# Report

## Training of Trainers (TOT) on Respectful Maternity Care (RMC) for Health Care Providers

**31st August 2019**

**At**

**LT2&3, Nehru Hospital,**
**Postgraduate Institute of Medical Education and Research (PGIMER), Chandigarh**



THE WHITE RIBBON ALLIANCE
HEALTHY MOTHERS HEALTHY WORLD

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We would like to thank Prof. Rajesh Kumar, Dean Academics of PGIMER, Head of the Department of Community Medicine and School of Public Health, PGIMER for his support in organising this program.

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# EXECUTIVE SUMMARY

**Introduction**

Pregnancy and childbirth is one of the most awaited and cherished moment in a woman's life. This period of nine months is full of hope and dreams for a new life but also a time of intense vulnerability for the childbearing woman. Hence, the concept of "safe motherhood" is beyond a mere concept of maternal mortality and morbidity. It is physical as well as psychological safety encompassing respect for women's basic human rights. Globally, the number of maternal deaths has declined in the past two decades and India has also progressed on this front (World Health Organisation[a], 2016) but with the access to maternal health care services, the quality of care should not be undermined. It has been found that high institutional birth is inadequate to reduce maternal mortality ratio without improving quality of care at health facilities (Randive, Diwan, De Costa, 2013). While the National Rural Health Mission has succeeded in improving access to maternal health facilities for women in India, much needs to be done to improve the experience and quality of care in institutional facilities (Nair & Panda, 2011). To improve maternal health outcomes, the quality improvement initiatives in maternity care are indispensable (Sarin, et al., 2017).

Evidence all over the world suggests that disrespect, abuse, perceived poor quality of care and fear of discrimination during childbirth are key barriers to women seeking facility based care (Bohren, et al., 2014; Kujawski, et al., 2015). Studies and reports globally (Bohren, et al., 2015; Chadwick, Cooper, & Harries, 2014; McMahon, et al., 2014; Human Rights Watch, 2011; D'Ambruoso, Abbey, & Hussein, 2005) have also documented mistreatment, neglect, abuse and disrespect that women face in healthcare institutions. In 2010, Bowser & Hill classified disrespectful and abusive care into seven categories i.e. physical abuse, non-consented clinical care, non-confidential care, non-dignified care, discrimination, abandonment and detention in health facilities. In 2011, the White Ribbon Alliance published a document on the rights of childbearing women- Respectful Maternity Care Charter: The Universal Rights of Childbearing Women (White Ribbon Alliance, 2011). In 2014, WHO published a statement to reaffirm every woman's right to dignified and respectful care (World Health Organisation, 2014). In 2015, a systematic review by Bohren, et al. (2015) supplemented it highlighting a failure to meet professional standards of care, poor rapport between women and providers, and health system constraints. In 2016, WHO published new guidelines to improve quality of care for women in institutional maternal healthcare. This statement placed focus on ensuring respectful and dignified care (World Health Organisation[b], 2016). Respectful maternity care is a universal right of a childbearing woman and Governments all over the world are supporting this initiative.

**Background**

In December 2016, researchers at the School of Public Health (SPH), PGIMER with support from White Ribbon Alliance India (WRAI) and MacArthur Foundation undertook a qualitative research study on Respectful Maternity Care in one district of one north Indian state. A Masters in Public Health student, under the guidance of the Principal Investigator and Co-Principal Investigator of the WRAI and Mac Arthur Foundation funded research study, undertook a mixed methods research into Respectful Maternity Care in another state of northern India. Together, these studies gathered evidence on RMC at the primary, secondary and tertiary care level. On 25th January 2018, a stakeholders' meeting was organized by SPH-PGIMER and WRAI in Chandigarh. The stakeholders' meet saw participation from stakeholders from two states and one union territory in north India of the heads of department of gynaecology and obstetrics of government medical colleges, staff of government nursing college, government maternal health programme officers, government doctors, academicians, students and civil society members.

The present program of "Training of Trainers (TOT) on Respectful maternity care for health care providers" is a part of the second phase of the project "Respectful Maternal Care in Punjab: A qualitative study for advocacy" which emphasizes on the intervention of RMC in a tertiary care setting. The training was organized by Department of Community Medicine and School of Public Health, PGIMER, Chandigarh alongwith the Department of Obstretics and Gynaecology, PGIMER. This TOT was conducted as a first activity to develop the capacity as a mentor for bringing behavioural change among the service provider. The program was held on 31st August'19 from 12-6pm at LT2&3 Nehru Hospital, PGIMER and was conducted by expert faculty from Indian Council of Medical Research (ICMR), White Ribbon Alliance India (WRAI), Trained Nursing Association of India and freelance consultants. After successful completion of the Training of Trainers (TOT) program designed for the faculty and nursing officers of the Obstetrics and Gynaecology department, PGIMER, Chandigarh, the intervention will be mentored and monitored for four months. This report is presented in two parts because there were two separate sessions for the faculty and nursing officers simultaneously due to limited time. Though the starting and concluding sessions were kept as same.

**Key recommendations for intervention**

Respectful Maternity Care is a universal human right that is due to every childbearing woman in every health system around the world.

- Every consultant will be a mentor. Set the example for your team. The monthly meetings will be a platform where team members would discuss with mentors about the issues they faced, resolved, and are left to be resolved (last Tuesday review meeting of consultants and residents as practiced right now in PGI) and will also be mentors.
- The mentor is supposed to be that person whom everyone listens to. Take care to address all the soft issues which make part of our behavior.
- A combined meeting of doctors and nursing staff (consultant+ residents+ nursing officers) will be held so as to understand the problems faced by various categories of health care providers;
- Self monitoring- why did I behave in a manner that I did? This self evaluation will make us able to find solutions to the issues we are facing.
- On privacy, the use of curtains in OB II in CLR was suggested, 30-40% usage for females in active labor. Timeline for the same to be kept as 3-4 months and is a onetime activity.
- Birth companion was suggested for female in advanced labor and for supervised female only. The need for sensitization of CLR team was felt and was held as an immediate concern.
- To reduce money offerings by 50% in 6 months to the staff. It should be taken care of by the CLR sister incharge and to take assistance from resources like staff, security guard, patient, cctv camera. A baseline survey can be done and zero tolerance policy to be adopted for the same.
- Identification of local champions, personal aspirations, and positive attitudes.
- Addressing problem of poor communication e.g. the patients are not being called by their names in PGIMER.
- Posters on 'No violence policy".
- Smiling faces or emojies if allowed by the people managing the labour room
- Nice instrumental very light music to be played in labor room.
- LED display for post-partum patients on various self care practices; (Dr Narender said that they are already having material prepared in this regard and is being revised now; also, think of the solutions which can be implemented at the facility level on your own. I have witnessed at places an oath towards RMC and one or the other person reads it out loud every morning, he suggested)
- Innovative ways to generate funds for poor patients;
- Putting the right signage so that the patients are able to identify labs, and various rooms they may need to pay the visit to.
- To place suggestion box for feedback from the patients

# INAUGRAL SESSION

**Welcome address**
**Dr.Vanita Suri,**
**Professor and Head, Department of Obstetrics and Gynaecology, PGIMER**

The sessions started at 12 noon with the inauguration of the event. The welcome address was given by Dr.Vanita Suri, Professor and Head, Department of Obstetrics and Gynaecology, PGIMER. She welcomed all to this unique workshop on RMC. She specially thanked the dignitaries for taking time out and taveling long distances to be a part of training. She briefly gave orientation to the participants about the training. She said that child birth is a precious thing and many organizations take it seriously and respectful care is a new emerging concept. We want the mothers to remember their experience of child birth as a pleasant memory.

# GOVERNMENT PERSPECTIVE ON RMC

**Dr. Narender Goswami,**
**Senior Consultant**
**Ministry of health and family welfare**
**Government of India**

The second speaker was Dr. Narender Goswami, Senior Consultant, Ministry of Health and Family Welfare Department who gave Government perspective on RMC. He said that he met Dr Manmeet Kaur in a Laqshya workshop in Punjab a year ago and since then they have been talking about RMC. Its been a long time that we are having a high number of maternal deaths but we have come down drastically (SRS-131) in this regard and great achievements have been obtained. Now is the time to focus on the quality of care being provided, Dr. Goswami asserted.

The Ante-natal care and Pre-natal care indicators are still not very good and we can start from government side in the states like Madhya Pradesh and Bihar, etc. The issue with quality is related to the statistics of maternal complications during child birth including the haemmorhage, etc. We know that the institutional deliveries are happening but we see that once a woman comes to the hospital for maternal care, she might not visit it again because of the issues related to quality. In Laqshya program, we are covering the RMC as an important part. The Laqshya program has components like baseline assessment of facility, followed by improvement dimensions, including process improvement along with infrastructural improvements. Ultimate outcomes will be certifications for quality and improved indicators of maternal care targeting the quality of care. The indicators will include the documentation (ANMs right now are loaded with multiple registers and don't get time to deliver proper care), RMC, timely management and biological waste management.

Now why is RMC important? We know that the birth companionship part is certainly missing in the current situation, but there is an evidence of need for birth companion. There are many other things which act as an abuse to the mother, which happens intentionally as well as unintentionally. I have seen in many government hospitals that during some workshops or big programs, the infrastructure becomes beautiful and pleasing which vanishes once the meetings are over. What I mean is that more than this, respect to the mothers is more important. Informed consent makes the first and foremost thing to be looked upon. We want to tell you that informing about the procedures before you perform on the mothers has to be discussed with them so that they are aware what is happening in and with their bodies, be it using IUDs or so. So, next thing is to discuss either the mothers about the positions they are comfortable to deliver their babies so as to avoid this form of disrespect. We are no ones to judge if the lady delivering the child is married or unmarried. We need to focus on the dignity of the people who come to us for care, we should be concerned with using curtains when and wherever they need. The government is working to integrate RMC in the service quality of each and every government hospital across nation.

# KEYNOTE ADDRESS

**Prof. Rajesh Kumar,**
**Dean (Academics), PGIMER & Head,**
**Department of Community Medicine & School of Public Health,**
**PGIMER**

The keynote address was given by Prof. Rajesh Kumar, Dean Academic, PGIMER. He welcomed everyone including the participants and said that it's a great occasion today that we are discussing this issue. We know that maternal mortality is a great issue in our country. Now we have sample registration (SRS) data that has been keeping an eye on the maternal mortality ratio (MMR) and doing a great job to update us on the situation. The declining trends, taken as positive aspect, are the changes linked to many government initiatives including Janani Suraksha Yojna (JSY), Janani Shishu Suraksha Karyakaram (JSSK), accredited social health activist (ASHA) program. The question is- why despite of very good public health care infrastructure and facilities, the death are not drastically declining? People say that with the ambulance system in places, the deaths have now shifted from homes to the hospitals. Why is that?

We are succeeding in gearing up the hospitals with good infrastructure and every needed facility. NMH, which earlier worked in isolation, is working more in collaboration with other sectors. But the leadership, which is required to improve the quality has to come from the places where health care providers are trained, i.e. the institutions like PGIMER and other medical teaching hospitals. We have realized that there is a problem of lack of sense of leadership. Government has challenged us to work to improve the quality of care in the hospitals. I believe that with each passing generation, our children are going to be smarter. We should believe in the younger generation to bring positive changes, provided we give them this opportunity.

With White Ribbon Alliance, PGI has conducted studies on lack of RMC in system. We are blessed to be doctors and working in a scientific way, but I realize that our basic training only misses on working humanely, calling a dead person a body, which during our skills training hours won't say a word, no matter how we slice it. This then becomes our routine practice during our practice. The first thing is to consider ourselves as service providers. Our status because of our knowledge and power relationship, people consider us great. But we should shift to discussion and collective decision making with the people who seek care from us.

We believe that government schemes in health come from the tax payers money, which are us, but this is a misconception. Government actually collects greater amount of tax from each and everybody, including poorest of the poor, because everybody spends money on purchasing the daily necessities.
I hope that during the session, lots of issues will emerge. I urge not to fall prey to blame game because sometimes it is not one person, sometimes it is the system, responsible for greater chaos. Thanks to all.

## BACKGROUND AND OBJECTIVES OF THE RMC STUDY

**Dr. Manmeet Kaur,**
**Professor of Health Promotion,**
**Department of Community Medicine & School of Public Health, PGIMER**
**Principal Investigator, RMC**

We are entering a stage where we have to tackle a challenge- how we behave with others. With that thing in mind, we were struggling about providing quality services to the needy. We faced this issue that women were moving away from our hospitals for services, which more or less has to do with quality. In our study, we found that women acknowledge that there are problems that they face in the government hospitals, disrespect with mothers and pregnant ladies is one of them. Based on our study, we reached out to the government, and with their help, we are here together in this place together, working upon to understand our behaviors and change accordingly, for the betterment of the women who come to us for help. I call this training approach as RMCMP- respectful maternity care mentoring program.

The objectives of the training of trainers are to put emphasis on:

- Attitudes, practices and communication skills for patient-centered care.
- Creating an enabling environment in the health facilities for RMC.
- Develop a mentorship program for RMC

## VOTE OF THANKS

**Dr. Madhu Gupta,**
**Professor of Community Medicine,**
**Department of Community Medicine & School of Public Health,**
**PGIMER**
**Co-Principal Investigator, RMC**

She thanked Dr. Rajesh Kumar for continuous mentoring. She thanked Dr. Vanita Suri for continuous support and collaboration despite their busy schedule. Thanked Dr. Manmeet Kaur for creating this program, stating this program to be a brain child behind this. Dr. Narender Goswami, to represent from government and showing great interest in the issue. Dr. Pooja sikka for organizing and coordinating with their department, Chief Nursing Officer Mrs. Jaspal and Deputy Nursing Superitendent Mrs. Kalyan for coordinating with nurses of the department. Thanked the organizers Dr. Guneet, Dr. Nidhi, Dr Rajbir, Mr Vijin and Ms Tejinder from the Department of Community Medicine and School of Public Health.

# SESSION I: Introductory Session and Setting the Tone
## (For both Faculty and Nursing Officers)

**Dr. Nomita Chandhiok**
**Consultant, ICMR. Former Scientist G,**
**Division of Reproductive Biology and Maternal Health, Child Health,**
**Indian Council of Medical Research**

"We will start with introducing each other". The participants introduced themselves and told their expectations from the training program. She said that the issue is not specific to India but it exists in the neighboring countries as well and because of the typical style of skill building during the training years, one or the other type of disrespect keeps rolling unintentionally in everyday practice.

She started with everyone's understanding of the meaning of word RESPECT. Talking good, behaving in a good way, i.e. actions, behaviors with a feeling of regard towards someone. The understanding of words like respect, disrespect, dignified, abuse, etc. is very important to understand the extent to which we have to mend our ways to achieve quality in our work in form of respectful maternity care. RMC is a universal human right with woman's autonomy to decide which treatment she wants to have and which one she wants to refuse. Bowser and Hill in 2010 conducted a study to outline the levels at which disrespect and abuse is happening. Based on this, they discovered seven categories of disrespect. A charter on RMC has now been developed. White Ribbon Alliance (WRA) India actually worked to generate the evidence. Indian Council for Medical Research has also done studies in the same field. WRA India ran a campaign to ask women across the nation as to what they want in the form of care when they go for seeking health.

There are identified as drivers of disrespect and abuse in India at policy and governance level, in health system and at the level of individual and community. Our work cultures only have inculcated among us where certain disrespectful behaviours are normalized. So, in order to achieve the RMC, we have to work on all the three levels mentioned above. Considering this, we are starting with reforming actions at the health system level.

### Respectful maternity care – Key concepts

After discussion on the key concepts of RMC and the prevalence of RMC globally and in India, Dr Nomita explained the seven categories of disrespect and abuse in RMC. The first is physical abuse. The types of physical abuse at the level of health care facility include many things like stitching without anesthesia, applying fundal pressure. Non-consented care includes not explaining the procedures, inserting PPIUCDs without informing, coercion to go for c-sections, non-birth companionship, not making them understand the results written in report. Non-confidential care includes no curtains or visual barriers during physical examination, non-provision of covering sheets, sharing sensitive information with others including HIV status, marital status, etc. Non-dignified care including threatening and shouting at women and use of abusive language, shaming of the women about their reproductive choices, sharing bed by two women in need, lack of cleanliness in labour room bathrooms, scolding them for wrong outcomes, non-provision of menstrual pads as many times as needed because of whatever reason. Discrimination is also a form of abuse be it religion, age of the woman, education and economic of woman. Poor are poor and there is nothing much they can do, but they say that is why everyone behaves badly with them because they are poor. Neglect includes abandonment of the woman during labour and delivery, no response to woman's call in need, asking woman to clean the labour room on her own. Detention is another form of disrespect. It means that if the patient is unable to pay, then she is not allowed to leave. Also, demanding money for

the free services and asking for under the table money being asked to show new born babies to their families is also detention.

## Group work type of disrespect and abuse (occurring to women during pregnancy and childbirth) (Participants participated in the activity supervised by Dr.Nomita)

**Brainstorming activity**: Have you come across any incident of disrespect and abuse (D&A) during your work at this or any other facility? Each group to discuss and narrate incidents of disrespect and abuse for each category of RMC. Discuss incidents specifically, in relation to contexts and locations- where they occurred.

**Incidents to highlight various types of D&A**

**Incident one**: Had to save a patient's life without taking consent. **NON CONSENT**

**Incident two**: Witnessed a lady tied because she was a patient of eclampsia and the available staff did not know any other way to keep the patient in control. **PHYSICAL ABUSE**

**Incident three**: Denial of services because of non-production of BPL card etc. **ABANDONMENT AND NEGLECT**

**Incident four**: Whenever a VIP patient arrives, the beds have to be rendered vacant so that the VIP patient can be taken care of. **DISCRIMINATION**

**Incident five:** No help available to women in labour and delivery. **DENIAL OF CARE/ ABANDONMENT**

**Incident six:** Witnessed the very weak and serious patients who were forced to produce babies in order to finally give their family a son. That time we feel so sad that we abruptly say some things which we realize that they have no fault in committing. **VERBAL ABUSE.**

**Incident seven:** A nurse was prompted to tell about the HIV status of lady by someone in form of time it takes to get treated, whether or not it will be cured, etc. **NO CONFIDENTIALITY**. The nursing officer said that she worked to finally not disclose any related information

**ROLE PLAY:** Examine a pregnant lady who was shy to get examined in front of all the other ladies.

***Script:***

Patient: Madam mujhe sab ke saath nai baithna (*Madam I do not want to sit along with everyone*)

Doctor: Ye bhi sab tumhare jaise hain. To kya hua? (*They are all like you, so what happened?*)

Patient: Aap sab ke saamne check karoge madam mujhe ajeeb lag raha hai. (*You will examine and check me in front of everyone madam I will feel weird*)

Doctor: To baki ka bhi karenge. Tumhe hi alag kyun lag raha hai?
(*So, what we'll examine others as well, why you alone are feeling weird?*)

Patient: Madam mummy se mil kea a jaun? (*Madam can I come back after meeting my mother?*)

Doctor: Aisa kya ho gya bhi? Mummy kya kar legi? (*What has happened? What will mummy do?*)

Patient: Madam dard ki davai to de do (*Madam kindly give a medicine for pain relief*)

Doctor: Chup chaap apni seat par baith jao. Roti rehti hai yeh. (*Go back and sit quietly on your seat. You keep crying*)

Findings: Non-consented care (not allowing to meet mother), no privacy (telling her to go sit with others and do not feel shy unnecessarily), neglect (not giving the pain medicines when the lady urged), etc.

**ROLE PLAY TWO:** Dealing with apprehensive patients

***Script:***

Patient: will you examine all the patients together.

Doctor: Why are you crying?

Patient: I had a sister. Usko kisi ne nai dekha. Wo hospital me gyi thi. Kisi ne nai dekha aur bacha nai hua aur didi mar gayi. Maine to pehle bhi bola tha gahr walo ko ki maine shaadi nai karni, aur bacha nai karna. Gaao me hua tha ye. Didi ko bhi koi kagaz nahi diya tha. Mai kya karu? Mujhe kuchh nai pata. Mujhe darr lagta hai ki mere sath bhi yahi hona. (*I had a sister, she was not seen properly. She went to the hospital but was not taken care of, she didn't have a child and she died. I told my parents earlier that I do not want to get married and neither I want to have a child. The incident with my sister happened in village and she*

*was not given any papers. What should I do? I do not know anything. I feel scared that I too shall have same fate as my sister*)
Doctor: main sab kuchh bataugi. Aap ki sister k saath kya hua mujhe nahi pata aur main kuchh kar nai sakti. Par aap safe ho. (*I will tell you everything. I do not know what happened with your sister and I cannot do anything about it. But you are safe*)
Patient: mujhe parchi aur dawai bhi dogey? (*Will you give me a slip and medicines too?*)
Doctor: haan sab milega. (*Yes, you will get everything*)
Patient: aap kab dekhoge mujhe? (*When will you see me next?*)
Doctor: aapke card pe date dal jaygi yaha par. Aapko sab batati hu. Is aur is din aana hai. Abhi aap baitho, thodi der mein aap ko dekhungi. (*Your card will have a date written on it. You will be informed about everything, these dates you have to visit. As of now, you sit down, I shall attend to you soon*)

The types of physical abuse at the health care facility level include many things like stitching without anesthesia, applying fundal pressure.

Non-consented care includes not explaining the procedures, inserting PPIUCDs without informing, coercion to go for c-sections, non-birth companionship, not making them understand the results written in report.

Non-confidential care includes no curtains or visual barriers during physical examination, non-provision of covering sheets, sharing sensitive information with others including HIV status, marital status, etc.

Non-dignified care including threatening and shouting at women and use of abusive language, shaming of the women about their reproductive choices, sharing bed by two women in need, lack of cleanliness in labour room bathrooms, scolding them for wrong outcomes, non-provision of menstrual pads as many times as needed because of whatever reason.

Discrimination is also a form of abuse be it religion, age of the woman, education and economic status of a woman. Poor are poor and there is nothing much they can do, but they say that is why everyone behaves badly with them because they are poor.

Neglect includes abandonment of the woman during labour and delivery, no response to woman's phone call in need, asking woman to clean the labour room on her own.

Detention is another form of disrespect. It means that if the patient is unable to pay then they are not allowed to leave. Also, demanding money for the free services and asking for under the table money being asked to show new born babies to their families is also reported.

**ROLE PLAY THREE:**
Script: Patient assisted by family member visiting the nurse.
Nurse gives her the water, checks her weight and blood pressure, etc. and waits for the doctor. Doctor arrives; patient hesitates while doctor examines.
Doctor: Sister ye to checkup bhi ni kra rahi. (to her mother-in-law)- Auntie aap ne inko kuchh nai sikhaya? Nau maheene se aap ke pas thi kuchh nai bataya. Ab main ik din mein kya samjhau? Ye to checkup hi ni kra rahi! Yaha itne patient hain. Mere ko sab ko dekhna hai. Aise karegi to kaise chalega? Time waste ho raha hai. Kya kar rahi hai ye? (*Sister to the doctor- she is not getting checkup done nicely. Doctor to her mother-in-law - Aunty didn't you teach her anything. She was with you for nine months, didn't you tell her anything? Now what should I tell her in one day? She is not getting checkup done. There are so many patients here. I have to see each one of them. If she will do like this, then how will this work? Time is getting wasted, what is she doing?*)
FINDINGS: A mixture of respectful and disrespectful care, driven by many circumstances

# SEPARATE SESSIONS FOR FACULTY AND NURSING OFFICERS
## Part A: Sessions for faculty

# SESSION II: Caring for the care givers

**Dr. Aparna Shrotri**
**Former Head of the Department, OBG, BJ Medical College, Pune**

Dr.Aparna started with introducing work related stress leading to disrespect and abuse during facility based childbirth. A case study was discussed where the doctor was alone on duty, was denied leave, and encountered two patients in third stage of labour. She shouted on them. What could be done? Some action has to be taken at administrative level.

Case study II:

Inference: Addressing workplace stress through psychological debriefing.

- To restore the health and environment of staff and accelerate their return to routine functions.
- Could be an individual or group debriefing.
- Empathic, supportive and non-judgemental debriefing
- Acknowledging the grief and guilt emotions with a positive change in the attitude from blame to learning
- Ensure confidentiality and privacy.
- Discussion about medical errors aiming at quality

**Key messages for the health care providers:**

Even though we are health care providers, we are also human beings and we can also have other stresses. We need to learn to manage it and do our job even under stress. We need to understand that our role is crucial and our personal issues should not hinder with patient care because we are blessed with the skills to take care of the sick.

Discussion:

One participant: If the system requires the patient to bring the medical items and there is no person with the lady, and we are unable to find syringe with her, then it is a stress factor because this ultimately is wasting everyone's time. If we tell the patient why she didn't bring the things needed, is it an abuse? We mean to say things out of care at such situations.

If we are working in a group together, meaning we work in a team, we should have a good team leader who makes sure that the chaos does not happen. We should start by making convergence between nurses and the doctors if we want to work as a team in a hospital. So that the nurses doctors conflicts are reduced - maintaining interpersonal relationships.

Dr Narender: I want to add one thing here. Most of the things happen because of the high case load. I can claim that the case load will be reducing two years from now because the government is working in the peripheries as well and we will make sure that this burden reduces. Along with that, we have to still work on our behaviour because it is in our hands only, as policy can reduce the work load, but can't change the behaviour.

Dr. Nomita's experience: I have worked in a setting with heavy case load where patients would ask if they had to take folic acid tablet with warm or cold water. That time I would feel like killing them for asking such question but now I feel that it wasn't going to take much time to answer in one or two words rather than boiling my blood.

Some suggestions: Posters in the patients gallery can be displayed so that while waiting they are able to learn about general queries. Posters may be made based on your previous experiences with queries.

# SESSION III: Promoting mutual accountability

**Dr. Nomita**

- Key Stakeholders in RMC and Mutual Accountability

The partners which are involved in certain task. For RMC, they are ladies who come for care, the policy makers, the care givers, etc. Mutual accountability is between two individuals or groups to understand their responsibility. That is what is needed to negotiate things. It should be there from both clients and service providers.

- Responsibilities of health service providers and of patients/clients

Responsibilities coming under the mutual accountability include responsibilities of patients and providers. Patients maintaining their documents, taking medicines on time, giving full medical information correctly as a responsible patient. We making them understand the importance of all this very calmly makes us responsible.

- Client feedback and grievance redressal mechanisms.

Very important to know what others think about the services we provide and the way we provide them.

The redressal mechanism at place may help sort things based on the feedback from patients and the suggestions they give. There should be a suggestion box maintained regularly and paid full attention to.

Discussion: Under Laqshya program, Dr Aparna informed that the Laqshya hospitals have started taking feedbacks from patients.

Dr Narender: There is a helpline number to register one's grievances, but is not popularized much
He also informed it is not mandatory for the health care providers to fill forms from everyone. He clarified that under Laqhsya, only those institutes will get the forms filled who are as per the standards of Laqshya guidelines.

# SESSION IV: Implementing facility based respectful maternity care during service delivery

**Dr. Aparna Shrotri**

- Evidence based strategies to reduce disrespect and abuse

There should be a provider training on values and attitude transformation and interpersonal communication skills. If we understand that values and emotions of other people are important, we will feel ourselves enlightened because we stopped complaining and judging.

The facility should have a set up of quality improvement teams (quality circles), monitoring of disrespect and abuse, staff mentorship, improving privacy in wards and improving staff conditions (providing something to snack on for those on shift).

With community, we can have maternity open days, community workshops, mediation or dispute resolution, counseling of community members who have experience disrespect and abuse, providing a method for submitting complaints, educating women on their rights.

Multicomponent RMC policies appear to reduce women's overall experiences of D and A.

We should work according to the rights based approach to provide services taking care of respecting the patients.

- Global and Government of India recommendations for inclusion of RMC in a service delivery

Respectful care policies have shown to be effective as evidenced in the literature across the globe. WHO had made an intrapartum care charter. There are NICE Guidelines which focus on getting along a birth companion for support of patients. There are FIGO guidelines which talk about mother-baby friendly birthing facilities. There are Laqshya indicators as well. These focus on the aspects like informed consent and facilities allowing birth companions. Birth companions can be an important partner in care provision. We can have the identification card for the birth companion. But we should to tell them to administer saline. She is there for simple emotional support. Cochrane metaanalysis is there on the same as well, we can learn various ways to sustain and empower them to help as and when needed.

Position of choice is also a part of RMC. Give her the mobility-moving around and take any position she is comfortable, during labour and delivery. For example, the evidence favours upright position liked by the lady and is good for her as well (less episiotomy rates, etc.)

There should be separate policies for management of high risk pregnancies.

Discussion and insights: Dr Narender told that at the policy level also, we are taking care of what the patient wants. We are planning to have the birthing beds instead of delivery tables. It is going to be implemented in the years to come.

- Implementing RMC in childbirth (game)

Discussion session was there on various scenarios including timing on clamping and cutting the cord, recommended on allowing liquid and semi-soft diet during first stage of uncomplicated labour, shaving the perineal hair in order to control infections (didn't agree- becomes unnecessary intervention), early amniotomy and oxytocin infusion in all uncomplicated labours (may be violating RMC- unnecessary procedure), applying fundal pressure to shorten the second stage of labour (may violate RMC if it is not approved by the lady to perform); practice of performing suction of every newborn to help it to establish regular breathing (do not agree because the new born will tend to breath on its own), no need to inform woman and obtain her consent before doing necessary medical procedures in labour rooms like internal examination, oxytocin augmentation, giving episiotomy, etc. (violates RMC- Non-consented care; but may be due to high case load, may get violated), examining laboring woman in front of other women in case of high case load (may violate RMC- has to make a system to reduce the incidence); separate room for delivering HIV infected pregnant woman (mostly agreed; but trainers have to keep in mind that it is not infectious--- in response--- the doctors are practicing according to guidelines because there may be blood spilled which needs proper cleaning before making next patient use that bed, and it takes more resources to clean a room soiled with infected blood)

Planning to obtain RMC in our practices:

Identifying improvement goals; making a team (it is not a one person job) of enthusiastic, involved; making an aim statement (what, when, why, how much, by when); setting a timeline.

Conclusion: all the interventions should be medically indicated and not unnecessarily done

- Performance Standards and assessment of RMC

Set an aim; analyze current systems (explore detailed possible causes); develop simple measurement systems (e.g. % of women who were draped, asked their preference of birth companion, taken consent form, explained why some procedure was done, etc.). Follow a PDSA cycle to plan your interventions for RMC.

Key to success: Identifying local champion, personal aspirations, and positive attitudes.

Experience sharing: the PGI people found that there is a problem of poor communication e.g. the patients are not being called by their names.

## SEPARATE SESSIONS FOR FACULTY AND NURSING OFFICERS
## Part B: Sessions for Nursing officers

# SESSION II: Introduction & Ethics

**Mrs. Evelyn P. Kannan**
**Secretary-General, The Trained Nurses Association of India**

"Why did you want to become a nurse? What was the reason behind it? Mrs. Evelyn started her session by asking these questions to the participants. Participants responded, I wanted to give injection, passionate for uniform, accompanying doctor in the hospital corridor with stature, even if not interested we got into nursing. What was the first thing you learnt when you came into nursing? Did you learn about the injection? First three months were all about basic procedures, there was no injection, just basic medical procedures.

How many of us decided that we want to run away from this, I am not made for it. I tried number of times to leave as the scenario was completely different when I got into it. It was not merely giving an injection. I didn't understand what I had got myself into. I studied in Tamil medium and everything here was in English and studying in Mission hospital was very difficult, but then I could not leave it and go back home as I will get scolding from father so had to push on. One day in 1980, I was standing outside the OT and one ward incharge was pushing a trolley and taking patient from OT to ICU. She asked me to come and push this trolley from behind. I didn't like it, I am a nurse I am supposed to give injection and she is asking me to push trolley, this is not my job. What other people will think of my profession because it was a visiting area as well. So I was not willing but trying to be very clever, very cunning so I told her, ma'am I do not know how to push the trolley please teach me. I knew that this was not the time for teaching, we have to save the life of a patient. The moment I told her she got angry as she was very committed, very passionate and compassionate. She just looked at me angrily and told me "chodo" (leave it), I got very happy and ran inside the operation theater. But she took the patient to ICU, made him comfortable, handed over things nicely to the other sister and went to the Principal's office and complained that Evelyn is not willing to push the trolley. While imagining this incident she must have told the Principal that she has just joined first year of nursing and look at her aptitude, attitude, she should be sent back. Because in those times they used to say if your attitude and aptitude is not correct towards nursing, why have you come here to join as a nurse? So I was immediately called to the Principal's office and I thought to myself that today is my last day, as in those days teachers were very strict and if they did not find you fit as it was my preliminary period of three months, there was a high chance that I would be sent back. I told myself, God please forgive me this time because if I go back home then I shall be scolded very much. The moment I came to meet the Principal, she asked me one question, Evelyn if your mother would have been on that trolley or stretcher fighting for life or death, what would have been your reaction? Would you have given the same excuse?

She asked me this question three times and I just kept standing there for two hours after she left. On March 9$^{th}$, I got a telegram from home that my mother is no more. I was just in first year. One day I was just thinking what made my mother to die? Fortunately or unfortunately my mother also died in OT, her operation was not successful. That was the day when there was a change in my attitude and aptitude towards nursing. I thought as a nurse I can do much more even if I am a first year student.

When in first year, we do little bit of asking the history to the patient, asking how are you, then learning how to check the vitals and it is such a thrilling experience. Then going back in hostel room and checking everyone's vitals but in second year, there s a change and so on in subsequent years, you come to know the vitals of the patient s just by looking at them. No, checking vitals are important, I am sharing this as this is what happened with me. Now when I look back, everything was very important for my mother to survive, if somebody had not checked pulse of my mother properly I've lost my mother, maybe, somebody has not checked her breathing properly, then I've lost her. These are very basic things, maybe my mother would have required blood and the nurse would have gone to the blood bank and probably would have indulged in talking to them for long and when she came back, I've lost my mother, maybe, so somehow who is at loss? I am, because I am a motherless child. Let me change this about my nursing profession. I said to myself, Evelyn you can do much more.

The way I talk, the way I walk, the way I look, the way I touch, I can make a change. "Aap kaise hain, ek word kaafi hai" (How are you? Only one word is enough), as soon as the patient enters the ward, "Aap kaise hain? Neend aya kya? (How are you? Did you sleep properly?)" Ek word kaafi hai (One word is enough). As a nurse we can do much more that's why I always feel that, I used to fight with doctors that you are responsible for only 15%, but I am responsible for 85% and that is care, you are only cure. The doctor used to feel bad but this is true, 85% is care and I am responsible for it. Let us all feel proud and feel like wow, that I am a nurse. I can bring much more change, "yeh ek word change kar sakta hai"(This one word can change everything). I can do anything that's why I am a nurse.

So today we are going to talk about RMC. But this has been taught to us since the beginning, even I remember how they told us how to walk in the ward when patient is sleeping, how to explain the things to the patient, every procedure. They'll tell us welcome the patient, smile, yes or no? Make the patient comfortable , explain the procedure to the patient then only are we supposed to do anything.

So what is ethics? Rules for correct behavior. "Ghar me batate hain kaise uthna hai, kaise sona hai, kaise respect dena hai" (You are told at home on how to get up, how to sleep, how to give respect), isn't it? How to deal with our seniors and everything but as a professional we are being taught on how to take care of our profession, what are the professional ethics? Just touching upon this topic, I was wondering that this we have been learning since so long and now maybe only we are refreshing our knowledge but how much of it are we putting it into action?

A set of norms or rules for correct behavior. How to do that? That's what we are talking about all this, all these things you got to learn. These are the moral principles that guide a person's conduct or behavior'. The need for nursing is universal and respect for human rights and cultural rights. We as a nurse have learnt this in first year of nursing but if you go back to the nursing book and see its fundamentals, we have learnt all this, how to respect, how to address patients. We cannot address them as bed no. this or that but we have been taught how to address them as Mr. and Mrs., I used to write only the name of the patient and my principal used to tell me that no write Mr. or Mrs. The right to life of choice, dignity and to be treated with respect. What are the four fundamental duties of a nurse? These are the basic in first year. I know we have all gone through it long back, but let us all refresh these learnings and bring it back just to encourage and remind ourselves.

Nursing, the word itself is recognizing , understanding and meeting the health needs. Isn't it? Recognize, as soon as the patient comes, we come to know what is wrong with the patient so nursing care is

respectful of and unrestricted by considerations of age, colour, creed, culture, disability or illness, gender, sexual orientation, nationality, politics, race or social status, these all things we have learned so whatever maybe, you and me are supposed to give them the extraordinary care to the individual. So 6 keys in ethical principles of nursing and this also we have learnt earlier as Non-maleficence, Beneficence, Fidelity, Autonomy, Integrity and Justice.

Addressing the elements of code of ethics, what is the first element of code of ethics? Nurses and people because we are not dealing only with the instruments, we are dealing with the human beings. The nurse's primary professional responsibility is to the people requiring nursing care. In providing care, the nurse promotes an environment in which the human rights, values, customs and spiritual beliefs of the individual, family and community are respected. That's what we are talking about respect and abuse and if we follow these, we are not going to be in the problem at all.

The 2nd elements of the code of ethics are the nurses and practice. First you consider them as a human being, second whatever I have learned in my life as a professional nurse, I am supposed to do it. Responsibility and accountability for nursing practice and for maintaining competence by continuous learning- The nurse maintains a standard of personal health such that the ability to provide care is not compromised. Whatever I have learnt I have to put it in proper practice.

3rd element of the code is nurses and the profession because this nursing is our calling. It does not matter how we have come into this profession, by choice, by force or by anything else but now none of us wants to leave this profession and want to carry this whole life so this is our profession. The nurse assumes a major role in determining and implementing acceptable standards of clinical nursing practice, management, research and education. We have already talked so much about abuse, verbal abuse, physical abuse, and as a nurse I am not supposed to do all these things, I am supposed to implement the acceptable standards that is why the behavior, what am I supposed to do, how am I supposed to talk, all this you have to take care.

The 4th element of the code i.e. nurses and co-workers - the nurse sustains a collaborative and respectful relationship with co-workers in nursing and in other fields. I am not only that, the nurses and the people, nurses and the profession and practice, I also am a co-worker, I am not only an individual. As a nurse we also have to work along with all our co-workers maybe in different faculties, other departments, as a nurse we have to coordinate and cooperate with others because our fundamental right is taking proper care of the patient, alleviating suffering, in order to take care of all these goals, I have to work along with other co-workers, these all are enlisted under the code of ethics.

# SESSION III: Understanding rights-based approach

**Mrs. Evelyn P. Kannan**

Nursing is not a new profession, it is many thousand years old. Archeological evidence of woman demonstrates the existence of midwifery in 5000 BC. If we read old bible, two Hebrew midwives Shiprah and Puah, the King had given orders to kill all the male children but due to fear of the God, they saved them. That means in those days, from the beginning the midwives used to care for the human beings even if they had to disobey the order of the Kings because they know that they had to take care of the patients, which is their primal responsibility.

ICM which is International Confederation of Midwife recognizes midwife as a responsible and accountable professional who works in partnership with women to give the necessary support, care and advice during pregnancy, labour and the postpartum period, to conduct births on the midwife's own responsibility, and to provide care for the newborn and infant, that means the reproductive cycle. As a nurse I am supposed to give proper care even in partnership with the midwife because the meaning of midwife is "with woman" isn't it? As this is the whole process, we have to support and be with the woman. This care includes preventative measures, the promotion of normal physiologic labour and birth, the detection of complications, the accessing of medical care or other appropriate assistance and carrying out of emergency measures. They have seven competencies, everything about this was learnt in 4$^{th}$ year of nursing.

Competency 1: Midwives have the requisite knowledge and skills from obstetrics, neonatology, the social sciences, public health and ethics that form the basis of high quality, are culturally relevant, have appropriate care for women, newborns, and childbearing families. So, as a nurse this is the competency, we have to equip ourselves with knowledge, then after that we have to transfer, the qualities of the nurse i.e. care , compassion to the heart and have to put it into action. Competency 2: Midwives provide high quality culturally sensitive health education and services to all in the community in order to promote healthy family life, planned pregnancies and positive parenting. Competency 3: Midwives provide high quality antenatal care to maximize health during pregnancy and that includes early detection and treatment or referral of selected complications.

Sharing an instance of a 7$^{th}$ month pregnant woman coming from a village in South, as a community worker I have also worked in that village so I knew where she came from. She came, got check up done and it was the case of PROM and was still in leaking period, had lost her child. The nurses told her to immediately get admitted. She was not willing to get admitted and somehow went back to the village and came back the third day. All the nurses started shouting, why didn't you get admitted when we asked you to? I just went upto her and asked politely why didn't you get admitted, what was the reason? She said my husband has left me, and I didn't have money to get admitted, I went back home worked for three days in the field, and at that time they used to pay Rs.7/- per day for work. I have just collected 21Rs, she then handed it over to me, this was her reason. I was in tears, the day I remember all these instances, it makes me think. But I was not aware of all these things, I as a nurse am shouting at the patient why didn't you come but nobody wants to lose a child, even animals are so protective of their babies. As a nurse, I should realize that as a mother I would do everything I can to save the life of one's child. Let us identify what made us do what we did.

Story of another patient, a 70 year old man, again doctors were shouting, we have told you that you have TB and need to take six months medication but why have you come like this after six months? Do you know its seriousness, you'll die. Then I asked the patient softly, why what happened, why didn't you come after one month, you are coming after 6 months? Every month you are supposed to take drugs for the cure of TB. He said madam I did not know, they gave me 6 packets of medicine and I took them one by one. They told me to come two days before it gets finished, now why are they shouting at me, I do not know, where I went wrong? This is actually my responsibility as a nurse, because we are blaming them, not doing this and that, he was supposed to be given discharge summary with proper explanation, what type and when to take the medicines, its side effects and everything. We learnt this in second year of nursing, isn't it? Right medicine, right patient, seven and now ten rights but then whom do you blame? Please think what am I supposed to do, sometimes we start shouting at the patient unreasonably.

Competency 4: Midwives provide high quality, culturally sensitive care during labor, conduct a clean and safe birth and handle selected emergency situations to maximize the health of woman and their newborns. She shared a sensitive story of a 5$^{th}$ gravida patient in this context. We need to sensitize ourselves so that we can change, we cannot change everyone. Lot of gaps are there, nurse –patient ratio is 1:5, other issues like no promotions, but as a nurse whatever I am supposed to do, I got to do. It is not about making us feel bad but what am I supposed to do as a nurse, we should realize. So taking care of the patient, giving them water to drink, comforting them, all these little things matter.

Labor is the only pain we are increasing , other pain we always tend to decrease but labor pain is only increasing by this behavior of disrespect and abuse. As a woman how we tend to cover ourselves, the drape given to the patient is sometimes worn in a wrong manner but then the patient is laughed at. As a patient, think that for the first time I am coming to the hospital for this procedure and everything is different for me, they do not know. So, inform them nicely, because our perspective is different from theirs. If we mock at the patient how she has draped the robe, then we are giving her a mental trauma and a humiliating experience she will carry for her whole lifetime. I have two kids and they both are grown up, but I still remember the labor pain, doctors and nurses who attended to me 23 years ago and who all were there during my labor. I still remember every minute of it, so if you have done it nicely to the patient, they shall remember and if not, they will still remember it. They won't know the name but they will remember face of the nurse. You are beyond a nurse merely giving an injection. We are in a wonderful profession. How our teachers used to scold us for a mistake and then used to tell us to wash your face and go, don't show this face to a patient, Isn't it? At times we know how to smile and we know how to cry. We know how to take care of ourselves, to take care of husband and family, so nurses are very mentally stable.

We as a nurse can do multi-tasking, and those too Indian nurses only. Recently TNAI has become a recruiting agent and I happened to meet the immigration officer to whom I asked as to how are the Indian nurses? They said Indian nurses are excellent, they are critical thinking nurses but we like to put them into ICU and CCU. But why not general wards, I asked. In general wards, we need Philippine nurses, as Indian nurses don't talk too much though they are hardworking and focused but we need them in more intensive care units whereas Philippine nurse will ask how are you, they are good at talking and speaking, so we put them in general wards. So this is the area I felt which is the communication aspect that we need to work upon and change. She shared an instance of a girl who used to explain the procedure very nicely to the patient, spending around 40 minutes on it. The other day I asked that girl what is the name of the patient and she said I don't know. From morning till evening she was working but

how many patients in ward, how many patients in post natal care, she doesn't know. This is what we have to change. Nursing is full of energy and power, let us get back that power. Let us get back our 85%. If we try we can bring the heaven down.

Competency 5: Midwives provide comprehensive, high quality, culturally sensitive post-partum care for women. Every area, ante-natal, intra-natal and post-natal we have to be sensitive so that is the competency because we need to know every little information and put it into action. I and You are responsible. Competency 6: Midwives provide high quality, comprehensive care for the essentially healthy infant from birth to two months of age. Competency 7: Midwives provide a range of individualized, culturally sensitive abortion-related care services for women requiring or experiencing pregnancy termination or loss that are congruent with applicable laws and regulations and in accord with national protocols.

What are the areas that we nurses can take part as, because this is the very sensitive area as we all are human beings. Let us all work together, let us all come together, you and me have to come together. I have the power, you have the power, we all have the power. When this I, you and we put together we can change the entire scenario altogether and we are talking about the respectable maternity care now but it was already being talked about back in those days. Let us rededicate ourselves. As a nurse, whichever area I have, let us do my area seriously. The main goal of providing maternal and child care is to ensure to have healthy mother and baby. Once we come to know that we are pregnant, this is the most precious moment. I will be thinking, I will be imagining, I will be dreaming how my child will be, so this is one of the most precious and important moment. Our main goal is at the end of it, we want a healthy mother and a healthy baby. All women deserve respectful and dignified care during pregnancy and childbirth and no woman should be penalised and abused for choosing to become mother. Shared an instance of a senior nurse taking charge from junior doctor and how she saved a life of the mother and the child as her moral responsibility.

Interactive session with nurses was done who also shared their experiences, asked a query on their protocol. Mrs. Evelyn said nurse midwifery is also coming now with legal abiding nurse practice act. As of now, we do not have a nursing act. We do have Indian nursing council act but they are for regulation and not in practice. So we should know what in practice as a nurse we should do and what not to do. Then when act comes, we will be accountable and punishable at the same time if we do something wrong. All these years, things have improved and with due course of time, this shall also improve. "Ek din hum honge kaamyaab (One day we shall succeed)".

**Role of Nurses to ensure Maternal and Newborn Health through Respectful Maternity Care (RMC)**

We have already gone through the categories i.e. physical abuse, non-dignified care, non-consented care, non-confidential care, discrimination, abandonment or withholding of care and detention in facilities. We have already learnt about physical abuse, i.e. sometimes pinching when you are conducting the delivery when the patient is not bearing in the second stage. We do pinch, push on the abdomen, unnecessary episiotomy is done, stitching without anesthesia on the excuse that it takes time for giving local injection is practiced.

If we see, the second stage of labour is just 30-40 minutes but we linger the first stage too much. It is so difficult, the pain is unbearable and moreover when you are keeping the patient in one position for long, cramps in legs are bound to happen and is so painful but we don't even bother if the patient keeps

saying. How do we feel ourselves? when in middle of the night, cramp in leg comes? Immediately you tend to stand up, you wont put yourself in that position for long, Isnt it? Nursing is full of empathy.

Each category of RMC was discussed with patient's experiences in each one of them.

**Recommendations to promote RMC**

She proposed certain recommendations at policy, facility and at individual and community level. At the policy level:

1. Incorporating RMC as an integral component in maternal health programmes.
2. Inclusion of RMC in training and curricula of health care providers.
3. Ensuring a good working infrastructure (beds, screens, hygiene, medical supply, blankets and sheets) and service providers (Doctor and Nurses)

At the facility level:

1. Observe a zero tolerance rule for all forms of disrespect.
2. Allow a birth companion during labor and delivery
3. Training for service providers on interpersonal skills, clinical empathy, patient's rights, behavior, communication and gender sensitivity.

At the individual and community level:

1. Keep women in the centre.
2. Enable women to expect and demand for RMC as their basic right.
3. Promotion of birth preparedness among women and communities.

# SESSION IV: Psychological debriefing of healthcare providers

**Mrs. Evelyn P. Kannan**

Stress is a normal part of life that can either help us learn and grow or can cause significant problems. Stress itself is not harmful – it is our reaction to stress/ stressors that causes illness or disease. If we don't take action, the stress response can create or worsen health problems. Prolonged, unexpected, and unmanageable stressors are the most damaging types of stress. The current scenario of stress was highlighted emphasizing on the fact that as per World Health organization (WHO), by 2020, five of the top ten medical problems world-wide will be stress-related.

Briefly touching upon the type of stressors and its implications on personal and professional life, certain stress management strategies were highlighted. The significance of physical health where one needs to take care of the nutrition intake, exercise, sleep and relaxation was discussed and mental strategies on assertive communication, planning vacation, developing hobbies were emphasized upon. Taking care of the spiritual aspect where meditation, seeking solace in prayer, participating in support groups, networking and also seeking professional counseling were discussed.

Organizational strategies such as employee assistance program, formal discussion groups, professional consultations, time management classes and employee wellness programs to combat stress were discussed. Unhealthy ways of coping with stress like smoking, drinking too much, over or undereating, intake of drugs to relax, might give short term benefits but are pretty harmful in the long run. Stress and mental health problems are closely related to unhealthy lifestyles that pose risk for mental and physical health. The message that there is no health without mental health is worthy of notice. Indeed, mental health is closely related to physical health, therefore interventions for promoting mental health, such as stress management will also improve physical health. While concluding the session, she told story of a tortoise and a butterfly. We have all heard about tortoise and rabbit. But this story is of tortoise and a butterfly. So among the two which one we like the most, butterfly or a tortoise? Butterfly ofcourse. Why? As they are beautiful, they are colorful, they fly high, they bring honey.

But how much is life span of a butterfly? Only 3-4 weeks but on the contrary the tortoise lives for around 100-150 years. They are hard, they are lazy and they move very slowly. So one day this butterfly happened to go to the tortoise and he said, hey butterfly how dare you, do you know who I am? But butterfly didn’t have time to talk, she went away, enjoyed, danced over one flower after another, drank honey and enjoyed completely. In evening while returning back, the butterfly again came across the tortoise. He was still sitting at the same place, in a very angry mood. Hey butterfly how dare you, do you know who I am? Yes, I know you are a tortoise said the butterfly and do you know how long I live? Ofcourse 100-150 years, the butterfly said. Do you know who you are? I know I am a butterfly. Do you know how long you live? Yes sir, I live for only few days. How dare you can come to me, I live for so long. She just looked at him and said, how long you live do not matter, how you do and I live matters.
We nurses are like butterflies but with quantity of life like a tortoise. The way I walk, the way I talk, the way I look, the way I touch, I can make a change.

Can you make a change?

Yes we can and we will. The nursing officers responded.

# COMBINED SESSION FOR FACULTY AND NURSING OFFICERS

# SESSION V: Developing an action plan to implement RMC

**Group work**

**Dr. Manmeet Kaur**

The main concern now remains: how to monitor the program you planned!
Dr Manmeet Kaur suggested choosing a mentor amongst themselves. The team members can practice self-monitoring- why did I behave in a manner that I did? This self evaluation will enable us to find solutions to the issues we are facing.

Conclusion: Every consultant will be a mentor. Set the example for your team. Monthly meetings will be a platform where team members would discuss with mentors about the issues they faced, resolved, and are left to be resolved (last Tuesday review meeting of consultants and residents as practiced right now in PGI). The mentor is supposed to be that person to whom everyone listens to, taking care to address all the soft issues which make part of our behavior.

Suggestions to plan and implement interventions:

- All consultants will be mentors
- Every month last Tuesday will be a review meeting
- Bed side nurses will be mentors
- A combined meeting of doctors and nursing staff (consultant+ residents+ senior nursing officers) will be held so as to understand the problems faced by various categories of health care providers;
- On Privacy:
    - Use of curtains in OB II in CLR
    - 30-40% use for female in active labor
    - In 3-4 months time
    - One time activity
- Birth companion
    - For female in advanced labor only
    - For supervised female only
    - Need sensitization of CLR team
    - Immediate
- AIM – To reduce money offerings by 50% in 6 months
    - Baseline survey (as we do not know current)
    - CLR Sister incharge
    - Resources – sister, security guard, patient, cctv
    - Zero tolerance
    - Discharge from the hospital
- Posters on ‘NO VIOLENCE POLICY’,
- Smiling faces or emojies if allowed by the people managing labor room
- Instrumental nice very light music if possible in the labor room
- LED display for post-partum patients on various self care practices

(Dr Narender said that they are already having material prepared in this regard and is being revised now; also, think of the solutions which can be implemented at the facility level on your own. I have witnessed at places an oath towards RMC and one or the other person reads it out loud every morning);

- Innovative ways to generate funds for poor patients;
- Putting the right signages so that the patients are able to identify labs, and various rooms they may need to pay the visit to.
- Identification of local champions, personal aspirations, and positive attitudes.
- Addressing problem of poor communication e.g. the patients are not being called by their names in PGIMER.

## SESSION VI: VOTE OF THANKS

**Dr Madhu Gupta**

Dr Madhu thanked all the participants and facilitators for their participation and commitment towards respectful maternity care. Participant's involvement and the drive to bring change were appreciated.

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# APPENDIX-I
# LIST OF CHAIRPERSONS, SPEAKERS AND PARTICIPANTS

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# APPENDIX-II
# AGENDA FOR FACULTY

**Training of Trainers (TOT) on Respectful Maternity Care (RMC) for Health Care Providers**
**Postgraduate Institute of Medical Education and Research (PGIMER), Chandigarh**

**Date 31.08.19**

***Venue: LT 2&3, Nehru Hospital, PGIMER, Chandigarh***

**AGENDA FOR FACULTY**

**Objectives**

- Attitudes, practices and communication skills for patient-centered care.
- Creating an enabling environment in the health facilities for RMC.
- Develop a mentorship program for RMC

| Time | Session Details (combined for Faculty and Nursing Officers) | Dignitaries |
|---|---|---|
| 12:00-12:02 | Welcome address | Dr.Vanita Suri, *Prof and Head, Department of OBG, PGIMER* |
| 12:02-12:12 | Government perspective on RMC | Dr. Narender Goswami, *Sr.Consultant, MOHFW* |
| 12:12-12:22 | Inaugral address | Prof. Rajesh Kumar, *Dean Academic, PGIMER* |
| 12:22-12:37 | Keynote address | Prof. Jagat Ram, *Director, PGIMER* |
| 12:37-12:42 | Background and objectives of the RMC study | Dr. Manmeet Kaur, *Professor of Health Promotion, PGIMER* |
| 12:42-12:45 | Vote of thanks | Dr. Madhu Gupta, *Professor of Community Medicine, PGIMER* |
| **12:45-13:15** | **Lunch** | |
| **Time** | **Session** | **Facilitator** |
| **13:15-14:15** (1 hour) | **Session I: Introductory Session and Setting the Tone**<br>• Welcome, Introduction, Expectations, Training Norms,<br>• Visioning Activity,<br>• Objectives, Training Methodology<br>**Respectful Maternity Care–Key Concepts**<br>• RMC and its key concepts-disrespect, abuse, dignified, rights-based approach<br>• Global and Indian evidence of D&A<br>• Categories of disrespect and abuse during pregnancy and childbirth<br>Drivers of D&A<br>**Group Work on Types of Disrespect and Abuse**<br>• Group work on disrespect and abuse<br>• Roleplay-Scenario 1,demonstrating D&A followed by discussion.<br>• Role play- Scenario 2, demonstrating D&A followed by | Dr. Nomita Chandhiok *Consultant, ICMR. Former Scientist G,Div.of RBMCH, Indian Council of Medical Research* |

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|---|---|---|
| | discussion<br>• Roleplay-Scenario 2, demonstrating RMC followed by discussion | |
| **14:15-14:25** | **Break - Nurses separated. For Faculty only** | |
| **14:25-16:50** (2hours 25mins) | **Session II: Caring for the Care Givers**<br>• Work-related stress as a driver of D&A during facility-based childbirth<br>• Impact of difficult or traumatic work experiences on providers<br>Interventions that can lower work related stress and reduce D&A<br>**Session III: Promoting Mutual Accountability**<br>• Key Stakeholders in RMC and Mutual Accountability<br>• Responsibilities of health service providers and of patients/clients<br>Client feedback and grievance redressal mechanisms.<br>**Session IV: Implementing Facility Based Respectful Maternity Care During Service Delivery**<br>• Evidence based strategies to reduce disrespect and abuse<br>• Global and GoI recommendations for inclusion of RMC in service delivery<br>• Implementing RMC in childbirth (game)<br>Performance Standards and assessment of RMC | Dr. Aparna Shrotri<br>*Former Head of the Department, OBG, BJ Medical College, Pune*<br><br>Dr. Nomita Chandhiok<br><br>Dr. Aparna Shrotri |
| **16:50-17:00** | **Nurses proceed to LT2. Sessions combined for Faculty and Nursing Officers** | |
| **17:00-17:40** (40mins) | **Session V: Developing an action plan to implement RMC Group work**<br>• Mentoring, supporting and supervising residents<br>• Summary of the days learnings<br>• Wrap-up for the day | Dr Manmeet Kaur<br>Dr. Madhu Gupta |
| **17:40-17:45** (5mins) | **Vote of Thanks** | Dr. Madhu Gupta |

# APPENDIX-III
# AGENDA FOR NURSING OFFICERS

**Training of Trainers (TOT) on Respectful Maternity Care (RMC) for Health Care Providers**
**Postgraduate Institute of Medical Education and Research (PGIMER), Chandigarh**

**Date 31.08.19**

***Venue: LT 2&3, Nehru Hospital, PGIMER, Chandigarh***

**AGENDA FOR NURSING OFFICERS**

**Objectives**

- Attitudes, practices and communication skills for patient-centered care.
- Creating an enabling environment in the health facilities for RMC.
- Develop a mentorship program for RMC

| Time | Session Details (combined for Faculty and Nursing Officers) | Dignitaries |
|---|---|---|
| 12:00-12:02 | Welcome address | Dr.Vanita Suri, *Prof and Head, Department of OBG, PGIMER* |
| 12:02-12:12 | Government perspective on RMC | Dr. Narender Goswami, *Sr.Consultant, MOHFW* |
| 12:12-12:22 | Inaugral address | Prof. Rajesh Kumar, *Dean Academic, PGIMER* |
| 12:22-12:37 | Keynote address | Prof. Jagat Ram, *Director, PGIMER* |
| 12:37-12:42 | Background and objectives of the RMC study | Dr. Manmeet Kaur, *Professor of Health Promotion, PGIMER* |
| 12:42-12:45 | Vote of thanks | Dr. Madhu Gupta, *Professor of Community Medicine, PGIMER* |
| **12:45-13:15** | **Lunch** | |
| **Time** | **Session** | **Facilitator** |
| **13:15-14:15** (1 hour) | **Session I: Introductory Session and Setting the Tone**<br>• Welcome, Introduction, Expectations, Training Norms,<br>• Visioning Activity,<br>• Objectives, Training Methodology<br>**Respectful Maternity Care–Key Concepts**<br>• RMC and its key concepts-disrespect, abuse, dignified, rights-based approach<br>• Global and Indian evidence of D&A<br>• Categories of disrespect and abuse during pregnancy and childbirth Drivers of D&A<br>**Group Work on Types of Disrespect and Abuse**<br>• Group work on disrespect and abuse<br>• Roleplay-Scenario 1,demonstrating D&A followed by discussion. | Dr. Nomita Chandhiok *Consultant, ICMR. Former Scientist G,Div.of RBMCH, Indian Council of Medical Research* |

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|---|---|---|
| | • Role play- Scenario 2, demonstrating D&A followed by discussion<br>Roleplay-Scenario 2, demonstrating RMC followed by discussion | |
| **14:15-14:25** | **Break - Nurses proceed to LT3** | |
| **14.25-16:50** (2 hr 25 mins) | **Session II : Introductory session** | By Participants |
| | • Principles of ethics<br>• Themes of ethics that promote RMC<br>• Core Competencies for Basic Midwifery Practices<br>**Session III: Understanding rights-based approach**<br>• Rights-based approach to reproductive health<br>• Universal rights of childbearing women<br>• Nurses Role to ensure Maternal and Newborn Health through RMC<br>**Session IV: Psychological debriefing of health care providers**<br>• Work related stress as a driver of D&A during facility based childbirth<br>• Psychological debriefing sessions as a strategy to reduce work related stress<br>Role Play-Communicating Women's Right to dignified Child Birth | Mrs. Evelyn P. Kannan<br>*Secretary-General,*<br>*The Trained Nurses Association of India* |
| **16:50-17:00** | **Nurses proceed to LT2. Sessions combined for Faculty and Nursing Officers** | |
| **17:00-17:40** (40mins) | **Session V: Developing an action plan to implement RMC Group work**<br>• Mentoring, supporting and supervising residents<br>• Summary of the days learnings<br>• Wrap-up for the day | Dr Manmeet Kaur<br>Dr. Madhu Gupta |
| **17:40-17:45** (5mins) | **Vote of Thanks** | Dr. Madhu Gupta |

# RESPECTFUL MATERNITY CARE TRAINING OF TRAINERS