

# Staha Project: Building understanding of how to promote respectful and attentive care in Tanzania

## Implementation Research Report

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## **ABBREVIATIONS**

AMDD	Averting Maternal Death and Disability
D&A	Disrespect and abuse in childbirth
DMO	District Medical Officer
FGD	Focus group discussion
IDI	In-depth interview
IHI	Ifakara Health Institute
MoHSW	Ministry of Health and Social Welfare, Tanzania
URC	University Research Co., LLC
USAID	United States Agency for International Development
WHO	World Health Organization

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## 1. EXECUTIVE SUMMARY

Staha is one of the first studies to test rigorous approaches to measure prevalence of disrespect and abuse (D&A) of women in health facilities during childbirth, as well as to develop and monitor approaches to reduce its occurrence. The study, based in eight facilities in two districts of the Tanga region, Korogwe district (intervention) and Muheza district (comparison), was initiated in 2011.

After conducting baseline research, we convened stakeholders ranging from community to national levels for phased participatory planning. This process resulted in consensus on the Staha Change Process which includes: 1) local adaptation and activation of the national Client Service Charter and 2) a quality improvement process at the Korogwe district hospital. These activities were carried out between February 2013 and June 2014 by implementers from the district government, health facilities and local government, with technical support and facilitation by the research team. A number of the activities continued after facilitation concluded.

In addition, to a rigorous quasi-experimental evaluation design, the project also undertook a program of implementation research to better understand how and why the observed results occurred. Diverse methods were used to monitor progress, document activities and capture implementers' perceptions throughout the course of facilitated implementation and after its conclusion. This included: 1) self-completed patient exit surveys; 2) in-depth interviews and focus groups with those engaged in implementation; 3) project documentation and monitoring; and 4) participant observations. Each method was analyzed and findings triangulated to develop an overall case study of the implementation.

The implementation research revealed that stakeholders, implementers and community members alike, found the interventions to be acceptable and feasible as a means to promote respectful care. Monitoring data from the patient exit surveys showed that at the hospital, the activities brought about improved ratings of the quality of care, including respectful care components, and these higher ratings stabilized over time. Reports from other facilities indicated that there had been important shifts in respectfulness of care, particularly as indicated by a reduction in complaints about provider attitudes. The charter adaptation process opened dialogue between the system and communities, and this engagement was fundamental for fostering ownership of the ultimate charter document, as well as providing opportunities to build connections between the two. Strong leadership at district, health facility and community levels and an openness to change and to reflect on problems enabled an effective process. Persistent deficits in health system resources, such as medicine and staff shortages, were considered the greatest challenge in meeting the obligations laid out in the client service charter. While the charter adaptation and quality improvement process required technical facilitation, the actors undertook additional unplanned activities in support of these efforts and many of the activities continued after facilitation support concluded. Community outreach components, with more time and facilitation, likely would have further strengthened the results. Ultimately, respondents' comments indicated that there had been an important shift in thinking about respectful care and some recommended extension to other aspects of care and other regions.

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## 2. BACKGROUND

### Disrespect and abuse in delivery care

A rapidly growing body of evidence reveals that women in labor and delivery experience a range of disrespectful and abusive treatment at the hands of health care providers all over the globe (1–5). Such disrespect and abuse (D&A) is intrinsically problematic: it violates the fundamental right of every woman to be treated with dignity within the health care system, and it does so at a particularly vulnerable moment when even a routine, uncomplicated delivery can be a painful and frightening experience. In low- and middle-income settings, evidence suggests that such treatment is even more detrimental as it may be a critical factor driving women away from facility-based health services (6). Furthermore, the experience of poor care and the reputation of a facility for poor care may contribute to a corrosion of trust in the health system with reverberations well beyond childbirth services (7,8).

Disrespectful and abusive treatment in childbirth has remained largely unacknowledged globally until recently, despite some active movements in a few countries. While widely recognized by women users themselves (9,10) and by those who work at the frontline of health systems, its nature, prevalence and causes have until recently rarely been researched, much less addressed. The growing body of evidence and experience in methods to improve quality of care, including the World Health Organization's new vision for maternal and newborn health quality of care (11), provide an important opportunity to examine interpersonal aspects of care, including experience of disrespect and abuse.

Efforts to tackle disrespectful and abusive treatment have generally focused on individual health care providers, attempting to modify behaviors through training and through the promulgation of new rules and standards of care. A second set of initiatives attempts to sharpen the demand for respectful, good quality care, by strengthening accountability and participation mechanisms with such tools as citizen charters, legal redress, public tribunals and participatory hospital management boards. However, for sustainable change, the structural and political roots of the problem should be tackled as well. A multi-level approach to shift the dynamics and values of systems, cultures and ultimately behaviors will be needed. (12).

Annex 1 depicts the definition of D&A that the Staha team developed in collaboration with the Population Council's *Heshima* project in Kenya. The definition acknowledges that D&A can be in the "eye of the beholder", but is not *only* a subjectively experienced phenomenon. It can also be defined by departure from pre-determined standards of care and of facility capacity. Recognizing that different definitions of D&A would be appropriate for different purposes (i.e, designing interventions, measuring prevalence, conducting advocacy), we developed a layered and nuanced definition. As shown by the bull's eye diagram in Annex 1, D&A is defined by women's subjective feelings of humiliation, even when the provider believes his/her behavior to be proper; conversely, the definition acknowledges that D&A is often highly normalized such that behaviors that are considered by others to be abusive or even behaviors that are intended by the provider to be abusive, may in fact be experienced by women as normal, expected and accepted. Finally the definition acknowledges that D&A experiences in the patient-provider interaction may be caused by deficiencies at other levels of the system (e.g., stock-outs of drugs) and so the definition takes a whole system perspective (3).

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## **D&A in Tanzania**

Tanzania is a predominantly rural, low-income country with a population of 41.9 million, a high fertility rate among rural, mainland women (6.1 births) and a stagnant level of facility-based deliveries (50%), which has not significantly changed in nearly a decade. The most recent estimate of the maternal mortality ratio in Tanzania is 398 maternal deaths per 100,000 live births, with a lifetime risk of 1 in 45 (13).

As in many sub-Saharan African countries, there is striking discordance between utilization of the formal health care system for antenatal care versus intrapartum care. While ANC is nearly universal, with 96% of women who had a live birth preceding the recent DHS reporting at least one ANC visit, only about half of those women return to facilities to give birth.

In Tanzania, nearly 90% of the population lives within 10 km of some level of health facility and maternal health services are, officially, exempt from user fees. Although distance and out of pocket costs are still important determinants of facility utilization for childbirth in Tanzania, the quality of care in facilities – including disrespectful and abusive treatment – has surfaced in recent studies as a factor influencing women’s decisions about where to deliver.

A discrete choice experiment study conducted by the University of Michigan, AMDD and IHI in Kigoma, a remote rural district of western Tanzania, found women rated a respectful provider attitude and availability of drugs and equipment as the most important factors in choosing a facility for delivery services (14). A similar study conducted recently in the Pwani region found that the attitude of the provider was again ranked as the number one characteristic in preference for a facility (15). Other research on factors affecting coverage of facility-based delivery care cite reports of poor treatment by providers that included verbal abuse, denial of care, lack of privacy, harassment and mistreatment (9,16–18). A study by Leonard et al suggests that households deliberately collect information about health facilities and providers, and use this information when seeking new providers for illnesses of different types and severity (19).

### **The Staha Project: Promoting respectful and attentive care in Tanzania**

The Averting Maternal Death and Disability Program (AMDD) of Columbia University and the Ifakara Health Institute (IHI) embarked on the Staha Project aiming to help build the evidence base on disrespect and abuse experienced by women during facility-based childbirth. Key partners included district and regional government staff, health managers and providers, and local communities in two districts of Tanga as well as the Tanzania Nursing and Midwifery Council.

The Staha project was designed to study approaches to reduce disrespect and abuse and its impact on facility delivery rates. One district, Korogwe, was assigned to intervention, while the second district Muheza, was assigned to comparison for a quasi-experimental study design. Corresponding implementation research aimed to further understanding of how the intervention influenced the root systemic and contextual factors that our formative research suggested drove disrespect and abuse. In this way, the implementation research could inform the refinement, scale up, and sustainability of the

intervention in Tanzania, as well as its adaptation to other countries (20). The core objectives and research methods of the Staha Project are outlined in Table 1.

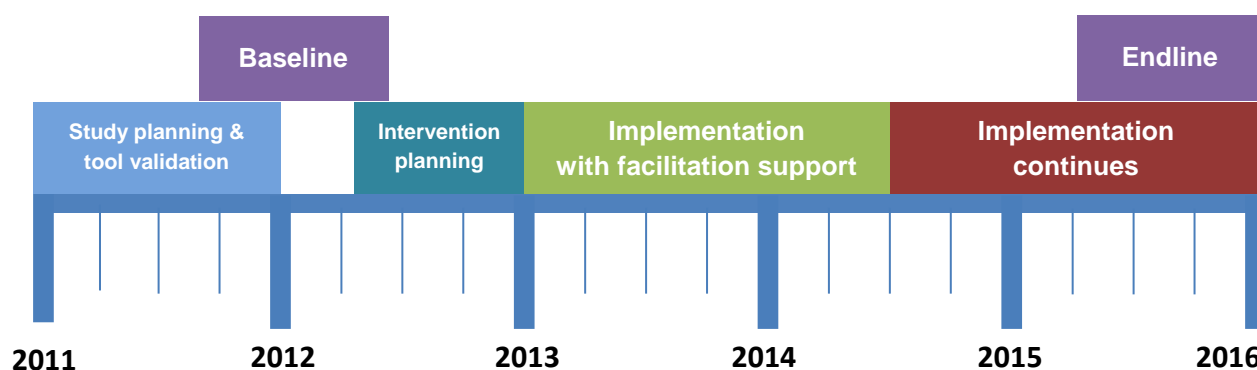
The intervention, which is described in detail in section 4 below, included two main components: (1) Adapting of client service charter at community and facility levels; and (2) a facility-based quality improvement process.

**Table 1. Staha Project objectives and study methods**

OBJECTIVE	STUDY METHODS
1. Develop and validate tools for measuring prevalence of D&A	<ul style="list-style-type: none"> <li>• Developing common definition of D&amp;A</li> <li>• Focus group discussions</li> <li>• Validation of exit questionnaire</li> </ul>
2. Determine the manifestations, types, correlates, and prevalence of D&A in childbirth	<ul style="list-style-type: none"> <li>• Facility exit interviews</li> <li>• Community follow-up interviews</li> <li>• Maternity ward observations</li> </ul>
3. Identify and explore potential drivers of D&A	<ul style="list-style-type: none"> <li>• Focus group discussions</li> <li>• Stakeholder interviews (FGDs/IDIs)</li> </ul>
4. Design, implement, monitor and evaluate the effectiveness of interventions to reduce D&A	<ul style="list-style-type: none"> <li>• EmOC needs assessments</li> <li>• Delivery statistics from study facilities</li> <li>• Implementation research plan (as detailed below)</li> <li>• Facility exit interviews at endline</li> </ul>

The Staha project was carried out over a period of approximately five years as depicted in Figure 1.

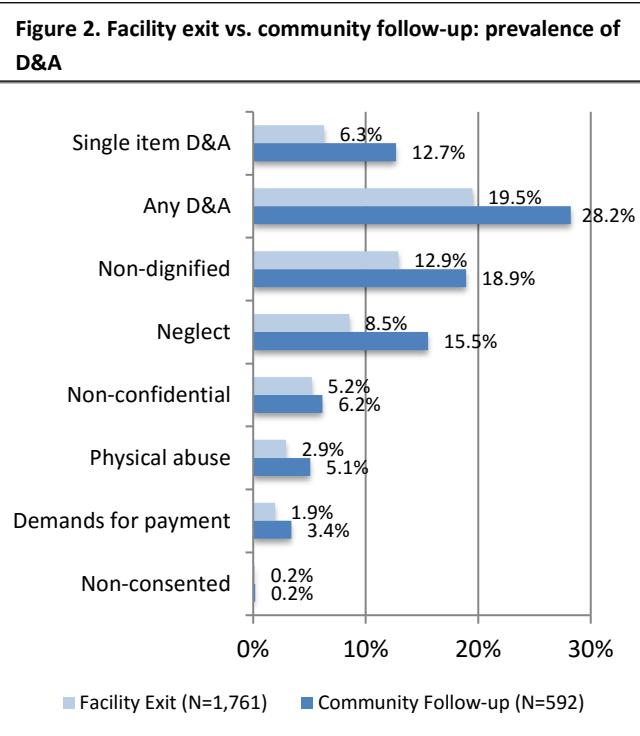
**Figure 1. Overall timeline of the Staha project**



### Baseline findings

The baseline research explored the phenomenon of D&A in the study districts through a variety of methods, including exit interviews to measure prevalence as well as qualitative methods for exploring drivers of disrespect and abuse in childbirth. This research was conducted during the second half of 2011 and the first half of 2012. It began with formative qualitative research and a validation process for survey instruments. Data collection for the baseline prevalence measurement commenced in December 2012 and included exit interviews at eight health facilities in the study districts (n=1,799), follow-up interviews at home at six to 10 weeks post-partum with a sub-set of the women interviewed at exit (n=593) (see Figure 2), and then observations of deliveries for another set of women (n=310) as well as exit interviews of the women whose deliveries were observed. This produced three measures of disrespect and abuse:

- *Self-report single item D&A:* This measure is based on asking women during exit or community follow-up interviews whether they experienced anything that they considered disrespectful or abusive during their delivery at the health facility.
- *Self-report any D&A:* This measure is based on women reporting experience of at least one or more of 14 disrespectful or abusive actions or conditions.
- *Observed any D&A:* This measure is derived from observation of deliveries with a woman experiencing at least one or more of the 14 disrespectful or abusive actions or conditions.



From the exit interviews, almost 20% (n=343) of women reported experiencing any type of disrespect and abuse, although only 6.3% reported yes to the single-item question. The most common types of D&A reported were: shouting and scolding (9%), ignoring/abandoned (8%) and negative comments (4.5%). The youngest women (15-19 year olds) reported experiencing the most disrespect and abuse compared to other age categories. When the Staha team followed-up with women in their homes six to ten weeks later, more women (28%) reported experiencing any disrespect and abuse for the single item question (12.7%). The types of disrespect and abuse reported changed slightly with reporting of ignoring/abandoned at 14%, shouting and scolding at 13%, and negative comments at 8%. (3). The Staha team then conducted observations of deliveries in the hospitals with another sample of approximately 300 women and found substantially different results with observers indicating that 71.3% of women had experienced any D&A. Of the women observed, only 10% reported experiencing any D&A when they were interviewed at exit. Further analyses revealed that D&A during childbirth was associated with lower satisfaction with delivery experience and a reduced likelihood of rating quality of care as excellent or very good (21). Annex 2 provides a visualized overview of the findings across the different methods.



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Through qualitative research with health workers, district and facility health management, community leaders, and women and men with children under one year, the Staha team explored the characteristics and perceptions of D&A and potential drivers of disrespect and abuse. Providers' and patients' perceptions of drivers were often quite similar, but differed in terms of which were considered most important. Patients placed more importance on characteristics of the interactions between the patient and provider, such as power dynamics, discrimination, and favoritism, while providers were more likely to talk about dysfunctional work environments, such as the poor availability of supplies and drugs, staffing shortages, and inadequate supportive supervision.

Sometimes poor interactions between patients and providers stemmed from misunderstandings about health provider behavior as compared to system constraints (e.g. stock-outs of medicines and supplies), including the failure to fulfill the policy promise of free maternity services. There was reported mutual distrust between the health workers and the community, with communities suspecting providers of stealing medicines and health workers concerned with false accusations from the community. Community members and health providers were also both concerned with the lack of accountability systems, including mechanisms to report and receive responses to complaints. Both community and health system respondents called for mutual respect in their interactions with each other, and health workers in their interaction with supervisors and management.

### **3. IMPLEMENTATION RESEARCH METHODS**

Implementation research, embedded in all project phases, was designed to document and assess (a) whether the intervention was implemented as intended (i.e, fidelity), and (b) whether the intervention worked through the mechanism predicted by the causal theories developed through the formative research. The objective was to determine not only whether the intervention worked, but to understand *why* and *how* it worked. Drawing from the Consolidated Framework on Implementation Research (CFIR) and implementation fidelity literature (22,23), the Staha team developed an implementation research plan to study and uncover the process of the implementation – fidelity to the intervention as designed, context, organizational readiness, moderators of change, and support mechanisms. The following five questions were central to the research.

1. Was the intervention implemented as designed? What was planned and what was emergent?
2. What are the core elements of the intervention that make it effective and would need to be retained for implementation at scale?
3. What are the intervention components that will require adaptation to ensure implementation? What are the contextual factors that need consideration?
4. How did the intervention work as compared to the expected theory of change?
5. What were the organizational, leadership and capacity drivers required to effectively implement the intervention?

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## **A. Data collection methods, sampling and analysis**

### **Patient exit surveys**

Patient exit surveys were administered by maternity staff who asked each maternity patient to complete a brief survey upon discharge to illuminate patterns of patient experience. Women were asked to rate the following components on a five point scale from excellent to poor:

- Overall quality of care
- Knowledge and competence of providers
- Respect showed by providers
- Language used by the providers
- Physical privacy
- Explanations from providers
- Availability of drugs, supplies and medical equipment
- Quality of information on availability of drugs/supplies
- Facility cleanliness

The survey was self-completed, although some women who had trouble reading sought assistance from family, other patients or even the health providers. Completed surveys were placed in a locked box that was only opened weekly. The maternity ward has collected these surveys since August 2013. During the 43-week period from August 2013 to June 2015, a total of 2,066 surveys were completed. This includes two weeks of data collected in July 2013 prior to commencing the QI interventions. Data were used on an ongoing basis for project implementation through calculation of frequencies and presentation of run chart graphs highlighting the data.

For this report, statistical analyses were conducted using STATA version 12. Descriptive statistics were gathered using frequencies and cross-tabulations, and multivariate regression was used to compare pre- and post-intervention periods.

### **Focus group discussions and in-depth interviews**

Focus group discussions (FGD) and in-depth interviews were conducted throughout implementation among a purposive sample of implementers (see table below). In total 57 IDIs conducted with 36 respondents and five FGDs were conducted between January 2013 and January 2015. Data collected from these qualitative methods were used on an ongoing basis to improve implementation activities and approaches. Sampling for IDIs is described in the below table. Some respondents were interviewed multiple times over the course of the project; therefore, Table 2 delineates how many total interviews overall were conducted among what number of respondents.

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**Table 2. Sampling for implementation research IDIs**

Type of respondent	No. of interviews	Total no. of respondents	Gender	
			M	F
District Political Leaders	3	1	1	
District Managers	4	2	1	1
Health Facility Managers	17	10	8	2
Health Providers	8	7	2	5
Ward/Village Political Leaders	15	11	7	4
Ward/Village Managers	5	3	3	
Facilitators	5	2	1	1
TOTAL	57	36	23	13

FGD sampling:

- four focus groups with community members (as part of charter development)
- one focus group with maternity staff involved in QI process (all female)

Two researchers developed a codebook based on the domains from the Consolidated Framework for Implementation Research (23). This was adapted for relevance to the project, context, and iteratively while interacting with the data. Coding of the transcripts from the IDIs and FGDs was conducted by three coders using Nvivo10.0 and interpretation by the same three researchers, two based in New York and one in Tanzania. The preliminary results were presented to stakeholders in Korogwe district, many of whom had been respondents, for their reactions and feedback to strengthen the validity of our conclusions

### **Project documentation and monitoring**

Implementation of Staha activities have been continuously documented and monitored. After each field visit, the Staha team writes a field report describing what has been observed and discussed during the field visit. Observations by the Staha team regarding activities and meetings have been captured in reports, and weekly and monthly reports from the hospital quality improvement team and regional facilitator have been collected. The quality improvement team has captured monitoring data in reports from those involved and from outsider observations. The charter process was documented in drafts of the charter including comments regarding the drafts, as well as the final charters. These reports were utilized to support particularly the description of implementation and triangulated with the patient surveys and the interviews for the analysis.

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## **Participant observation**

Periodically during relevant implementation activities, such as workshops and team meetings, a qualitative researcher performed participant observations following ethnographic methods with the aim of capturing process and interaction. These were reviewed by other Staha team members who participated to add additional insights into what had occurred.

### **B. Limitations and considerations**

Several limitations should be taken into consideration when reviewing the implementation of this project. Disrespect and abuse is a relatively new area of research, and as such, definitional and measurement challenges exist which influence our ability to assess the implementation of this project. The measures of patient experience are subjective in nature. However, given that one of the goals of this research is to improve user experiences and utilization, perceptions from women themselves, rather than an objective or outside viewer, were pertinent for our analyses.

For the patient exit surveys, while the timing of administration aimed at reducing bias, it may have led to over-reporting of positive experience if the women felt influenced by their presence in the facility to rate their satisfaction highly. In some instances, women required the assistance of health providers to read or understand the survey which may have further heightened their concerns. The survey was limited in length and detail since it was difficult to keep women in the facility for long durations after discharge. As such, the patient responses were not linked to demographic information so analysis of the data is limited to descriptive statistics regarding these questions and cannot be cross-analyzed with other information. This limitation has been addressed in the Staha endline data collection where women's ratings of care are being collected concurrently with demographic and other information.

For the in-depth interviews, some were conducted by Staha team members, which may have increased risk of social response bias. Assurances that the information would be used to improve the project and refine approaches may have helped to reduce concerns. In addition, whenever feasible, research assistants who were not involved in project implementation were hired to conduct the interviews to create some distance between implementation and the research.

Additionally, our research did not include certain aspects of the health system, such as waiting time or distance to the delivery facility, which have been shown in the literature to influence satisfaction and perceived quality of care.

## **4. INTERVENTION DESIGN & IMPLEMENTATION PROCESS**

This section describes the processes of designing the intervention and initiating and carrying out the implementation. It focuses on the roles of the Staha project facilitation team (henceforth called the Staha team) as well as those of key implementers within Korogwe district. This description is based largely on the reports developed by the Staha team after field visits and for quarterly reporting to the donor. The final section, emergent activities, relates to additional activities undertaken by implementers that were revealed to the Staha team during interviews and conversations and not explicitly planned as part of the initial intervention.

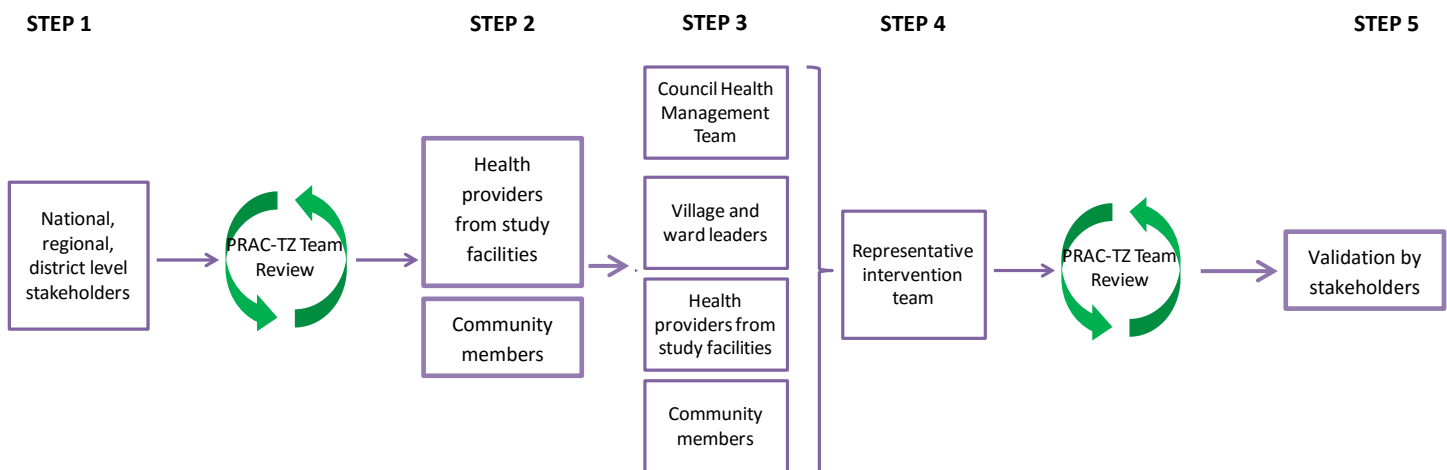
## A. Intervention planning process

The baseline findings, as well as the extant literature, informed intervention planning and implementation. The development of the Staha intervention was based on the growing recognition that mere introduction of an ‘innovation’ or ‘intervention’ is not sufficient to ensure its embedding in routine practice. In addition, we recognized disrespect and abuse as an organizational problem that required collective action rather than purely individual behavior change and an interactional issue requiring engagement of communities that play an important part in the interaction.

We therefore sought approaches that would trigger sustainable change driven by local processes at different levels of the district health system, including community. We posited that by addressing disrespect and abuse and its systemic causes through change processes – as opposed to introducing ‘interventions’ as traditionally defined – we would make long-lasting incremental changes in system functioning at facility-level organizational units. We were interested in processes which enable and empower communities and health workers to develop standards and identify problems and solutions together. At its best, we posited that this would foster the ‘co-production’ of health outcomes transforming previously adversarial relationships into partnerships based on mutual trust (24). At the same time, we recognized that simplicity and feasibility were essential and focused on approaches that could be implemented locally with minimal resources and without requiring major national policy change.

The activities of the Staha project respond directly to the on-the-ground realities of women in the Tanga region. In designing and implementing the Staha intervention, a multi-stage process was utilized to ensure that the intervention was locally-driven and validated by diverse stakeholders. Community and health system players were systematically engaged in reviewing baseline findings and shaping the design of the intervention. Baseline research enabled the Staha team to develop a theory of how key individual, organizational, structural and contextual factors contribute to and maintain the disrespectful and abusive treatment in Tanga. The diagram below depicts the Staha team process for planning the intervention and ensuring its appropriateness for the context through engagement of national, regional, district, village, and community-level stakeholders.

**Figure 3. Participatory process for planning the intervention**



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**Step 1:** Immediately following the conclusion of the baseline, stakeholders were convened in Tanga to review and interpret the findings. Participants in the meeting included representatives from the Ministry of Health at the national, regional and district levels, professional associations, nongovernmental organizations (NGOs), health providers from study facilities, and community members within the study facility catchment areas.

In addition to sharing preliminary findings from the baseline study, the meeting aimed to elicit partner inputs in interpreting the findings, analyzing the drivers and causes of D&A during delivery, and determining the next steps in the intervention planning process. Participants were split into groups and asked to list causes of D&A and to suggest potential solutions that required minimal resources. The most mentioned causes were lack of professional ethics and poor work environments, with solutions including education and supportive supervision.

**Step 2:** Two meetings were then convened—one with nurses from the maternity wards in the four Korogwe study facilities and one with community members in the catchment villages of the Korogwe facilities – because the team sensed that these groups, the most embedded in the daily experience of D&A, did not have the space for adequate voice in the larger gathering. The smaller meetings allowed these key groups greater freedom to express their opinions and perceptions about D&A. Eleven nurses and 28 community representatives attended. The meetings engaged the participants to think about the causes of D&A, the roots of these causes, and possible solutions. The meeting facilitators asked the participants to list causes of D&A during delivery which participants identified as:

- Individual health provider behavior
- Lack of medicines/supplies
- Patients/relatives are uncooperative/provoke
- Lack of motivation for health providers in the workplace
- Shortage of health provider staff/ Work overload
- Health providers forget work ethics
- Lack of adequate training for health providers
- Lack of supportive supervision for health providers

The participants ranked what they saw as the top three problems that could be solved locally by the health providers and the district health system. They identified these as forgetting professional ethics, lack of cooperation by patients, and individual behavior of providers – interestingly mostly individual level rather than organizational issues. Participants also mapped institutions, organizations, or people who could provide resources (financial or non-financial) and be influential in reducing D&A. Based on the problem analysis and institutional mapping, the groups then were asked to come up with a solution to their assigned problem that would be implemented by the health providers/health facilities. These insights were used to inform the design of the Staha project intervention activities.

After gathering intervention ideas from the stakeholder meeting and the two groups, the Staha team met internally and performed literature reviews for further evidence about what interventions have been found to work (or not), why and under what conditions. In creating a list of possible interventions, the team ensured that any possibilities should be responsive to stakeholder ideas and needs, as well as meet the criteria of: proximal, sustainable, affordable, evidence-based, and innovative. Combining the Staha team

knowledge and ideas from the stakeholders, a list of potential interventions was proposed as presented in Table 3.

**Table 3. Potential interventions to reduce D&A identified through stakeholder process**

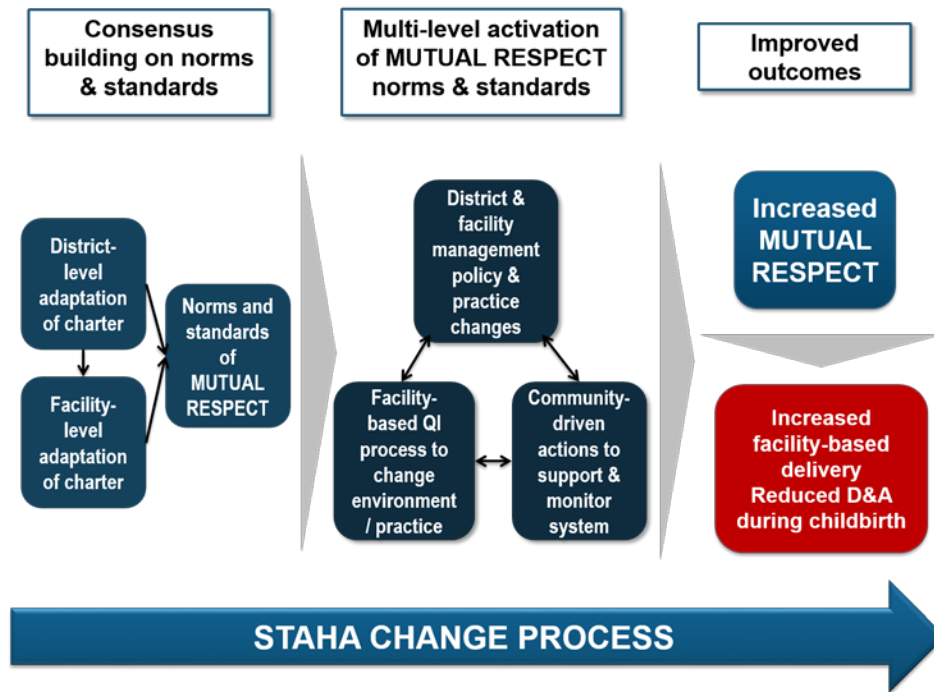
Community Engagement	Workplace Systems	District Management
<ul style="list-style-type: none"> <li>• Permanent agenda in village meetings</li> <li>• Community leaders receive and take action on complaints</li> <li>• Patient rights elaborated/ client charter</li> <li>• Birth companions</li> </ul>	<ul style="list-style-type: none"> <li>• Better practices during shift change</li> <li>• Improve maternity assignment</li> <li>• Health worker recognition/rights</li> <li>• Nurse counseling</li> </ul>	<ul style="list-style-type: none"> <li>• Exit client interviews</li> <li>• User satisfaction reporting line</li> </ul>
CHAMPIONS – community, facility, district, politicians		

As Table 3 shows, the literature and the stakeholder discussions indicated that there was a need for activities and ongoing processes at multiple levels of the district health team and by multiple actors at each level. This confirmed initial understanding of D&A as a systemic and complex problem requiring multiple leverage points to enact change.

**Step 3:** The Staha team then returned to Korogwe to present the intervention ideas to different stakeholder groups and solicit feedback. Representatives were convened in four separate meetings divided into groups including: 1) community members, 2) village and ward leaders, 3) health providers, and 4) district health management. The groups were divided to improve participants comfort to voice their real concerns. In each meeting, participants discussed the proposed interventions and the context, requirements, and potential risks and challenges to implementation for each. Two representatives from each of these four groups were then chosen to attend a final meeting to reach consensus and decide the way forward.

**Step 4:** The Staha team, including representatives from the Tanga regional government, Korogwe District, AMDD and IHI, met in early 2013 to review the outcomes from the local meetings and finalize the approach. This team agreed a framework and platforms to ensure interaction among activities at multiple levels was needed for the approach to be effective. Finally, the Staha team sought to develop an intervention that was as evidence-based as possible, while still open to innovation and new ideas for intervention design. Staha team members were determined to avoid interventions that have been shown repeatedly to be inadequate at creating meaningful change in provider behavior (such as training on standards of respectful care, without addressing underlying causes of disrespectful care). To guide intervention design and implementation, the Staha team documented a theory of change which depicted contextual and evidence-based relationships related to D&A and delivery care in Tanzania (Figure 4).

**Figure 4. Staha process theory of change diagram**



Through the Staha Project’s baseline research, both health providers and users of the health system described experiencing a loss of respect from others and identified this as a driving cause of D&A during childbirth. The Staha team therefore adopted “mutual respect” or “mutuality of respect” as the driving value for the process. The Staha change process that was ultimately developed involves two main, interacting components aimed to reduce D&A and build mutual respect between patients and providers: 1) the adaptation of the patient-provider charter and 2) and a facility-based change process (see Annex 3).

In February 2013, the Staha team facilitated the launch of the intervention in Korogwe. The team first called together the CHMT, the charter elective committee, and the representative intervention group to present the final intervention process and receive feedback (Figure 3, Step 5). The charter elective committee was invited by the district government and composed of the District Legal Officer, the Chairperson of the Council Health Service Board (CHSB), the Chairperson of the Social Welfare Committee of the District Council, the District Medical Officer, the District Hospital Medical Officer in-charge, the Chairperson of the District Hospital Governing Committee (HGC), the District Health Secretary, and two representatives nominated from the representative intervention group (the two nominated members were a Village Executive Officer from the catchment of one health center and the health center in-charge from another). This committee was selected based on recommendations from the district stakeholders and those involved in the participatory process. With all of these stakeholders informed and on-board, implementation of the Staha project began.



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## **B. Implementation**

Once all had agreed on the plans for moving forward, activities commenced with the charter adaptation process followed by the launching of the quality improvement process. In addition to the below description, Annex 4 provides a timeline of key milestones in the implementation.

### **Charter adaptation and activation**

#### **Patient-provider charter adaptation - district level**

Early in the new millennium, Tanzania had adopted a national Client Service Charter (CSC) for the health sector outlining the rights and responsibilities of patients and providers. It was written in broad terms with the expectation of further adaptation at the local level. Similar to the experience in many other countries, the charter was never implemented at national level or adapted at local level. The Tanzanian charter, however, is unique in containing elements of both patient and provider rights. As the charter was already supported by policy, it was decided to use this as starting point for the conversation about mutually acceptable standards of respectful care.

The team worked with the charter elective committee to adapt the national charter to meet district-specific needs. This first draft of the district charter was then distributed to 70 local stakeholders for feedback, including village executive officers, ward executive officers, district council authorities, health facility in-charges at intervention facilities, representatives from NGOs in the district, and political leaders. Eighty-six percent of the stakeholders provided feedback. The majority mentioned their appreciation and excitement about the charter, although there was some apprehension noted due to previous failed or unimplemented projects. The issue of mutual respect and respectful care was mentioned, with stakeholders advocating for equity, rights of patients, and accountability measures. Mutual respect and respectful care was further defined by the following changes:

- Health providers using better language
- Doctors not insulting or looking down on patients
- Health providers not showing favoritism when providing care to patients
- Equitable health services provision
- Disciplinary action against providers that use bad language
- Confidentiality of patient information

The feedback was reviewed by the charter elective committee and discussed for inclusion. In order to ensure the community voice and responsiveness to their needs, focus group discussions and community meetings were organized. Four community meetings were held in the catchment areas of the intervention health facilities. Four focus group discussions were also conducted among women of reproductive age in the catchment of the health facilities due to concerns that women might not feel comfortable to speak in a public meeting. Both groups were asked questions about general perceptions of the health system (maternity care, their rights, rights of the providers), whether the charter responded to their needs and how best to disseminate the charter. During these meetings issues of respectful care were raised, including transparency of services, communication between providers and patients, and responsiveness to patients' needs. Further feedback included important components to be added in the charter, such as: availability of medicine, consistent availability of a vehicle at the health facility, consistent availability of water and

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electricity, regular supervision to observe service provision, among others. Stakeholders also requested channels to provide feedback on their experiences at the hospital.

The Staha team compiled all of the feedback from these platforms and presented the information to the charter elective committee, who then made several final changes to the charter, which included:

- making the providers' rights more specific
- emphasizing transparency of fees and services
- ensuring timeliness of service provision
- creating a corruption-free environment
- providers' language style and tone when speaking to patients

This final draft of the charter was then presented to the Social Welfare Committee of the District Council, which gave its approval in July 2013. Approval of the full district council was received shortly thereafter.

### **Patient-provider charter—facility level**

After completion of the district charter, the facility charter adaptation was initiated at each of the four study health facilities. At each facility, a representative technical charter team was composed to adapt the charter to the facility's needs. The team included six members at each site, including:

- Health facility In-charge
- Chairperson of the Health Facility Governing Committee
- female member of the Health Facility Governing Committee
- Chairperson of the village in which the health facility is located
- In-charge of the maternity ward or the reproductive and child health unit
- Representative from a community based organization within the catchment area

A one-day workshop was held at each facility to arrive at a first draft of the charter. Once the first draft was finalized, the team began the process of receiving feedback from stakeholders. More than 300 draft charters were distributed to stakeholders in the four catchment areas for feedback and comments about the facility-level charters. The feedback forms were collected by research assistants in the first week of August and sent to the project team for review. In each catchment area, at least 70% of the feedback forms were returned with one catchment area returning 94% of the forms. The Staha team assisted each facility's team with assembling and summarizing the feedback

Half-day workshops were held with each of the four health facility technical teams to incorporate comments into the facility charters. Major changes made between the first and the second drafts came largely from the community/stakeholder feedback. These changes included the addition of:

- A section regarding insurance schemes
- A section regarding corruption
- Sections to address the rights and responsibilities of providers and patients, highlighting the importance of mutual respect
- Language prohibiting discrimination due to socio-economic status, religion, gender, age, or disability

- Language regarding the importance of equitable care and the need for greater transparency of cost, and
- A well-defined system to submit and receive complaints

After all comments on the facility charters were integrated, the charters were shared with district leaders and health facility in-charges for final review and comment. The final drafts of the charters were then provided to the Ward Development Committee\* in each catchment area. Ward Development Committee meetings occurred in October and November and all four facility charters were approved in full by the respective committees. The Korogwe District Medical Officer gave final endorsement of the facility charters in November 2013.

### Charter contents

The Client Service Charter is intended as an agreement between the government, as the service provider, and the community, as the service receiver. As the Korogwe District charter states:

*This charter will assist our clients to understand services that we are obliged to provide and how we can be contacted, what you should expect by way of service standards and alternatives in the event that you are not satisfied with our services.*

### Key charter messages

- Mutuality of respect
- Patient rights & responsibilities
- Provider rights & responsibilities
- Standards of service, including relationships
- Standards of ethical conduct
- Accountability, feedback and complaint mechanisms
- Equality and respect for all
- Ongoing maintenance of charter

The charter documents are quite extensive including a number of sections that outline rights, responsibilities and obligations. For instance, Section 3 outlines core principles of service delivery, which fall under the obligations of the district health system. These standards are listed in Annex 6. Another section describes the rights of a number of stakeholders, including health service clients, the District Council, the District Health Department, politicians, development partners and NGOs, training institutions, and district health boards and facility governing committees. Health sector employees are included in this list, as well as having a specific section dedicated to their concerns.

Accountability mechanisms are established in the charters in order to ensure timely and effective response to complaints. The District Health Department on behalf of the District Council agreed to respond to all complaints within 30 days or less after community feedback indicated that the original 60 days was not responsive enough. In the case of investigations, the reports must be provided within two weeks of their conclusion. Specific persons are identified for channeling and responding to complaints as follows:

- At the health facility level: The health facility in-charge or the chairman of the facility governing committee, an elected community member

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\* The Ward Development Committee is the next administrative level above the village in a district.

- At the village level: Village Executive Officer or Village Chairman, or in some cases to authorities at the ward level
- At the district level: Complaints officer in the district hospital or the District Health Secretary

Contact information is also provided for the District Medical Officer and the District Executive Director. The charter promises maximum confidentiality in the case of a complaint and that information will be used to improve services.

Uniquely, the charter outlines both rights and responsibilities of the clients – recognizing the role that they play in ensuring quality services and mutual respect in interactions. Table 4 shows both the rights and obligations.

**Table 4. Client rights and responsibilities**

<b>Rights</b>	<b>Responsibilities</b>
<ul style="list-style-type: none"> <li>• To be provided with the charter and have their questions answered</li> <li>• To lodge complaints according to the established procedures</li> <li>• To be provided information on their health status and options for care</li> <li>• To obtain health services in health facilities, according to their needs, with special care particularly for the disabled and the needy</li> <li>• To decide on the course of treatment after thorough education by the provider</li> </ul>	<ul style="list-style-type: none"> <li>• To respect and abide by established procedures and regulations</li> <li>• To assist in ensuring quality care, by sharing necessary information with the health provider</li> <li>• To maintain good relationships with health sector employees</li> <li>• To avoid providing gifts, favors or convincing health workers to provide special favors</li> </ul>

#### **District and facility charter dissemination**

The Staha team supported the printing of the charters on behalf of the districts and facilities. Based on feedback from the charter process as well as discussions with the charter committee members, a draft dissemination plan to reach stakeholders at the district, facility and community level was developed.

The charters were quite lengthy, with some complicated language, so it was decided to develop communication materials that would outline the key messages to different audiences. First a poster was designed to be displayed at health facilities and relevant public settings. The poster (in Swahili) can be found in Annex 7. In addition, two versions of summary points were created that listed fundamental patient rights and responsibilities. The summary points were intended for use by health facility and community leaders when informing their constituents about the charter. The posters and summary points were field-tested through focus groups with community members and discussions with health facility staff to assess whether the language was clear and the necessary information was communicated. Overall, the key informants found that both materials provided relevant information in easily understandable language. They also expressed their willingness to share information in community forums and/or during staff meetings at the health facilities.

The charter dissemination took place in June 2014, and included meetings with officials and workshops with relevant health facility and community leaders at the project sites. The Staha team met with the District Executive Director for Korogwe District, the Executive Director of the Korogwe Town Council, the District Medical Officer (DMO) and a representative of the District Commissioner, who are the key local government authorities responsible for ensuring implementation of the charter and had been previously informed or involved in the charter process. Each was provided with copies of the charters and the supplementary materials. In each meeting, the team emphasized that this is the district’s charter, thus its implementation relied upon their actions, and the Staha team would be available to provide facilitation support. It was agreed that the DMO would take the main responsibility for ensuring the Charter’s dissemination and use. Copies of the district charter and additional materials were provided to the DMO for distribution to all facilities in the district.

It was determined in the charter adaptation process that a variety of leaders at facility and community levels would need to be engaged to disseminate the charter’s key messages. At each of the four sites, the Staha team members assisted in facilitating orientation workshops to inform local leaders about the charter and plan for dissemination. The workshops were designed to:

- Train community and health system leaders to understand the key components of the charter and conduct dissemination activities
- Distribute charter materials
- Plan for follow-up actions and dissemination activities at community and health system levels

Workshops were held separately with community leaders and then with health facility leaders. The relevant Ward Councilor (Diwani) and Ward Executive Officer for the catchment area assisted with opening and closing the workshops. Each meeting with community level leaders included from 20-40 participants, depending upon the size of the catchment area. The facility level workshops included about 10 participants each at the health centers and 20 participants for the hospital. The below table outlines the types of representatives invited to participate, which varied at the sites based on local discretion. The participatory workshops provided a forum to discuss the content and process of developing the charter, strategies for dissemination, village and individual planning for charter implementation, and templates for monitoring its use. Full copies of the facility-specific charters were distributed to all participants, as well as posters and summary points. Each health facility also received extra copies of their specific charter.

**Table 5. Participants in charter dissemination & activation workshops**

COMMUNITY	HEALTH SYSTEM
<ul style="list-style-type: none"> <li>• District and Ward Councilors<sup>a</sup></li> <li>• Ward Executive Officers<sup>b</sup></li> <li>• Chair, Health Facility Governing Committee<sup>a</sup></li> <li>• 4-5 representatives from each village in the facility catchment area:               <ul style="list-style-type: none"> <li>- Village Executive Officers<sup>b</sup></li> <li>- Village Chair<sup>a</sup></li> <li>- Village Health Workers</li> </ul> </li> </ul>	<p><i>Health centers</i></p> <ul style="list-style-type: none"> <li>• health facility in-charge</li> <li>• maternity and/or RCH in-charge</li> <li>• others recommended by in-charge</li> </ul> <p><i>Hospital</i></p> <ul style="list-style-type: none"> <li>• Medical Officer In-Charge</li> <li>• Nursing Officer In-Charge</li> <li>• Maternity In-Charge</li> </ul>

<ul style="list-style-type: none"> <li>- Religious leaders</li> <li>- Other Civil Society leaders</li> </ul>	<ul style="list-style-type: none"> <li>• Department In-charges (all)</li> <li>• Quality Improvement lead</li> <li>• Chair and assistant, Hospital Governing Committee</li> <li>• Chair and Assistant, Council Health Services Board</li> <li>• RCH Coordinator</li> <li>• Principal of the Nursing School</li> </ul>
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- a. Elected officials
- b. Government civil servants

**After facilitation by the Staha Team**

Following the dissemination launch, health facilities and community leaders were tasked with developing work plans to activate the charter, including meetings within communities to discuss the charter. By March 2015, health staff within the two health facilities in Korogwe district indicated that activities had been conducted to increase knowledge of the charter and to improve respectful treatment of patients by health staff. One health facility-in-charge described how he was encouraging maternity staff to refrain from shouting and using harsh language when working. At the district hospital, the posters are displayed throughout, the heads of all departments confirmed that they are engaged in disseminating the charter to their respective staff, and the charter is considered an important part of improving quality of care.

Despite the actions at health facilities, the Staha team found that there was less charter dissemination activity by community leaders than expected. One reason offered was that there were local elections during this period; therefore, the village chairs were engaged in campaigning rather than disseminating information and village executive officers in organizing voting. There were a number of newly elected chairs who now need to be informed about the charter. Similarly, changes in officials at the district level, especially the DMO, meant that there was less follow-up from higher levels.

**Hospital-based quality improvement (QI) process**

**Initiating the process**

After the district charter was completed, the facility-based change process was initiated. The Staha team utilized tools from the US-based Institute for Healthcare Improvement (IHI-US) as the structure to plan with health providers at Korogwe’s District Hospital. In addition, the Regional Quality Assurance advisor was engaged to provide support to the hospital team.

Two consecutive full-day trainings were conducted at the hospital to reach as many providers as possible. Tools from IHI-US, such as process maps, driver diagrams and a focusing matrix were used to facilitate training of the health providers from the maternity ward and other key departments (ANC, pharmacy, laboratory, theatre). The training was facilitated by a research scientist from Ifakara Health Institute who had significant experience in quality improvement. She had accompanied the project team to Korogwe on a prior visit to talk to hospital staff and gather information about their current quality improvement processes. In total, 26 providers received the training, which included nurses from the maternity ward,

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theatre, and RCH clinic; clinical officers from the maternity ward; the Medical Officer in-charge of the hospital; the hospital patron; and the hospital QI focal person.

Each training group created a process map that illustrated how a woman moves through the labor and delivery process and where potential issues/bottlenecks arise that can lead to disrespectful care. They then created a driver diagram to identify root causes of disrespectful care, identifying both primary and secondary drivers. From the secondary drivers, the participants brainstormed possible interventions that would address the specific problems identified and lead to greater mutual respect between provider and patient. The Staha team emphasized that the group should focus on interventions that could be implemented by maternity ward staff. Based on discussions in the two training groups, a list of nine interventions was compiled.

All 26 participants then came together for a third day to conduct the focusing matrix exercise. This exercise involved ranking each of the nine interventions based on degree of importance/priority and feasibility to implement. The four top-ranked interventions were:

- moving the admission and discharge area to a private room
- explaining to women during admission/first exam what to expect during labor and delivery
- putting curtains/screens between the beds for privacy
- creating a stock out list from the pharmacy every week to hang in maternity ward

The participants also voted for who would represent them on the QI team and chose six representatives: two nurses and one doctor from the maternity ward, one nurse from RCH, one nurse from the theater, and the pharmacist.

### **Implementing the QI process**

The Staha team returned to Korogwe to launch the process with the hospital QI team that had been formed during the training. The entire QI team met together for their first weekly meeting, which was facilitated by the team leaders. The group went over the baseline data results and the list of interventions that were proposed during the training. The team decided that their first intervention would be to move the admission/discharge area into a private room rather than admit/discharge patients at the nurses' station, which was located in the middle of the maternity ward. The providers' had identified that this would ensure more confidentiality of patient information, as other patients would not be able to overhear the history or discharge instructions. The team also selected a champion from among maternity ward staff who would make sure that the intervention was being implemented and would be in charge of monitoring and measuring its progress. To monitor progress with the interventions, the Staha QI team instituted a number of measurements. The main source of data was patient surveys, which had been requested by the hospital in-charge. Upon discharge from the maternity, women would be asked to complete a short survey of about 10 questions on the quality and respectfulness of care related to the interventions. Additional data sources used by the team are described in the section below.

The hospital team began to implement this first intervention in early August 2013 and the surveys at the same time. About one month later, the hospital team had seen some progress in women's ratings of privacy, but resolved that this change alone would not be sufficient to increase ratings to excellent.

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Therefore, it was decided to add phase two of the privacy intervention, which entailed installing curtains over the entryway into the labor rooms/cubes and using moveable screens in the maternity wards during patient exams. The curtains were procured and old screens were restored with hospital funds.

After a few months and marked improvements in women's ratings of privacy, the QI team decided to introduce the next intervention which was informing patients and their relatives about the availability of drugs and supplies in the maternity ward. Health providers described that women often do not believe that providers are telling the truth when they say that certain drugs or supplies are unavailable and ask patients to purchase them. As maternity care is supposed to be free according to national policy, women expect that drugs and supplies will be available and often suspect that the providers are lying in order to make money for themselves. Providers consider this an important trigger for negative interactions, therefore, they decided upon this intervention to improve transparency about drug supplies and reduce negative perceptions among patients.

The hospital pharmacist began compiling a weekly list of available and out-of-stock drugs and supplies, which was then posted in the maternity ward, the outpatient department, and the pharmacy, and made available in the maternity ward's admission and discharge room. Additionally, women received information about the availability of drugs and supplies during the admission process and were shown the posted lists. If literacy was an issue, the nurse would read and explain the list to the patient. A new question was added to the patient exit survey to assess how patients rate the information provided about the availability of supplies and drugs during their delivery experience.

The final intervention was focused on provider recognition, as prior interventions had been patient-focused. Providers requested that management provide tea for all shifts in the maternity, as staff members often found it too busy to take breaks. The management team approved the request and corresponding budget and the intervention began implementation in July 2014.

### **Monitoring and management of the QI**

The QI team met every week to review the data, discuss progress, and address any issues as they arose. The Regional QI Advisor attended the majority of these meetings for technical support. To monitor progress with the interventions, the QI team instituted a number of measurements. The main source of data was patient exit surveys. These data were entered and analyzed weekly by the Chief Nursing Officer at the hospital and reviewed by the Regional QI Advisor. Since they were initiated out of a need from the hospital, they have been maintained. In addition, a champion, selected by the maternity ward staff, provided a report on her observations of performance throughout the previous week. Providers were also requested to complete weekly surveys regarding their experience, but these were rarely completed even when the frequency was extended to monthly.

Recognizing the need to improve documentation and ensure that the intervention activities were being carried out and reported accurately, the hospital QI team sought technical assistance from the Staha team to create an individual patient checklist for completion after each activity. When the QI team suspected that providers were not accurately completing the forms, the QI team made the decision to engage an outside observer (someone who did not work in the maternity ward and was not on the QI team) to submit a weekly narrative detailing his or her observations. The Staha team assisted the QI team with the roll-out



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these new documentation tools in December 2013. Finally, they asked for support for a research assistant in April 2013 who did daily observations and checks with women for a period of three months, to ensure that women were being informed about the supplies availability.

### **Revising the QI process for sustainability**

The technical advisor for quality of care at GIZ assisted with reviewing the functioning of the QI process and possible means to strengthen and increase its sustainability. Based on his findings, a refresher/refinement workshop was held in Korogwe, facilitated by the Staha team and the head of QI at the district hospital to review the quality improvement experience for respectful care to date, to explore possibilities for integration with existing hospital quality improvement structures, and to develop recommendations for future interventions and sustainability of those underway. Participants included the current members of the Staha QI team, hospital and district health management team staff, members of the Health Facility Governing Committee, and members of the Council Health Services Board.

The participants in the workshop decided to transition the Staha quality improvement team into the broader hospital quality improvement structures. It therefore became a department-specific Work Improvement Team (WIT) with membership limited to maternity ward staff. Greater integration with the existing structure was deemed to provide clearer lines of communication between management structures, such as the Hospital Management Team, the Hospital Governing Committee, and the District Health Management Team. The reformed maternity WIT began in July 2014, after facilitation support had concluded. The WIT team holds meetings regularly—at least two times per month—to discuss and review progress. In addition, the hospital management team convened a maternity forum where the progress of the Staha project was discussed with staff from across the hospital.

Finally, a peer-to-peer learning exchange with the Regional Hospital's quality improvement team was conducted. The head of quality improvement presented the hospital's experience in improving customer care at the first meeting. Both district hospital staff and the regional hospital's quality improvement facilitator felt that they could greatly benefit from the exchange going forward.

### **C. Emergent actions**

Through in-depth interviews and regular dialogue with the implementers, it emerged that some implementers had taken actions that went beyond those specifically planned either for the charter activation or the quality improvement process. Four potentially significant actions were identified::

- *Respectful language and peer accountability:* The maternity ward staff at the hospital indicated that they were focused on being more respectful in their interactions with patients, notably in using more respectful language. Although mutual respect was an explicit goal, improving language was not one of the interventions selected for a QI intervention cycle. They also stated that they would remind each other and hold peers accountable by saying 'eeh Staha' whenever they saw a colleague speak in a disrespectful manner.
- *Discussions in routine meetings:* Morning meetings conducted by hospital management included a standing item on respectful care highlighting the issue for all departments and sharing progress with the Staha project. In addition, a hospital-wide maternity forum was held to share the experiences with

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promoting respectful care in the maternity. At the health centers, the charter was discussed in other routine meetings, including reading and discussion of charter sections. One staff member was assigned as the focal point who reminded staff about the charter, organized reading of the charter in staff meetings and informed new staff at the facility.

- *Staff counseling and transfers:* Hospital managers and the manager at one health center said that they individually counseled maternity providers who were not providing respectful care. In some instances, they transferred staff to another department or another facility if their behavior did not improve.
- *Complaints mechanisms:* At the hospital, numbers for three managers were posted for patients to call with complaints. At other facilities, communication was established between community leaders and the health facility managers, based on the chain of communication described in the charter.

## 5. MONITORING INTERVENTION RESULTS

This section outlines key findings related to how the activities led to observed changes. Although interlinked, it is divided between the charter-related activities and the quality improvement process, as the quality improvement only took place at the hospital, not all four sites. The interaction between the two components is described in the quality improvement section where relevant. Each section focuses on how the intervention worked vis-à-vis the theory of change. The analysis for the charter section is based primarily upon qualitative interviews, using triangulation between different types of respondents to increase validity, as well as referencing other project documentation and observations. The analysis for the QI section includes data from the patient exit interviews, QI team meeting reports and in-depth interviews.

### A. Charter adaptation and activation

The charter had the potential to support change in multiple ways, including providing support for the maternity QI process at the district hospital. Thus unpacking how the charter resulted in observed changes is challenging. Nonetheless, implementers described changes that they had observed in a variety of ways.

#### **Improvements in quality**

Providers who were interviewed were able to articulate clearly, and in line with the charter, what was respectful and what was disrespectful and how they should respond even in difficult circumstances. They understood patient rights as well as their own. They described the key components of the charter and patient and provider rights, as well as the characteristics of mutual respect as defined in the charter. Consequently their behaviors may have changed as well.

*Yes, it has made service providers to be keen even those who had behaviours of mistreating women and other patients have changed their behaviors, we don't receive such cases. Yes, you know in a normal circumstance you find if you have 10 nurses you will find one that lots of people complain about him/her, they keep complaining. Eventually what we were doing is to find somewhere perhaps we transfer him/her to another work station but now we don't see this situation happening that means even the providers got the knowledge, they learnt something and this has helped us. (Health center*

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manager)

Nonetheless, while welcoming of perceived changes, respondents acknowledged that there were still improvements needed to improve the quality of care. In challenging situations, such as the moment of delivery, some were still having difficulty in changing their language towards patients for example.

*Yes, I must admit that there are areas we haven't achieved by 100% of improvement but at least we have reached 50-60%. There are steps that have been taken, when you look at places where patients sleep for example I went to the district hospital previously you would find a patient sleeping on a bed without a bed net, bedsheet is not changed in the morning a patient woke up from a dirty bedsheet. Now things have changed you find that even unconscious patient sleeps on a bednet at least patients are now enjoying despite of their illness. (District Political Leader)*

*Yes! I think they have reduced to 70% although sometimes they resulted due to poor cooperation from the clients especially those who are giving birth for the first time and that normally upset the situation and they are forced to use power over them. (Health Facility Manager)*

### **Greater satisfaction with services**

Health facility staff asserted that women were more satisfied with the services overall, and this was mostly supported by the ward and village leadership.

*Results, I have seen big changes even now if you go and talk to pregnant mothers, there is a difference since the time we sensitized and previously, you can now visit labor ward or maternity ward you find a client is well comforted it is quite different from previously, at least there are changes because of this education. (Ward Political Leader)*

Respondents also identified a reduction in complaints as one important indicator that women were satisfied. In some of the health centers, the management felt that the changes in behavior brought about by the charter resulted in receiving fewer complaints.

*I think they [the providers] understand because there have been fewer complaints about abusive and disrespectful care. It has been months since I received \ complaints of any abusive incident, so I believe that they are currently more aware and there is a friendly service. (Health center manager)*

*First of all it has reduced misunderstandings between service providers and service receivers. As a health facility in-charge I can say complaints that I have been receiving have been reduced. You can stay for months without hearing someone who came to complain; it is not there. You can stay for months or years without hearing someone who complains, so I can say this has helped, it is different from previous years we were receiving complaints 'a patient has insulted me or a nurse has done this or this to me.' So these are things that are at higher levels and there were many. Now they are reduced, we don't see them anymore, perhaps they still exist but they don't come to us but if they were there it means they could come. (Health center manager)*

*It is because of changes because those service providers have been aware of everything they are supposed to do for a client, one, two, three; these are his/her rights we should give. So, it is due*

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*to that changes it is not easy to get complaints saying I have been mistreated, I should call, no.*  
(District manager)

**Faster resolution of complaints, less escalation**

The clarity of the charter describing mechanisms for reporting and responding to complaints within a timely manner was remarked upon as important progress. The respondents described how it has helped with resolution of problems and complaints more quickly. They were happy that the problems could be resolved before they became too large or political.

*Before you gave us this education I received many complaints, someone comes to my house saying we have gone to the dispensary and we found 'one, two, three..'. But after educating people they no longer come to my house, they have recognized that there is a village chairman, hamlet Chairman the matter ends at the hamlet Chairman. The village Chairman tells you, 'Yesterday a certain pregnant woman came, I took these steps and it was over'.* (District Political Leader)

*Decisions are now done quickly because the charter demands us to make decisions in time. So we have improved especially I terms of referrals, because of the charter we believe that there are things we need to do them in time.* (Hospital Manager)

*For example if there is an issue of disrespect that has happened what we do is if she comes directly in the office we involve both sides, we listen to a person who complain and a staff. So if we note that a staff committed mistakes we must make sure that at least the staff apologizes to the client to make her leave while satisfied. And we do that and if it happens that she brings her complaints directly to her VEO, a good thing is we have set good communication system with the office for those who call or come and say there is a woman who complain about this and this.*  
(Health center manager)

A few of the village and ward leaders described how this had enabled them to have a more open dialogue with the providers at the facilities. They recognized that sometimes the complaints were related to shortages of staff and medicines rather than bad behavior of the providers.

*There was a certain lady there I don't know her name she was alone as a midwife, so you can receive complaints that the lady there [delayed providing service]. But we do correct that, we tell the doctor, 'let us talk about this.' You can't take this as a person's fault. What should she do if she is alone? Now at least the problems I used to hear have been reduced.* (Ward Political Leader)

Nonetheless these relationships were still developing and not all were always happy with the dialogue. There were concerns from health facility managers that the village leaders were not always bringing issues to the health facility in the manner described in the charter. One respondent highlighted that not all of the village leaders possess the skills to manage complaints in this manner.

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### **Empowerment of patients regarding their rights**

The results were also attributed to women's expanded understanding of their rights, which was considered transformative because many were not previously aware and now had a document that could be referenced. Respondents described that this enabled women to demand quality of services in ways not previously observed.

*But most patients did not understand that when they go in service provision areas for receiving services it is a regulation that s/he should be attended and not by favour. It is like when you go to a shop and you say 'I want some sugar.'* (District Political leader)

*People have known their rights for example when they are offended, when I am mistreated I will consult a DMO and contacts are there; I will consult a Director and contacts are there. Those who had time to read the charter clearly has used those opportunities to get their rights, the one who provided substandard service next time s/he won't do that because s/he knows that if s/she mistreats a person, people have access to DMO and Director offices.* (Hospital Manager)

These types of actions and awareness of rights may have helped to improve provider accountability.

*I used these meetings to ensure that every woman gets to know her rights so when she is offended she should know where to report, she should not feel lonely, when she is offended you tell her the steps to follow to get help. So instruction we have been providing has shocked the nurses, they have realized that women are now aware that clients know their rights and can report them, so love have been noticed.* (Ward Political Leader)

*We were educated about this charter and the rights for service providers, and patients were also educated about their rights. Therefore everyone is aware that if I go against the charter I will be held responsible, so respect does exist.* (Health provider)

The charter as a means to increase awareness of rights, however, had not reached its full potential. Community leaders had done some education, but more facilitative support was needed. Without this broad awareness, not all women were empowered as to their rights.

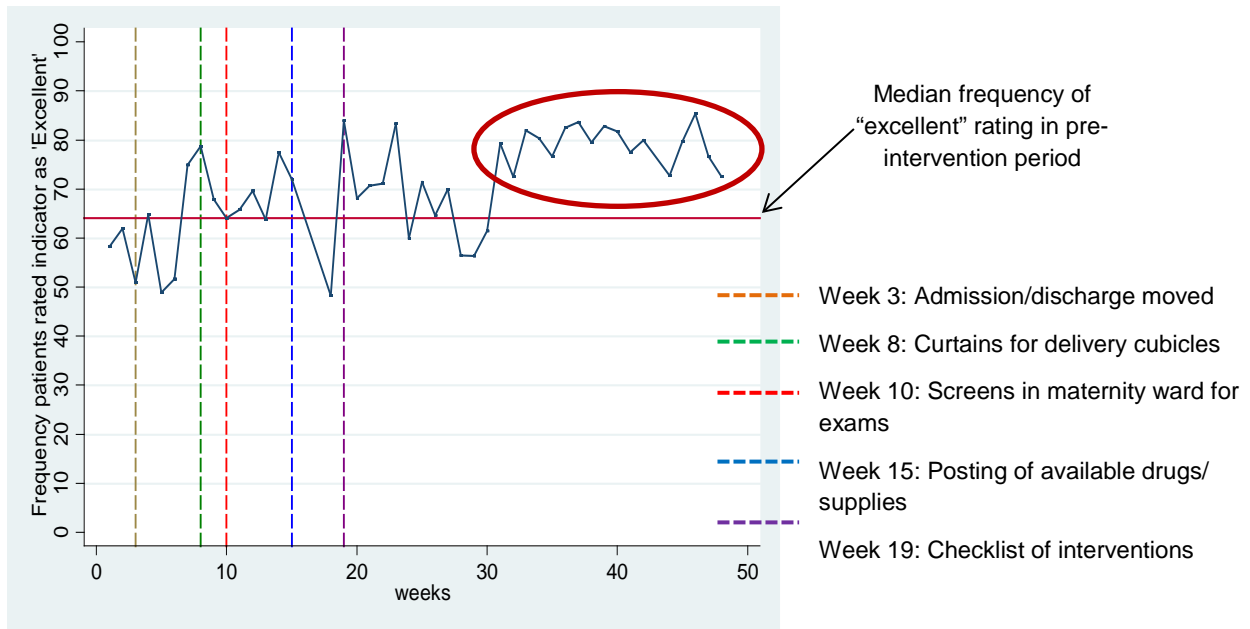
*To the side of a community, it is not that all people have a good understanding about this charter, some of them know nothing, they fear even to express themselves thinking maybe they will not get their rights, so she stays calm even if she has not been attended properly, so those are things we see. Challenges are there but when you get a third person s/he can tell you freely because it cannot be heard by a respective person directly, but this education has not reached many people, I think it is a big challenge that it has not reached many people.* (District manager)

### **B. Quality improvement process**

The nature of the quality improvement process allowed ongoing assessment of how the activities were affecting women's perception of care in real time. Therefore even prior to impact evaluation, there were observable effects. As we see from the below graph, women's ratings of care improved over time and then stabilized at around 32 weeks remaining well above the median frequency from the pre-intervention

period for the following 16 weeks. The stabilization is evident in the decreasing fluctuations from week to week, no longer exhibiting the extreme variations seen in the earlier stages.

**Figure 6: Proportion of women rating overall quality of care as excellent**



To establish the pre- and post-intervention timing, the team reviewed the QI team weekly minutes and monthly reports, as well as project field reports to identify dates when interventions were introduced and other events occurred. Based on this review, it was determined that the last intervention had been introduced at 15 weeks and a checklist to monitor implementation was introduced at 19 weeks. Data were therefore divided into pre-post intervention at week 19. The median frequency of excellent shown in the above graph is based on frequencies in the initial 19 weeks.

Table 1 shows the ratings for the two periods for each of the key elements assessed in the survey. As shown in the table, similar patterns were observed for all of the items except provider knowledge. Annex 9 shows the run charts for each of the quality components that were included in the survey.

**Table 6: Patient exit surveys: Ratings of quality components by time period**

	< 19 weeks				≥ 19 weeks			
	Excellent	Good	Fair	Poor	Excellent	Good	Fair	Poor
<b>Overall quality of care</b>	63.34	32.69	3.69	0.27	75.98	22.36	1.59	0.08
<b>Respect</b>	61.39	35.61	2.73	0.27	77.42	21.59	0.91	0.15
<b>Privacy</b>	62.79	32.28	4.79	0.14	72.94	25.25	1.66	0.15
<b>Language use</b>	58.07	37.24	4.55	0.14	70.51	24.91	1.58	0.05
<b>Provider explanation</b>	60.64	36.58	2.23	0.56	72.83	25.58	1.58	0.00
<b>Supply availability</b>	62.17	32.87	4.26	0.69	77.27	20.54	1.74	0.54
<b>Provider knowledge</b>	70.66	27.27	1.79	0.28	77.02	20.86	2.12	0.00
<b>Ward cleanliness</b>	58.45	37.60	3.27	0.68	72.51	24.77	2.42	0.30

To further depict changes in quality of care pre- and post-intervention, a regression model was developed in which the outcome was categorized as excellent vs. other categories and the main predictor was pre- and post-intervention at 19 weeks. The model also controlled for age and clustered on date. As shown in Table 2, the odds of a patient rating the quality as excellent during the second phase was significantly greater than during the first 19 weeks for all of the items except for provider knowledge. The odds were nearly two times greater for respect and availability of supplies.

**Table 7: Patient exit surveys: regression results comparing responses before 19 weeks and after**

<b>Outcome</b>	<b>Odds Ratio</b>	<b>95% CI</b>
Overall quality of care	1.70***	1.31-2.20
Respect	1.77***	1.35-2.34
Privacy	1.47**	1.16-1.88
Language use	1.88***	1.47-2.41
Provider explanation	1.57***	1.23-1.99
Availability of supplies	2.05***	1.59-2.64
Provider knowledge	1.24	0.95-1.61
Ward cleanliness	1.63***	1.26-2.10

P-value: \*<0.05, \*\*<0.01, \*\*\*<0.001

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Prior to the full intervention, the graphs reveal women’s sensitivity to ongoing health system events. Each week, as the QI team met to review the results of the maternity exit surveys, they noted events in the facility that might contribute to the ratings. Particularly, negative events such as stock-outs or staff shortages or changes were noted, as were positive events such as the implementation of new quality improvement interventions.

For example, a peak in quality of care ratings of “excellent” was seen in week 8 and was explained by QI staff as a response to increased privacy in the ward from the implementation of new curtains in delivery cubicles. A major stockout in supplies that occurred in week 23 is met with a severe decrease in high ratings of quality of care. Similarly in week 24, some nurses are transferred out of the maternity and replaced by new staff, while nursing students also arrived for their rotations. The new staff and nursing students were not oriented for several weeks, continually affecting ratings. During weeks 28 and 29, many health facility staff were away from the facility to execute an immunization campaign resulting in a severe and rapid decrease in high ratings of quality of care. These and other observations from the QI team weekly and monthly meeting minutes inform the interpretation of the quality of care trend line, indicating that changes in health system factors are perceived by women delivering in the facility as changes in the quality of care received.

Early in the implementation, similarly, some of the sharp lows and highs might be interpreted as effects of the implementation. For example, a particularly low point is documented around week 19, not long after the original site QI lead was transferred, but is followed by a drastic increase after a new lead is identified and the implementation of a list displaying availability of medicines and supplies. In later weeks, as described above, we see a stabilization of the ratings despite some instances of stockouts and staff rotations.

A project to provide women with free health insurance coverage during pregnancy, delivery and post-partum was also being conducted in the district at the same time. This project may have contributed to improved perceptions about supply availability for women, as well as for providers, because it was tied to reimbursements that could be used for purchasing supplies.

Each of the interventions likely provided a unique contribution to the overall improved ratings of quality. In addition, as noted above, there were emergent actions taken to further advance the overall goal of improving mutual respect. The qualitative research also exposed additional theories of change that were not initially identified and unexpected consequences of the intervention, often positive.

For example, reviews of weekly QI team meeting minutes revealed a shift in the explanations provided by the QI team in the weekly and monthly meeting minutes depicting an improvement in critical thinking over time. Early in the process, the QI team was quick to attribute drops in the reported ratings of quality of care as due to lack of knowledge of the women or low understanding of the survey instrument. However, as time passed the QI team began to identify apparent linkages between health system factors and perceived ratings of quality of care by the women. With this shift, the rhetoric documented in the meeting minutes shifted from a deferral of responsibility to acceptance of responsibility and began to include discussion of the actions needed to rectify poor quality of care as well as recognition of successful gains in quality of care.



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The observed stabilization around week 30 appeared to be a confluence of these factors coming together over time. All of the QI interventions combined with the provider and management actions came together resulting in changes beyond the individual intervention effects. Results were not immediately apparent and it may have required time for the learning and response to take effect.

With new leadership in the maternity, there may have also been more emphasis on the project. Around the time of stabilization, a new maternity in-charge joined the hospital and showed strong commitment to the project. She also ensured that all of the maternity ward staff saw and understood the results from the patient surveys, which were presented in a meeting involving all maternity staff. Similarly, at the same time the QI team began to share the findings more widely throughout the facility. A maternity forum was held in which the accomplishments of the QI process were shared across departments in the facility. This acknowledgement of the effort, combined with management actions to enforce compliance among maternity staff may have over time helped to reinforce the messages.

While staff was pleased with this progress, which was widely acknowledged, it was understood that it was still necessary to improve and continue the process. They recognized that it is still an uphill battle to change reputation and rebuild trust.

*But if you observe [the hospital] as it is, there are good things done, but people have just got that attitude since before, you know when a bad thing is done, it stinks, it remains so even if it will be modified and become good, people still know that it is bad, but generally people are working hard. (Hospital manager)*

## **6. FACTORS RELATED TO IMPLEMENTATION**

This section focuses key findings related to the implementation and factors that may have influenced implementation. It describes the findings related to implementer beliefs about the intervention, the inner setting/organizational context, and the process to try to explain why implementation occurred as observed. The analysis for this section is based primarily upon qualitative interviews, using triangulation between different types of respondents to increase validity, as well as referencing other project documentation and observations.

### **A. Implementers' Perceptions of the interventions**

#### **Client Service Charter**

Generally, the charter was well accepted by the different parties as an intervention that could make a difference in the quality of services. Awareness of rights and responsibilities was highlighted as one of the key reasons that it would be useful. These statements implicitly spoke to a previous situation where both patients and providers were lacking knowledge that would improve their interactions. The general support for the charter was seen across managers, providers and community; each with their own nuanced perspective. Each found an element of the charter that addressed their specific concerns about their own rights or responsibilities.

Health providers were initially skeptical about the charter and concerned that it was primarily an instrument which would enable attacks against them. As they became more familiar with the content, their acceptance and support for the charter grew. In supportive statements, maternity providers

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emphasized that the charter provided the community with information that they were lacking, but also recognized their own previous misconduct, for example, in disrespecting patients.

*I think that this charter is our saviour and in other words if you read this charter from these handouts quickly you will see that it helps people to be aware of the basic things and what ought to do especially in the community where most of members are ignorant. On the other side, the service providers have been working without understanding the limitations and sometimes we have been over-lapping and violating the rules but through this charter will make us (service providers) to understand our limitations we have known our responsibilities and our rights, we have recognized where we were mistreating our clients and we should not keep on doing that. (Health Provider)*

*Staff reaction was good because they have seen it has assisted them as I said earlier that it has reduced several misunderstandings which used to happen because a person would come and think that a service provider is just a mere messenger or something that has no value but now they see service providers as worthy people, they respect us. And we also do things to them according to regulations, for instance you can no longer hear a service provider abusing a client or arguing with a client, in most cases you can find that with a hot tempered client a service provider remains calm. (Hospital manager)*

Some of the providers tended to place more emphasis on the community accepting changes and community obligations, rather than the fully mutual relationship envisioned in the charter. However, fortunately, some of these attitudes were most evident at the beginning of the process and seemed to undergo a subtle shift over time.

*First it will change peoples' attitudes; people will see there is a need of changing their attitudes that it isn't just a provider responsibility. Previously, the community thought it is only them who have the right of demanding rights; they should also know that they have a responsibility. For example, there is a section that says a patient should listen health workers' instructions, but they should know that health workers do advise patients, but decision remains on their hands. So, when you look at the charter everything good starts when community accept changes. (Health Center Manager)*

Those who had been exposed to the charter at the community level were most interested in how it could empower them to demand their rights. They recognized the mutual and collaborative processes required for it to be implemented and achieve its full intentions.

*This poster has successfully helped to remove the worries of the community by identifying their rights, many people went to health facilities but they are not aware with their basic rights, so this poster has summarized their rights and now they are aware that it is their right to get treatment, they also get to know their responsibilities and hence people can get services without giving corruption. (Community FGD participant)*

*Working together on the charter, protecting the charter, that the community members should protect the charter, be aware of their rights, and the service providers as well should be aware of*

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*their rights. Leaders who receive complaints should also be aware of charter content. So I think if we work together on those areas the charter will be firm. (Village Political Leader)*

At the district level, the key managers and political leaders recognized the opportunities provided by the charter to effect change in a number of different ways. District health managers were pleased that it could contribute to achieving goals related to improving maternal and newborn health, while others described the contractual nature of the document which transparently outlines rights and obligations for all parties. The mutual nature of trust and respect was also very clearly understood by district level respondents.

*...because health facility delivery currently is very low, less than 50%, and probably this will raise the number or proportion of pregnant mothers who will be willing to visit and deliver at health care facilities because there will be mutual trust through our implementation and our mutual understanding of the client service charter. So we hope healthcare facility utilization will increase for antenatal care and during delivery and probably maternal and newborn death and morbidity will decrease. (District Manager)*

*Yeah, I think if we will be able to prepare this charter and take it to the community level after being completed, it is going to help because the charter is very clear and transparent and therefore even the community members who are the receiver of the services will feel that we care about them by giving them something like that as well as the service providers because this charter is related with both sides. So even the service providers will be pleased with this because they also have their complaints sometimes, but they do not have a way to submit them so I think this is a good thing. (District Manager)*

*By having this Charter it will make the District Council accountable because they know that they have a contract with the community who are aware of what should be done for them. (District Political leader)*

Despite these positive reactions, and expectation of mutual trust, it was clear that there was still some distrust to be overcome between the community and providers. In particular, the ward/village political leaders expressed continuing cynicism about providers' efforts to implement the charter and to fulfill the obligations laid out in the charter.

*I think the providers do not see the importance of the charter because they think if this passes they won't get some allowances. I have seen that they shouldn't hide such a thing from me. We spent a lot of time on this. IHI researchers came all the way for this then they fail to inform me as a Councilor about the charter. Yesterday I found a lot of books (charters) in his office why? He doesn't want to distribute them for them not to be known. (Ward Political Leader)*

Although the charter was developed through a consensus process involving all levels of the district health system, including clients, there were still some components that were not well-received. In particular, some respondents, in both community and facility, expressed concern about the right of a client to refuse treatment. These statements emphasized the expertise of the health provider and questioned patients' knowledge.

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*... because when you are asking the client to decide on treatment, it means you can give the client a certain treatment and the client can say 'I don't want this kind of treatment, as I said this is the treatment I want', while you as an expert you know this is not a right procedure but the client emphasizes her/his decision. I can't accept that because I will be violating treatment procedures but because a client sees a loophole she/he says, 'Listen we read that we have a right to refuse why do you deny that? why are you telling me to use ALU while quinine drip has been my treatment?'* (Maternity Provider)

*The section that I would like to be removed from the charter is giving a chance to a client to see the doctor in charge or others, I think the clients is not entitled to refuse the treatment prescribed by a professional doctor. I would like that section to be removed because due to the level of understanding of people in rural areas it might cause trouble.* (Ward Political Leader)

All types of respondents were concerned that health system limitations would affect the ability to implement the charter. The shortages of medicines, human resources and adequate maternity space were raised as serious impediments to the implementation of the charter. Some even felt that the project should have tried to address these issues as part of the intervention.

*Because even when we were having a problem of inadequate necessities, for instance, at that period when the country had scarcity of sugar, getting sugar was like a miracle but eventually the problem was solved and we had sufficient supply. So this charter will improve the service but other things should be improved too, when other things are improved, the charter will definitely work.* (Religious Leader)

*With regard to improvement of health services, I would personally request them to do more. First of all our labour ward is very small, so I would ask them to expand it because if you enter people are full. You cannot serve them in that situation, so you just pick out one mother after another. Currently there are many pregnant women, if you enter in the antenatal ward you will find even two women sleeping on a single bed.* (Maternity Provider)

*So this matter of lack of medicines has distorted the client service charter, it has brought a problem because if a pregnant woman goes for operation now, she has to buy everything, and there are very few equipments available which are provided to her. Therefore if you have told a pregnant woman, some are from villages, they have no relatives, we start donation, and now what money do I have to donate for every patient! So I pass along the corridor for donation until I get some money and I donate a little.* (Hospital Manager)

There were also significant feelings of distrust and disillusionment with the government to be overcome. Community leaders particularly highlighted that government programs often do not deliver as promised and were skeptical that the charter would have the robust implementation necessary to succeed.

*During the implementation, this implementation has two sides as it is stipulated in the charter, a client's side and a service provider's side. So when a provider serves people well, then clients will have evidence that things have really been changed, but if a client will find the same situation as it was before then he/she will regard it as a mere talk we are used to like "Kilimo Kwanza*

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*(Agriculture First)” a policy that came to pass but peasants are still at their low level. (Religious Leader)*

*I would like to request the government to make sure that it implements its policies because ensuring the implementation of its policies is how it gains the trust of the community. But if the government does not fulfill its promises to the community it's obvious that the community will no longer have trust in it. (Village leader)*

Yet, the implementers expressed their understanding that it was their obligation to ensure that the charter was implemented as expected.

*It has been brought by Ifakara Health Institute but it has involved the Council, so many people do not trust on government system because every day there are researches so even when you tell them about issue of charter they do not believe that it can be implemented. Something which we tell them that it can be implemented, we try to talk to people and we see now they have started to understand us that the charter can be implemented, so business as usual, that is the first thing. (Hospital manager)*

*...because as [a district manager] and as a person who is expected to supervise implementation of policies and policy guidelines in the district these are the things I have been doing. But through this service agreement it will improve my ways in terms of supervisions and make sure what is in the service charter is implemented and measured. (District Manager)*

### **Quality improvement process**

The hospital managers were supportive of the quality improvement from its early stages. Their involvement in the charter, as well as the research findings, had demonstrated the need for action. Maternity providers took longer to be completely committed to the process and this evolved over time for some of the staff. For some it was not clear how this would benefit them, especially as they perceived that the QI team staff had received payment from the project.

*Not all of them have reacted positively towards the interventions, others are ignoring it just because there is no payment or they think that we have been paid for this and we don't pay them. But, if you observe them, you will note that most of the staff have accepted Staha. (Maternity provider)*

### **Privacy and confidentiality interventions**

These interventions were proposed to respond to any concerns that women might have had with privacy, as well as fairly simple tasks that would improve the confidence of providers to make change. Interestingly, the movement of the desk had additional benefits as described by the providers. Some mentioned that it enabled them to take better histories of patients, because the clients could be more open when not concerned that others were listening. They also felt that they experienced fewer distractions as its location in a private space meant that colleagues and others were not making additional requests.

*At first, we used to stay in a place that is not conducive for work because all things, including documentation, were done at the same place. And, we were having a long queue which becomes*

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*difficult especially during documentation. But now we are able to concentrate with one patient in a room so documentation is improved and time is well managed. (Maternity provider)*

*Benefits, I have been given a screen there, I have curtains inside there and we have changed, pregnant women enter inside one after another, may be they would quarrel outside there, because there is a story of a woman mentioning a father's child while he is another woman's husband (the woman was also in a labour room). So in one way or another it avoids some conflicts which could occur, that privacy has increased, it is not as it was before. (Hospital manager)*

One provider noted that it actually provided a better space to develop a relationship with the patient:

*When you talk to one patient at a time you listen to patient's problems. They tell you things they hadn't told you before. I listen to them and become close to them as their close friend. (Maternity provider)*

### **Informal payments and non-dignified care: Transparency regarding supply stockouts**

As described above, the routine public listing of stockouts was intended to reduce misunderstandings between patients and providers surrounding availability of medicines. Compared to the previous interventions, this encountered more implementation challenges. Nonetheless, when it was functioning, the QI team and staff were enthusiastic about its benefits, including the hospital pharmacist. First, the providers felt it lessened conflict to have the official notice, so that patients were less likely to suspect that they had taken medicines or were diverting them to provider-owned pharmacies. Second, the health providers were pleased to have routine updates about medicines availability. They noted that previously they might not know if a medicine was in or out of stock and might provide incorrect information to the patient, further deepening mistrust. Finally the pharmacist perceived that it helped him to better forecast for procurement. Therefore, if more supplies were available it might have also contributed to improving women's experience.

*This has also helped because when clients are told that, 'there is not a certain medicine, go and purchase.' they see on a list and the pharmacist has said there isn't, s/he is satisfied directly because a declaration is from the senior authority not mine, told her to buy a syringe. In our discussion, when you tell her to read, she feels peaceful that nurses are not selling syringes from their pockets. (District Manager)*

### **Accountability to women: patient exit surveys**

Besides serving as a monitoring tool, the patient exit surveys may have also served as a reminder to the providers that they are accountable to the women delivering in the health facility, not just to the system itself, and for aspects of respectful care not directly related to the QI interventions.

*The questionnaire has helped us because the patients are filling the questionnaire, so we providers are scared that the patient will rate us badly in the questionnaire. Thus the presence of the questionnaire is a great motivation for us to serve with respect even if you have your own stress. The women tell each other and say if the nurse disrespects you, just note down in the questionnaire. (Maternity provider)*

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*The other thing is the freedom of expression to women, previously they were attended without being given a chance to express their opinions but nowadays they are given the questionnaires and they can express themselves in through the questionnaires. (Maternity Provider)*

A few of the maternity providers also mentioned that they had collaborated with patients to have them make suggestions about supplies that were lacking. The women's comments assisted the providers and enabled them to work together towards change.

### **Using respectful language**

Although not explicitly an intervention, providers made efforts to improve the language that they used to talk with women an important part of the QI process. And, it was an important component of how they described mutual respect. It appeared that at a certain point, they began to remind each other to improve their language

*Also the language has changed is different from the language that was used previously, that alerts someone for example when a provider wants to scold a mother another provider would tell, 'Hee Staha' she/he quickly change a language tone and start speaking politely. (Maternity provider)*

### **Addressing concerns of providers: maternity staff recognition**

This occurred near the end of implementation and it was difficult to capture the reactions of providers. Nonetheless, maternity providers described other ways that they felt empowered by their QI efforts and received recognition. For example, the maternity accomplishments were recognized by management and shared across the health facility as a model to emulate. A decision was taken to scale the relevant components to all hospital departments.

*I think that this is good because even the HMT [health facility management team] will be participating. I think it is amazing that the Hospital Management will also participate on this. As you can see, we get the chance to meet [the hospital in charge] and other Doctors who attend the workshop. (Maternity provider)*

The recognition in the hospital may have been reinforced by improvements in community interactions. Providers expressed pleasure at the changes in their relationships with patients and perceived that more women were coming from farther places because the reputation of the hospital had improved.

*We are proud when the community praises us for working hard, that gives us respect rather than being told that we are lazy. (Maternity provider)*

*Yes it has, because formerly we had small number of those who deliver in here, they were below three hundred, but now it is about three and four hundred per month, so the number of people have increased. Even in the streets our services are applauded... Previously when patients came here providers spoke to them impolitely, in the labour room women were slapped. Now grateful, most women come to deliver here. (Maternity provider)*

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## B. Inner setting/Organizational context

### Readiness to provide promised care

For nearly all of those interviewed, the service delivery environment was characterized by scarcity, seriously hampering health service delivery. System scarcity descriptions referenced medicines, health providers, fuel for referrals, and beds and space for laboring mothers. As noted above this created disillusionment with the system, for providers and patients alike, as they struggled with the stark difference between aspirational policy and day to day reality in the service encounter. The most visible reminder of the system's failure to meet expectations was the lack of available medicines and supplies, epitomizing the distrustful relationship.

*They fail to understand you because it has been announced in the radio that these services should be given for free and today you tell them to buy these supplies which cost them not less than 20,000. (Health center manager)*

*What we are discussing here is currently happening in our health facility. The services which we have been told are given for free to women and children; I can say they do not exist here. As the previous speaker said, at the same time the patient may be transferred to Korogwe so you cannot move with the supplies. (Community focus group participant)*

Providers believed that patients were often not aware that supply system problems are beyond their capability and blamed them for the stockouts, intimating that they had stolen them or were diverting business to their own pharmacies. The feelings of distrust were deeply embedded for many, with the implication that it would take time and repeated positive interactions in order to rebuild the trust.

*Challenges as I said, people do not trust the system, that is the biggest challenge, I think people do not trust even government systems, a lot of commissions have passed, many projects have passed ... (Hospital manager)*

At the same time, respondents also were concerned about the demotivation of health workers given the challenging working environment. They recognized that this demotivation might have stemmed from lack of support from supervisors or the community or both. Their demotivated status might make them less open to taking on extra projects and obligations, especially if they felt that the burden or blame was placed solely on them.

*For example, the patient will be told no oxytocin is available at 11pm at night, then they start looking for this at this time. This having essential drugs and supplies will be difficult. Another thing is the support from the employer you may want to move forward and do not get support thus the employer can demotivate you or slow you down. (Maternity provider)*

*There are people who are willing to work throughout the day but they get stranded because there is no motivation, they have not being encouraged. Let us take an example of the labour ward where there has been a lot of complaints, but I was also admitted there and witnessed the challenges which those nurses are facing. (District Manager)*



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*If they are demotivated, that is the only way which may prevent them from changing their practices. How are they demotivated? First is their relationship with the clients. If the patients have no respect for them or they do not appreciate the service being given that may prevent them from changing their practices. (Hospital Manager)*

The community respondents also acknowledged that some of the observed negative behaviors might be due to overwork or lack of time to attend patients carefully.

*You know sometimes they are very occupied with their work schedule due to few staff, you will find them occupied that they fail to attend patients. (Village Manager)*

*You know there are many obstacles because first we can say that staffs are few, someone may make a mistake because she/he is tired, some other persons can respond to you badly because she/he is tired, which you can find the same doctor from morning to ten pm till next morning. (Ward Political Leader)*

### **Leadership commitment and readiness**

Despite these challenges, there were marked expressions of commitment by respondents in leadership positions. This support came from different levels of the system, and also among multiple people at each level. Many were able to clearly stipulate their responsibilities and obligations as a leader to advance the charter and the quality improvement process.

*Because every human being is unique, with different psychological make-up and thoughts, I cannot know them all, but for village leaders and religious leaders who have been gathered here, this education will spread because both of us have followers. There is no one here who came personally, they are all representatives of the majority. I have people who come to my office, so when they see a poster that I am going to pin on the office wall, they will question “ Oh what is this?’ So when I educate that individual the education will be spread to many others who will be educated (Village Political Leader)*

*My contribution is that I have been on frontline, I have been a source of change, because me as a leader I have to be on front line so that they can see that “Madam is here talking about something.” So you who insist on something, you must personally be on front line to show that that thing is very important. Sometimes you have to be aggressive to get things done, so I consider myself as a source of change on that. (Hospital Manager)*

*The adaptation process of the charter, as I can see, most of the CHMT members and the participants who were here, seem to be committed and I, myself, I am very much impressed with the participation of the members, with aim of the charters. So we commit ourselves as Korogwe to continue adapting it, to continue improving it till to its final stage. (District Manager)*

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These levels of commitment may have been related to feelings of ownership. Over time, many of the key implementers came to realize that it was their process and their charter, not an external project that would have a finite duration. Its success would depend on their actions rather than outside efforts.

*I will try to sensitize the community to understand that this charter is for us, that this charter is not brought by our colleagues from Ifakara Health Institute, no, it is our charter between the Health Center and the community. (Village Manager)*

*Later we recognized that we were responsible to work on this, we depended on Staha to do this and this but we were the ones responsible for that. Later on when we were left with the task of improving it, we continued doing and it placed us to the point of doing things as usual, we organize by ourselves. (Hospital Manager)*

Leadership's public expressions of support may have been important for ensuring that it was implemented by all. This seemed to be especially the case in the health facilities, where either high level management or district management expressed support.

*I cannot say that there is big challenge, no, very rarely you may find a person perceives it negatively, but because it is from a senior personnel, may be s/he has to accept but not positively, but because it is an order from senior, s/he must implement it. (Hospital Manager)*

*They are very committed to carry out the implementation. Let me give you an example of the new in-charge of the maternity ward. We informed her about Staha and she accepted to give full participation without complaining that she was not engaged before. (Maternity provider)*

*It is good because we see that they [district management] have not separated us, we are together; I mean we work together. You know the goodness of a job is to work together. It should not be seen as a separate job, maybe this is for [one person] only. But also they see that this thing is important, let's go and observe what our colleagues do, because they do not come with bad motive, they come with good intention, to see what good is done and if there are bad things, then what should we do to improve. (Hospital Manager)*

While hospital leadership was quite positive about the district managers' engagement, at the health center level, the facilities mentioned that district management had not done enough to follow-up on charter dissemination and support their efforts. Similarly, community level leaders expressed concern there had not been sufficient follow-up after the dissemination and requested more support.

Although, in two of the sites, it was mentioned that the District Health Secretary had continued to follow-up, discussing both allowances to motivate providers as well as informing providers of the consequences if they receive too many complaints.

*We have agreed with the Health Secretary and he has told the providers, "Guys, I want you to work, implement your responsibility, I don't want complaints, those doctors who enter, even if four times per day, let their overtime be recorded so that we pay them so that if we find a person*

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*not implementing his/her responsibility we fire him/her without having any problem.” (Ward Political Leader)*

In two of the facilities, the health facility managers also took decisive actions when staff were not changing their behavior as expected. These actions demonstrated to providers that there would be consequences if they did not adhere to the mutual respect standards. In the hospital, the providers were counseled and then transferred out of the maternity ward if their behavior did not improve and in one of the health centers staff were transferred to another facility.

*Some problems are caused by health service providers and we have been calling them one by one or as a group and talk to them so as finally we will be able to provide services which meet the expectations of the clients. (Hospital manager)*

*They accept the charter but they continue to act in a different way I really don't know why, I don't know how to make it clear nurse, because I daily receive cases concerning unethical actions. The same person being blamed. Of course I take action, I have already transferred two of them. I took them to the District Health Secretary and told him that I don't need them. (Health Center Manager)*

### **Leader characteristics**

Some of the key leaders exhibited an openness to learn and self-evaluate. These characteristics may have better positioned them to be reflexive about their own role and to be open to change. As disrespect and abuse is a sensitive topic, this may have been particularly important for this project.

*Ah, I don't know if it is impact but it has given me a chance to do self-assessment, because we make analysis and see why have we gone down to a certain point in this month, so we evaluate ourselves, that is true, this week we didn't talk to pregnant women. There is a tendency of forgetting for example to talk to pregnant women, and you will know it when you attend seminars and they say we were not educated clearly, therefore you increase speed of encouraging one another, therefore that has made us evaluate ourselves and see where we need to increase motivating ourselves, so it has been very helpful. (Hospital Manager)*

*Apart from being a leader I learned a lot yesterday. That is why they say that education has no end. (District political leader)*

### **Implementer turnover**

Staff rotations in the health system and local governance were an important challenge for ensuring continuity for the charter and QI implementation. The turnover of leadership, however, may have particularly affected the charter implementation. During the life of the project, the District Medical Officer changed three times. The original District Medical Officer who had spearheaded the charter development was transferred just after the launch, when the dissemination was to begin. Another district health management team member who was involved tried to maintain the momentum, but found it challenging with shifting priorities under the new leadership.

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At health facilities, the facility manager turnover was less frequent. Early in the QI process, the original QI lead was transferred out, but another leader was selected who was wholly committed and well-placed to take over. The maternity in-charge at the hospital also changed, but the new maternity lead seemed even more engaged and interested than the previous. At all health facilities, however, the overall health facility manager was present throughout the implementation which may have helped with continuity. Rotations of health providers in and out of the maternity wards did create temporary challenges, for which resolutions were sometimes found; however it continued to be an issue as there was a need to continually update new staff.

*For instance now... there is a change list, therefore new staff will enter in the ward, so there is another big task of instructing them because those newcomers are not aware, and others are new employees so I must start afresh to explain to them from the beginning to the end, to take time to get used to it and see that it is a part of service, that must be insisted. (Hospital manager)*

In some facilities, staff who had been placed in charge of informing others about the charter and providing community education were transferred out and were not immediately replaced.

*Previously when we were receiving the charter every morning, there was a health provider who was educating the community. It was important to tell and remind people to read the charter and also to read fixed fliers that tell on their rights and providers' rights. So that was happening every morning, it was sustainable. But now we are stuck, the team is reduced, a person who was assigned to do the task has been transferred; we need to elect someone else to perform the task of educating people in every morning. (Health center manager)*

The community level was even more challenging because many of the leaders oriented for dissemination were political leaders. Local elections were held several months after dissemination, thereby shifting focus to campaigning and organization of elections, and many were unseated in the elections.

### **C. Process**

#### **Engagement of relevant stakeholders**

Throughout the charter process, the Staha facilitation team asked for feedback about who should be involved in each of the stages. From initiation to dissemination, the district managers were involved in identifying the key stakeholders. In addition, respondents from across the system were asked in interviews about who should be involved in the next stage and who had been missed. In order for all components to work, it required engagement of a number of district management team members, health facility managers and maternity health providers, as well as a broad array of different stakeholders representing the community interests, from both government and political positions. Consequently, implementers generally felt that the right actors had been engaged in each stage of the implementation and that it was highly participatory.

*The Charter adaption process has been perfect in terms of first involving the technical personnel in collaboration with the community members from the council service board, Health Facility Governing Committee from the district hospital, then representatives from the elected leaders, the politicians, in collaboration with your technical advisors. (District Manager)*

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*The process has been going nicely because it has inclusion from the community to the health providers up to the district level. Most of them have been included, including the political figures, so we are sure that because most of the important groups are included in the process. (Hospital Manager)*

The strong leadership of the first District Medical Officer was an important component for ensuring the implementation. It was recognized that the District Medical Officer is responsible for improving the quality of care throughout the district health system, and overseeing implementation of related projects.

*The current one has been here for only a month, but a former DMO was supervising and we used to discuss even in meetings with CHMT, HMT, labour ward meeting, maternity meeting which includes all health centers. We discussed about the client charter and DMO was making a follow up and ensured that those agendas are included. And I hope even this new one will follow up but frankly speaking the former DMO was active on this. (Hospital Manager)*

The leaders at ward and village level remarked that early community involvement was also an important aspect of the project.

*Because when we are creating it, each and every stakeholder participated as I told you that they started from the ground, they involved different groups including women themselves. As a leader I have witnessed it and participated as well until today. (Ward Political Leader)*

*This project has been engaging the community in all stages, lucky enough the project implementers have to inform the village government through the Ward Executive Officer before reaching the community, so this project has used participatory approach. (Ward Manager)*

They also felt that they were the correct stakeholders for disseminating the charter and keeping it active in their communities. Some mentioned that they typically receive complaints, so it will be in their interest to ensure that the charter is implemented and shared widely. One political leader mentioned that since they are native to their communities, it is their responsibility to act on behalf of the community. Health facility managers similarly felt that engagement of providers in the drafting of the charters eased the facilitation at later stages.

*This was not a challenge because most of staff were involved in the charter, so everyone has the knowledge except few who were new comers they had to be informed by their colleagues. But a big percentage of the team were involved in the charter from the beginning, they were involved during interviews with pregnant mothers so they were knowledgeable of what goes on. (Health center manager)*

At later stages, for the dissemination of the charter, many different actors were engaged. Yet beyond the District Medical Officer, no one person was assigned the task of working on implementation of the charter. Two district managers suggested that this might improve the focus on implementation.

*Personally what I can advise is that this should be sustained and to be included in our plans to make it a special area. At least we can get one Social Welfare Officer and tell him/her, "As a*

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*Social Welfare Officer you will be dealing with customer care and everything concerning the charter”. Then we should decide to have a coordinator on that area who will be advising the management and we will be working with him/her. (District Manager)*

For the QI process, all maternity staff and other key personnel were involved in the training. This group selected the team that would be responsible for leading the QI process. In the initial stages, the group decided that it was important to have members from across the facility, as the problems were not limited to the maternity alone. This, for example enabled them to involve the pharmacist for problems related to stockouts. Several management staff, including the Chief Nursing Officer and the Health Facility In-Charge, were involved, but it was later determined that it would have made the process smoother if additional management were engaged at earlier stages.

*Now they have engaged the hospital management, now it is aware of what has been done so that means even the when the project ends, it will provide supervision and by doing so the project will be sustainable. (Hospital Manager)*

### **Facilitation of implementation**

Facilitation was an important component for the charter adaptation and launching the QI process. Given the sensitive nature of the issue, these early conversations required careful facilitation, while also allowing space for challenging conversations. The facilitator needed to be comfortable to allow the tension and venting of long held concerns, but not let it overtake the process. For example, some topics that sparked heated debate included functioning of insurance schemes and exemptions, availability of adequate medicines and supplies, and availability of vehicles and fuel for referral. With multiple types of stakeholders, it also meant dealing with people from a variety of backgrounds, who therefore speak in different ways and bring diverse experience and expertise.

Those involved in the meetings generally expressed their happiness with the facilitation and the participatory nature of the meetings.

*Let me say one thing first about this issue, what I see is that the Ministry was very correct in selecting those people who were educating us yesterday, basically they have ability and are sincerely intend to do this even when they are educating us, for instance the way the facilitator teach us you can see that his intention is to make people understand and be aware of their responsibility. (District Political Leader)*

Many respondents requested additional support for charter follow-up. They were concerned that without routine follow-up that the issues would not receive the attention needed. And specifically, they noted that technical support and monitoring would still be needed by the project. Facilitation for the charter dissemination was limited, consisting of one main workshop in each of the sites and discussions with the district management team. Compounded by the transfer of the DMO and local elections soon after, the community level dissemination was not as extensive as originally intended. One district manager still envisioned the possibility of continuing dissemination efforts.

*Personally I think there is still a need for us to continue advocating it and I think these fliers are not enough, we should have more. Let’s even look for possibility of using our local media we have so that we advocate it to a larger area, for example I have been listening to a local radio*

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*called Voice of Africa radio which covers Korogwe area only, which when we make our special program perhaps people will be interested to hear that, “When you go to hospital you will get this and this”. They will definitely understand because it focuses people’s lives. (District manager)*

While the QI process facilitation ended around the same time, the intervention seemed to have been more embedded in the hospital’s routine practice and activities continued. The hospital managers involved in the QI recognized that it was a process that could be built upon with additional interventions.

#### **D. Reflections**

Respondents were asked to reflect upon the project, what they had learned and how sustainable it would be to maintain. Some of the comments intimated that a change in norms had taken place in the health facilities and in ways that might potentially be maintained.

*What I have learnt is that, previously we were not doing right things to women; you think you are right but you are not. For example admitting a woman in an open space I thought is a normal thing but it wasn’t. There was unnecessary loss of documents and data, the language we used was not good. (Maternity provider)*

*My opinion is that; the service is good, we wish it to be sustainable and we hope it will be so while maintaining respect among both us as providers and mothers. I say so because we are now educated. As I said earlier you can’t compare now and previously; we are now educated and we have seen this is a good thing that is worthy to be copied by others. (Hospital manager)*

Yet others recognized that while changes had taken place, it would require continual effort to sustain these improvements.

*Of course as I have said, that type of problem is reduced or eradicated, but as a human behavior, today this one starts then comes another thing, so it becomes continuous you cannot say that it is over so let us relax. (Hospital manager)*

Some felt that the interventions merited extension to health services beyond the maternity and scaling to other districts and regions.

*Moreover, the problems that we are discussing affect the whole country in general therefore we should not look for Korogwe District only we should reach out other community within the community such as Mtwara and other places, if we will be able to reach them out then there is a big possibility that government would have the groups which are aware of their responsibility in both sides, the community and the health service workers. (District Political Leader)*

*... I would be happy to see that Staha services do not end at the maternity ward only, but are extended to other units like medical ward, surgical ward, pediatric and other departments because it is a good thing. It provides freedom to the service providers, also helps providers to know how to attend a patient properly. (Maternity provider)*

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## 7. CONCLUSIONS

The Staha Project provides an important early example of an approach to reducing disrespect and abuse and increasing respectful maternity care. Rather than take a traditional intervention approach, the project focused on developing a joint vision of mutual respect with participatory processes that allowed space for dialogue to build consensus and rebuild trust as well as a platform for linking multi-level multiple discrete interventions. The charter adaptation revealed that the process of bringing together actors from all parts of the district to discuss and negotiate standards was an essential part of the transformation, not just the production of a formal document codifying rights and responsibilities. Throughout the process, it was clear that not only government and health system actors were needed, but also community representatives were essential and keen to engage in discussions about the quality of the health services. The system can also provide simple mechanisms, such as routine patient surveys, which provide a voice for women as well as remind health system actors about accountability to clients. Many activities could address the challenges encountered by both patients and providers in their daily interactions. Combined, the multiple efforts, which often will need to be defined locally to address local needs, may coalesce to produce important shifts in norms and expectations, as well as the quality of services.



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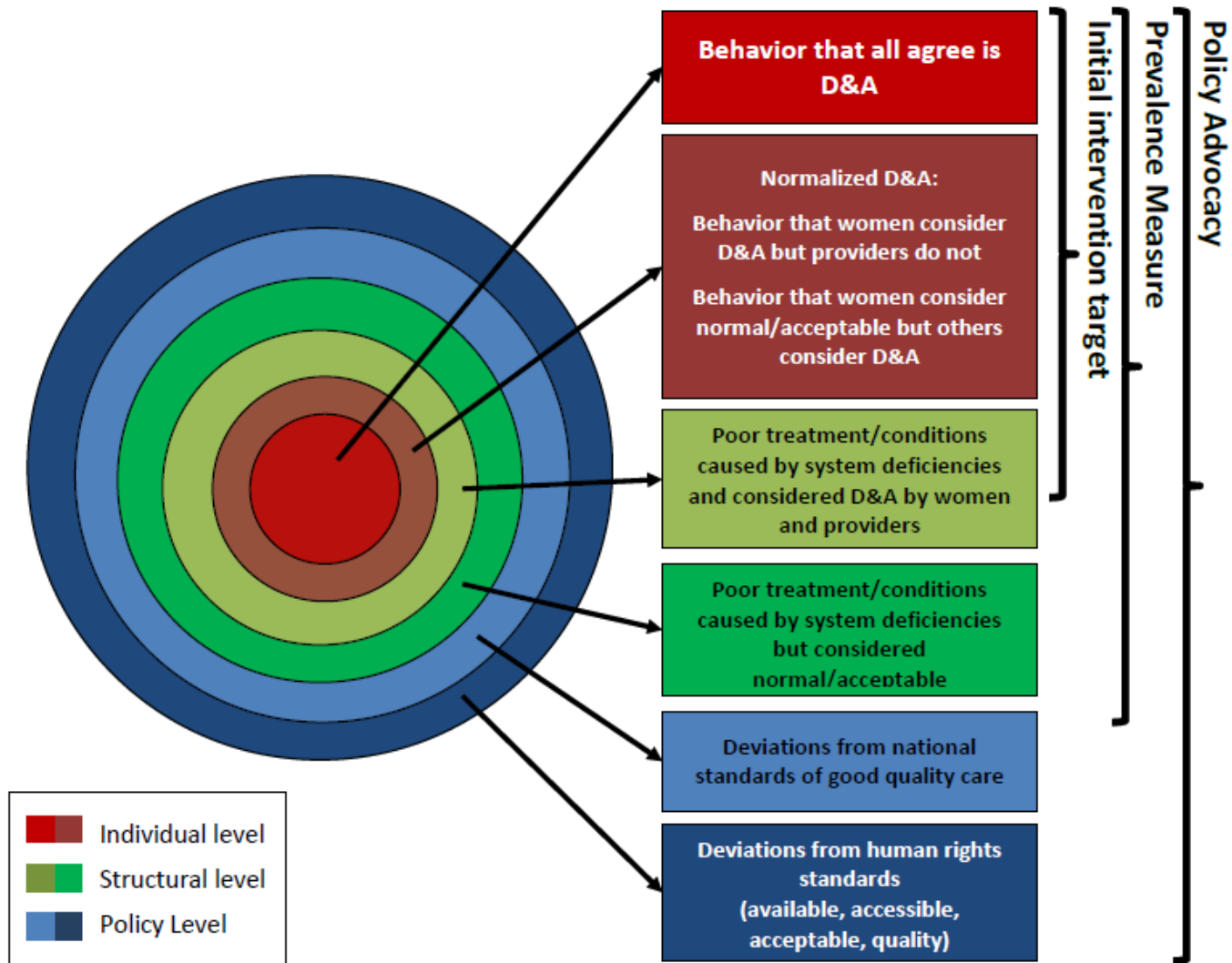
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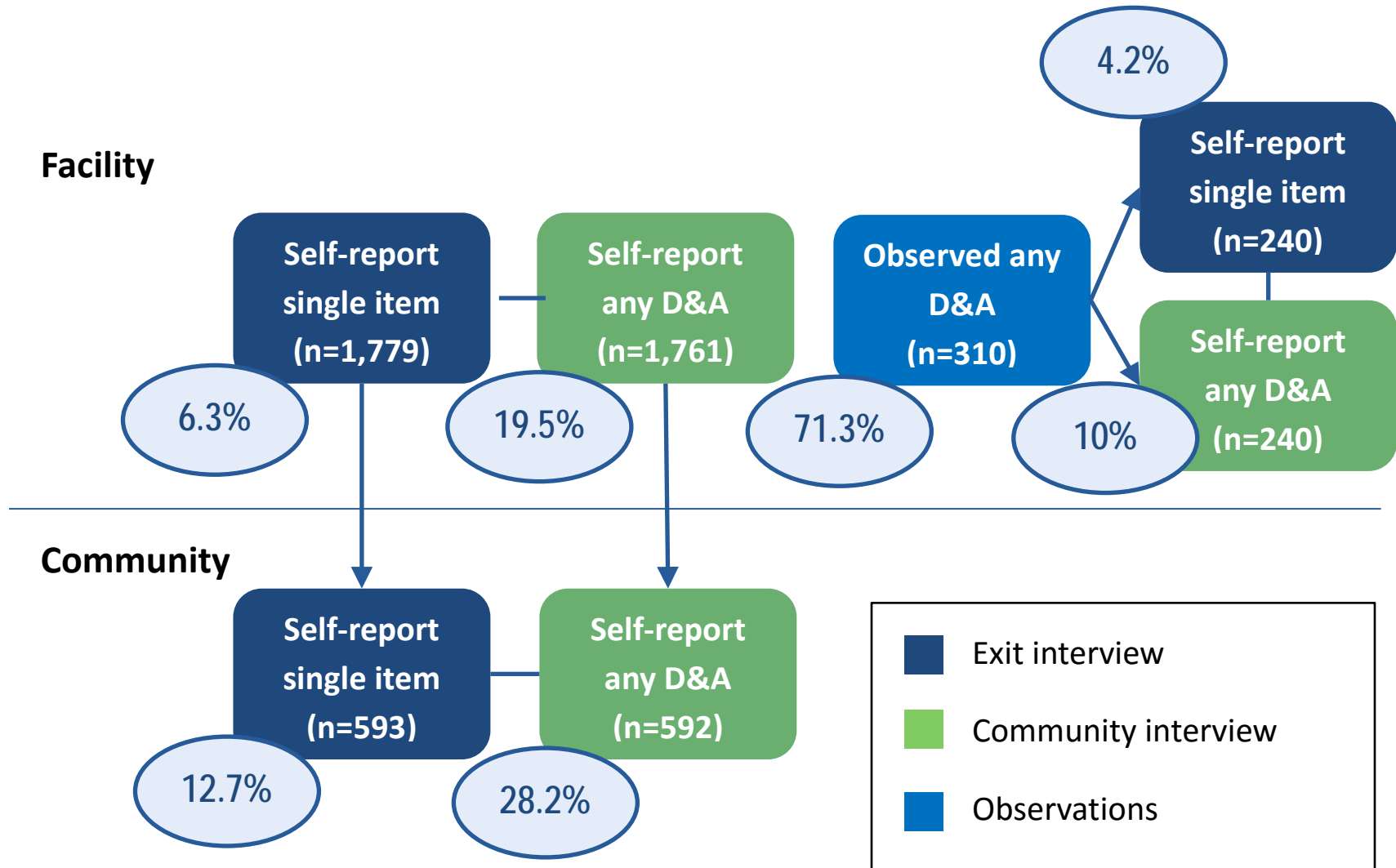
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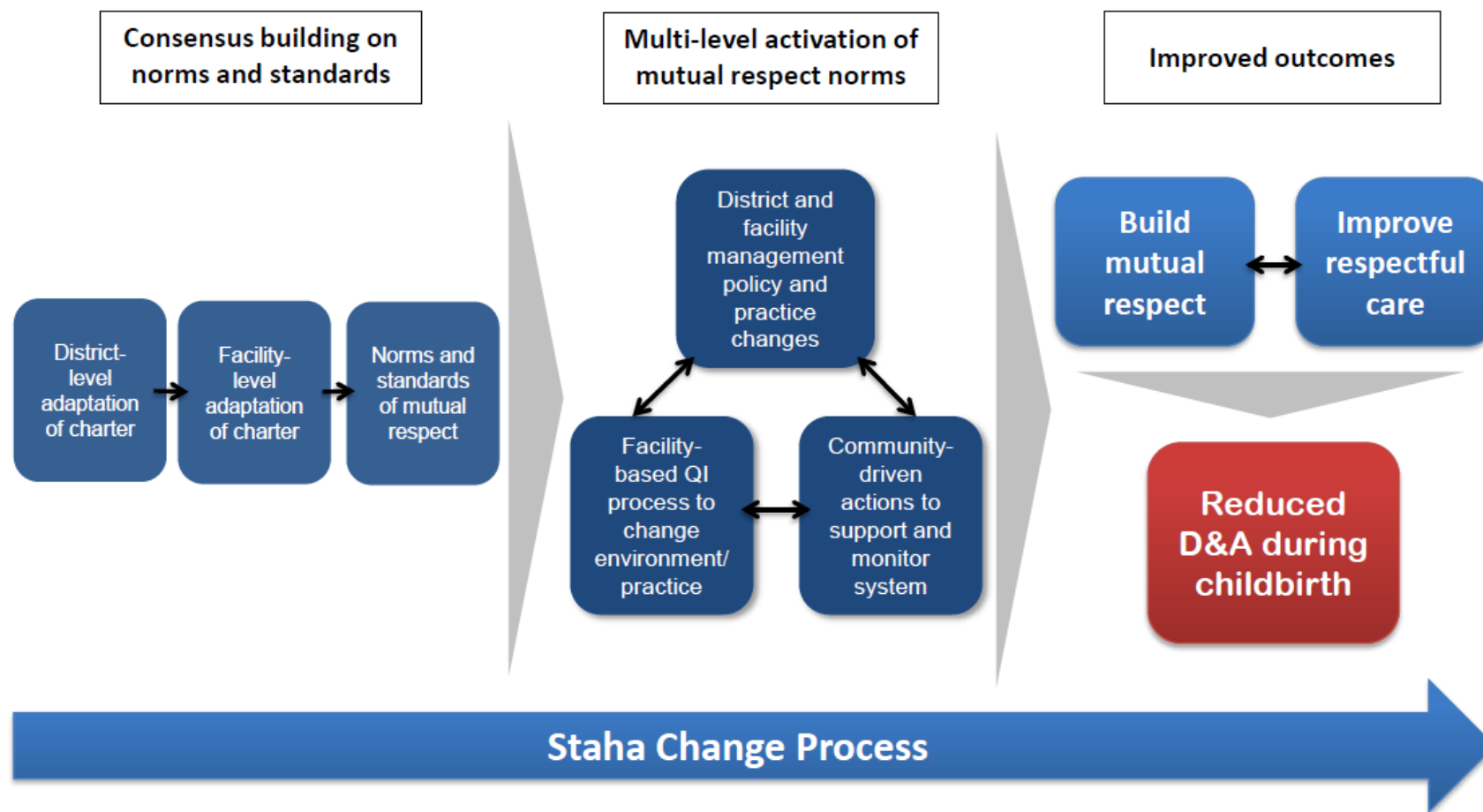
**ANNEX 1: DEFINING DISRESPECT AND ABUSE DIAGRAM**



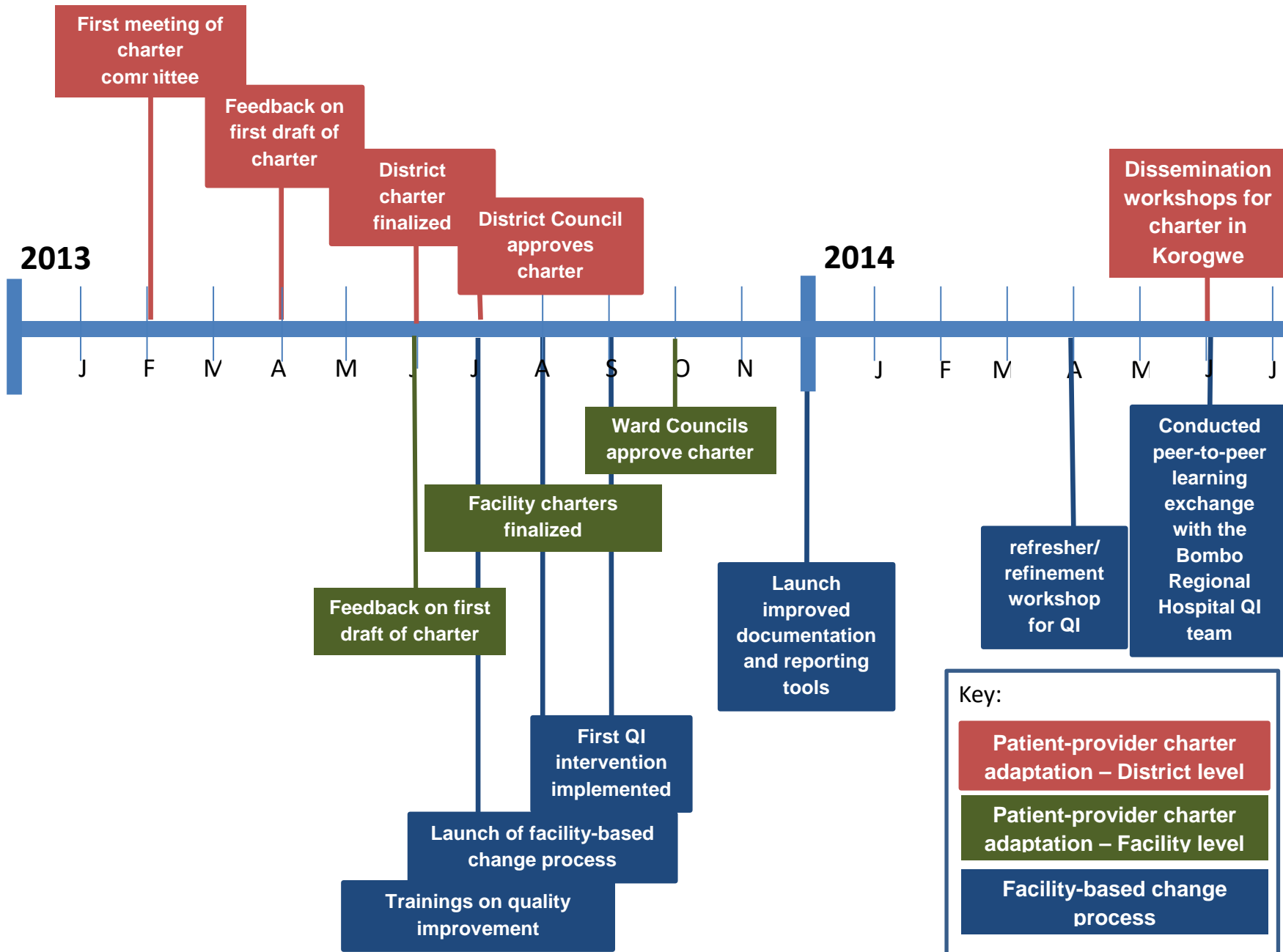
**ANNEX 2: BASELINE FINDINGS ON D&A PREVALENCE BY METHOD**



### ANNEX 3: STAHA CHANGE PROCESS DIAGRAM



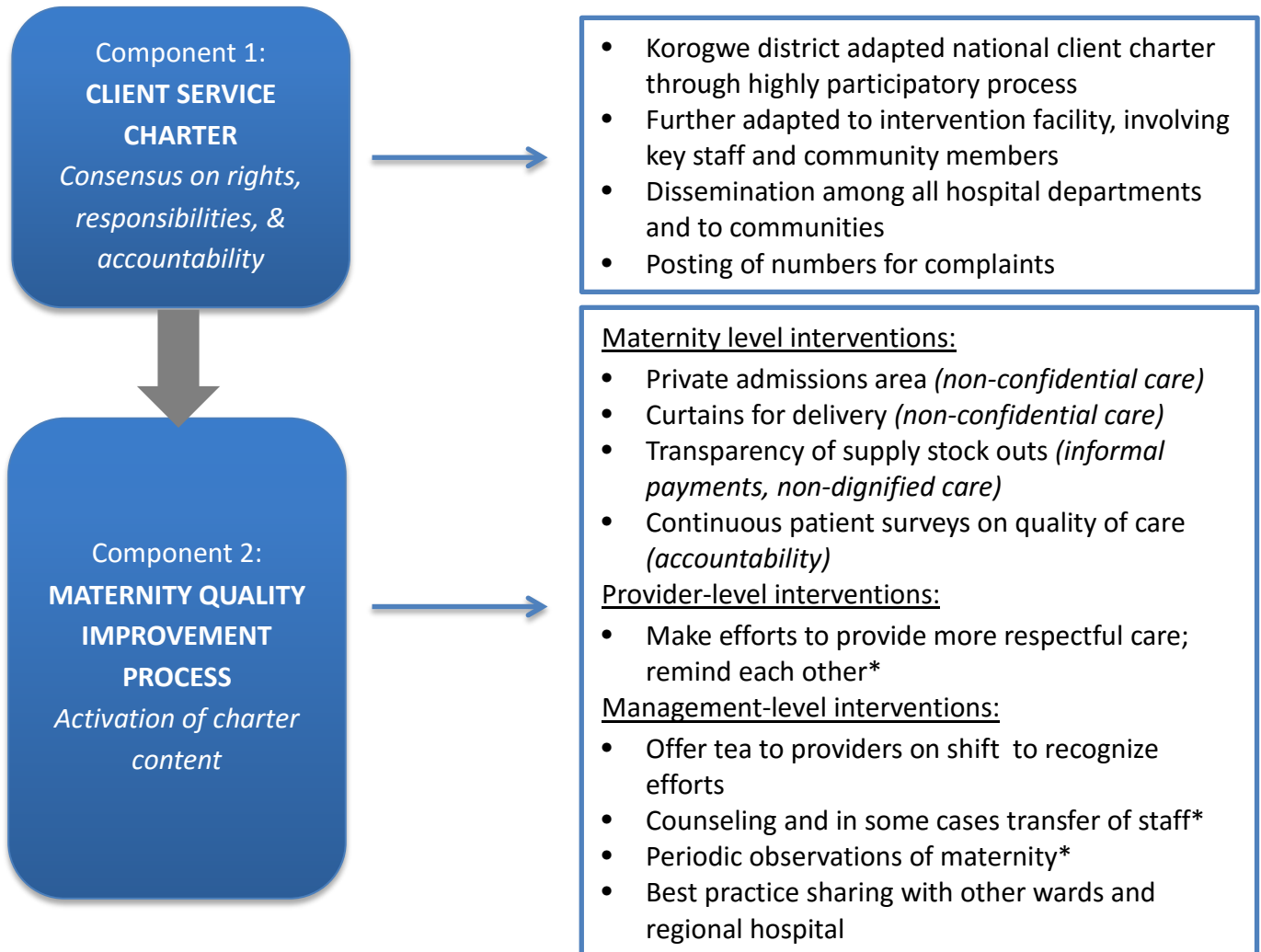
**ANNEX 4: TIMELINE OF ACTIVITIES (FACILITATED IMPLEMENTATION)**



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## ANNEX 5: DIAGRAM DEPICTING KEY ACTIVITIES AT DIFFERENT LEVELS



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## **ANNEX 6: CHARTER SECTION 3: CORE PRINCIPLES IN SERVICE DELIVERY**

### **3.1 Setting Standards of Service:**

We will set clear standards of service that users can expect; we shall monitor and review our performance and evaluate the results.

### **3.2 Be open and provide information**

We will be open and communicate in a clear language with people who are using our services; and we will provide our customers with information about our services, cost (if needed) and our performance annually.

### **3.3 Consult and Involve**

We will consult and involve present and potential users of our services, as well as employees, to solicit their views to improve health services.

### **3.4 Insisting accessibility and announcing quality of service**

We intend to make our services accessible and reachable; giving our clients options when possible to anyone in need. We also use new technology depending on the availability of resources.

### **3.5 Treat all fairly**

We will treat all people fairly, respecting privacy and status, and be humble as we provide special service to those who need special attention.

### **3.6 Put things right when they go wrong**

We will always strive to put things right quickly and effectively, learn from complaints and have a clear procedure of addressing complaints and reviews when possible.

### **3.7 Use of resources effectively**

We will use resources effectively in order to provide best value for taxpayers, partners and users.

### **3.8 Innovate and Improve**

We will continually look for ways to improve services and work tools.

### **3.9 Collaborating with other service providers**

We shall coordinate and translate policies and standards for health facilities (hospitals, health centres, dispensaries, clinics and pharmacies) to ensure good service delivery. We shall collaborate with other sectors, departments, non-governmental organizations and other service providers.



## ANNEX 7: CHARTER DISSEMINATION POSTER



# Mkataba wa Huduma kwa Mteja *Tambua haki zako*

### Haki za mtumiaji wa huduma ya afya

- ❖ Kulalamika au kutoa mrejesho kuhusu huduma aliyopata.
- ❖ Kupewa taarifa anazohitaji kuhusu ugonjwa na matibabu yake.
- ❖ Kutunziwa kwa usiri taarifa zake za kiafya.
- ❖ Kupata matibabu pasipo kusemewa bila ya kukosewa heshima kama vile kukemewa, kukaripiwa au kufedheheshwa.
- ❖ Kupata huduma kwa wakati na kusubiri huduma kwa muda mfupi iwezekanavyo.
- ❖ Kuamua kuhusu tiba anayopata na endapo anataka anaweza kukataa matibabu.
- ❖ Kufuatilia mchakato wa kupata huduma za afya ikiwa ana mahitaji maalumu kama vile ulemavu, ujauzito, watoto chini ya miaka mitano na wenye magonjwa ya kuambukiza.

### Majukumu na wajibu wa mtumiaji wa huduma ya afya

- ❖ Kufuata taratibu na kanuni za kituo cha afya.
- ❖ Kuonesha heshima kwa wahudumu wa afya ikiwa ni pamoja na kuwasemsha kwa heshima.
- ❖ Kumueleza mhadumu wa afya taarifa zozote ambazo zitamuwezesha kutibu vizuri ikiwa ni pamoja na kumpa kumbukumbu za matibabu ya nyuma alizonazo.
- ❖ Kutafuta matibabu kwa wakati mwafaka ili wahudumu wa afya waweze kutoa huduma sahihi.
- ❖ Kukataa kutoa malipo yoyote yasiyo rasmi pamoja na kupatiwa risiti ya malipo ya fedha aliyotoa.

Kumbuka kuwa ili kupata na kutoa huduma bora, wateja na wahudumu wa afya kwa pamoja wanapaswa kuheshimiana. Heshimu ili uheshimiwe.  
Fahamu! Kuelewa zaidi kuhusu Mkataba wa Huduma kwa Mteja kwenye kituo chako cha tiba, wasiliana na Mganga Mfawidhi wa kituo chako cha tiba au Mtendaji wa Kijiji au Mtendaji Kata wa mahali unapoishi.

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## ANNEX 8: MATERNITY PATIENT EXIT SURVEY

Please clearly circle your response. Surveys are anonymous and will be used to improve quality of care at this facility. Your feedback is appreciated.

1. How would you rate the knowledge and competence of health workers for your delivery?

*Excellent*            *Good*            *Fair*            *Poor*

2. How would you rate the respect providers showed you during your delivery?

*Excellent*            *Good*            *Fair*            *Poor*

3. How would you rate the language that the providers used toward you?

*Excellent*            *Good*            *Fair*            *Poor*

4. How would you rate your physical privacy during delivery?

*Excellent*            *Good*            *Fair*            *Poor*

5. How would you rate how well the providers explained things so that you understood?

*Excellent*            *Good*            *Fair*            *Poor*

6. How would you rate the information you received about the availability of drugs, supplies and medical equipment?

*Excellent*            *Good*            *Fair*            *Poor*

7. How would you rate the availability of drugs, supplies, and medical equipment?

*Excellent*            *Good*            *Fair*            *Poor*

8. Did providers come quickly when you called them?

*Yes No*

9. How would you rate the cleanliness of the facility?

*Excellent*            *Good*            *Fair*            *Poor*

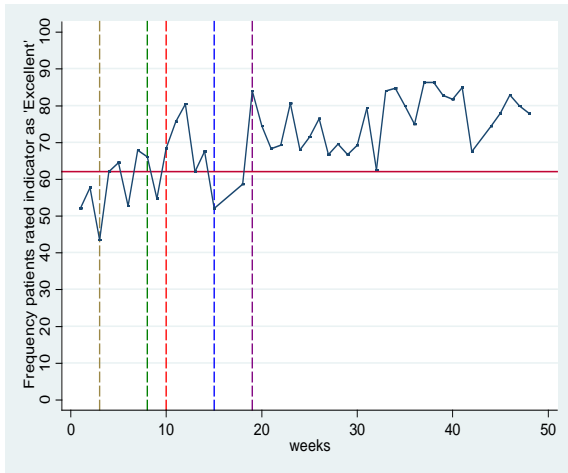
10. Overall, taking everything into account, how would you rate the quality of care you received during your delivery?

*Excellent*            *Good*            *Fair*            *Poor*

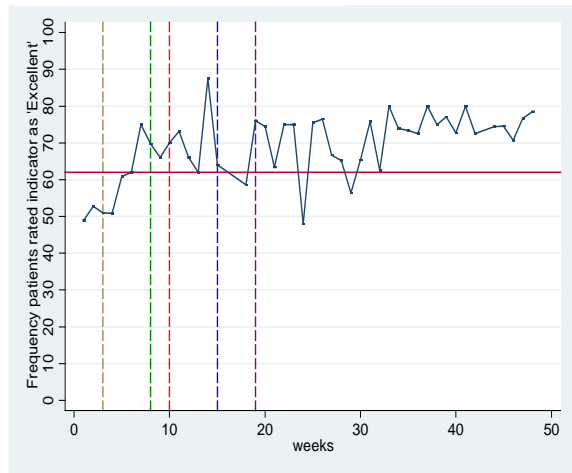
11. General comments / feedback about delivery experience:

# ANNEX 9: RUN CHARTS FROM MATERNITY EXIT SURVEYS

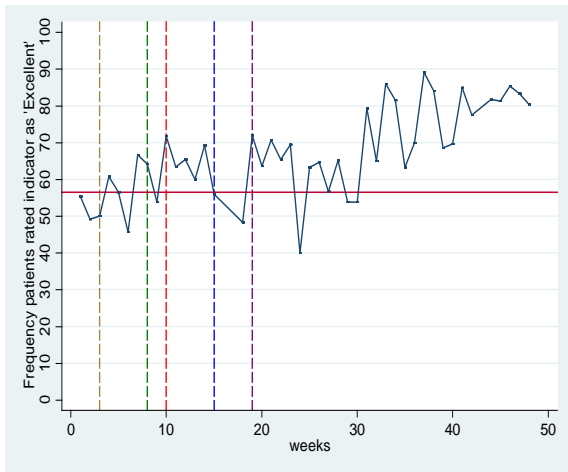
### Provider Respect



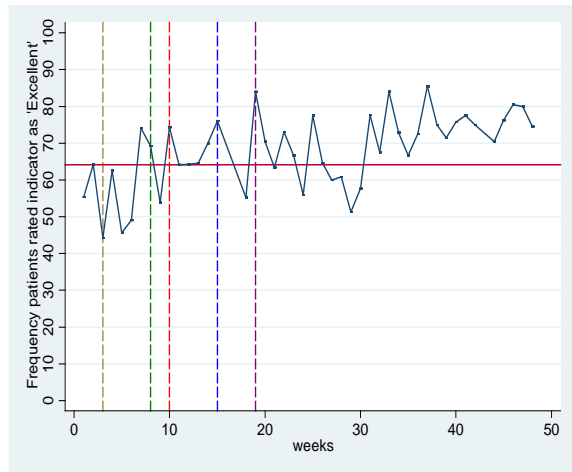
### Privacy



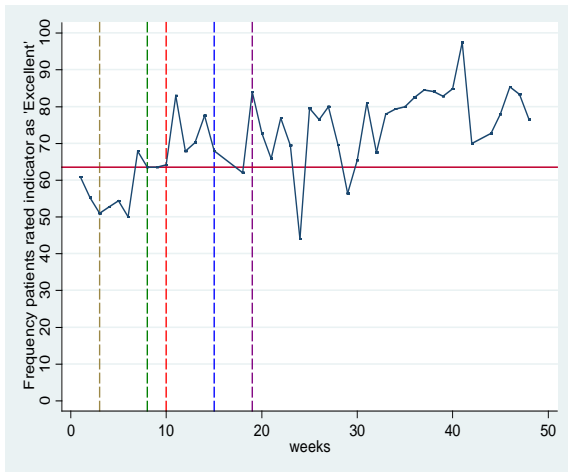
### Language used by providers



### Provider explanations



### Availability of supplies



### Provider knowledge

