inform ongoing MCSP RMC work in Tanzania (and in other MCSP countries).
- National policy guidelines on RMC will be developed in collaboration with the MOHSW, professional associations, MCSP, and WRATz, which is taking the lead.
- MCSP will collaborate with WRATz on advocacy activities at the national level.

- National, regional, and district ownership is important for setting strategies for participatory approaches from the beginning of the project.
- MCSP to integrate RMC interventions into other relevant project thematic areas, including linking with gender-sensitive services.
- Advocacy work will be supported for the creation of a conducive environment for RMC to be implemented (i.e., addressing issues on client privacy).
- Behavior change among service providers is key to address D&A at the facility level and will be addressed as part of MCSP programming.
- MOHSW, MCSP, and WRATz will review and advocate for RMC inclusion in national policy and in relevant guidelines, training materials, quality standards, job aids, etc. (national, regional, and facility).
- Explore use of scorecard meetings at the community level as an option to raise RMC action points.
- MCSP will address RMC as a key aspect of QOC as part of ongoing and future QI efforts in targeted regions.
- Community engagement—addressing demand creation for health care, education, and promotion of clients' rights—should be a priority.
- Engaging civil society organizations and maximizing their role in implementation and the learning side of RMC interventions.

A small group of staff from MCSP and USAID met in the afternoon of Day 2 to debrief and discuss next steps.

References

Abuya T et al. 2015. Exploring the prevalence of disrespect and abuse during childbirth in Kenya. *PLoS One* DOI: 10.1371/journal.pone.0123606.

Bohren MA et al. 2014. Facilitators and barriers to facility-based delivery in low- and middle-income countries: A qualitative evidence synthesis. *Reprod Health* 11:71.

Bohren MA et al. 2015. The mistreatment of women during childbirth in health facilities globally: A mixed-methods systematic review. *PLoS Med* 12(6): e1001847. doi:10.1371/journal.pmed.1001847.

Bowser D and Hill K. 2010. *Exploring Evidence for Disrespect and Abuse in Facility-Based Childbirth: Report of a Landscape Analysis.* Washington (District of Columbia): United States Agency for International Development.

Freedman LP and Kruk ME. 2014. Disrespect and abuse of women in childbirth: Challenging the global quality and accountability agendas. *Lancet* 384:e42–4.

Freedman L et al. 2014. Defining disrespect and abuse of women in childbirth: A research, policy and rights agenda. *Bull World Health Organ* 92:915–917.

International Federation of Gynecology and Obstetrics; International Confederation of Midwives; White Ribbon Alliance; International Pediatric Association; World Health Organization; International Federation of Gynecology and Obstetrics. 2014. Mother-baby friendly birthing facilities. *Int J Gynaecol Obstet* 128(2): 95–9.

Kruk ME et al. 2014. Disrespectful and abusive treatment during facility delivery in Tanzania: a facility and community survey. *Health Policy Plan* doi: 10.1093/heapol/czu079.

McMahon SA et al. 2014. Experiences of and responses to disrespectful maternity care and abuse during childbirth; a qualitative study with women and men in Morogoro Region, Tanzania. *BMC Pregnancy Childbirth* 14:268.

Moyer CA et al. 2014. 'They treat you like you are not a human being': Maltreatment during labour and delivery in rural northern Ghana. *Midwifery* 30(2):262–268

Okafor II, Ugwu EO and Obi SN. 2015. Disrespect and abuse during facility-based childbirth in a low-income country. *Int J Gynaecol Obstet* 128:110–113.

Sando D et al. 2014. Disrespect and abuse during childbirth in Tanzania: Are women living with HIV more vulnerable? *J Acquir Immune Defic Syndr* 67(4):S228–34.

Tunçalp Ö et al. 2015. Improving quality of care for mothers and newborns—the WHO Vision. *BJOG* 122(8):1045–9.

Warren C et al. 2013. Study protocol for promoting respectful maternity care initiative to assess, measure and design interventions to reduce disrespect and abuse during childbirth in Kenya. *BMC Pregnancy Childbirth* 13:21.

World Health Organization. 2014. *The prevention and elimination of disrespect and abuse during facility-based childbirth.* Geneva, Switzerland: World Health Organization.

Appendix 1. Workshop Schedule

Agenda		Presenter/Facilitator	
9:00 –9:15	Welcome, meeting objectives, and introductions	Raz Stevenson Dunstan Bishanga	USAID/Tanzania MCSP Tanzania Chief of Party
9:15–9:30	Tanzania MOHSW's vision of improving quality of care with focus on RMC	Tanzania MOHSW representative	MOHSW
Key lessons learned from research, implementation, and monitoring and evaluation (M&E) in Tanzania relative to specific dimensions of RMC and/or D&A: significant contextual variables and critical success factors			
9:15–9:45	Tanzania approaches to addressing RMC: • WRATz engagement on RMC (15 min) • CCBRT (15 min) – What it takes to promote RMC within the existing care system	Rose Mlay Brenda D'Mello	WRATz CCBRT
9:45–10:15	RMC program development in Tanzania: lessons from implementation research	Kate Ramsey and Godfrey Mbaruku	Ifakara /AMDD
10:15–10:30	MHTF RMC experience/research in Tanzania	David Sando	MHTF/ MDH
10:30–10:50	MCSP Tanzania RMC thinking	Dunstan Bishanga	MCSP
10:50–11:15	Tea break		
History, progress, and lessons learned from global initiatives and other countries			
11:15–11:30	Background to USAID support of RMC	Mary Ellen Stanton	USAID/Washington
11:30–11:45	USAID-supported RMC implementation research: Tanzania and beyond	Neal Brandes	USAID/Washington
11:45–12:15	RMC program experience in Kenya: lessons from implementation research	Charity Ndwiga and Timothy Abuya	Population Council, Kenya
12.15–12 30	Q&A		
12:30–1:30	LUNCH		
Taking stock of what we have learned and looking forward to identify opportunities			
1:30–1:45	Key findings: WHO Systematic Review of Mistreatment of Women in Childbirth	Kathleen Hill	Review latest typology per WHO review

Agenda		Presenter/Facilitator	
1:45–2:30	Building momentum: Linking RMC to global initiatives	Mary Ellen (Every Woman Every Child and the Partnership for Maternal, Newborn and Child Health) (10 min) Rima (EPMM) (10 min) Kathleen/Sheena Currie (WHO QOC) (10 min)	USAID/DC MHTF MCSP
2:30–3:00	Key opportunities: Discussion	Craig Ferla, Chairperson of Board of Directors, WRATz	Brainstorm opportunities for Tanzania and beyond
3:00–4:15	Group work and report out: 1. RMC research gaps in Tanzania 2. Problems and how we address them in Tanzania context: Provider group 3. Problems and how we address them in Tanzania context: Structural/system group) 4. Addressing RMC through QI approaches 5. Roles and responsibilities at different levels of the health system	1. Shannon McMahon 2. Kate Ramsey 3. Raz/USAID 4. Sheena 5. MOH CNO	John George
4:15–4:30	Reflections on Day 1		Monica with Sheena
4:30	Closing Remarks Day 1	Raz Stevenson	USAID/TZ

Day 2 Morning Session

Agenda		Facilitator (remove Facilitate column before sending)	
9:00–9:15	Review Day 2 Agenda	John George	MCSP/TZ
9:15–9:45	Participant reflections on Day 1	Kathleen Hill / Sheena Currie	MCSP
Formulating priorities and actions for RMC programs in Tanzania based on best available evidence and lessons learned			
9:45–11:00	Moving to Action: Group work *(with tea break)*	Facilitated group work	All-conceptual framework to frame group discussions *Advocacy* *Policy* *Training* *Service delivery* *Social and behavior change communication* *M&E and learning* *Across continuum of care*
11:00–11:45	Report out and discussion	Dunstan	MCSP/Tanzania

Agenda		Facilitator (remove Facilitate column before sending)	
11:45–12:15	Partner reflections	MOHSW, WRATz, CCBRT, USAID, MCSP, IHI Institute, MDH, MHTF, AMDD, E4A	
12:15–12:30	Next steps	Dunstan Bishanga	MCSP/Tanzania
	Closing remarks	MOHSW	
12:30–1:30	LUNCH		

Appendix 2. Participants List

Attendance Sheet for Respectful Maternity Care Workshop	
Dates:	20 - 21 July, 2015
Location:	Protea Courtyard Hotel, Dar es Salaam, Tanzania

Name	Title	Organization	Email	Phone Number
1. Dr. Amalberga Kasangala	Ag. Director of Nursing and Midwifery Services	MoHSW Tanzania	amalberga@yahoo.com	+255 712 833013/ 0685 251615
2. Grace Mallya	GBV Coordinator	MoHSW Tanzania	gracefmallya@gmail.com	+255 787 655355
3. Neal Brandes	AOR Traction	USAID	happiness.willbroad@jhpiego.org	
4. Rima Jolivet	Maternal Health Technical Director	MHTF	rjolivet@hsph.havard.edu	
5. Mary Ellen Stanton	Senior Maternal Health Advisor/Global Health	USAID	mstanton@usaid.gov	
6. Debbie Armbruster	Senior Maternal and Newborn Advisor	USAID	dambruster@usaid.gov	
7. Mary Rwegasira	Gender Advisor	MCSP Tanzania	mary.rwegasira@jhpiego.org	+255 767 599003
8. Dr. Rachel Makunde	Newborn Advisor	MCSP Tanzania	Rachel.Makunde@savethechildren.org	+255 787 755661
9. Timothy Abuya	Associate I	Population Council Kenya	tabuyae@popcouncil.org	+254 722 291149
10. Charity Ndwiga	Program Officer	Population Council Kenya	cndwigao@popcouncil.org	+254 722 395641
11. Supriya Madhavan	Senior Implementation Research Advisor	USAID Washington DC	smadhavan@usaid.gov	
12. Dr. Beata Mukarugwiro	Technical Director	MCSP Rwanda	Beata.Mukarugwiro@jhpiego.org	
13. Cornelius Kondo	Country Manager Migoli	MCSP Kenya	cornelius.kondo@mcsprogram.org	+254 702 143662
14. Dr. Deborah Kajoka	National PMTCT Coordinator	MoHSW Tanzania	dkajoka@yahoo.com	+255 754 767148
15. Dr. Shannon McMahon	Research - John Hopkins / Technical Advisor to MCSP Tanzania	JHU USA	shannon.mcmahon@jhu.edu	
16. Ephrem Daniel	M&E Team Leader	MCSP Ethiopia	ephrem.daniel@jhpiego.org	
17. Rose Mlay	National Coordinator	WRATZ	rose.mlay@gmail.com	+255 754 316309
18. Dr. Nguke Mwakatundu	Country Director	Worl Lung Foundation	nmwakatundu@worldlungfoundation.org	
19. Donat Shamba	Research Scientist	Ifakaha Health Institute	dshamba@ihi.or.tz	+255 683 105670
20. Kate Ramsey	Senior Research Officer	AMDD/Columbia University USA	kmr2006cumc@columbia.edu	+19177921255
21. Godfrey Mbaruku	Chief Research Scientist	Ifakaha Health Institute	gmbaruku@ihi.or.tz	+255 784 492129
22. Paul Shidende	Hospital Patron	Korogwe District Hospital	pshidende@gmail.com	+255 752 303022

Name	Title	Organization	Email	Phone Number
23. Kathleen Hill	Maternal Health Lead	MCSP Washington DC	kathleen.hill@jhpiego.org	
24. Rita Mutayoba	Senior M & E Officer	MCSP Tanzania	rita.mutayoba@jhpiego.org	+255 765 284367
25. John George	Deputy Chief of Party	MCSP Tanzania	john.george@jhpiego.org	+255 754 821707
26. Monica Fox	Senior Program Officer	MCSP Jhpiego USA	monica.fox@jhpiego.org	
27. Sheena Currie	Senior Maternal Health Advisor	MCSP Jhpiego USA	sheena.currie@jhpiego.org	
28. Brenda D'mello	Technical Advisor & Program Manager	MNH Capacity Building Project CCBRT	brenda.dmello@ccbrt.or.tz	+255 754 295465
29. Adrienne Strong	PhD Candidate - Washington University in St. Louis	Sumbawanga Regional Hospital	adrienne.strong@wustl.edu	+255 688 208908
30. Haika Mawalla	External Affair Director/Deputy CEO	CCBRT	haika.mawalla@ccbrt.or.tz	+254 773 444440
31. Martha G. Rimoy	Project Coordinator	Tanzania Midwives Association (TAMA)	martharimoy@tama.co.tz	+255 754 383824
32. Ukende Shalla	Pre-Service Education Midwifery Advisor	MCSP Tanzania	ukende.shalla@jhpiego.org	+255 784 731734
33. Kathleen McDonald	Independent Consultant	URC/USAID/Traction	kathleen.p.mcdonald@gmail.com	
34. David Sando	Director SI & Research	MDH Tanzania	dsando.tz@gmail.com	+255 767 000751
35. Kezia Kapesa	Executive Secretary	PRINMAT	maykapesa@yahoo.com	+255 784 269057
36. Rose J. Mnzava	Midwifery Advisor	MCSP Tanzania	RoseJohn.Mnzava@jhpiego.org	+255 782 888144
37. Lucy Ikamba	Quality Improvement Advisor	MCSP Tanzania	lucy.ikamba@jhpiego.org	+255 754 378712
38. Dr. Mary Mwanyika-Sando	Deputy CEO	Africa Academy for Public Health (AAPH)	mwanyika.sando@gmail.com msando@aaph-tz.org	+255 758 808877
39. Dr. Leopold Tibyehabwa	Technical Advisor	Engenderhealth	ltibehabwa@engenderhealth.org	+255 767 894050
40. Dr. Dunstan Bishanga	Chief of Party	MCSP Tanzania	dunstan.bishanga@jhpiego.org	+255 783 180280
41. Miriam Kombe	MCH Specialist	USAID Tanzania	mkombe@usaid.gov	+255 764 105020
42. Angasyege Kibona	PC-RCH	EGPAF	akibona@pedaids.org	+255 767 780009
43. Paul Magesa	President	TANNA	gesa080@yahoo.com	+255 713 599593
44. Anna Magreth Mukwenda	Capacity Building Advisor	MCSP Tanzania	annamagreth.mukwenda@jhpiego.org	+255 766 753243
45. Mary Drake	M & E Director	Jhpiego Tanzania	mary.drake@jhpiego.org	+255 768 800944
46. Rhonica Ngatunga	Program Assistant	MCSP Tanzania	rhonica.ngatunga@jhpiego.org	+255 754 275677
47. Caroline Shilinde	Senior Program Assistant	MCSP Tanzania	caroline.shilinde@jhpiego.org	+255 683 631548

Appendix 3. Mapping RMC and Mistreatment Categories in Tanzania—Based on Tanzania-Specific Evidence (and Global Review)

"Type" of Mistreatment *(WHO Mistreatment Typology "2nd order theme")*	Prevalence and Characteristics in Tanzania (quantitative and qualitative literature; see illustrative examples)	Corresponding WHO QOC Dimension (Experience of care)
Verbal Abuse (e.g., shouting, scolding)	Kruk et al. 8.71% (exit survey); 13.18% (home follow-up survey)	No exact corollary Domain 4: "Effective communication" not the inverse of verbal abuse
Physical Abuse	Kruk et al. 2.68% (exit survey); 5.10% (follow-up home survey); Sando et al. 4.55% (self-report discharge)	No exact corollary
Neglect (e.g., giving birth alone, no care during labor or after birth)	Kruk et al. 8.53% (exit survey); 18.8% (home follow-up survey) McMahon et al. Neglect emerged as key theme.	Domain 1: Every woman and newborn receives evidence-based routine care and management of complications during labor, childbirth, and the early postnatal period Domain 7: For every woman and newborn, competent and motivated staff are consistently available to provide care
Lack of supportive care from health workers		Domain 6: Every woman and her family are provided with emotional support that is sensitive to their needs and strengthens her own capabilities.
Denial or lack of birth companions	Okafor et al. 14% (Nigeria)	Domain 6: Every woman is able to experience labor and childbirth with a companion of her choice.
Discrimination	Sando et al. 12.2% of HIV-positive women and 15.0% HIV-negative recalled any form of D&A during delivery McMahon et al. Fear of discrimination emerged as strong theme	Domain 5: Women and newborns receive care with respect and dignity
Lack of mobility and birthing position		
Non-consented "care" (e.g., vaginal examinations, episiotomy without consent)	Kruk et al. 0.06 (exit survey); 0.17% (home follow-up survey) Sando et al. 0.26% (self-report); 81.59% (observation of non-consented vaginal exams)	No exact corollary Note: Discussion at WHO QOC expert consultation about adding **safety** dimension to framework

"Type" of Mistreatment *(WHO Mistreatment Typology "2nd order theme")*	Prevalence and Characteristics in Tanzania (quantitative and qualitative literature; see illustrative examples)	Corresponding WHO QOC Dimension (Experience of care)
Non-confidential care	Kruk et al. 4.39% (exit survey); 6.16% (follow-up home survey) Sando et al. 1.6% (self-report)	Dimension 5: All women and newborns have privacy around the time of labor and childbirth, and their confidentiality is respected.
Lack of privacy	Kruk et al. 4.39% (exit survey); 6.16% (home follow-up survey); Sando et al. 1.89% (self-report); 65% (observation)	Dimension 5 *(see above)*
Detention for failure to pay or bribe	Kruk et al. *Bribe*—1.78% (exit survey); 3.07%); (follow-up home survey) Sando et al. Detention in facility 91.54% (observation)	No exact corollary

Appendix 4. Group Work Discussion Notes Day 1

Community Leader from Village:

- Verbal abuse is top concern – rude language and shouting.
- Bad power dynamics – you look at us with contempt (think we are backward and not developing – you see us as "the other").
- We know your morale is low because of poor infrastructure and supplies – we think some of you take these supplies and sell them (we are suspicious).
- We don't feel like we have any way to hold providers accountable.
- Even though the service is free, we paid for it in our taxes.
- We don't know a lot about our rights, so hard to hold providers accountable.
- Yeah, sometimes we arrive late or we don't have the supplies you told us to bring (sometimes we start off the interaction negatively, and are the abusive ones).
- Our second issue is neglect – some we realize is due to staff shortages, but sometimes we think it's an attitude (not a shortage of staff) when I cry out in pain and you are talking at the nurses station.
- We want some community dialogue – we are worried about some gender dynamics.
- We need to expect what will happen when we come in the delivery room (tell me what's going on, how I have progressed).
- There are community facilities that haven't developed as should have – need to reinvest.
- CHW cadres + existing cadres that might be able to facilitate the dialogue.
- We have a client service charter – let's use it.

Facility Group:

- Verbal Abuse:
    - Habit that is moving from generation to generation – skilled and unskilled
    - Provider – lack of knowledge, over-worked, so you end up scolding because of stress
    - Provider panic sometimes because they don't have the skill (I don't want a stillbirth) – and then they shout
    - Opportunities – educating client on what to expect (Open Maternity Days), also could do a pre-check checklist (did she go through introductory process – maybe having a few questions about what to expect). The birth companion – if the health care providers know a mother or husband is there, this might help to encourage better behavior, and might calm the mother down.
- Lack of Privacy
    - Infrastructural – even when have partitions, no space for a chair. Privacy is a right. Bottom line is shortage of human resources. Even if privacy is available, the provider wants the curtains open because she is working with two or three women delivering. Bad habits – women's breasts exposed when there is no need.

- Companion
    - Cultural expectations – providers do not know the importance of the evidence. No space for them. Providers don't actually want to be watched. Concerns within health care system for safety. Companions might be too afraid (don't like to see blood). Community education and PSE (including in the CHW curriculum on the importance of companions and leadership orientation).

Regional/DHMTs

1. **Lack of Privacy**

   Lack of prioritization during planning – the Councils or Regional Health Management Teams (CHMTs/RHMTs) can plan to have 20 computers or cars or building admin block, but don't think of improving infrastructure of maternity wards. Another issue is budgetary constraints – see improvement in surgical ward as money that will come back.
   Don't forecast that we have so many staff who have left or retired, and need to hire more, but do so too slowly, so are short staffed. Also inadequate supervision. CHMTs/RHMTs don't have a specific schedule for doing supportive supervision in their areas. They need to use standardized QI tools (should be used top to bottom – peers in workplace – while one doing procedure, one can do the checklist). Supervision should not just be at the top levels.

2. **Denial or lack of birth companion**

   Poor infrastructure, not enough or poorly arranged (room will be too crowded). Lack of creativeness. Lack of cultural change. You may go to a place with only four deliveries in a week (the mindset is not there to encourage the woman to come with a birth companion). What are the opportunities to address? People need to see the importance of this. A pilot should be done to encourage birth companions.

3. **Neglect and Abandonment**

   Shortage of human resources, high workload. Lack of supportive supervision and lack of peer-to-peer supervision (through use of QI or checklist). Councils are now allowed to hire, so they need to plan and be accountable to make sure that there are high enough skilled providers – mechanisms in place to ensure deployment and retention of them. If there is a retention mechanism with some incentives, they may decide to stay. RHMTs/CHMTs need to have a schedule in place to conduct supportive supervision using the standardized QI tools. Will help the supervisors and providers to see the same issues. Also peer-to-peer supervision.

National Policy Group

- Lack of Privacy – poor infrastructure and limited space
- Neglect and abandonment
- Denial and lack of companionship

Appendix 5. Working Group Instructions Day 2

Scenario:
Your team has been asked to design and implement a program to reduce D&A in facility childbirth in the Gombi district of Moudawi region. A baseline assessment that included quantitative measurement of D&A and semi-structured interviews with community members demonstrated that _____(*fill in the blank*) are the most prevalent form(s) of disrespect in maternities in the Gombi district as reported by women during maternity exit interviews and follow-up home interviews. You are a district manager and have been asked to design a program to reduce _____(*fill in the blank*) in all facilities in the district (one district hospital and 13 health clinics.) You have a budget of $150,000 to work in the Gombi district for a period of 18 months.

Instructions:

1. For the categor(ies) of disrespect and abuse assigned to your group, define a measurable goal for what you hope to achieve in an 18-month period.
2. Reflect on the main drivers for this kind of D&A (_____) in Gombi district and decide how you will work with local stakeholders to analyze key drivers of demonstrated D&A and identify three to four approaches you will test/implement to address key drivers, specifying system level(s) at which you will work for each program approach (national, district management team, facility, community.) Please note that some approaches may be implemented across levels.
3. Identify the key stakeholders you will work for each approach and specify **how** you will implement exactly.
4. Define the key measures (indicators) you will track to measure your progress, including the data source for each indicator and the frequency of data collection.

MEASURABLE GOAL related to reducing specific types of D&A:

Through a consultative process with local stakeholders prioritize three to four promising approaches you will implement to try to achieve your goal, including the system level(s) at which you will apply each approach, the key stakeholders with whom you will work, and **how** you will implement the program approach.

Decide how will you engage local stakeholders to reflect on key drivers of local forms of D&A and identify approaches to test to try to reduce D&A	Key stakeholders with whom you will work	Program approach and system level(s) at which you will implement (community, facility, RHMT/DHMT, national/policy)

Define the indicators you will monitor to track the progress of your program and to inform your ongoing implementation. Remember that you must stay within your budget.

Indicator	Numerator	Denominator	Data Source	Frequency of measurement