How to Make Maternal Health Services More Women-friendly

A Practical Guide

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Acknowledgements

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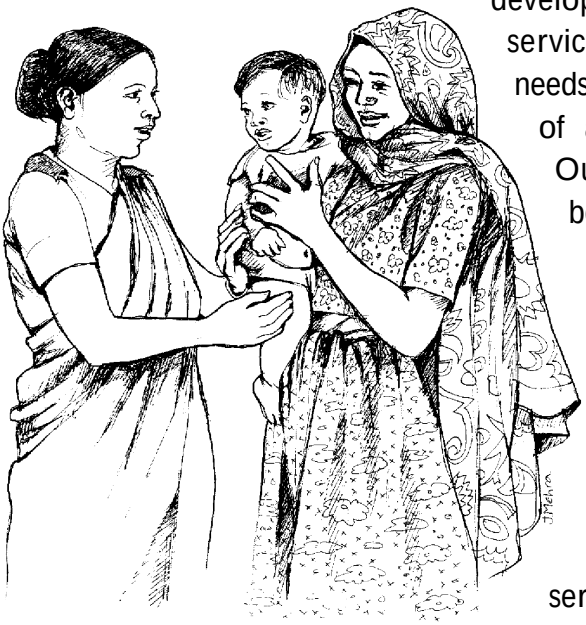
It is about time…

New life cannot begin without pregnancy and birth and yet, even today, with all the scientific knowledge and medical achievements, thousands of women continue to die, or suffer in silence because they do not receive the care they need or the respect they deserve. Our health services could be more responsive to women's needs, and able to provide them with the care they deserve during a dangerous and delicate time in their lives. The survival of the newborns depends on the survival and well being of their mothers.

Women's voices must be heard in the long overdue change in our approach, design, and development of health services to service the needs of an important half of all our communities. Our mothers deserve better.



This guide has been developed for health service managers and health personnel who wish to improve the quality of maternal health services and make them more 'friendly' to women.

Introduction to the Guide

What do we mean by women-friendly services?

In Mexico in 1999, an international workshop sponsored by WHO, UNICEF and UNFPA, recommended that, to be women-friendly, services should:

- **be of high technical quality**
- **be accessible**
- **be affordable**
- **be culturally acceptable**
- **satisfy users' needs**
- **support and motivate providers**

Why are women-friendly services needed?

The Safe Motherhood Initiative has highlighted the need for evidence-based, technically competent care at local level and at referral level (see Annex 2). A lot still has to be done in this area.

Assessments from a number of countries also suggest that the human environment in many maternity care facilities is inadequate and often disrespectful. Emotional care has often been neglected, yet may have important consequences for timely service utilisation of maternal services and therefore affect obstetric outcomes.

Attention to quality of care is important for a number of reasons:

1. The right of all individuals to dignified care.
2. The high maternal mortality ratios in developing countries and the high proportion of avoidable deaths which these reflect.
3 The high incidence of maternal morbidity and the avoidable suffering which these reflect.
4. The frequent under-utilisation of maternity services by those who most need them.

Previous experiences with the health care system and its perceived quality of care may play an important role in the decision to seek, or to delay seeking, medical care in times of need.

The purpose of the women-friendly services movement is to improve the quality of health care, and the responsiveness of health providers to the needs of women.

The lack of 'women-friendliness' often has greater impact on the health of poorer women who are at greater risk of maternal mortality and morbidity. Poor women have less voice and may be more vulnerable to neglect, abuse or poor communication, especially when staff are under pressure.

Poor women's needs must be addressed if there is going to be any significant reduction in maternal mortality and morbidity in developing countries.

Why this guide has been developed

This guide aims to provide low cost tools for improving the quality of services in reproductive health care facilities in resource poor settings. It also recognises that staff need to be affirmed and supported in their work.

The guide starts from the premise that both "technical" care and "emotional" care are essential in these services. Women-friendliness should include both technically sound services and a supportive and respectful human environment.

"The quality of women's health care is often deficient in various ways, depending on local circumstances. Women are frequently not treated with respect, nor are they guaranteed privacy and confidentiality, nor do they always receive full information about the options and services available"

(The Plan of Action of the Fourth World Conference on Women, Beijing 1995)

Who should use this guide?

The guide is primarily meant for senior personnel at district or health facility level who are responsible for providing Safe Motherhood services. However user groups and community-based organisations concerned with reproductive health may also find the process outlined in this guide useful.

How to use this guide

The guide is designed to take you through a step-by-step process of discovery and change. It will enable you to create openness to change, and involve other people who care for women and receive care. It will also help in checking how you are doing. This will assist in designing solutions and making changes for the better.

You can work your way through it with your team in the sequence as it is presented. Alternatively use this guide to design the process that best suits your needs. But, remember not to skip steps that encourage 'working together' and help to create a larger constituency of support for women-friendly services. Have faith both in the process and the cause, and change *will* occur.

The vision

The development of more women-friendly facilities is part of a larger effort to ensure that all women with complications or emergencies are able to reach the right facility and receive appropriate and timely services and care.

It recognises that even if services are technically competent or cost effective they can be impersonal and inappropriate to the needs of women and their families.

There may also be some needs that are specific to a particular

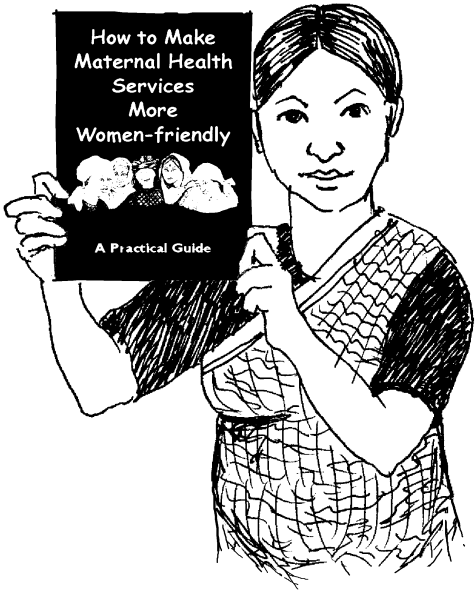
culture or community, such as a preference for female providers. Maternity services need to be women- or mother-friendly and some countries have initiated policies to address this.

Different actors (such as users of health care, clinical care providers, managers or public health programmers) have different perspectives on what health services should provide and how they should provide it, and this framework allows these perspectives to be recognised and explored, and for them to be used in synergy.

Where do we go from here?

This guide outlines a process by which this vision can be translated into practice. All it requires is a genuine commitment to change where change is needed and to respond where response is needed.

We hope you recognise that the journey is inspiring and the destination is worthwhile in your society and for your health services.



What is your vision of women-friendly maternal health services?

My vision of women-friendly maternal health services is:

Getting Started

Working with the women-friendly perspective at country level

All journeys begin with a small step. In this journey to make your health services more women-friendly the first step is to find out what we mean by women-friendly in your country and your society.

What is your vision of good maternal health services for women in your country?

Give each person in your team this worksheet to fill.

Maternal health services in my country <u>should be</u>:

Now compare everyone's worksheets. Write down the main points that your team has suggested about what maternal health services should be.

MAIN POINTS
Maternal health services in my country should be:

Now discuss with your team and write down how this compares with what maternal health services are like in your country.

Maternal health services in my country <u>are</u>:

What are the most significant gaps between what maternal health services should be and what they are?

Most significant gaps are:

What can you do to reduce the gaps between your ideal (what they should be) and reality (what they are)?

What <u>we can do</u> to reduce the gaps:

Save these worksheets. You will find them useful later when you work with your team on the "Diagnosis" section.

The Discovery Process

You have gone through a general understanding of what is meant by women-friendly maternal health services. Now it is time to look more closely and carefully at the services and facilities you work in. This means involving your team and staff in working out ways to make your services and facilities more receptive to women's needs.

This is the beginning of the discovery process in your own work and area. In the next pages you will also learn how the process was applied in a real situation.

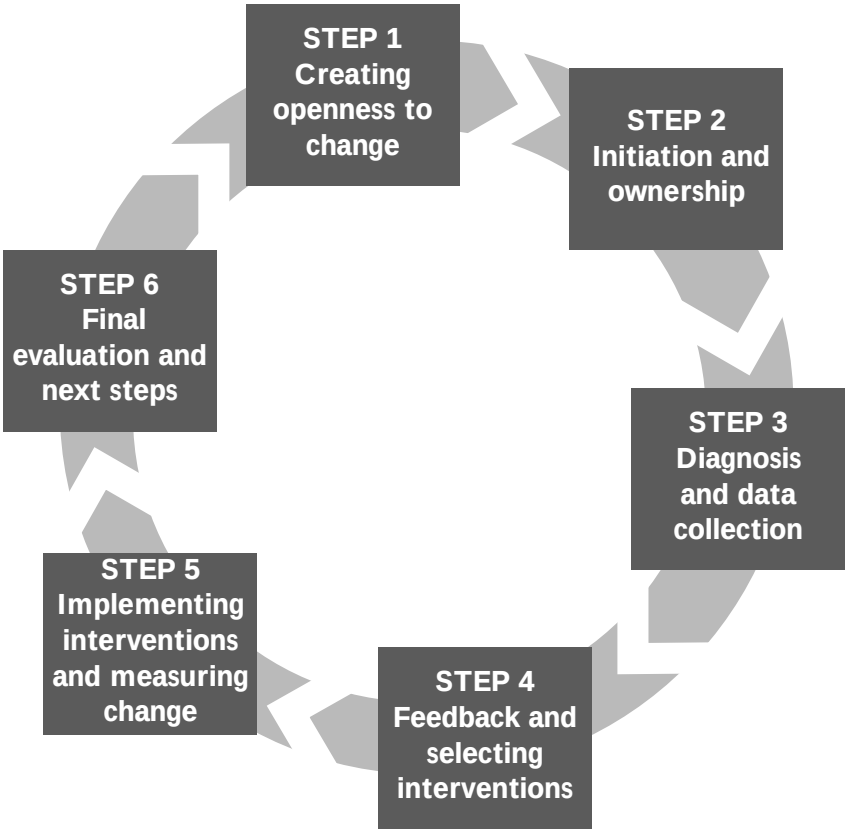
Follow the step-by-step process of discovery and change that could lead to better understanding of how to improve the conditions and situation in your facilities to make them women-friendly.

The six-step process is a cycle of activities. You won't be able to take on everything at once. You can go round the cycle as many times as you wish in order to implement change in different areas.

The process is described with the use of a real life case study from Lusaka, Zambia. This guide takes you through the steps that were implemented and introduces you to the tools that were used to create more women-friendly maternal health services in Lusaka, the capital city.

Lusaka's maternity system is a good model for urban maternity care; it has satellite maternity clinics with beds which are managed by midwives, a referral hospital, and a radio network and emergency ambulance system but even if you are working in a situation with far less infrastructure, you can still use these tools to assess your own situation.

The six step discovery and change cycle for women-friendly maternal health services



STEP 1: Creating Openness to Change

Change does not happen unless people are aware of why it is needed and are willing to embrace it. Creating receptiveness to the concept of women-friendly health services and to the process of change is the first important step if you are to succeed.

a. Believe strongly

To begin this step you need to be sure that you believe in the concept and that you are willing to be involved and are persistent. Your conviction and your commitment will drive the process and encourage others to join in. Believe strongly you can make services women-friendly. Believe you can bring about change.

b. Find partners

The next stage in creating receptiveness is finding appropriate partners who will work with you with commitment and will support each other in the process.

I strongly believe in the concept of women-friendly health services because:

What I am willing to do to achieve women-friendly health services in my area/facility is:

My potential partners in this process are:

c. Identifying stakeholders

Stakeholders are all those persons who influence and are affected by the health services you want to change. These could be those who have the power to influence change. They could be those who will benefit from change or they may be those who do not yet want change or would block the process if they were not involved. Stakeholders include:

- Women users of services
- Husbands and partners
- Managers of services
- Health care providers including ancillary staff
- Community organisations
- Local health committees

d. Involving stakeholders

To sustain the efforts of change stakeholders need to be involved so they support what you are doing. What methods can you use to involve stakeholders?

- Hold a meeting to present ideas
- Produce a poster
- Bring the subject up at staff meetings
- Write a newspaper article
- Speak on the local radio

Who are the stakeholders in your situation?

What methods will you use to involve stakeholders?

What was done to create openness in Lusaka?

An initial assessment of the interest in, and possibilities for, change is always necessary. Most people will "buy in" to the project as the process develops, but the commitment of key senior people to the vision of women-friendly services is likely to be a major factor in the success of this kind of work. In this case the active participation of the Head of the Department of Obstetrics and Gynaecology at the University Teaching Hospital and the Director of the District Health Management Board were crucial. This is because the public maternity services in a primary care and referral hospital setting are provided by these two separate organisations in Lusaka.

Who are the senior people who need to be committed to your process?

Naming the Initiative

What is the best way to name the initiative – so that you create interest and get people involved? In Lusaka the name was chosen through a competition. The announcement for this competition is shown on the next page. The competition was won by a clinic cleaner. To create receptiveness the Lusaka women-friendly services project chose the name ***Bwafwano***, which means, "helping each other."

The name for your initiative is important so that all persons concerned know what the purpose or mission is and also what your approach is going to be. ***Bwafwano*** has a warm tone and implies that we will be working together.

The announcement for the competition in Lusaka

WOMEN-FRIENDLY SERVICES IN LUSAKA
COMPETITION ANNOUNCEMENT

DO YOU WANT TO WIN A TV?!!!

In November we are starting a NEW PROJECT in the maternity clinics and UTH. We will be creating a system for looking at what we need to do to improve the services for women presently on offer. We will be looking at both the technical side of care and at how women feel they are received.

Meetings for all levels of staff will be held at all maternity centres and UTH to explain more and answer questions. The aim is to involve all staff in making decisions about what changes we would make to give a better service. We will examine how our care is organised, looking at information on staffing and referral of women with complications as well as the condition of women and babies. We will ask people in the community, about what they think "women-friendly services" should be.

SO DO YOU WANT TO WIN A TV??

We need a catchy name for this project – in English or in vernacular. The name should convey to everyone what the project is about. If you can think of a good name then you might win a television! Get your ideas in, with your name and contact address and phone number.

All submissions by the end of November please

Creating Interest in Women-friendly Services

Keeping everyone informed is one way of creating and maintaining interest in the women-friendly initiative. This is important because it helps you to ensure that people know what is going on and therefore do not feel left out and create resistance.

In Lusaka this was achieved through developing a simple newsletter called ***Bwafwano*** to keep everyone informed about activities and progress being made. This was displayed on clinic and hospital noticeboards, for staff and service users to see.

Extract from a sample newsletter

A very big THANK YOU to all staff who filled in the questionnaire about their job in December. In all the clinics and UTH 743 people were given one and 412 returned them filled in. Most of you filled in the forms yourselves but we were pleased to get forms from those who had help filling them in because everyone's view is important.

Eighty six per cent (354) of respondents were female and 14% (57) male. Most of you had been in your jobs for a long time too, 78% (322) for more than five years. We are very grateful for all the time and trouble people took with the questionnaire.

Our next step is to ask women in the community about what they think and then to organise meetings where we can discuss suggestions from them and from you.

Good information is the foundation for engaging and involving people and creating ownership in the process of change.

Summarise the steps you will need to take to create openness to change and to increase interest in your initiative

STEP 2: Initiation and Ownership

Information by itself is not enough to initiate and bring about change. Change comes about with more people getting involved, understanding the reason for change, learning about what needs doing through good data, working together to design and implement changes and learning from what works and does not work.

The approach selected should be one that helps to achieve changes in the quality of service provision. Often what is required consists of 'cultural' change within the organisation and amongst staff.

Introducing this kind of change runs into difficulty unless there is commitment and ownership among those required to put the changes into practice. For example it would be possible to rewrite the procedures for admitting and caring for maternity patients and tell staff to implement them. However bringing about and sustaining change this way is often not successful because staff do not feel ownership.

We have to, therefore, improve ownership and commitment all the way through the process. This way change is negotiated with all those concerned, rather than enforced.

Initiation and Ownership in Lusaka

Initiating the process in Lusaka began with the setting up of "initiation and orientation" meetings with the key resource stakeholders. These meetings involved district health officials and senior hospital managers to create a common understanding of the objectives of the initiative and general agreement on the steps that would be used to bring about change.

What will you do to initiate the process and create ownership in your setting?

In order to create ownership in the wider community a Steering Committee was established which included health services managers, representatives from women's organisations and other non-governmental organisations, neighbourhood health committees, as well as District Medical Officers, Nursing Officers and a representative from the Central Board of Health.

Who would you include in your Steering Committee?

The purpose of the Steering Committee was to provide advice and support to the Implementation Team. Its role was:

- To provide a link between institutions implementing change processes and community organisations which can give support
- To review progress and give advice and guidance on implementing changes
- To support changes by publicising them at community level and among service users

The Steering Committee met approximately every three months.

Creating Commitment and Involving Providers

The next stage was creating commitment from health providers. It is important to use the skills, experience and interests of existing staff. For example, there may already be people who have research or training skills that are relevant to the process. One person should take responsibility for coordination. This will mean negotiating time and resources for them to be able to play these roles. Someone who is interested in research would be a good person to coordinate the information collection and synthesis.

Who you would involve and what skillls/experience they have

Who to involve	What experience/skills they have

Here are some of the additional activities carried out in Lusaka to create involvement and ownership.

- Facility-level staff were involved early on through a staff questionnaire asking about their work and their views on the services.
- Different staff members were involved in aspects of data collection during the 'diagnosis'.
- Regular feedback was provided to all the members on all activities and results.
- Meetings were arranged to be informal, with a facilitator encouraging discussion with everyone together.

STEP 3: Diagnosis and Data Collection

You need to find out the strengths and weaknesses of current service provision. This "diagnosis" needs to take account of the views of key stakeholders in your area such as users, non-users, clinical care providers, managers and others and should try to include the public health and social justice perspectives that feature in the "women-friendly" principles. For this, 'mixed' methods of data collection, both quantitative and qualitative, and multiple data sources will probably be required.

You need to start with building up a profile of your maternal health services, and deciding what to look at in more detail. Data cannot be collected on everything at once. The steering committee working with the your team will have to agree what are their priority areas for investigation. To do this they will have to pool their members' expert knowledge of services, the population they serve, and its health and social problems. You will need to begin by collecting together any existing studies and documents that may help you. These will include research studies and government surveys. Annex 5 on resources may also help you think about and define the standards against which you want to measure the quality of your services.

Diagnosis in Lusaka: data collection on current practice

The following pages outline the process of data collection and introduce the tools that were used in Lusaka. You will need to adapt these tools to your situation. A combination of qualitative and quantitative tools are useful.

Take a whole-district or whole-area approach as in most settings births take place in a variety of settings within and outside the public health care system. It is often most useful to think about where your service fits within that bigger picture, even if you are assessing only a single facility.

As a general rule, in your data collection for your 'diagnosis' it is good practice to:

- Consult your staff.
- Consult the people who use and the people who don't use your service.
- Analyse the routine health service statistics.
- Observe the care that is actually being given.

Let us look now at what data sources were used and how in Lusaka. First, what methods and tools were used in Lusaka for all criteria that related to 'women-friendly services'.

Choosing methods for data collection

The overall purpose of data collection and analysis is to assess the extent to which the maternal health services are women-friendly. Therefore, it is important to relate the purpose, methods and questions for data collection to the criteria for 'women-friendly services'.

Methods used in Lusaka

We assessed the women-friendliness of maternity services in Lusaka using four main tools to collect the data:

1. *A community survey* of 1,210 women who had been pregnant in the last two years.
2. *A staff survey* of all cadres in the maternity services in both the hospital and clinics.
3. *Analysis* of the maternal referral system through *routine health service data*.
4. *Observation* of antenatal clinic bookings.

Using these methods in Lusaka, we asked questions about different aspects of women-friendliness which were identified for improvement.

Data collection relating to the six dimensions of women-friendly services

1. *Issues of high technical quality*
   We compared the reported rate of caesarean section and episiotomy from the survey with what should be expected in this kind of population. We observed the clinical care at women's first appointment at antenatal clinic, listening to the questions asked and watching the physical examination. We reviewed labour records and evaluated referral decisions and fetal outcomes. During our observations we noted when care was sub-optimal because equipment was missing.
2. *Issues of accessibility*
   We asked women the name of their nearest health clinic

and how long it would take them to get there, how many antenatal check ups they had had and where they had delivered their baby. From the community survey we were able to estimate the coverage rates for ante-natal, delivery and postnatal care for the system as a whole and for different levels of facility. If women had their delivery at home we asked them why.

3. *Issues of affordability*
   We asked women about the cost of having a baby and how difficult it was to manage. Staff told us about resources available to them. We tried to see if there were any women in particular who were finding it difficult to afford their maternity care.
4. *Issues of cultural acceptability*
   In the community survey we asked about what women found acceptable or unacceptable about their care.
5. *Issues of user satisfaction*
   We asked many questions about the women's perceptions of the care they had received and what they felt to be most important and where there were problems. We looked for areas in which staff felt they needed more training or support. We also asked staff how care could be improved.
6. *Issues of support and motivation of providers*
   We asked staff in the survey about their work. We noted competence when we observed the antenatal bookings.

From the following table you can see that the community survey was an important source of information in Lusaka but took up a large part of our resources. If you cannot afford to do a community survey there are useful alternatives: for example you could use a survey of women at the baby immunisation clinic, plus some focus

groups in the community to get view of women who didn't use the service.

The following table summarises the main methods used for data collection in Lusaka.

Dimensions of women-friendliness	Main methods used in Lusaka
High technical quality	Community survey Observation of care Record review Routine health service data
Accessible	Community survey Focus groups
Affordable	Community survey Focus groups
Culturally acceptable	Community survey Staff questionnaire Focus groups
Satisfy users	Community survey Observation of care-giving Focus groups
Support and motivate providers	Staff/provider Questionnaire Observation of care-giving

1. Developing the Community Survey

The views of service users and non-users are crucial to any attempt to make services more women-friendly but it is important to ask them the right questions in a way which obtains their views clearly.

Use of focus groups

The function of holding focus groups with local people is to find out what they know about the present services, how they perceive what is available and what they feel about the way care is given. Their responses can be used to design questions for a community survey if one is to be carried out. Another function is to find out the words local people use to be able to ask questions in a locally appropriate way. You should have several groups with different types of participants who may have differing perspectives.

Participants in focus groups

- Women who have had a baby in the last two years – older women with one child already.
- Women who have had a baby in the last two years – younger women having their first child. These groups should be held separately because young women can be sometimes inhibited by those with more experience.
- Male partners of women who have had a baby in the last two years. Men can play an important role in providing support (or not providing it) to women when they are pregnant. It is important to know what they think.
- Influential older women.

If mothers or mothers-in-law in your community are decision makers in households, it will be important to hold a group with them too.

Hold a practice group first. You will need to try out techniques of recording what people are saying while reassuring them about confidentiality. You will need to think about a good place to hold the groups; in Lusaka groups were held in both non-bed or first level clinics and second level or clinics with beds. Women with babies at the vaccination clinic were asked if they would come to a discussion. There was a room set aside for the purpose.

The facilitator gave an introduction in the commonest local language although he and the notetaker also translated and interpreted for people from other tribal groups.

Introduction by facilitator in Lusaka

"Thank you for coming to our focus group on maternity services.

We are working with the clinics and UTH to move towards what we call a women-friendly service. This means trying to make women feel that they will be welcomed and looked after when they come for care.

We are interested in what you think of the service at present and how you think it could be better. There is no right answer; we want to hear different opinions! We would like your permission to tape record the discussion.

We will call you by the colour scarf you are wearing, (hand out scarves of different colours) Mrs. Green, Mr. Brown and so on so that we do not say your name.

We will write notes and later a transcript of the discussion but will not show it to anyone else, simply take out some comments. Can we have your permission? Then we will start the discussion."

Focus group questions for the women:

- Please tell us about your experiences when you had your baby.
- Please tell us about your experiences when you went to the clinic for antenatal care.
- Please tell us about after you had the baby.
- What was good about the care?
- What was bad?
- What would you do next time you were having a baby, or what would you tell a friend?

(the men were asked "Please tell us about your experiences when your partner…")

The facilitator thanked everyone at the end of the session and gave them a drink. He transcribed the tapes (wrote down the conversation word for word). All points made were listed and those most commonly voiced were put into the community survey which is reproduced in full in Annex 4.

Conducting the survey

Lusaka has nearly 50,000 deliveries per year. A large enough sample was needed to represent the views of the large number of women in the different areas of Lusaka. Therefore, the community survey consisted of 1,210 women who had been pregnant in the last two years. The survey was carried out by a team from the Central Statistics Office who based the sample on the listings of compounds, census supervision and enumeration areas. The size of the sample depends on the total population to be surveyed and the number of different variables that need to be represented. If the area your programme covers is smaller you will need a smaller

sample. Consult the local statistics or demographic health survey personnel to help you with sampling.

The community survey explored issues of access, utilisation and quality of care in the maternity care services. We were fortunate to be able to do a large and comprehensive survey. You may not have the resources for this. Useful alternatives are:

- Focus groups
- Interviews with women who bring their babies to vaccination clinic. (*Childhood immunisation rates are high in Lusaka; most women bring their babies to the clinic so this was a good way of getting their opinions but of course it does exclude those whose babies have died.)*
- Meetings with local community representatives such as neighbourhood or district health committees, church groups and mothers groups.

Results of community survey

The results of the community survey are presented in the context of the six criteria for 'women-friendly' services. This helps to identify areas where there are the biggest gaps that need special attention and improvement. In Lusaka many of the results were very positive, there was good care which was appreciated by the women. It was important to tell the staff this and it helped foster openness to the changes that were needed.

In addition the community survey also asked women for suggestion for improving maternity services in Lusaka. 73% of women who delivered in Lusaka made suggestions.

Of the women who responded:

Dimensions of women-friendliness	Positive findings from community survey
High technical quality	99.5% of had at least one antenatal checkup 67% had five checkups or more
Accessible	89% had delivered in a clinic or a hospital 91% said it took them 5 minutes or less to get to a clinic
Affordable	70% did not find it difficult to pay for expenses related to delivery 95% had to buy some item for the delivery
Culturally acceptable	58% remembered someone who had done their job well during delivery
Satisfy users	88% said that maternity care was 'good' or 'very good'
Support and motivate providers	Not covered by the community survey, see staff questionnaire

Dimensions of women-friendliness	Negative findings from community survey
High technical quality	16% wanted health resources, such as equipment and drugs, to be improved
Accessible	12% wanted midwives to always stay near women during labour
Affordable	20% wanted charges for poor women to be dropped
Culturally acceptable	12% wanted the cleanliness of the facility to be improved
Satisfy users	65% wanted staff attitudes to be improved 21% of women remembered someone who treated them badly
Support and motivate providers	Not covered by the community survey, see staff questionnaire

These results significantly influenced the types of interventions that were implemented to make services more women-friendly.

2. Staff Questionnaire

Staff views on their work, and their opinions on the quality of service currently given, were collected through a self completing questionnaire, and the results were fed back to the clinics and hospital in the form of the project's first newsletter. Key non-medical staff that often play "gatekeeper roles" in health services such as cleaners and guards were consulted along with doctors and midwives, and a number of these were also asked to give in depth interviews. This data collection was carried out early on in the process because it also was was an important tool towards getting staff involved in the process at facility level, and helped us to know what interventions might be well received and supported by staff.

The staff questionnaire from Lusaka

Thank you for taking the time to help us with our women-friendly services project. We are asking staff how they think care could be improved. This form does not have your name on it and only the researcher knows each person's number. So please feel free to say what you think.

First some personal details

Sex Age School grade

Years in job Hours of work

Please write what you think in the space below each question. If you don't have anything to say move on to the next question.

1. What do you like about your job?

2. What do you find frustrating?

3. What would help you to do your job better?

4. What would help make it a better service for women?

5. Are there any particular groups of women who need more help from the service than they currently get? Who are they?

6. If yes what extra could be done?

Thank you very much.
Please put the form in the envelope and seal it.
It will be collected from…

Results of staff questionnaire included:

Characteristics of respondents	Number
Enrolled midwives	190
Casual daily employees/maids	82
Registered midwives	76
Guards	39
Doctors/clinical officers	15
Clerks/cashiers	6
Clinical teachers	4
Total staff responses	**412**

What they most commonly liked about their work:

(The percentages do not add up to 100 because staff did not always answer the question and sometimes gave more than one answer)

Top three	Percentage
Curing sickness	35%
Caring for/assisting a health process/birth	26%
Feeling of self worth	26%

Commonest sources of frustration:

Top four	Percentage
Lack of physical resources	62%
Poor rewards for staff	33%
Lack of human resources	27%
Lack of respect from colleagues/the public	21%

Staff suggestions for how to improve services for women:

Top three	Percentage
More equipment and facilities	35%
Increased communication/participation	31%
More education of women/staff	25%

Groups of women who need more help from the services:

Top three	Percentage
The poor/uneducated and those with social problems	26%
Adolescents	24%
Widows	59%

Principal interventions suggested by staff:

Top four	Percentage
Education/training/ counselling	40%
Home visits/transport for visits	17%
Donations of money/equipment	17%
Clubs where women can learn skills	15%

3. Routine health service data

Reviews of records of care such as registers, medical notes and partographs help to assess current utilisation patterns of the maternity services by women with obstetric complications, referral patterns between clinical and hospital levels, or the quality of clinical care and decision making in selected facilities. Staffing levels and staffing patterns can also be documented.

The quality of records in Lusaka was quite good, making it a worthwhile exercise to examine individual cases and how a particular case had been managed. You will need to look at some registers or notes to decide if, in your area, the records are complete and accurate enough to do this. Do they seem strangely uniform, with all measurements being the same? Are essential factors like times, diagnoses, or who was present omitted? If the answer is yes to any of these questions then it may not be possible to use records to asses what really happened. Spending valuable resources on examining records would not be productive at this point, but you may decide that better record keeping should be the focus of some new staff training as part of your women-friendly services initiative.

Referral rates for complications in labour from the clinics to the hospital were also calculated in Lusaka. The equation was

$$\frac{\text{number of women in labour referred to hospital}}{\text{number of women in labour referred } \textit{plus} \text{ number of women delivered in the clinic}} \times 100 = \% \text{ referred}$$

The main reasons for these referrals and how the system was currently working were assessed and the clinics with the highest and lowest referral rates were examined in more detail over a two month period.

Form to trace a woman who has been referred

ADMISSION REGISTER

Date

Age of mother

Parity

Reason(s) for referral

Code of Referring Clinic

MEDICAL NOTES OF LABOUR

Any antenatal risk factor (taken from list used by clinics)

Mode of delivery

Other management (syntocinon etc)

Standard of maternal observations? (good/ intermittent/not at all)

Standard of fetal observations? (good/ intermittent/not at all)

Decision/intervention time interval

Continued on next page

Baby – alive/stillbirth

If stillbirth – fresh or macerated

Apgars at 1 minute and 5 minutes

Baby to special care? yes/no

Mother alive/dead

PPH yes/no

Partogram used/not used

Partogram construction (lines correctly plotted)

Labour line to left of alert line yes/no

Labour line crossed alert line yes/no

Labour line reached alert line yes/no

Reason for referral to UTH

Length of time between call to ambulance service and arrival at hospital

Referral form used yes/no

Results from routine health service data included:

Over the two-month period the review of registers showed a total of 2,847 pregnancy related referrals to the hospital:

Antenatal/Gynaecology referrals	2,080	73%
Labour referrals	678	23%
Post natal referrals	89	3%

Clinic A had the highest referral rate for women in labour, 11% and Clinic B the lowest referral rate, 5%. On examining the clinic records in detail in most cases the decision to refer or not was appropriate. Most of the time, partographs were used correctly in both clinics and were a good aid to decision making.

This examination of existing data about referrals showed good practice in Lusaka and was another positive result to tell to staff.

4. Observations of clinical care

A senior midwife carried out observations of antenatal consultations in a sub-sample of clinics and in the University Teaching Hospital antenatal clinic. Antenatal care was chosen because observational work already existed concerning standards of labour care at UTH, and the project also had detailed information from the community survey concerning women's most recent experiences of labour and delivery care. A situation analysis of family planning services had also recently been carried out in Lusaka.

The Lusaka team developed a tool for assessing the quality of antenatal care. This was based on what experienced midwives said was the routine booking interview and examination and linked to a conceptual framework for quality of care developed by Bruce and adapted by Mensch. There is a reference for this framework in the resources annex. This tool does not include organisational structures of health care, but is useful for other aspects.

Two elements of women-friendlyness were dealt with by the observations of antenatal care. These were the technical quality of history taking, examining and informing the woman and the cultural acceptability of the behaviour of the midwife in terms of appropriate ways of communicating, maintaining privacy and allowing questions.

OBSERVATION TOOL

Y = yes N = no N/A = not applicable

Welcome

Greeted woman in polite manner	Y/N
Sat down with client for history taking	Y/N
Ensured privacy	Y/N

Took medical and obstetric history

Medical – Checked if following in self or family

Diabetes	Y/N
Hypertension	Y/N
Epilepsy	Y/N
Kidney disease	Y/N
Sickle cell	Y/N
TB	Y/N
Cardiac abnormalities	Y/N
Past injury or surgery	Y/N

Obstetric – Asked if any previous pregnancies – if yes asked

Miscarriage	Y/N
BP	Y/N
Eclampsia	Y/N
APH	Y/N
Operative or normal deliveries	Y/N
PPH	Y/N
Sepsis	Y/N

Babies Asked if any stillbirths/premature/small for dates/sick

Took history of present pregnancy

LMP	Y/N
Gave woman EDD	Y/N
Quickening	Y/N
Asked if any vaginal discharge	Y/N

Explained the need to take blood for Hb and RPR Y/N

Took blood Y/N

Prepared for examination

Made woman comfortable for examination	Y/N
Checked privacy	Y/N

Carried out physical examination

BP – taken	Y/N
Anaemia – checked	Y/N
Abdomen – inspected for scars etc	Y/N
Palpation – of fundal height	Y/N
Lie and presentation	Y/N
Listened to fetal heart	Y/N
Assessed any complaints made during history	Y/N

Explained findings of examination Y/N

Told about iron, side effects and reassured about size of baby Y/N

Listened to woman when she spoke Y/N

Told about danger signs requiring health care straightaway Y/N

Referred

Took appropriate action on any abnormality found Y/N/NA

Referred if necessary Y/N/NA

Informed

Why referred to UTH and how to go Y/N/NA

When to return for check up and when clinic open Y/N

Gave choice

That husbands can come to clinic and classes Y/N

Overall quality of interaction

Gave woman chance to ask questions Y/N

Conducted interaction in a respectful manner Y/N

Avoided moral judgements Y/N

Spent adequate time with woman Y/N

Kept confidentiality Y/N/impossible to tell

Consultation disturbed how many times in total

Results from observations:

The overall quality of the interactions in the observed consultations was good. They were conducted in a respectful manner, women were greeted politely, midwives sat down with the clients to take histories, women were given a chance to ask questions and no inappropriate moral judgements were made.

History taking was of a generally good standard, personal and family medical history was complete with a few omissions. The history taking about the present pregnancy was good except the midwife seldom asked if the woman had a vaginal discharge of any kind, perhaps because privacy was a problem.

The standard of physical examinations was good, women were made comfortable, their modesty was respected, their blood pressure was taken and signs of anaemia checked, abdomen examined and palpated.

The need to take blood for haemoglobin and syphilis testing was well explained. Blood was taken for routine testing except in one clinic where there were no gloves.

All women were given information on when to return for the next checkup and clinic opening times.

However, examination findings were only explained to women in about half the cases. In only half the consultations were women told about the danger signs for which they should seek immediate medical attention. These were areas where improvement was needed.

In this section we have tried to give you a flavour of the kinds of data collection that you can do. Please refer to the resources list for further help on methods. If no one in your team has prior experience of research, you will need to get advice on study design and analysis of information before you start data collection. This could be from other government departments, universities or research centres.

You can use the worksheet on the next page to help you to work out what data you need to collect in your area to complete the diagnosis of the "women friendliness" of your services .

Choose your methods according to the questions to ask the question you want answered; but remember: using a mixture of different methods will give you a better picture.

Always involve staff and community in some way.

Your context – identifying your information gaps

Use this worksheet to note down the aspects of your maternal health services that you need to collect more information on

Dimensions of women-friendliness	What do we want to find out?	What method could we use?
Issues of high technical quality		
Issues of accessibility		
Issues of affordability		
Issues of cultural acceptability		
Issues of user satisfaction		
Issues of support and motivation of providers		

Now adapt the Lusaka tools, or design your own, to collect that missing information and to make your own "diagnosis" of the current state of women-friendliness in your own maternity services.

The Change Process

STEP 4: Feedback and Selecting Interventions

After the data has been analysed you will need to prepare a series of presentations in a format that can be understood by all the staff and other stakeholders concerned. The implementation team needs to plan the workshops carefully so that they accomplish three tasks:

1. Feedback of findings.
2. Decision making by staff on what areas they would like to improve at this point in time.
3. Identification of specific interventions in these areas (see Step 5).

You will need to consider the resources available for feedback. Ideally you could hold a series of feedback sessions for different categories of staff, and then a final meeting for representatives from those meetings. If that is not feasible, you could instead hold a larger meeting with representatives from different areas but you will have to ensure that the rest of the staff are kept informed of what is going on. It is important to find people with good facilitation skills to run these meetings.

Feedback in Lusaka

A feedback workshop was held with some 60 staff representatives from the clinics and University Teaching Hospital. This workshop

discussed project findings and selected which interventions could be tried to address issues coming out of the study. Positive findings are important as well as those which show need for improvement. Maternity care utilisation rates in Lusaka seemed to be good compared with many urban African settings, and many women reported themselves to be satisfied with the care they receive so this positive message formed the background to the feedback workshop for maternity service staff.

The group work had two aims, to brainstorm ideas for realistic interventions and to come up with a simple action plan. Each group was allocated a facilitator. The facilitator's role was to keep time and ensure that every person could contribute their ideas. At the start a group member was chosen as rapporteur to give feedback to the plenary session and this person was given flipchart paper and pens. In the brainstorming, anyone could offer an idea and the rapporteur wrote down all suggestions.

When the group moved on to choosing an intervention, if there was more than one suggestion there was a discussion about which one(s) the group thought were most appropriate to take forward. Finally the groups discussed the following questions: what resources were needed for the chosen interventions, for example peoples' time, training and equipment; who would be involved; who would take the lead and what was the next thing that needed to be done. The rapporteur made a list for the plenary session.

Sample agenda from the feedback workshop

WORKSHOP AGENDA

8.30 - 9.00	Welcome and introductions:
9.00 - 10.15	First feedback session and discussion: • Community and staff surveys
10.45 - 11.30	Second feedback session and discussion: • Clinic observations
11.30 - 12.15	Third feedback session: • Referrals • Maternal mortality
12.15 - 12.30	Key themes from the data collection to be developed in the group work
1.30 - 2.30	Small group work on interventions and moving forward
2.30 - 3.00	Plenary: feedback from groups
3.00 - 3.45	Discussion and next steps

Areas identified from diagnosis where change was needed

- Improving staff attitudes and the way women (and other staff) are treated.
- Improving women's experiences of childbirth by offering them the option of a companion during labour
- Providing more help for poor women.
- Improving staff skills in the areas of staff support and supervision and resource management.
- Increasing information and understanding in the community.

The list of interventions was discussed at a meeting of the head of obstetrics and gynaecology at the hospital and the director and deputy director of the district health management team. This was to ensure that the team did not try to implement anything which a key stakeholder thought was unrealistic or unhelpful, For example, during this meeting it was decided that it was best to focus on informing men what their partners needed for the delivery rather than trying to hand out birth kits or set up schemes for poor women to earn money.

Specific interventions selected in Lusaka

Ideally most interventions need to run for about a year in order to collect good pre- and post-intervention data and to have a realistic chance of creating a change. Staff in Lusaka identified six interventions as ways of improving services still further.

1. Interpersonal skills training for maternity service staff particularly midwives and cleaners.

Aim: To reduce the incidence of women clients being scolded and shouted at, and of staff complaining of lack of respect from colleagues.

2. Training for maternity service managers (District and UTH) in staff support and appraisal methods .

Aim: To improve support and motivation for junior staff.

3. Offering women the option of a chosen (female) companion with them in labour and the option of husbands accompanying them to antenatal care sessions if they preferred.

Aims: To offer women a better labour experience, possibly improving outcomes by reducing anxiety which can impede progress in labour and to improve men's understanding on women's needs in pregnancy.

4. Improving the explanation of the processes and procedures in the clinic, and by improving advice on danger signs in pregnancy.

Aim: To improve women's understanding of examinations and findings, of how pregnancy progresses and when to seek help.

5. Transport for women in labour from home to clinic.

Aim: To reduce the numbers of women who stay art home and do not seek skilled attendance because they find it difficult to get to the clinic.

6. Training managers in skills for ordering and managing supplies.

Aim: To reduce shortage in basic supplies caused by bad management

STEP 5: Implementing Interventions and Measuring Change

Usually you will want to "pilot" your interventions in a few places first. It is also important to collect "before and after" data so that you know the impact, if any, of the intervention. The four stage mini cycle for implementing change, is shown on the next page. It includes:

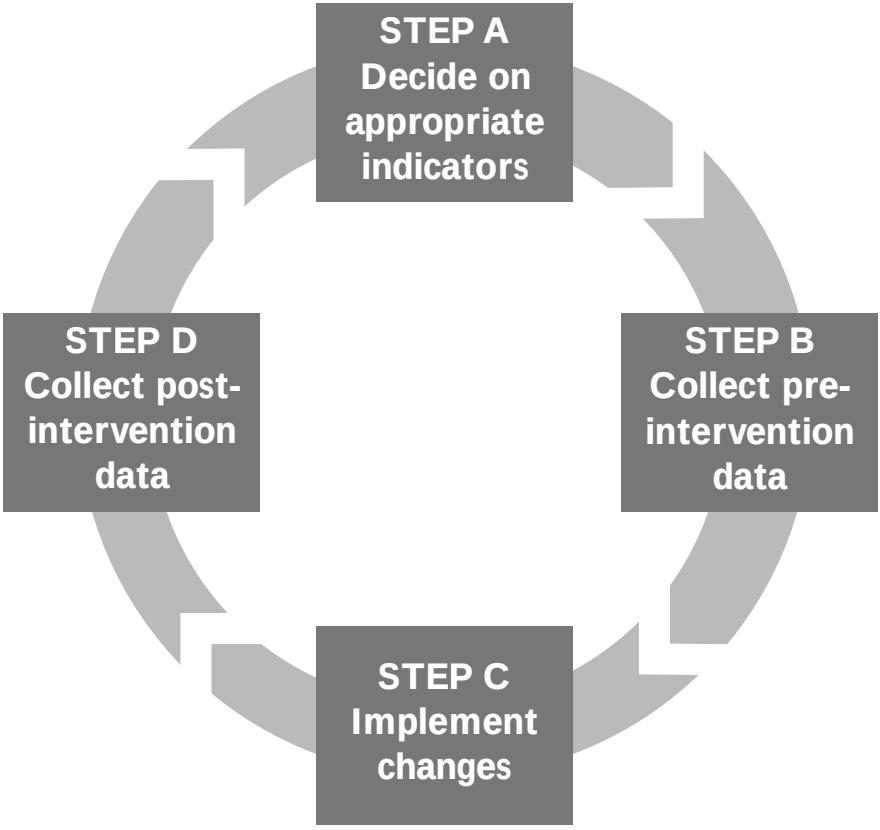
- Deciding on appropriate indicators
- Collecting pre-intervention data
- Implementing change or interventions
- Collecting post-intervention data

Deciding on appropriate indicators

Good pre-intervention data is essential for measuring the effectiveness of interventions. Interventions need to be piloted in selected clinics or hospitals, and evaluated against pre-intervention data to assess their efficacy in achieving women-friendly objectives. It can be helpful to decide on a suitable 'standard' and indicators for each intervention you aim to pilot. The standard is what you hope to achieve and the indicators are the tools by which you measure progress towards your standard. Many indicators are quantitative in nature; they measure progress numerically. However it is often appropriate also to collect qualitative data to interpret your findings and why change did or did not occur.

In the next few pages we give examples of a standard with indicators and pre- and post-intervention evaluation tools. Then we take you through a successful intervention from the Lusaka project.

Mini-cycle for Implementing Change



Example of a standard and indicators for a pilot intervention introducing female labour companions

Standard: All women who want it, receive social support from a chosen female companion during labour.

Indicators: Percentage of women in labour at the pilot facility during the intervention time period who were offered the option to have a female labour companion,
Percentage of women wishing a female labour companion who had one.

Other information you may need to collect: Women's reasons for wanting or not wanting a labour companion, women's accounts of the positive and negative aspects of the experience of having a labour companion, midwives' accounts of the positive and negative aspects of care-giving with a labour companion present.

Data sources: Facility registers, post-natal interviews, provider interviews.

Note: Involve as many stakeholders as possible in implementing change or interventions and in evaluating the impact of interventions.

Examples of pre-intervention data and post-intervention evaluation tools from the inservice training courses

If you devise good data collection tools for the "diagnosis" you may be able to use them again for your pre- and post- intervention information gathering.

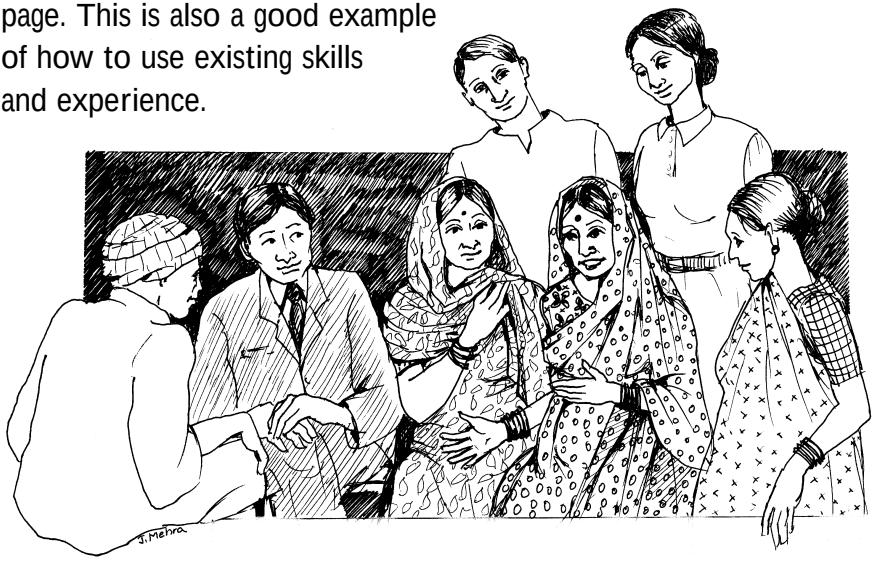
- The six week interpersonal skills training was piloted in two clinics. Before the course started 120 consecutive women who brought their babies to the clinics for vaccination at six weeks old were asked some questions about the quality of maternity care. For this we used the same questions as in the community survey. Then, after the training the exercise was repeated to see if there was any change in how women now perceived the quality of their care.
- Before the management training a question sheet was handed out asking participants to give three examples of situations they found difficult to handle as a team manager. A knowledge pre and post test was also given. Finally after a few months staff were asked to give examples of situations which they had handled better thanks to the training, and examples of any situations they still found difficult.
- Before the supplies training a quiz was done to see what midwives knew and where there were gaps in knowledge. This was repeated after the day workshop.

Example of a successful intervention

To work towards the three women-friendly goals of services being culturally acceptable, able to satisfy users and support and motivate providers, interpersonal skills training was conducted over a period of six weeks in two health centres in Lusaka. Its main purpose was to identify factors that adversely affect provider-client relationships (as perceived by health workers) and to determine/identify possible solutions to problems in this area. Emphasis was placed on identifying solutions that could be applied at the health centre level.

Participants included both professional and support staff such as cleaners in maternal and child health services. Participants were taken through a series of workshops adapted from the WHO "Health Workers for Change" manual (see resources annex at the end of this manual). Our two trainers had been part of the team that developed the manual under the auspices of WHO and the University of Witwatersrand, South Africa.

Their applicability to women-friendly goals can be seen within the list of planned sessions shown on the next page. This is also a good example of how to use existing skills and experience.



Session 1 To investigate factors that motivated health workers to choose their careers in health sector and how or if these influenced their relationships with female clients *(support and motivate providers).*

Session 2 To establish clients' perceptions about health workers' attitudes toward them and how these affect their relationship with women clients *(being culturally acceptable).*

Session 3 To explore health workers' understanding of the most important factors that influence a woman's position in society and how these affect their relationship with female clients *(being culturally acceptable).*

Session 4 To explore unmet health needs as perceived by health workers and identify possible solutions *(support and motivate providers).*

Session 5 To examine health workers' problems in the work situation that influence their relationship with women clients *(satisfy users).*

Session 6 To itemise the most important problems identified by health workers and propose realistic actions to be taken at health centre level *(support and motivate providers).*

The workshop method

(using the example of session 5: problems in the workplace that can affect relationships with women clients)

Problem identification and prioritisation.

Group discussions were held to identify the most pressing problems in the work place. These were later ranked according to priority in two steps.

Participants split into small groups. Each group identified, discussed and agreed on perceived problems in the workplace that affected the health worker-woman client relationship. They considered both material and non-material problems. These were captured on flip charts and later presented to the larger group.

In a plenary session, a common list of problems was generated and written on a flip chart. In order to come up with the most pressing problems, each participant voted for five (5) most important problems from the common list using a score sheet. After all participants had cast their votes using a secret ballot, scores were counted and the problems that scored highest became the priority problems. These were later discussed in order of priority. This also helped them to propose solutions, which in some cases, they could not have thought about prior to the workshops. By the time the workshops were completed, some of the health workers had already commenced applying lessons learnt from the workshops in their work situations.

Staff enjoyed the workshops. Importantly the post-intervention survey of women service users showed some improvements in the care they received.

Question: *Looking back at the pregnancy and delivery and your care in the health service, was there anyone out of all the people you met who you particularly remember as someone who did their job well?*

Before workshops		After workshops	
Yes	231	Yes	239
No	7	No	1
All did	2	All did	0
Total	**240**	**Total**	**240**

Question: *If yes who was that?*
(more than one answer could be given)

Before workshops		After workshops	
Midwife	227	Midwife	238
Cleaner	51	Cleaner	117
Other	3	Other	5
Total	**231**	**Total**	**239**

Question: *Was there anyone who treated you badly in some way?*

Before workshops		After workshops	
Yes	83	Yes	53
No	157	No	187
Total	**240**	**Total**	**240**

Question: *If yes who was that?*
(more than one answer could be given)

Before workshops		After workshops	
Midwife	76	Midwife	45
Cleaner	11	Cleaner	9
Other	1	Other	0
Total	**83**	**Total**	**53**

Question: *And thinking of your own experience of the maternity services as a whole, that is while you were pregnant and when you had the baby and afterwards, would you say that the care you received on the whole was very good, good or fair, bad or very bad?*

Before clinics		After clinics	
Very good	7	Very good	20
Good/fair	226	Good/fair	219
Bad	6	Bad	1
Very bad	1	Very bad	0
Total	**240**	**Total**	**240**

Question: *Is there anything you would like to see changed?*

Before workshops		After workshops	
Yes	158	Yes	97
No	71	No	133
Don't know	11	Don't know	10
Total	**240**	**Total**	**240**

Some interventions may not work as planned

During the project in Lusaka we were hampered by two important factors. One was a doctors' strike and the other was a scheme to allow nurses who had worked for the government for a long time to take redundancy or voluntary retirement package. Both these events adversely affected patient care and staff morale as well as making it difficult to introduce new ideas. These are the sorts of realities we all have to face, but some change for the better is still possible even in difficult situations.

Don't be too surprised if some interventions don't work as you thought they would. That is why we pilot them first. Sometimes pressures on staff means that good ideas cannot always be translated into practice. This happened in Lusaka too. For example, observational data on the antenatal consultations showed that the MCH clinics at that time were too short-staffed to support the intervention we had planned. We had wanted midwives to improve information-giving during check-ups but the pre-intervention observation showed that they did not have time to do this. Recognising this, we piloted a pictorial leaflet explaining danger signs in pregnancy in the community instead.

Sometimes a good idea turns out not to be quite so good after all. In Lusaka, in the poorest areas roads are impassable by motor vehicle especially in the rainy season. So women with problems in pregnancy or labour cannot reach the clinic. A stretcher on wheels was built locally and tried out in the community by a neighbourhood health committee. Despite local publicity the stretcher was hardly used. We discovered that there were problems with the design: it required two people to push it and importantly, women didn't like it because it looked too much like a morgue trolley. We learned an important lesson that it is important to consult extensively with potential users at the design stage.

Implementation chart

Here and on the next two pages, are examples of implementation charts for the Lusaka pilot interventions. These can be helpful in organising the work, who will do it, and when.

Intervention	What to do	When	Who was involved
Training in interpersonal skills	Decide on indicators to measure change	Before course starts	Staff in the two clinics
	Select pilot sites		Trainers
	Collect pre-intervention data		A person not associated with the clinic
	Contact trainers		
	Arrange staff attendance		
	Conduct training		
	Collect post-intervention data (survey at baby clinic)	After course finishes	A person not associated with the clinic
Training in how to manage junior staff	Decide on indicators to measure change	Before course starts	Staff who will attend
	Decide who to train		Training team
	Collect pre-intervention data		
	Arrange training venue		
	Arrange staff attendance		
	Conduct training		
	Collect post-intervention data	After course finishes	

Intervention	What to do	When	Who was involved
Accepting a companion in facilities for women in labour	Decide on indicators to measure change Select pilot sites Collect pre-intervention data Work with staff to introduce intervention Collect post-intervention data (interviews)	Before accepting companions in facilities After accepting companions	Staff in antenatal clinic and labour wards A person not associated with the clinic
Improved communica-tion in antenatal clinics	Decide on indicators to measure change Collect pre-intervention data Work with staff to change organisation of clinic Collect post-intervention data	When staff numbers allow After clinic organisation changes	Clinic staff

Intervention	What to do	When	Who was involved
Transport from home for women in labour	Decide on indicators to measure change Select local area Collect pre-intervention data Contact designer and workshop staff to make stretcher Contact local health committee and agree responsibilities Collect post-intervention data (record of use)	Before and during the building of the stretcher After stretcher has been in use	Designer, workshop staff and local health committee
Training in ordering supplies	Decide on indicators to measure change Decide who to train Collect pre-intervention data Administer knowledge quiz then design and conduct workshop Collect post-intervention data (pre and post test of knowledge)	Before workshop date After workshop	Clinic staff Trainer

STEP 6 Final Evaluation and Next Steps

The final stage in this women-friendly cycle is evaluation of the pilot interventions, expansion of the successful elements, and planning of future activities. It is just as important to learn from failures as from successes.

An important part of this final step is to share your findings with all the stakeholders. Again it is a good idea to use a workshop format and to arrange one or more workshops depending on how many people are able to attend.

Findings should be presented by the people who were involved in the interventions, not just by your team. It is a good idea to have small group discussions on the findings and encourage participants to collectively decide on what they will do next. Other staff can be kept informed through a regular newsletter.

When you have made significant progress in the women-friendliness of your services you should publicise this. You can use your local radio or newspapers to tell people the good news and encourage women to use your services.

The Process of Discovery and Change

It is important to look at the six-step cycle as a whole when evaluating the project as the process can also teach us lessons. Here are some of the things we learnt in the process in Lusaka.

- In Lusaka the most effective way of creating ownership was the distribution of the anonymous staff questionnaire. It signalled that we were concerned about the workers' welfare as well as the women and babies they were looking after.
- For the community survey interviewers who were not nurses were used. This meant more work because they had to be trained in how to get the medical information, but it was worth it because women felt free to comment on their care and it made comments on the health services more authentic.
- Telling staff about what women thought was good about their care as well as about problems helped them to feel valued and helped to enlist their help to introduce improvements.
- The time and energy spent by the team contacting lay people in non-government organisations outside the health service to help us during our meetings was important because it helped us to retain a focus on disadvantaged women.
- It was important not to "reinvent the wheel". If there was a good idea that had been tried elsewhere we adapted it for Lusaka. If there was not, we felt free to create something which suited us.

- Always check whether staff and neighbourhood health committees want to try the suggested intervention, discuss it with them, then accept their decision.
- When observing clinical care it is best for relations with staff to be open about what you are observing. You have to be aware, therefore, that what you will then see is "best current practice". Staff should also be assured of personal anonymity – that they will not be named when results are reported. The aim is not to punish any individual. It is to find ways collectively to improve the care we give.
- You need to keep people up to date and should offer to speak time on the women-friendly issues and initiatives at other meetings, whenever there is an opportunity.
- Newsletters and implementation meetings are important to maintain interest. Time needs to be made available to visit facilities to talk to anyone there.
- Be inclusive of *all* cadres of staff not just the professional service providers and talk to clients if they wish to know about any aspect of the initiative.

* * * * *

We had times when it was not clear how much we would be able to achieve, but what motivated us was the thought that we could improve the childbearing experience of many disadvantaged women and support the good work of staff who are poorly rewarded.

We hope that we have communicated to you our deep respect for women everywhere and those who provide care for them in difficult conditions.

We hope you feel we respect what you have done so far and encourage you to move closer to women-friendly services.

Good luck!

* * * * *

Annexes

Annex 1

A Working Definition of Women-friendly Health Services

Health services can be considered women-friendly when they:

- Are available, accessible and affordable. They are located as close as possible to where the women live and are reasonably priced for both the women and the health care system.

- Provide safe and effective health and maternal care that complies with the highest possible technical standards, and makes use of the necessary supplies and equipment, even at the lowest level facility.

- Motivate providers, encourage their participation in decision making and make them more responsive to our needs.

- Empower users and satisfy their needs by respecting their rights to information, choice, safety, privacy and dignity and by being respectful of cultural and social norms.

Reference: Systematising Experiences in Implementing Women-Friendly Health Services Workshop in Mexico City 26-28 January 1999

Annex 2

The Safe Motherhood Initiative:
The Ten Safe Motherhood Action Points

1. Advance Safe Motherhood Through Human Rights.
2. Empower Women, Ensure Choices.
3. Safe Motherhood as a Vital Social and Economic Investment
4. Delay Marriage and First Birth.
5. Every Pregnancy Faces Risks.
6. Ensure Skilled Attendance at Delivery.
7. Improve Access To Quality Maternal Health Services.
8. Prevent Unwanted Pregnancy and Address Unsafe Abortion.
9. Measure Progress.
10. Power of Partnership.

Reference: The Safe Motherhood Action Agenda Priorities the Next Decade Family Care International 1997

Annex 3

Building Women-friendly Societies to Make Motherhood Safer

Maternal mortality must be considered *a violation of women's human rights* necessitating changes in the legal, political, health, and education systems to provide more equitable, women-centred health services through strong partnerships between governments and communities.

Greater investments in basic social services (health, education, nutrition, water and sanitation) are essential to achieving safe motherhood.

National and local governments need to provide *high quality health care* and nutrition for infants as well as women that are responsive to women's needs and respectful of their rights.

Men, parents, in-laws, families, and neighbours need to join efforts to *support women in improving their lives and health*. They must also help break down barriers to health care by mitigating distance, cost and socio-cultural obstacles by providing education, integrating customs and traditions, and enhancing women's status and decision-making powers.

Annex 4

Women-friendly Services Survey Questionnaire

In Lusaka, the questionnaire was translated into the major local language. The interviewers between them spoke the other six major languages.

CONFIDENTIAL

Questionnaire Number
Township/Compound Name
CSA No. : SEA No. :
Structure No. : Household No. :
Density Code:
Women ID No. :
Date of Interview: Date Checked:

SECTION 1:
Basic demographic education and socio-economic

1. How old are you? *(Age last birthday)*	1 = < 15 Years 2 = 15 - 19 Years 3 = 29 Years 4 = 39 Years 5 = 40 Years or over
2. Who else lives with you in your household? *(Circle all categories that are applicable)*	1 = Lives alone 2 = Husband/Partner 3 = Children 4 = One or more parent 5 = One or more parent-in-law 6 = Other relatives 7 = Other non-relatives

3. What is the highest level of school you attended? *(Read list and tick one category)*	1 = None 2 = Primary 3 = Secondary 4 = Higher/University
4. What tribal group do you belong to? *(Circle one category)*	1 = Lozi 2 = Tonga 3 = Nyanja 4 = Bemba 5 = Lunda 6 = Kaonde 7 = Luvale 8 = Other *(Specify)*
5. How long have you lived in Lusaka?	1 = Less than 4 years 2 = 4 -10 years 3 = Over 10 years 8 = Don't Know
6. What is your nearest health clinic?	1 = Name 8 = Don't know
7. What is the main means of transport that you use to get there?	1 = Walk 2 = Public transport *(bus, taxi, etc)* 3 = Bicycle 4 = Private Vehicle 5 = Other *(Specify)*
8. How long does it take to get there from your home?	1 = Minutes 8 = Don't Know
9. What sex is the head of household?	1= Male 2 = Female

10. What is the employment status of the head of household?	1 = Minutes 8 = Don't Know 1 = Self Employed 2 = Central Government Employee 3 = Local Government Employee 4 = Parastatal 5 = Private 6 = International organisation/embassy 7 = Employer/Partner 8 = Unpaid Family Worker 9 = Retired 10 = Other (Specify)
11. Do you consider your household to be very poor, moderately poor or not poor?	1 = Very Poor 2 = Moderately Poor 3 = Not Poor
SECTION 2: Pregnancies in last two years and outcomes	
12. How many pregnancies have you had altogether? *(Including live births, deaths still-births and miscarriages or abortions)*	Number:
13. Tell me how many times you were pregnant altogether *(excluding any current pregnancy)* in the last two years? *(Circle all categories that are applicable)*	1 = One birth in the last 2 years *Go to 18* 2 = births or more born in last 2 years *Go to 18* 3 = 1 or more miscarriage in the last 2 years 4 = 1 or more termination of pregnancy in the last 2 years 5 = Other (Specify) *Go to 18*

(Questions only for those women who have had a miscarriage in the last two years)	
14. Did you seek medical care?	1 = Yes 2 = No *Go to 18*
15. Where did you go to?	1 = Clinic 2 = Hospital (UTH) 3 = Private Doctor 4 = TBA 5 = Pharmacist 6 = Other (Specify)
16. Was the care you received there at that time?	1 = Very good 2 = Good 3 = Poor
17. Why do you say so?	1 = They were kind to me 2 = They scolded me 3 = Other (Specify)
(Questions only for those women who have had one or more babies in the last two years) (If no babies go to Section 6)	
18 Talking about your most recent baby, was your baby: (Circle all categories that are applicable)	1 = Born healthy with a good weight 2 = Small than it should have been when it was born 3 = Sickly in the days after the birth 4 = Born dead, or dead within hours of birth 5 = Other (Please explain)

SECTION 3: Care seeking behaviour in pregnancy/delivery/post partum and obstacles to seeking care	
19. Was your baby born in Lusaka? *(Most recent baby)*	1 = Yes *Go to 21* 2 = No
20. If No, why was this? (Circle one category)	1 = I was living/travelling somewhere else at that time. *Go to Section 6* 2 = I went home to my family to have my baby. *Go to Section 6* 3 = Other (Specify). *Go to Section 6*
21. Where did you give birth to that baby (the most recent one)? *(Circle one category)*	1 = Local clinic *Go to 23* 2 = Hospital (UTH) *Go to Section 23* 3 = Private clinic/hospital *Go to Section 23* 4 = Marital home in Lusaka 5 = Natal home in Lusaka 6 = Other (Specify) *Go to Section 23*
22. If marital or natal home, why did you have your baby at home rather than in the clinic or hospital?	1 = The baby came too quickly 2 = The clinic is too far away 3 = I was frightened of the clinic/hospital 4 = I can not afford the cost 5 = I think the costs are too high to be worth it 6 = I prefer to be with the TBA 7 = I like to be at home 8 = Other (Specify)

23. Who assisted you with the delivery of the baby? *(Probe further if there was anyone else) (Circle all categories that are applicable)*	1 = Doctor 2 = Student Nurse 3 = Midwife/Nurse 4 = Traditional Midwife 5 = Female Relative 6 = Husband 7 = Hospital/Clinic cleaner 8 = Ambulance Driver 9 = Unspecified Health Worker 10 = I was alone 11 = Other response (Specify)
(Now I want to ask you about having someone to accompany you in labour and at the birth. First I want to ask you about labour, afterwards I'll ask you about the birth)	
24. Is it important to you to have someone you know with you when you are in labour, apart from any health staff?	1 = Yes 2 = No 8 = Don't know
25. If No, why do you say this?	I'd rather be alone *Go to 27* It is just something you have to get through *Go to 27* They may say things afterwards *Go to 27* Other (specify) *Go to 27*
26. If Yes, who would you most like to have with you when in labour? (Circle one category)	1 = Mother 2 = Sister 3 = Husband/Partner 4 = Mother-in-law 5 = Sister-in-law 6 = Traditional midwife 7 = Friend 8 = Other (Specify)

27. Thinking more specifically of the moment the baby is born, who would you most like to have with you at the moment of the birth, apart from a health worker? *(Circle one category)*	1 = Mother 2 = Sister 3 = Husband/Partner 4 = Mother-in-law 5 = Sister-in-law 6 = Traditional midwife 7 = Friend 8 = No one 9 = Other (Specify)
(Now I want to ask you about the pregnancy)	
28. Did you have any check-ups by a midwife at the clinic or hospital or by a doctor during the pregnancy? (Antenatal)	1 = Yes 2 = No *Go to 30*
29. If yes, how many times did you have a check-up done?	Number: *Go to 31* 88 = Don't know *Go to 31*
30. If no, why didn't you go for check-up in your pregnancy? *(Circle all categories that are applicable)*	1 = I felt/fine 2 = It was too expensive 3 = I was too busy/I had to work 4 = I had no one to leave the children with 5 = No money for transport 6 = The waiting times are to long 7 = I don't like the way they treat you at the clinic 8 = Other (specify)
31. Did you have a check-up at any point in the 6 weeks after the birth? *(postnatal check)*	1 = Yes 2 = No *Go to 33*

32. If yes, why did you go? *(Circle all categories that are applicable)*	1 = Because I was ill *Go to 34* 2 = Because the baby needed it's immunizations/was ill and I had a check-up at the same time *Go to 34* 3 = Because the midwife had told me I should *Go to 34* 4 = Because I wanted to see about family planning *Go to 34* 5 = Because I wanted to make sure I was back to normal *Go to 34* 6 = Other (specify) *Go to 34* 7 = Don't remember *Go to 34*
33. If no, why not? *(Circle all categories that are applicable)*	1 = I felt well/fine 2 = It was too expensive 3 = I was too busy/I had to work 4 = I had no one to leave the children with 5 = No money for transport 6 = The waiting times are too long 7 = I don't like the way they treat you at the clinic 8 = Other (specify)
(Now I want to talk about the whole pregnancy and delivery again)	
34. Did you have to pay for anything?	1 = Yes 2 = No *Go to 37*
35. How much did you pay for the delivery care? *(Ask this if attended at clinic, hospital or by TBA)*	1 = Amount 8 = Other (Specify)

36. How did you pay?	1 = Cash 2= Scheme arrangement 3 = Other (Specify)
37. Did you have to buy anything for the birth?	1 = Yes 2 = No Go to Section 4
38. If yes, what did you buy? Circle all categories that are applicable)	1 = Gloves 2 = Clothes for the baby 3 = Cloth to wrap the baby in 4 = Pad, cotton wool 5 = Peg 6 = Intravenous infusion (drip) 7 = Syringe and needle 8 = Other (specify)
39. Thinking about what you had to pay altogether, was it:	1 = Difficult to find money 2 = Quite difficult 3 = No difficult to find the money 9 = Missing
SECTION 4: Quality of care in labour if birth took place in clinic or hospital in Lusaka (If a woman had her baby at home go to Section 5)	
40. Were you left alone at all while you were in labour at the clinic/hospital?	1 = Yes 2 = No *Go to 42* 3 = Don't remember *Go to 42*
41. Did it seem to you that you were left alone?	1 = Too Long 2 = Not too long 3 = The right amount of time really

42. Did they cut you down below to help the baby out?	1 = Yes 2 = No *Go to 46* 3 = Caesarean Section *Go to 46* 8 = Don't know *Go to 46*
43. Was this a problem for you?	1 = Yes 2 = No *Go to 45*
44. If Yes, why?	1 = It hurt *Go to 46* 2 = It took too long to heal *Go to 46* 3 = Other (Specify) *Go to 46*
45. If No, why?	1 = Not enough room 2 = It is normal 3 = Other (Specify)
46. Looking back at the pregnancy and delivery and your care in the health service, was there anyone out of all the people you met who you particularly remember as someone who did there job well?	1 = Yes 2 = No 3 = They all did their jobs well
47. If Yes, who was that? *(Circle all categories that are applicable)*	1 = Clinic Midwife 2 = UTH Midwife *Go to 49* 3 = UTH Doctor *Go to 46* 4 = Pharmacist 5 = Clinic Cleaner 6 = Hospital Cleaner 7 = Ambulance Driver 8 = Porter or Guard 9 = Receptionist or Clerk 10 = Unspecified Health Worker 11 = Other (Specify)

48. What was it that you liked about them?	1 = Person was kind 2 = They didn't shout 3 = They were encouraging or understanding 4 = They gave good care 5 = They examined gently 6 = Taught well 7 = Other (Specify)
49. Was there anyone who treated you badly in some way?	1 = Yes 2 = No *Go to 52*
50. If yes, who was that? *(Circle all categories that are applicable)*	1 = Clinic Midwife 2 = UTH Midwife 3 = UTH Doctor 4 = Pharmacist 5 = Clinic Cleaner 6 = Hospital Cleaner 7 = Ambulance Driver 8 = Porter or Guard 9 = Receptionist or Clerk 10 = Unspecified Health Worker 11 = Other (Specify)
51. What did they do?	1 = Shouted or scolded 2 = They did not teach well 3 = Examined roughly 4 = Did not come when called 5 = They rushed us 6 = Other (Specify)

52. And thinking of your own experience of the maternity services as a whole, that is while you were pregnant and when you had then baby and afterwards, would you say the care you received on the whole was... *(Read list and circle one category)*	1 = Very Good 2 = Good/Fair 3 = Bad 4 = Very bad
53. Is there anything you'd like to see changed?	1 = Yes 2 = No *Go to 55* 8 = Don't know *Go to 55*
54. If yes, what?	1 = They should be kind 2 = They should not shout or scold 3 = Have good attitude 4 = Not charges (Money) 5 = Provide equipment 6 = Stay near by 7 = Have clean toilets and bathroom 8 = Other (Specify)
SECTION 5: Serious morbidity	
55. Did you have any serious problem during your last pregnancy, delivery or in the month after the birth?	1 = Yes 2 = No *Go to Section 6*

56. If yes, what was it? *(Circle all categories that are applicable)* *(Do not read the answers)*	1 = Fits 2 = Massive bleeding/haemorrhage 3 = High fever 4 = Pain (specify) 5 = Malaria 6 = TB 7 = BP 8 = Oedema 9 = Other (specify)
57. Were you able to get medical treatment quickly/as soon as you felt you needed it?	1 = Yes 2 = No *Go to 59* 3 = No answer *Go to Section 6*
58. If yes, where did you go? (Circle all categories that are applicable)	1 = Clinic *Go to Section 6* 2 = Hospital *Go to Section 6* 3 = Private Doctor *Go to Section 6* 4 = Pharmacy *Go to Section 6* 5 = Traditional Healer *Go to Section 6* 6 = Other (Specify) *Go to Section 6*

59. If no, why not? *(Circle all categories that are applicable)* *(Do not read the answers)*	1 = Didn't realise it was serious at first 2 = It was at night time 3 = Felt to ill to go anywhere 4 = No one to take me 5 = It was too expensive 6 = I was too busy/I had to work 7 = I had no one to leave the children with 8 = The clinic/hospital was too far away to go to 9 = The waiting times are too long 10 = I don't like the way they treat you at the clinic/hospital 11 = Medicine not available 12 = Other (Specify)
SECTION 6: Unwanted pregnancy	
60. In the past, were you ever pregnant when you did not want to be?	1 = Yes 2 = No *Go to 62*
61. If yes, what did you do? *(Circle one category)*	1 = Nothing 2 = Attempted to stop the pregnancy but did not succeed and gave birth 3 = Attempted to stop the pregnancy and succeeded 4 = Other (Specify)

62. Thinking about women in your community, if they are pregnant and do not strongly want the pregnancy, what do they do to stop the pregnancy?	(Circle all categories that are applicable) (Do not read the answers) 1 = Go to the clinic for medical help 2 = Go to Hospital for medical help 3 = Go to a private doctor 4 = Go to the pharmacy to buy drug 5 = Go to someone in the community for help 6 = Take traditional remedies 7 = Nothing, they have to accept the pregnancy 8 = Poking 9 = Terminate 10 = Don't Know 11 = Other (specify)

Annex 5 Resources

General information on safe motherhood

Family Care International
588 Broadway Suite 503
New York New York 10012 USA
email smi10@familycareintl.org
http://www.safemotherhood.org

UNICEF
Women-friendly Health Services Experiences in Maternal Care
Report of a WHO/UNICEF/UNFPA workshop, Mexico City, 1999
(UNICEF 1999)
http://www.unicef.org/programme/health/document/mexeng.pdf

WHO (4/2001)
Reproductive Health Library Disc
(WHO Geneva 2001)
Go to http://www.cochrane/rhl.htm for details on how to order

WHO
Safe Motherhood Needs Assessment
WHO/RHT/MSM/96.18

Examples of other manuals concerned with improving quality of health care

AVSC International
COPE Client-Orientated Provider Efficient Services
A Process and Tools for Quality Improvement in Family Planning and Other Reproductive Health Services
(AVSC International New York 1995)

Hulton L, Matthews Z and Stones R
A Framework for the Evaluation of the Quality of Care in Maternity Services
(University of Southampton, Southampton 2000)

Maine D, Akalin M Z, Ward V M and Kamara A
The Design and Evaluation of Maternal Mortality Programs
(Center for Population and Family Health, Columbia University, New York, 1997)

Semeraro P and Mensch B
The Quality of Care in Maternal and Reproductive Health Services: Definition, Assessment, and Improvement in Baby Friendly Mother Friendly ed Murray S F
(Mosby London 1996)

The Population Council 1998
The Situation Analysis Approach to Assessing Family Planning and Reproduction Health
Robert Miller et al
http://www,popcouncil.org/publications

WHO
Health Workers for Change: A Manual to Improve Quality of Care
TDR\GEN\95.2
(WHO Geneva 1995)
http://wholibdoc.who.int/hq/1995 TDR GEN 95.2.pdf

Useful readings on practical research methods

Bruce J
Fundamental Elements of the Quality of Care: A Simple Framework
(Studies in Family Planning 2 (2) 61-91 1990)

Campbell O, Clelland J, Collumbia M and Southwick K
Social Science Methods for Research on Reproductive Health
WHO/RHR/HRP/SOC/99.1
http://wholibdoc.who.int/hq/1999/WHO RHR HRP SOC 99.1.pdf

Nadler D
Feedback and Organisation Development: Using Data-Based Methods
(Addison Wesley 1977)

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