OIC PEER-TO-PEER CLUSTER MEETINGS FACILITATOR'S GUIDE

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Breakthrough ACTION FOR SOCIAL & BEHAVIOR CHANGE

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Contents

Overview

Providers play an important role in fever case management, labor and delivery, and malaria in pregnancy. In addition to providing care in adherence with national guidelines, they must also provide care in a respectful and client-centered manner. Studies in Nigeria have shown a high prevalence of disrespect and abuse during antenatal care, labor, and delivery; prevalent knowledge gaps in malaria in pregnancy protocols; and low reliance on malaria tests to guide prescribing practice. Making strides in these areas require shifting norms and attitudes among providers, improved skills and knowledge, as well as a supportive work environment.

The "cluster meeting" approach is designed to address many of these factors. The primary target audience are the heads of primary health care facilities, called officers-in-charge (OIC), who convene once a quarter to discuss common misconceptions and barriers, troubleshoot, share progress and exchange successes and lessons learned, and to track each other's progress. The theme changes every quarter, cycling from appropriate fever case management, prevention and treatment of malaria in pregnancy, and respectful maternity care, with brief follow-up and refreshers on the previous quarter's theme.

Meeting activities include engaging discussions, games, and role play, and each meeting covers cross-cutting skills such as interpersonal communication skills, facility management, and appropriate documentation in health facility registers (in addition to the focus theme). Between quarterly meetings, contact between OICs is sustained through each cluster's WhatsApp group, where they continue to discuss challenges, tips, and successes.

Cluster meetings create a platform for accountability and peer exchange and help establish norms. OICs are tasked with facilitating similar conversations among staff *within* their facilities, and the interchange among OICs sets norms *across* facilities. Other Breakthrough ACTION-Nigeria activities, including facility mentoring/coaching, clinical meetings with state and LGA authorities, and integration of content with professional associations, were all used along with OIC cluster meetings to change norms and set new standards across the health profession in Nigeria as a whole.

This guide includes resources for planning and facilitating OIC cluster meetings for fever case management, malaria in in pregnancy, and respectful maternity care. To assess progress, pre- and post-test data are digitized and used to track changes over time. Data on trends in OIC perceptions scores are triangulated with Health Management Information System (HMIS) data on fever case management and malaria in pregnancy to see if changes in OIC perceptions track with improved facility performance. In the case of respectful maternity care, outcome data on the client experience may not be available through HMIS, so periodic client exit interviews may be needed. When progress in OIC scores is not matched by progress in health facility performance, direct follow-up support to facilities to better understand the facility context and ensure alignment among all providers may be needed (see Breakthrough ACTION-Nigeria's Facility Mentoring/Coaching Guide).

Fever Case Management Cluster Meeting Facilitation Tools

Preparatory activities and supplies needed

- Flipchart
- Markers
- Pen and paper for providers
- Print copies of materials for the meeting:
- Provider dialogue framework (one per facilitator)
- Step-down meeting planning form (1 per participant)
- Pre-test (1 per participant)
- Post-test (1 per participant)
- Fact and Myth cards (one pair per participant)
- Print-out of “Separating myths from facts” slides (1 per facilitator)
- Print and compile one packet of materials per OIC to use when they return to facility
- Step down meeting planning form
- Provider dialogue framework
- Separating myths from facts print-out
- Report form

Agenda

Opening and pre-session evaluation	**30 mins**	
Materials needed	Pretest forms and pens	
Opening	**Welcome remarks, introductions & objectives of the meeting** ● Welcome everyone. Introduce yourself and ask participants to introduce themselves ● Read and explain the objectives of the meeting as follows: ○ To address provider misconceptions around fever case management ○ To develop action plan for step down orientation at the facility ○ To discuss ways that the PHC providers can strengthen this network and continue to support one another.	15 mins
Administer the pre-session evaluation	● **Explain** that you will administer a pre-test to understand what they know about the issue and to help us compare how the former evaluation conducted a quarter ago, differs from this ● **Distribute** the pre-test forms and pens. ● **Instruct** them to fill out their information on the first page. ● **Say** you will read the questions out loud. They should quietly fill in their answer. ● **Read** each question out loud. ● **Collect** the forms at the end.	15mins

Provider dialogue framework	**60 mins**	
Materials needed	Provider dialogue framework	
Addressing misconceptions around fever case management	● **Introduce** each question on the dialogue framework ● **Address** provider misconceptions around each point on the dialogue framework ● **Ask** participants to reflect on what we learned and how they want to improve ● **Ask** participants to write down action points on how they will improve	60 mins
Tea break	**15 mins**	

Separating myths from facts	**30 mins**	
Materials needed	Fact and Myth cards PowerPoint slides/Laptop/projector OR Print-out of slides	
Group Activity	**Make an interactive presentation using the slide deck or the print-out of the slides** ● **Share** “fact” and “myth” cards to participants. Each participant gets on of each ● **Explain** to the participants that you will project or read out a series of statements	30 mins

	• **Tell** the participants to listen to each statement and decide whether it is a fact or a myth • If they think the statement is a fact, they should hold up the "fact" card. • If they think the statement is a myth, they should hold up the "myth" card • **Encourage** everyone to participate • **Read** out each statement and let each participant hold up a card that reflects what they think about the statement • **Reveal** the correct answer • **Explain** the reason for the answer. • **Give** some time after each statement and reveal for discussion and to address any lingering misconception	

Action planning for step-down orientation at facility	**30 mins**	
Materials needed	Step-down planning templates	
Group Activity	**Develop action plan for step-down orientation at facility** • **Share** forms in duplicate to participants • Participants develop plans for step-down using the planning template • Participants submit a copy of the plan to the RBM focal person who is responsible for collecting the reports	30 mins

Peer-to-peer linkages and WhatsApp group engagement	**30 mins**	

Discussion	• **Brainstorm** on strengthening this peer-to-peer linkage
	  ○ Does this forum add any value to providers?
	  ○ How can we strengthen the network among providers?
	  ○ How can we have effective WhatsApp engagement?
	• **Brainstorm** on WhatsApp discussion questions. Potential questions:
	  ○ How are the step-down orientations going?
	  ○ Reiteration about the accuracy of malaria RDT tests and to ask if anyone is experiencing any challenges.
	  ○ How else can we strengthen this network?
	• Ask people to volunteer – appoint someone to ask a WhatsApp discussion question for each month. You don't have to use the questions above.
	• Remind people to add these to the action points in their planning forms.
		30 mins

Post-session evaluation and closing	**30 mins**	
Materials needed	Post-session evaluation forms	
Administer post-test	• **Distribute** copies of the post-test • **Say** you will read the questions out loud. They should quietly fill in their answer. • **Read** each question out loud. • **Collect** the forms at the end.	15 mins

Next steps and closing	• **Share** next steps
	  ○ Invite providers to share some of their action points
	  ○ Reminder on conducting step downs and being active on the WhatsApp platform.
		15 mins

	• Closing remarks	
Lunch		**30 mins**
Facilitators debrief- prep and lessons learned for next time.		

Provider Dialogue Frameworks for Fever Case Management

Methods for Diagnosis

Discussion questions	What providers might say and how to respond
Why do you think some health care providers do not trust RDTs?	Some health providers think that sometimes an RDT may give negative results, but when you do a microscopy, the result is positive. **FACT:** Most microscopists have not been trained ***specifically in malaria microscopy*** The training is very hard. It is easy to confuse artefacts and contaminants and other pathogens with malaria, and the malaria parasite itself has different shapes in different stages. Among people who have completed malaria microscopy training in Nigeria, only about 40% passed the test.
	Some providers think that RDT can miss some species of malaria **FACT:** P. falciparum is the most common species in Nigeria (95-99%). The other species are rare and even then, they rarely cause severe disease. You have the best technology possible for detecting malaria in Nigeria today.
	Some providers think that RDT misses cases with low parasite load **FACT:** Any patient with symptoms would have enough parasites to be detectable by RDT.
	Some providers think that when the storage is not good, the RDTs may go bad due to heat, or some may have expired, which is why they may give incorrect results. **FACT:** mRDTs are made to withstand our high temperatures. Even when they are recently expired, they still give correct results mRDTs that have been compromised for any reason will give an invalid outcome, NOT a false result.
How many health care providers do you think can accurately diagnose malaria based on their clinical judgment?	Some providers believe that doctors would be able to accurately diagnose malaria based on clinical judgement. **FACT:** You cannot diagnose malaria accurately without a malaria test Research has shown that only 12% of all health workers are able to diagnose malaria with anaemia correctly. Only 36% of medical doctors were able to give a correct diagnosis.

In your opinion, which is more accurate? A rapid HIV blood test or a malaria RDT?	Some providers feel that HIV RDT is more accurate than malaria RDT **FACT:** They are equally accurate (99-100% sensitive). They use the same technology.
When can you use microscopy?	Some providers feel that they can use microscopy if they have a microscope in their facility. **FACT:** You can use microscopy to **diagnose** malaria ONLY if you're a certified expert in malaria microscopy. If not, use RDT. Certified malaria microscopists are not available in PHCs. If a child has symptoms of **severe malaria**, use RDT to confirm malaria rapidly and give a pre-referral treatment. Refer the child immediately to a higher level of health care. The experts there can use microscopy to monitor parasite density in the first 2-3 days.

Quality Assurance for mRDT

Discussion questions	What providers might say and how to respond:
What quality assurance do you think is done to ensure the mRDTs give accurate results?	**FACT:** mRDTs are approved by WHO There are 3 laboratories in the world that conduct mRDT quality assurance by WHO One of the labs is in Lagos. mRDTs that come into Nigeria undergo quality assurance testing by the laboratory Lagos.
Did you hear about a study funded by WHO in 2017 where they collected mRDTs from heath facilities and national medicine stores and tested them for accuracy?	**FACT:** The study was conducted across 6 geopolitical zones in Nigeria Samples of CareStart and SD-Bioline RDTs were collected from 414 health facilities and National Medical Stores out of 646 in the study area. All the RDTs passed lot testing (100%), *even though some of the RDTs had expired.*
Based on the testing by NAFDAC, and the WHO study, do you think we can trust RDT results?	They should say they can trust the mRDT results.
Which malaria test is more susceptible to user errors (mistakes in the testing process) – RDTs or microscopy?	**FACT:** User error happens with both RDTs and microscopy. Sometimes the person conducting the RDT does not use the correct number of drops of buffer, or uses the wrong buffer solution, or does not wait the correct amount of time before reading the results. Different brands of RDT have different protocols. Always read and be familiar with the manual inside each pack of RDT before use.
Despite the potential for user error to affect the results of both microscopy and RDT, which one do you think is most reliable?	Some providers feel that microscopy is more reliable than RDT. **FACT:** RDT is the more reliable test especially for the PHC providers The health care provider can ask the lab tech to confirm that the correct procedure for the RDT is followed when performing the test.

Finding the Correct Ailment

Discussion questions	What providers might say and how to respond:
How common is malaria in children under 5?	Some providers think that malaria is the commonest cause of illness in children under 5 **FACT:** Malaria prevalence in Nigeria decreased to 27% in 2015 from 42% in 2010 (NMIS, expert microscopy). Malaria is declining in Nigeria. From 2015-2017, for example, over 62 million nets were distributed in Nigeria More people have a bed net than before, so it makes sense that the risk of malaria overall is decreasing.
What should a provider do when they see a child with fever?	Some providers still feel that most fevers are due to malaria **FACT:** Not all fever is malaria Assess the child for different causes of fever. The child may have malaria alone, no malaria, or malaria and co-infection with other diseases.
If a provider can trust the results of an mRDT, what does it mean when a fever patient tests negative for malaria?	If a provider trusts the results of the mRDT, It means the patient does not have malaria, The provider should ask other questions look for the cause of the fever in that patient
What are the other leading causes of fever?	Other leading causes of fever include meningitis, pneumonia, and diarrhea. We need to pay more attention to the whole child, not just malaria.
What might happen if those diseases go undiagnosed or treatment was delayed?	If the provider does not diagnose the real cause of the fever and treat immediately, The illness may become severe It could lead to hospitalization and death According to a Lancet article, meningitis, pneumonia, and diarrhea. are among the leading causes of death among children under 5 in Nigeria.
What should a provider do next?	If the RDT is negative, do not provide antimalarials. Use the national IMCI guidlines to evaluate the child for other causes of the child's illness. If you can test for other illnesses (such as typhoid) then order those tests. You can prescribe something to relieve the symptoms, such as an analgesic or something to reduce fever. If you are still not sure, REFER the child immediately
What if a child got better after taking ACT when a test showed no malaria? Was the test wrong?	Some providers may think that the mRDT was wrong **FACT:** No, it means that the child probably had a virus which would have gotten better on its own.

	Evidence from Sub-Saharan Africa has shown that the majority of systemic infections and acute respiratory infections in children are due to viruses.
Are ACTs free to patients? If no, why not?	Providers think that ACT is free and should be given out to people who ask for it **FACT:** ACTs are only truly free if the patient has confirmed malaria. If you give ACT without confirmation, then you might be costing that family more money and worry, and ultimately the life of that child. Studies in other parts of Africa have shown that children treated presumptively had higher rates of death.

Pre and Post Cluster Meeting Evaluation Forms

Name: _____ Date: _____ Facility: _____

State: _____ LGA: _____ Ward: _____

S/N	QUESTION	ANSWER (TICK AS APPROPRIATE)
1	Age	25 – 30 years 31 – 35 years 36 – 40 years 41 – 45 years 46 years and above
2	Cadre	Doctor Nurse CHEW CHO Others (specify)……
3	Years of experience	1 – 5 years 6- 10 years 11- 15 years 15- 20 years 21 years and above
4	How many years have you worked in your current facility	
5	Have you attended training on Malaria case management within the last 2 years	YES NO
6	Have you attended training on Malaria diagnosis using mRDT within the last 2 years	YES NO
7	Have you attended this OIC cluster meeting before?	YES NO If YES, how many times?_____
8	Do you or your facility own a copy of the National Guidelines on Diagnosis and Treatment of Malaria?	YES NO

QUESTION	AGREE	DO NOT AGREE	DON'T KNOW
A quality assured malaria RDT is as good as expert microscopy			
If a patient got better after taking ACT when a test showed no malaria, then the test was wrong			
Poor storage and high temperatures can cause RDTs to give false negative results			
An mRDT has the same level of sensitivity as a HIV RDT			
As an experienced clinician, you can accurately diagnose malaria based on clinical judgement alone			
Malaria RDT is the best technology possible for detecting malaria in Nigeria today			
RDTs are quality-assured to ensure they give accurate results			
Any patient with malaria symptoms would have enough malaria parasites to be detectable by RDT			
It is good clinical practice to give ACT if the test is negative but clinical assessment strongly suggests malaria			
Any laboratory scientist who knows how to use a microscope can do microscopy to diagnose malaria			
Current mRDT detects only p. falciparum and is not reliable for malaria diagnosis in Nigeria			
Malaria is the commonest cause of illness in Nigeria			
Microscopy is the confirmatory test for malaria when an RDT gives negative results, but the client has malaria symptoms			
I am confident I can systematically assess the patient for other causes of fever if the malaria test is negative	¨	¨	¨
I am confident I can convince a parent of a child with a negative malaria test result not to treat with an antimalaria	¨	¨	¨

Follow-up activities

- Take note of the WhatsApp facilitator names and topics, as well as other action points.
- Submit the pre and post-assessment forms for data entry
- Submit the activity forms for data entry
- Monitor if the WhatsApp discussions are happening. Provide encouragement and reminders to the volunteers.

Malaria in Pregnancy Cluster Meeting Facilitation Tools: Module 1

Preparatory activities

- Ask providers to bring their performance management forms and action plans from the previous quarter.
- Review results from the last cluster meeting
    - Post-evaluation results (identify the top 3-5 worst-performing questions)
    - Action points

Supplies needed

- Flipchart
- Markers
- Pen and paper for providers
- Print copies of materials for the meeting:
        - Provider dialogue framework (3 copies, one per facilitator)
        - Pre-evaluation (1 per participant)
        - Post-evaluation (1 per participant)
        - Blank paper for action plans and notes
- Print and compile one packet of materials per OIC to use when they return to facility
    - Step down meeting planning form
    - Provider dialogue framework
    - Performance management forms

Agenda

Time	Activities	Resources
10:00-10:30	Welcome remarks (SMEP or LGA coordinator) Objectives 1. To identify and address barriers to adherence to national guidelines on malaria in pregnancy 2. To discuss the role of the OIC in improving access and uptake of IPTp at the facility 3. To develop action plans to promote adherence to MIP guidelines at the facility. **Administer pretest** • Distribute copies, read pre-evaluation aloud, and collect papers	Copies of pre-evaluation
10:30-12 pm	**Malaria in pregnancy dialogue framework** • Introduce each question • Discuss key points from the framework	MIP dialogue framework
12– 1 pm	**MIP Action planning** • Ask: Based on our discussion, what do you think are the biggest challenges to providing mothers with IPTp in your facilities? • Which of these challenges are within our control? • Ask providers to write down 3 action points for him/her/their facility. Each action point should be specific and indicate what, how, when, who and why. • Invite providers to share examples.	Flipchart sheet with instructions (2-3 action points) What, how, when, who, and why) Notetaker to document examples so you can follow-up.
1-2pm	**Lunch**	
2-3 pm	**Proper documentation of IPTp** • Ask providers to write how 1st IPTp is documented, then 2nd and 3rd. Invite providers to show their work to the room. • If a woman has been receiving IPTp as prescribed in the guidelines, she may receive up to 6 doses depending on her gestational age when she registered. Invite providers to show how the 4th, 5th and 6th doses might be documented. • Discuss how to record doses if the facility is still using the old register • Ask participants to spend 10 minutes looking at their own IPTp records when they return. • Ask for a volunteer to check in with the group via WhatsApp to see what they observed from review of IPTp records.	Photocopies of new registers LGA M&E Officer and/or RBM Focal Point
3-4 pm	**Step down planning and practice** • Distribute copies of the module. Invite 1 volunteer to give a step-down demonstration of the module to 2 providers. Ask participants what this volunteer did well and how they could improve • In groups of 3, have providers take turns facilitating 2-3 discussion questions from the dialogue framework. • Ask OICs how the step-down for the MIP module should be done. When should it be done? Who should be there? How	15 minutes 20 minutes Copies of the framework 5 minutes

	long should it take? How can they ensure it is participatory and supportive? Ask for examples. • Ask providers to complete the step-down planning form. The content should cover reporting and the dialogue framework. • Ask for a volunteer to check in with the group via WhatsApp to see who has completed the step-down and what questions were asked by their providers.	15 minutes Copies of the step-down planning form 5 minutes
4:00	Administer post-evaluation	Copies of the post-evaluation form

Provider Dialogue Framework for Malaria in Pregnancy

Questions	Discussion Points
Why is malaria in pregnancy an important problem?	Desired responses: • Pregnancy reduces a woman's immunity to malaria. Pregnant women, especially those in their first or second pregnancies, are at higher risk of getting malaria. • Malaria in pregnancy (MIP) can be devastating to a family. In sub-Saharan Africa (SSA), malaria contributes to an estimated 20% of all stillbirths and 11% of all newborn deaths. • A pregnant woman may have malaria parasites but not have symptoms of malaria. If the woman does not receive treatment, the parasites in her blood will attack the placenta and cause problems for the baby. • For mothers, malaria can cause severe anemia and maternal death. For babies, malaria can cause miscarriage, stillbirth, premature delivery, and low birthweight.
How can we prevent malaria in pregnancy?	Desired responses: • Early registration at ANC • IPTp with SP and proper use of mosquito nets.
How does IPTp work?	Desired responses: • Malaria parasites in the placenta is the main cause of the harmful effects of malaria in pregnancy. • Women have lower immune responses during pregnancy. This is for many reasons. One reason is that it allows their bodies to sustain the placenta, a new organ in women pregnant for the first time. • However, this means they are more vulnerable to malaria infection and malaria parasites can hide in the placenta. • Moreover, the woman may have malaria parasites from before pregnancy. • SP clears the existing parasites from the placenta and prevents new infections because the drug has a long half-life. • Introduce chant, **"SP, SP, it keeps the placenta parasite-free!"** • It is good for pregnant women to have access to a net if properly used, it prevents them from been exposed to malaria from mosquito bites when they are outside the net. IPTp is another way to protect pregnant women from malaria.
What do the guidelines say about IPTp?	The guidelines state that: • IPTp should always be given under Directly Observed Therapy (DOT) • Timing and spacing: Start as early as possible in the 2nd trimester (at 13 weeks) then monthly until delivery • Goal: at least 3 times per pregnancy. If the woman starts ANC in the first trimester and attends monthly, you could give IPTp as much as 6 times. • Why 3+ instead of 2: The more doses of IPTp the woman receives, the better it is for the baby. There is a lower risk of preterm delivery and low birth weight. • All women except those taking cotrimoxazole for HIV and those with a known history of hypersensitivity to sulphonamides should take SP.
What drugs are given at IPTp?	Desired response: Only SP should be given for IPTp. ACT, quinine or chloroquine should never be used for prevention.

	If they cite concerns about SP resistance, say: Studies show that SP continues to protect both the mother and her baby, even in places with resistance. There are no other drugs that are safer or more effective for prevention than SP.
What does Directly Observed Therapy mean? Why is it important to administer SP by DOT?	• Directly Observed Therapy means that the provider gives SP and water to the woman and the woman takes it in front of the provider. • It is very important to administer SP by directly observed therapy. • Studies show that women in Nigeria who do not get IPTp by DOT have 5 times higher odds of getting malaria during pregnancy. • When you give SP by prescription, you do not know if the women filled the prescription or took the medicine. In many cases it takes as much time to do DOT as to write out a prescription. • Some providers document SP as given because they gave it as a prescription. This is not technically true. The records are more accurate when you give SP as DOT.
What are some reasons for why many women do not get IPTp by directly observed therapy? *(Before correcting misconceptions, invite other providers to comment on these issues or how they can be resolved)* *After participants have corrected each other or provided solutions, state the recommendations on the right.*	If they cite concerns about safety of taking drugs on an empty stomach, say: SP is safe for PW to take with food OR on an empty stomach. If they say it will hinder palpation: There is no clinical basis for requiring women to come to ANC without having eaten. If SP is kept in the pharmacy, ask how they might ensure there is SP available during ANC? If the facility policy says that health workers who are not working in the pharmacy are not allowed to dispense SP: ask why this is the case and what can be done to ensure that a) women receive SP by DOT and b) this is correctly documented in the register. If they say stock-outs, ask how stock-outs can be prevented. Delayed submission of reports and using SP for treatment can cause stock-outs. If they say lack of clean water or clean cups: Suggest using sachet water. If they say to save time: Discuss how long it will actually take to administer SP (and other tablets given at ANC) during the consultation. If they say women do not want to pay for it: Usually SP (if it is not DRF) should be free. Many clients may not know which medicines are free and which are not. Health workers should counsel women to ensure they understand that malaria is a serious risk and IPTp is free or low-cost.
How do you know if a woman has started her second trimester?	• Confirm if she has missed three periods. If yes, she can start IPTp. • Measure symphysis-fundal height (SFH) if you can feel the uterus in the abdomen. If it is at least 3 cm (3 fingerbreadths) above the symphysis pubis, then she can start SP. • If she can feel the baby move. • Remember, that the goal is to start IPTp as early as possible in the second trimester (13 weeks). Most women do not feel the baby move

	until at least 16 or 20 weeks.
What should be done if you suspect malaria in a pregnant woman?	• Test the pregnant woman using mRDT. • Women can now take ACTs regardless of what trimester she is in. • If they say that quinine aborts pregnancies, explain that this is a misconception, malaria could result in abortion and not the drugs. The WHO recommends quinine + clindamycin for treatment of malaria in the first trimester.
Why is it important to provide counseling about malaria to pregnant women?	Pregnant women may not know about the benefits of IPTp or that they are more vulnerable to malaria because of pregnancy.
What are the challenges to providing this type of counseling?	Possible responses: No time, feeling overwhelmed, forgetting…. Remind providers that they are experts and that they have managed to learn and remember many topics. Sharing key messages about malaria does not take much time, and they are already probably providing some counseling regularly. Ask them how they can remember to include it as part of their regular "script" with patients. (If they suggest job aids, ask them what other types of reminders they can create for themselves).
What are some best practices for providing counseling?	Use encouraging words and act supportive. Do not criticize if the woman did not comply with instructions. Key points to cover during consultation: • Importance of going to ANC early and regularly • Importance of SP and why the woman should take it during the visit • What costs might be involved • Address concerns and misconceptions • Encouragement about completing monthly IPTp doses, using nets, and returning promptly for testing and treatment if feeling unwell

Pre and Post Cluster Meeting Evaluation Forms

S/N	QUESTION	ANSWER (TICK AS APPROPRIATE)
1	Age	25 – 30 years 31 – 35 years 36 – 40 years 41 – 45 years 46 years and above
2	Cadre	Doctor Nurse CHEW CHO Other (specify)……
3	Years of experience	1 – 5 years 6- 10 years 11- 15 years 15- 20 years 21 years and above
4	Facility type	Primary health center Secondary facility
5	Have you attended a training on Malaria in Pregnancy within the last 2 years?	YES NO
6	Do you own a copy of the National Guidelines and Strategies for Malaria Prevention and Control during Pregnancy?	YES NO

Question	ANSWER (TICK AS APPROPRIATE)		
1. Many pregnant women who have malaria parasites in their blood may not show any symptoms.	TRUE	FALSE	DON'T KNOW
2. Intermittent preventive treatment in pregnancy (IPTp) protects the placenta from malaria parasites.	TRUE	FALSE	DON'T KNOW
3. SP is safe to give in the last month of pregnancy.	TRUE	FALSE	DON'T KNOW
4. Providers should avoid giving a pregnant woman quinine because it can cause abortions.	TRUE	FALSE	DON'T KNOW
5. SP is no longer effective due to drug resistance.	TRUE	FALSE	DON'T KNOW
6. Women should receive a maximum of 3 doses of SP during a pregnancy.	TRUE	FALSE	DON'T KNOW
7. ACTs or quinine can also be given for IPTp.	TRUE	FALSE	DON'T KNOW
8. Directly Observed Therapy is far more effective in protecting women from malaria than giving SP by prescription.	TRUE	FALSE	DON'T KNOW
9. SP is the recommended treatment for malaria in pregnant women in the first trimester.	TRUE	FALSE	DON'T KNOW
10. I should wait for the woman to feel the baby move before I can give her IPTp.	TRUE	FALSE	DON'T KNOW
11. I feel confident that I can ensure that my clients take their SP in front of me during ANC consultations.	TRUE	FALSE	DON'T KNOW
12. I am confident that I can counsel my clients about the importance of returning for their next dose of IPTp.	TRUE	FALSE	DON'T KNOW
13. Most of the ANC clients in my facility receive IPTp.	TRUE	FALSE	DON'T KNOW

Follow-up activities

- Take note of the WhatsApp facilitator names and topics, as well as other action points.
- Submit the pre and post-assessment forms for data entry.
- Submit the activity forms for data entry.
- Monitor if the WhatsApp discussions are happening. Provide encouragement and reminders to the volunteers.
- Remind them to update their performance management forms every month.

Malaria in Pregnancy Cluster Meeting Facilitation Tools: Module 2

Preparatory activities

- Read through the entire module to help you prepare for the meeting.
- Read the facilitator's guide and make it your own. Feel free to adapt of translate to the local language if you so desire.
- Ask OICs to come with their completed IPTp facility performance forms
- Review results from the last cluster meeting
    - Post-evaluation results (identify the top 3-5 worst-performing questions)
    - Action points

Supplies needed

- Flipchart
- Markers
- Pen and paper for providers
- Print copies of materials for the meeting:
    - Provider dialogue framework (3 copies, one per facilitator)
    - Myth and Fact slide deck
    - Pre-evaluation (1 per participant)
    - Post-evaluation (1 per participant)
    - Blank paper for action plans and notes
- Print and compile one packet of materials per OIC to use when they return to facility
    - Step down meeting planning form
    - Myth and Fact slide deck
    - IPTp facility performance forms

Agenda

Opening and pretest	**15 mins**	
Materials needed	Pretest forms and pens	
Opening	**Welcome remarks** (Facilitator, SMOH/SPHCDA)	5 mins
Administer the pretest	• **Distribute** the pre-test forms and pens. • **Remind** participants to fill out their information at the top. • **Read** the questions out loud. They should quietly fill in their answer. • **Collect** the forms at the end.	10 mins
Review of past modules	**30 mins**	
Materials needed	• Talking points • Flip chart • Markers • Masking tape	

Brainstorming activity	**Review of past modules**
	• Review low-performing answers from last post-test (read old questions out loud and discuss participants' responses/opinions).
	• Peer learning of facility MiP performance
	  ○ Participants exchange IPTp facility performance forms
	  ○ Ask participants to discuss their performance with giving IPTp as DOT and documenting IPTp in the HMIS
	  ○ How do you document IPTp 3-6 in your facility?
	  ○ What worked and what didn't work?
	  ○ What will they do in the next quarter?
	• Invite volunteers to share their facility experience
		30 mins

MIP dialogue framework: Separating Myths from Facts	**30 mins**	
Materia needed	• Myth and Fact cards • Projector and laptop OR Print out of presentation slides	
Group activity	**Make an interactive presentation using the slide deck or the print-out of the slides** • Share "fact" and "myth" cards to participants • Explain to the participants that you will project or read out a series of statements • Participants will listen to each statement and decide whether it is a fact or a myth • If they think the statement is a fact, they should hold up the "fact" card. • If they think the statement is a myth, they should hold up the "myth" card • Encourage everyone to participate • Read out each statement and give the participants some time to hold up their cards • Reveal the correct answer • Explain the reason for the answer. • Give some time after each statement and reveal for discussion, address any lingering misconception	30 mins

MIP action plan review	**45 mins**	
Materials needed	Flipchart sheet	

Group activity	• Invite a few participants to share their experiences with step-down at the facility
	• How many providers were reached? What major issues were discussed? Challenges identified? How did the OIC address the challenges?
	
	Ask participants:
	• What lingering challenges do you have in providing mothers with IPTp in your facilities?
	  ○ Giving IPTp as DOT
	  ○ Documenting more than to IPTp2 in the HMIS?
	  ○ Counselling on IPTp during ANC?
	• Which of these challenges are within your control?
	• Ask providers to write down 3 action points for him/her/their facility. Each action point should be specific and indicate what, how, when, who and why.
	• Invite providers to share examples.
		30 mins

IPTp counselling	**45 mins**	
Materials needed	Case scenarios print out OR Slide deck	

Group activity:
Role play
	• Invite volunteers to act out a role play using the case scenarios below
	• Facilitate a feedback session at the end using the following questions
	  ○ What did the provider do well?
	  ○ What could have been done better?
	  ○ What more would you do if you were the provider?
	  ○ How can we include IPTp counselling in our routine ANC services? (Write the suggestions in your action plan).
	• Have as many participants as time will allow to take turns acting the provider.
	
	Case scenarios:
	1. Client: Amina is a shy and quiet 20-year-old woman who only has primary school level of education. This is her first pregnancy. She says she has missed her period two times. She has never heard of IPTp. This is her first ANC visit and she came with her mother.
	
	Mother: A loud and overbearing woman who wants to answer all the questions that the provider asks. She wants to know what the provider is telling her daughter. She has 7 children herself and does not think the medicine is better than herbs from the local TBA.
	
	2. Client: Ekaete is a 32-year-old woman who works in the LGA office. This is her 2nd pregnancy. And she is 28 weeks pregnant. She had only one SP at 16 weeks when she first registered for ANC. She does not think she needs IPTp because she is not sick and uses insecticides in her home regularly. She came to the clinic during break and must go back to work. She says she hasn't had breakfast and cannot take any drug till she has eaten.
		30 mins

Step down planning	**30 mins**	

Materials needed	Step down planning forms Print out of Myth and Fact slides	
Group work	● Distribute copies of the myth and fact printout. Invite 1 volunteer to give a step-down demonstration of the module to 2 providers. Ask participants what this volunteer did well and how they could improve ● Repeat with another volunteer if you have the time ● Ask OICs how the step-down for the MIP module should be done. When should it be done? Who should be there? How long should it take? How can they ensure it is participatory and supportive? Ask for examples. ● Ask providers to complete the step-down planning form. ● Ask for a volunteer to check in with the group via WhatsApp to see who has completed the step-down and what questions were asked by their providers.	30 mins
Post-test/evaluation and closing		**30 mins**
Materials needed	Post-test forms	
Administer post-test	● Distribute copies of the post-test ● Say you will read the questions out loud. They should quietly fill in their answer. ● Read each question out loud. ● Collect the forms at the end.	15 mins
Next steps and closing	● Share next steps ○ Step down orientation at facility ○ Step down report submitted to MCH coordinator ○ Continuous engagement on WhatsApp ○ Weekly SMS blasts ● Closing remarks	15 mins

Pre and Post Cluster Meeting Evaluation Tools

S/N	QUESTION	ANSWER (TICK AS APPROPRIATE)
1	Age	25 – 30 years 31 – 35 years 36 – 40 years 41 – 45 years 46 years and above
2	Cadre	Doctor Nurse CHEW CHO Other (specify)……
3	Years of experience	1 – 5 years 6- 10 years 11- 15 years 15- 20 years 21 years and above
4	Facility type	Primary health center Secondary facility
5	Have you attended a training on Malaria in Pregnancy within the last 2 years?	YES NO
6	Do you own a copy of the National Guidelines and Strategies for Malaria Prevention and Control during Pregnancy?	YES NO

Question	**ANSWER** (TICK AS APPROPRIATE)		
1. Many pregnant women who have malaria parasites in their blood may not show any symptoms.	TRUE	FALSE	DON'T KNOW
2. Intermittent preventive treatment in pregnancy (IPTp) protects the placenta from malaria parasites.	TRUE	FALSE	DON'T KNOW
3. SP is safe to give in the last month of pregnancy.	TRUE	FALSE	DON'T KNOW
4. Providers should avoid giving a pregnant woman quinine because it can cause abortions.	TRUE	FALSE	DON'T KNOW
5. SP is no longer effective due to drug resistance.	TRUE	FALSE	DON'T KNOW
6. Women should receive a maximum of 3 doses of SP during a pregnancy.	TRUE	FALSE	DON'T KNOW
7. ACTs or quinine can also be given for IPTp.	TRUE	FALSE	DON'T KNOW
8. Directly Observed Therapy is far more effective in protecting women from malaria than giving SP by prescription.	TRUE	FALSE	DON'T KNOW
9. SP is the recommended treatment for malaria in pregnant women in the first trimester.	TRUE	FALSE	DON'T KNOW
10. I should wait for the woman to feel the baby move before I can give her IPTp.	TRUE	FALSE	DON'T KNOW
11. I feel confident that I can ensure that my clients take their SP in front of me during ANC consultations.	TRUE	FALSE	DON'T KNOW
12. I am confident that I can counsel my clients about the importance of returning for their next dose of IPTp.	TRUE	FALSE	DON'T KNOW
13. Most of the ANC clients in my facility receive IPTp.	TRUE	FALSE	DON'T KNOW

Follow-up activities

- Take note of the WhatsApp facilitator names and topics, as well as other action points
- Submit the pre and post assessment forms for data entry
- Submit the activity forms for data entry
- Monitor if the WhatsApp discussions are happening. Provide encouragement and reminders to the volunteers
- Remind them to update their IPTp facility performance management forms every month

Respectful Maternity Care Cluster Meeting Facilitation Tools: Module 1

Preparatory activities

- Read through the entire module to help you prepare for the meeting.
- Read the facilitator's guide and make it your own. Feel free to adapt of translate to the local language if you so desire.

Supplies needed

- Flipchart
- Markers
- Pen and paper for providers
- Masking tape
- Written out "Attitudes" definition for VCAT session
- Smiling face and sad face signs
- Attitude statement cards
- Big brown envelope or paper bag
- **Print or write copies of materials for the meeting**:
    - Pre-evaluation (1 per participant)
    - Post-evaluation (1 per participant)
    - Blank paper (worksheet) for action plans and notes
    - Respectful Maternity Care charter (1 per participant)
    - Attitude cards
    - Attitudes definition (on flipchart)
    - Smiling face and sad face signs (each on a separate flipchart)
- **Print and compile ONE PACKET OF MATERIALS PER OIC to use when they return to facility**
    - Step down meeting planning form
    - Step down meeting reporting form
    - Respectful Maternity Care Charter
    - Attitude definition
    - List of sample attitude statements

Agenda

Opening and pretest	**30mins**	
Materials needed	Pretest forms and pens	

Opening	**Welcome remarks, introductions & purpose of the meeting**
	
	● Welcome everyone. Introduce yourself and ask participants to introduce themselves
	● Read and explain the objectives/purpose of the meeting as follows
	  ○ To discuss an overview of maternal health in Nigeria and factors that contribute to maternal mortality and morbidity
	  ○ To discuss RMC concepts, disrespect and abuse, as factors that contribute to maternal mortality and morbidity
	  ○ To identify views on how Disrespect and Abuse might affect individuals and society at large
	  ○ To discuss the participants' role in promoting RMC
	  ○ To develop action plans to promote the practice of RMC at the facility.
		15 mins

Administer the pretest	● **Explain** that you will administer a pre-test to understand what they know about the issue so we see how well we are able to share the content ● **Distribute** the pre-test forms and pens. ● **Instruct** them to fill out their information at the top. ● **Say you will** read the questions out loud. They should quietly fill in their answer. ● **Read** each question out loud. ● **Collect** the forms at the end.	15mins
Overview of maternal health in Nigeria	**10mins**	
Materials needed	● Presentation slides ● Talking points ● Flip chart ● Markers ● Masking tape	
Brainstorming activity	● Introduce the session with a brain storming activity. ● Ask participants to define or explain the term "maternal health." Write responses on the flipchart. ● Summarize and correct as needed. Discuss additional content to fill knowledge gaps. ● Ask participants about the current status of facility-based deliveries at their facilities and how the facility is performing ● Use the PPT presentation (or talking points) to discuss factors contributing to low skilled birth attendants and maternal mortality ● End by stating that among all the reasons mentioned, the cluster meeting will focus on promoting respectful care during childbirth. If this is not mentioned among the reasons given for low SBA, add it to the list.	10mins
RMC concepts, disrespect, and abuse during facility-based childbirth	**60mins**	
Materials needed	Presentation slides Printed copies of classification of disrespect and abuse Talking points	

Respectful Maternity Care concepts	● **Define RMC as an approach that** ○ Focuses on the interpersonal aspect of maternity care ○ Protects the women's right to choice and preferences ○ Recognizes that all women need and deserve respectful care ● **Read and Discuss what RMC promotes as follows:** ○ Respect for beliefs, traditions and culture ○ Empowerment of the woman and her family to become active participants in healthcare ○ Continuous support during labor ○ Choice of companion during labor and birth ○ The right to information and privacy ○ Freedom of movement during labor ○ Choice of position during birth	10mins
Definition of terms	Ask participants what they understand as Dignified, Respect, Disrespect, Undignified Use power point/talking points to explain the meaning of the terms and fill any gaps ● "Dignified": being tasteful in appearance or behavior or style ● "Respect": feeling of regard for someone ● "Undignified": lacking dignity or value for someone. ● "Disrespect": rude conduct and usually considered to indicate a lack of respect.	10mins
Discuss types of disrespect and abuse	Use power point slides/printed tables ● Discuss types and examples of disrespect ● Ask participants what they think are the drivers of disrespect and abuse ● Discuss additional content from slides (or talking points) to fill any gaps	20 mins
Group Activity	**Have you seen or heard about poor quality of care or humiliating treatment during childbirth?** ● Invite a few participants to share a few experiences about humiliating treatment during childbirth **Explore concepts of privacy** ● Ask the participants: *Is a client's privacy or confidentiality compromised when…* ● Breasts are exposed during breastfeeding? ● Gathering of medical history takes place alongside another client due to space constraints? ● Cleaners are present during procedures? ● She is not covered by draping after a vaginal exam?	20 mins

Values clarification	**60 mins**	
Introduce the session	● Brainstorm by asking participants what they understand by values ● Explain ○ Values define that which is right versus wrong when making choices ○ Our values are a fundamental part of our lives and influence our attitude and behaviour, both personally and professionally. ○ Values are closely related to and affected by our beliefs, ideals, and knowledge	15 mins

	● Engage participants with a short question and answer session on how attitudes and values affect maternity care services.
	  o Consider what is acceptable for you or your tribe. What about for the woman in your care? What may cause inadvertent offense? What should you know more about to provider culturally relevant and respectful care? Ask in terms of:
	  ▪ Greeting
	  ▪ Forms of address
	  ▪ Customs
	  ▪ Physical space issues
	  ▪ Food
	  ▪ Dress
	● Focus on interactive discussion in this session to complement exercises and activities
	● Encourage participants to reflect on their values as service providers	

Crossing the line exercise	**Facilitators preparation:** ● Clear a large area of the room to allow participants to move around and place a line in the middle of this area using masking tape. ● Review and adapt statements, if needed. ● Select in advance the statements you will read that most apply to your group of participants. It is advisable to end with a statement you think all participants can identify with **Facilitator's instructions:** ● Ask all participants to stand on one side of the line. ● Explain that you will read a series of statements and participants should step entirely across the line when a statement applies to their beliefs or experiences. ● Remind participants that there is no "in between," which means they must stand on one side of the line or the other, and that there are no "right" or "wrong" answers. ● Ask participants not to talk during the exercise unless they need clarification or do not understand the statement that is read. ● Stand at one end of the line and give an easy practice statement, such as: Cross the line if you had fruit for breakfast this morning. ● Once some people have crossed the line, give participants an opportunity to observe who crossed the line and who did not. Invite participants to notice how it feels to be where they are. ● Ask someone who crossed the line and then someone who did not to briefly explain their response to the statement. If someone is the only person who did or did not cross the line, ask them what that feels like. ● Invite all participants to move back to one side of the line. ● Repeat this for several of the statements about respectful maternity care. Select the statements that most apply to that group of participants. **Crossing the line statements** Cross the line if: ● At some point in your professional life, you witnessed or heard a mother in labor being shouted or jeered at by a colleague ● If you have been asked to keep a secret about a colleague you witnessed pinching or slapping a mother in a labor ward	45 mins

	● If you have ever heard a colleague or family member talk in a derogatory manner about women's actions and/or behaviors during childbirth, e.g., crying, screaming, etc. ● At some point in your life, you felt pinching a little bit or shouting was a way of helping women in labor ● If you were ever told to cover up a report of abuse by a colleague or someone in charge ● If you have ever stifled (subdued) your feelings about a mother's screaming while in labor ● If you ever avoided the issues of childbirth abuse at your workplace in order to keep safe or away from conflict ● If you believe all women deserve access to dignified care that is free from physical and emotional abuse After the statements are read, ask participants to take their seats. Discuss the experience. *Discussion questions:* ● How did you feel about the activity? ● What did you learn about your own and others' views on respectful maternity care? ● Were there times when you felt tempted to move with the majority of the group even when you disagreed? ● Did you move or not? How did that feel? ● What did you learn from this activity? ● What does this activity teach us about the stigma surrounding respectful maternity care? ● How might normalization of disrespect and abuse affect women's emotional experience and care-seeking behavior with future childbirth? How would it affect a woman's family? ● How might we discourage the normalization of disrespect and abuse/ **Debrief in particular the last statement.** ● If everyone in the group crossed the line, discuss this commonality. ● If everyone did not cross the line, discuss how these different views affect people's work on RMC and the broader issues of skilled birth attendance. **Solicit and discuss any outstanding questions, comments, or concerns.** ● Point out how the beliefs we hold may be transferred to clients and that we may perceive these as normal. ● Also stress the double standards we may exhibit that can affect practice and attitude, and how we start to value our weaknesses and work toward improving service delivery. ● Keep in mind that the exercise can draw a lot of disagreement, especially if participants think they were justified in saving a mother and/or their baby and therefore did their best in the circumstances at the time **Thank the group for their participation**.	

Rights and responsibilities of clients and providers during childbirth		**60 mins**
Materials needed	Presentation slides Talking points	
Respectful Maternity Care Charter	● Discuss the Nigerian adaptation of the RMC charter on rights-based approach to maternal health care as follows: "Health workers, let's ○ *Make it easier for pregnant women and mothers to feel **Safe** and **Comfortable*** ○ *Help them make **Informed Decisions** by discussing all aspects of their health care* ○ *Provide **Privacy** and **Confidentiality** at all times* ○ *Promote their **Dignity*** ○ *Provide the same **Standard** of care to all* ○ *Provide Quality maternal healthcare at all levels because it's her **Right** and not a **Privilege*** ○ *Provide service to **All Pregnant Women** and report concerns to the relevant authorities"* ○ *Allow the mother and her child to **Be Together** at **All Times*** ○ *Register the birth of **Every Child,** even if the child dies after birth* ○ *Ensure the mother and child has access to adequate nutrition and clean water.* ● Take note of the highlighted words and ask participants what they understand by each statement in the charter	20 mins
Rights and responsibilities of clients and providers	Use power point slides or talking points ● State the **rights of clients** as follows: ○ Optimum care by qualified health providers ○ Accurate information about her condition and health status ○ Personal/own opinion and to be heard ○ Timely service ○ Choice of health provider and service ○ Protection from harm or injury within health care facility ○ Privacy and confidentiality ○ Courteous and dignified treatment ● Discuss the responsibilities of providers as follows: ○ Protection of the client against harm ○ Coordination and provision of health services ○ Prompt response to clients' needs ○ Provision of accessible, equitable and timely services to all	15 mins
Group Activity	**What choices do we offer women in labor?** ● Divide the participants into 4 small discussion groups ● Each group discusses one question and presents in plenary ○ Do providers make suggestions for the comfort of the mother or themselves? ○ Are we more comfortable with evidence-based practice or tradition?	25 mins

	○ Most providers today are not comfortable with alternative labor positioning because they were not taught the practice, even though evidence supports it. How can we change this? ○ How can we improve mutual understanding, accountability, and respect between community members and service providers? ● Let each group discuss their thoughts ● Conclude the session by saying ○ As a provider, take responsibility for your own actions ○ Provide care that is **evidence-based** and shown to be **beneficial** ○ Explore opportunities for collaborative working to improve respectful quality of care	

Action plan for translating evidence into action	*45 mins*	
Materials needed	Printed copies of the partograph Planning template for step-down activity at facility Reporting template for step-down activity done	
Partograph use as RMC monitoring tool	● Distribute copies of the partograph ● Ask participants if they are familiar with its use ● Talk the participants through the form ● Use power point slide or talking points to discuss how the partograph can be used to monitor RMC uptake as follows: ○ Were vital signs, fetal heart and contraction are assessed and recorded according to stage of labour? ○ Were fluids provided during labour? ○ Were evaluations completed according to standard of care? ○ Was post-delivery assessment done one hour after delivery?	20 mins
Activity	**How can you make RMC monitoring a part of everyday routines in your facility?** ● Distribute planning template to participants ● Talk them through each part of the template ● Using the planning template, participants should develop an action plan with do-able points that they will implement at their individual facilities. ● Conclude the session by emphasizing the importance of continuous engagement on the group WhatsApp forum ○ Participants select point persons to initiate discussions as they choose	25 mins

Post-test/evaluation and closing	**30 mins**	
Materials needed	Post-test forms	
Administer post-test	● Distribute copies of the post-test ● Say you will read the questions out loud. They should quietly fill in their answer. ● Read each question out loud. ● Collect the forms at the end.	15 mins

Next steps and closing	● Share next steps
	  ○ Step down orientation at facility
	  ○ Step down report submitted to MCH coordinator
	  ○ Continuous engagement on WhatsApp
	  ○ Weekly SMS blasts
	● Closing remarks
		15 mins

Pre and Post Cluster Meeting Evaluation Forms

Name of provider_____ **Cluster** _____

Facility name_____

S/N	QUESTION	ANSWER (TICK AS APPROPRIATEI)
1	Age	25 – 30 years 31 – 35 years 36 – 40 years 41years and above
2	Gender	Female Male
3	Cadre	Nurse/midwife CHEW Other (Specify)_____
4	Years of experience	1 – 5 years 6- 10 years 11- 15 years 15- 20 years 21 years and above
5	Years of service in current facility	
6	Have you attended training on Maternal and Child Health within the last 2 years?	YES NO
7	Have you attended training on Respectful Maternity Care within the last 2 years?	YES NO
8	Have you provided labor and delivery services to women in the last 6 months?	YES NO
9	Have you attended this cluster meeting before?	YES NO If YES, how many times?_____
10	Are you the OIC of your facility?	YES NO
11	Are you the maternity focal person?	YES NO

S/N	QUESTION	I AGREE	I DON'T AGREE	I DON'T KNOW
1.	A pregnant woman who refuses care because of a health worker's attitude is not serious about her health and that of her baby.			
2.	A woman in labor or immediately after birth should never be left alone.			
3.	Fear of disrespect and abuse may prevent a woman from facility delivery even more than financial problems.			
4.	Confidentiality is important in family planning and reproductive health care, but not in maternity care.			
5.	Abusive and disrespectful care occurs in all countries, including Nigeria.			
6.	The parents of a pregnant unmarried adolescent should be present during consultation and counselling because she is a minor.			
7.	Pregnant women with HIV or other infectious diseases should be attended to using a separate room and tools for their delivery.			
8.	Illiterate women cannot understand the explanations about their health conditions.			
9.	I feel that it is sometimes necessary to shout at stubborn clients to make them cooperate when you tell them what to do during childbirth.			
10	It is okay for a woman to have a male relative with her during labor and childbirth.			
11	All service providers in a facility have the right to know the HIV status of every client in the facility to prevent infections.			
12	Our facilities should attend to every pregnant woman whether they have money to pay or not.			
13	Having a companion of choice in the labor ward during labor and delivery can help ensure continuous support for the woman in labor.			
14	I believe that women in the community should be able to report to the authorities when they are treated badly during labor and delivery.			
15	It is difficult to provide respectful maternity care when a pregnant woman comes without any money or maternity items.			

Follow-up activities

- Take note of the WhatsApp facilitator names and topics, as well as other action points.
- Submit the pre and post assessment forms for data entry
- Submit the activity forms for data entry
- Monitor if the WhatsApp discussions are happening. Provide encouragement and reminders to the volunteers.

Respectful Maternity Care Cluster Meeting Facilitation Tools: Module 2

Preparatory activities

- Read through the entire module to help you prepare for the meeting.
- Read the facilitator's guide and make it your own. Feel free to adapt of translate to the local language if you so desire.

Supplies needed

- Flipchart
- Markers
- Pen and paper for providers
- Masking tape
- Written out "Attitudes" definition for VCAT session
- Smiling face and sad face signs
- Attitude statement cards
- Big brown envelope or paper bag
- **Print or write copies of materials for the meeting**:
    - Pre-evaluation (1 per participant)
    - Post-evaluation (1 per participant)
    - Blank paper (worksheet) for action plans and notes
    - Respectful Maternity Care charter (1 per participant)
    - Attitude cards
    - Attitudes definition (on flipchart)
    - Smiling face and sad face signs (each on a separate flipchart)
- **Print and compile ONE PACKET OF MATERIALS PER OIC to use when they return to facility**
    - Step down meeting planning form
    - Step down meeting reporting form
    - Respectful Maternity Care Charter
    - Attitude definition
    - List of sample attitude statements

Agenda

Opening and pre-session evaluation	**30mins**	
Materials needed	Pre-session evaluation forms and pens	
Opening	**Welcome remarks, introductions & purpose of the meeting** ● Welcome everyone. Introduce yourself and ask participants to introduce themselves ● Read and explain the objectives/purpose of the meeting as follows ○ To review action plans and outcomes (successes and challenges) from the previous meeting ○ To discuss RMC concepts, disrespect and abuse, as factors that contribute to maternal mortality and morbidity ○ To discuss the participants' continuing role in promoting RMC at their individual facilities ○ To develop action plans to continue the promotion of the practice of RMC at the facility.	15 mins
Administer the pretest	● **Explain** that you will administer a pre-session evaluation to understand what they know about the issue so we see what has changed from the previous meeting ● **Distribute** the pre-evaluation forms and pens. ● **Instruct** them to fill out their information at the top. ● **Say** you will read the questions out loud. They should quietly fill in their answer. ● **Read** each question out loud. ● **Collect** the forms at the end.	15mins
Giving good care during labor	**45 mins**	
Materials needed	Instructional video (if facilities for playing video are available) Stick-it pads Flip chart Markers Masking tape	
Recap from last meeting	● Introduce the session with a recap of learnings from last meeting. ● Share stick-it notes to the participants ● Ask participants to write down 2 things each that they took home from the last meeting ● Ask a few participants to share experience about what has changed in their facilities after they attended the last cluster meeting (success stories) ○ What was the situation before? ○ What has changed? ○ What did you do to bring about the change?	30 mins
Reflection and Instructional Video	● Ask participants to share what has been difficult to change in their facilities ○ What is the current situation? ○ What is the change you would like to see? ○ What are the major barriers to this change? ○ How do you think you can overcome the barriers?	15 mins

	● Close the session by playing the video ● Give participants a few minutes to reflect on the video	

RMC concepts, disrespect and abuse during facility-based childbirth	**60mins**	
Materials needed	Copies of RMC key facts and messages	
RMC Key facts	● Distribute copies of the fact sheets with the participants ● Discuss the key facts and messages with participants ● Ask participants to explain what they understand by each of the 10 rights in the Charter, especially the words in **Bold** letters. **<u>Key facts</u>** ● Most deaths of mothers and newborns can be prevented. ● Mistreatment at health facilities can stop women from seeking the care that could save their lives. ● Over 300,000 women die each year in pregnancy and childbirth. ● 99% of maternal deaths occur in developing nations, mostly in marginalized communities. **<u>The right to RMC</u>** ● The trauma so often experienced in childbirth is not only a source of great personal suffering, but discrimination and abuse in childbirth are a violation of the rights of every person, everywhere. ● The Nigerian Charter for Respectful Maternity Care draws on the United Nations Universal Declaration of Human Rights and other international instruments to spell out 10 rights of childbearing women, tasking health providers to: ○ Make it easier for pregnant women and mothers to feel **Safe** and **Comfortable** ○ Help them make **Informed Decisions** by discussing all aspects of their health care ○ Provide **Privacy** and **Confidentiality** at all times ○ Promote their **Dignity** ○ Provide the same **Standard** of care to all ○ Provide **Quality** maternal healthcare at all levels because it's her **Right** and not a **Privilege** ○ Provide service to **All Pregnant Women** and report concerns to the relevant authorities ○ Allow the mother and her child to **Be Together** at **All Times** ○ Register the birth of **Every Child**, even if the child dies after birth ○ Ensure the mother and child has access to adequate nutrition and clean water. ● Discuss factors that contribute to mistreatment during childbirth ● Ask participants for ways that some of these factors can be improved **<u>Factors that contribute to mistreatment in childbirth</u>**	20 mins

	● Shortages of midwives, nurses, and other health workers who work long hours for low pay in challenging environments. ● Shortages of resources, equipment, supplies, and emergency transport contribute to delays in care and a stressed workforce. ● Lack of citizen accountability mechanisms and legal regulations to protect human rights. ● Individual and/or community attitudes that tolerate or support mistreatment. ● Lack of understanding of clients' rights ● Poor supervision ● Lack of professional support ● Weak implementation of standards and quality of care guidelines	
Key messages for change	Let participants take turns to read each of the key messages **<u>Key messages for change</u>** ● Every woman has a right to respectful maternity care: High-quality maternal care must include standards to protect the human rights and emotional security of women. ● Disrespect and abuse are widespread: Birth experiences in many health facilities around the world leave mothers traumatized ● Fear of disrespect and abuse costs lives: Avoiding health facilities for fear of disrespect and abuse leaves women vulnerable to life-threatening complications. ● Disrespect and abuse start with individual providers: Health workers need a change in knowledge, attitude and practice to provide quality, respectful care. ● Discrimination limits the rights of women around the world: Gender, race, marital status, age, and income are at the root of much disrespect and abuse of women in pregnancy and birth. ● RMC promotes: o Respect for beliefs, traditions and culture o Empowerment of the woman and her family to become active participants in healthcare o Continuous support during labor o Choice of companion during labor and birth o The right to information and privacy o Freedom of movement during labor o Choice of position during birth	10mins
Group Activity	**Can you identify disrespect and abuse in these four scenarios?** <u>Facilitator's notes:</u> ● Separate into small 4 smaller groups. Each group should read through one of the following scenarios and discuss the following questions. o Briefly describe what happened in each scenario from the perspective of each of the characters involved. o Were the characters happy with the outcome? What might they have wanted to change? o WHY did the characters in each scenario act the way they did? Make a list of possible reasons and causes. o SOLUTIONS: for the problems discussed, what are the possible solutions?	30 mins

	● Discuss the RMC charter and which rights are being violated by each interaction. *Scenario 1* A healthcare worker tells a mother in labour that her baby is in distress and must be born quickly. The mother does not know about her right to informed consent. She is not aware of any benefits or entitlements that might exist to pay for her care. She is told she needs a painful and expensive procedure, or her baby will die. When she asks what the other options are, the healthcare worker yells at her and says she is wasting time and needs to deliver immediately. The woman agrees to the procedure. *Scenario 2* A midwife approaches a woman in labour and tells her to lie down. With no warning, she performs a vaginal examination, involving inserting her hand into the woman's cervix to evaluate her progress in labour. The examination is very painful and the woman begs the midwife to stop. She replies that the exam is almost over and completes the procedure despite her protests. *Scenario 3* A mother lives very far from the nearest health centre and was unable to receive antenatal care. She is unaware of any complications with her pregnancy that might require her to deliver at a hospital. She went to her local health centre for delivery, which has only one midwife and no resources for emergency intervention. Her labour progressed very slowly and after several hours of pushing she is exhausted. The midwife has no equipment to accelerate the labour or offer pain relief and the nearest hospital is several hours away. There is no emergency transport available. She screams at the mother that if she stops pushing she will lose her baby. *Scenario 4* An HIV-positive woman arrives at the local public hospital. She is in labor and her baby is coming very soon. Because of her HIV status, she knows there are increased health risks for her and her baby, and she is anxious about the delivery. The health workers realize that she is HIV positive and are reluctant to care for her. They do not have the equipment to take care of her properly. They take care of several other patients first, telling her to wait. She delivers her baby without assistance while waiting for care.	
Action plan for translating evidence into action **45 mins**		
Materials needed	Copies of partograph Planning template for step-down activity at facility Reporting template for step-down activity done	

Partograph use as RMC monitoring tool	● Distribute copies of the partograph
	● Ask participants how they are using partograph in their facilities
	● Discuss how the partograph can be used to monitor RMC uptake as follows:
	  ○ Were vital signs, fetal heart and contraction are assessed and recorded according to stage of labour?
	  ○ Were fluids provided during labour?
	  ○ Were evaluations completed according to standard of care?
	  ○ Was post-delivery assessment done one hour after delivery?
		20 mins

Activity	**Making RMC monitoring a part of everyday routines in your facility** ● Distribute planning template to participants ● Refresh on each part of the template	25 mins

	● Using the planning template, participants should develop an action plan with do-able points that they will implement at their individual facilities. ● Conclude the session by emphasizing the importance of continuous engagement on the group WhatsApp forum ○ Participants select point persons to initiate discussions as they choose	
Post-session evaluation and closing **30 mins**		
Materials needed	Post-session evaluation forms	
Administer post-test	● Distribute copies of the post-session evaluation forms ● Say you will read the questions out loud. They should quietly fill in their answer. ● Read each question out loud. ● Collect the forms at the end.	15 mins

Next steps and closing	● Share next steps
	  ○ Step down orientation at facility
	  ○ Step down report submitted to MCH coordinator
	  ○ Continuous engagement on WhatsApp
	  ○ Weekly SMS blasts
	● Closing remarks
		15 mins

Follow-up activities

- Take note of the WhatsApp facilitator names and topics, as well as other action points.
- Submit the pre and post assessment forms for data entry
- Submit the activity forms for data entry
- Monitor if the WhatsApp discussions are happening. Provide encouragement and reminders to the volunteers.

Respectful Maternity Care Cluster Meeting Facilitation Tools: Module 3

Preparatory activities

- Read through the entire module to help you prepare for the meeting.
- Read the facilitator's guide and make it your own. Feel free to adapt of translate to the local language if you so desire.
- Review results from the last cluster meeting
    - Post-evaluation results (identify the top 3-5 worst-performing questions)
    - Action points

Supplies needed

- Flipchart
- Markers
- Pen and paper for providers
- Masking tape
- Written out "Attitudes" definition for VCAT session
- Smiling face and sad face signs
- Attitude statement cards
- Big brown envelope or paper bag
- **Print or write copies of materials for the meeting**:
    - Pre-evaluation (1 per participant)
    - Post-evaluation (1 per participant)
    - Blank paper (worksheet) for action plans and notes
    - RMC charter (1 per participant)
    - Attitude cards
    - Attitudes definition (on flipchart)
    - Smiling face and sad face signs (each on a separate flipchart)
- **Print and compile ONE PACKET OF MATERIALS PER OIC to use when they return to facility**
    - Step down meeting planning form
    - Step down meeting reporting form
    - RMC Charter
    - Attitude definition
    - List of sample attitude statements

Agenda

Opening and pretest	**20 mins**	
Materials needed	Pretest forms and pens	
Opening	**Welcome remarks** (Facilitator, SMOH/SPHCDA)	5 mins
Administer the pretest	• **Distribute** the pre-test forms and pens. • **Remind** participants to fill out their information at the top. • **Read** the questions out loud. They should quietly fill in their answer. • **Collect** the forms at the end.	10 mins
Review of past modules	**15 mins**	
Materials needed	Talking points Flip chart Markers Masking tape Participants' worksheet	

Brainstorming activity	• Review low-performing answers from last post-test (read old questions out loud and discuss participants' responses/opinions).
	
	OR
	• Invite a few participants to share what they have learned from previous meetings and progress on action plans
	  ○ What has stood out for you as a provider? As an OIC?
	  ○ How has your learnings changed your perception and attitude towards women during labor and delivery?
	  ○ What are you now doing differently?
	  ○ What areas do you need improvement in? As an individual? As an OIC?
	• Ask participants to reflect on what they have learned so far and write down their thoughts in their worksheets.
		15 mins

Values Clarification and Attitudes Transformation (VCAT) Session: Understanding how our own attitudes may affect Client-Centered RMC	**75 mins**	
Materials needed	Flipcharts, markers, tape Flipchart "Attitudes" definition Smiling face and sad face signs Flipchart with sample attitudes Attitude cards for Activity 2 LAPTOP/projector if available.	

Introduce the session	• Introduce and review the session objectives as follows:
	  ○ To identify and discuss providers' attitudes that facilitate or hinder access to and quality Respectful Maternity Care services.
	  ○ To develop useful strategies to manage attitudes effectively.
		15 mins

	Facilitator's note: Attitudes play a very important role in many aspects of our lives. Sometimes we may not be aware of how attitudes influence how we see the world or how we interact with each other. As health service providers, developing an awareness of our attitudes and strategies to manage them effectively is very important to ensure that our work is effective.	

Activity 1: What are attitudes?	● Ask the participants to reflect on the following statement (show on slide/flipchart): **"Attitudes are ways of responding to situations, events, and people. Attitudes are learned and we may show them without being aware of their effect. Attitudes are shaped by experiences, how we grow up, the beliefs that we may have about certain issues, the assumptions that we may make about people, and what we feel is right and wrong."**
	
	● Invite a few participants to share their opinions about the definition and ask questions for clarification.
	● Ask the participants:
	  o How can we explain this definition through examples?
	
	● If participants cannot provide any examples, show the following flipchart/slide:
	  o A person is asked if a pregnant woman in labour asks to choose a birth position and immediately says "NO!"
	  o A provider finds out that a woman in labour defecates on the delivery couch and immediately accuses her of having done something "bad" or "unhygienic".
	
	Facilitator's note:
	Attitudes can also be expressed through body language. For example:
	A client tells the provider that she wants a particular provider to conduct her delivery. The provider opens her mouth very widely with a look of disapproval or disgust and withdraws from the client.
	● Facilitate a brief discussion using questions such as:
	  o What other attitudes have you observed in your facility about these kinds of issues?
	  o Which of such attitudes hinder access to and utilization of RMNCH services?
	It is also important to acknowledge that attitudes are not always negative and that they evolve over time.
	● Briefly discuss with the participants:
	  o Have you observed attitudes around ANC and childbirth/delivery that are not judgmental or negative?
	  o How common are these attitudes among providers that you know?
	  o How are attitudes to these and other RMNCH issues changing in ways that support access to RMC?
	  o What is influencing these changes?
		15 mins

Activity 2: Managing attitudes effectively	**Identifying providers' attitudes that enhance or hinder access to and quality of RMC services and strategies to manage attitudes effectively** **Facilitator's preparation:** ● Read the facilitator's guide thoroughly ahead in preparation.	20 mins

	● Select some sample statements that you want to use for the activity (see sample statements in the facilitator's resource section below) ● Write out the selected attitude statements in small cards and place them in a big envelop ● Before beginning the session, make sure that you have enough space to facilitate this activity. ● Post on the wall two signs, a smiling face and a sad face- The smiling face represents provider attitudes that enhance access to and quality of RMC services, while the sad face is obviously a sign for provider attitudes hindering access to and quality of RMC services. ● Ensure that there is enough space to list attitudes under each sign, as well as enough space between the two columns **Facilitation instructions:** ● Ask participants to join you in the middle of the room and to form a circle around you ● Move around the circle holding an envelope in which you will have placed strips of paper. Each strip has a statement written on it. The statements express attitudes, and therefore we call these strips the attitude cards ● Ask each participant to pick one or two cards from the envelope. ● The participant will decide without consulting with anyone else under which sign the card should be placed. ● If unsure, the card can be placed in the space between the two columns. ● Once the participants have completed arranging the cards, invite them to stand in front of the two columns and reflect on the result of the game. Facilitate a discussion asking questions such as: ● Based on your own experience, which provider attitudes in the "smiling face" list are essential to enhance access to and quality of RMC services? How do these contribute to these aims? How do these attitudes reinforce each other? ● Which attitudes in the "sad face" list are the most damaging to access to and quality of RMC services? Why? How might these attitudes reinforce each other to undermine provision of quality RMC services? ● Which attitudes in the "unsure" space would you move to either the "Enhancing" or "Hindering" listing, and why? ● Are there any additional attitudes that we have not considered either as "enhancing" or "hindering"? What are they? (Make sure you have a few blank cards to write any additional attitudes) ● Why is it important for us, as providers, to be aware of our own attitudes and beliefs about RMC issues? ● What can we do, as providers, when our beliefs about a particular RMC issue make us uncomfortable talking about it with clients? **Facilitator's note:** It is important to help participants avoid a "right" and "wrong" deadlock. As this activity requires developing comfort to discuss issues that may touch participants very closely, it is important to maintain an objective and non-judgmental atmosphere. To facilitate reflections and insights, you may want to provide a hypothetical, real life context when discussing attitudes and how participants have listed them, e.g. ● How can access to and quality of RMC services be affected if a provider will only discuss certain issues with clients who always agree?	

	● How could such an attitude enable the provider to help clients who may want to ask lots of questions, or challenge the advice that they receive? ● How can such an attitude help the provider develop skills to manage different types of clients and interactions? ● If a client told a provider that she would like her husband to be part of her ANC, and the provider expressed a negative or non-supportive attitude. What could be the implications for the counselling interaction and for the client to have her needs addressed? **It is important that you remain neutral in the discussion**. If you feel that it is useful to provide your opinion, it is advisable to do so by asking hypothetical questions, like the one provided above. Help the participants reflect on the fact that the activity is not about expressing a judgment on what people feel or believe, but on assessing the impact that such beliefs may have on helping clients to access quality RMC services. The important message to emphasize is: **Each one of us has developed attitudes around certain issues that reflect our values and beliefs. We have the right to keep our values and beliefs, but we also have a responsibility to ensure that we do not impose them on clients through our attitudes. We have a responsibility to prevent our attitudes from becoming barriers for clients to access and use health and social services.**	
Activity 3: Group work	● Still in front of the attitude wall, randomly divide the participants in small groups or in pairs. If you do not have enough participants for pairs or small groups, ask them to work individually. **Instructions:** ● Select a few attitudes from the "hindering" listing and assign the same attitude to discuss to at least two pairs/participants. ● Ask them to imagine that they have become aware that they hold that attitude. What can they do to minimize its impact on the way they provide RMC services? ● Each pair/participant discusses for five minutes a possible solution. They join the other pairs/participants that were assigned the same attitudes and spend five more minutes comparing and discussing ideas. ● Invite a few pairs/individuals to share their ideas. ● Conclude the activity by stressing the following message: **It is important to recognize that each one of us may hold "hindering" attitudes and not be aware of them. The important issue is to become aware of how attitudes may support or hinder what we aim to achieve.** The process we just went through is a type of values clarification, i.e., it helps us become aware of how what we consider "right or wrong" (our values) influence how we respond to issues and situations (our attitudes). Whether or not we choose to abandon or change some of our attitudes, we have a responsibility to prevent them from creating barriers for clients to access RMC and other services.	25 mins

Rights of women and newborn- The RMC Charter	**60 mins**	
Materials needed	Presentation slides Talking points	
Respectful Maternity Care Charter	Discuss the RMC charter on rights-based approach to maternal health care as follows: **1. Everyone has the right to freedom from harm and ill-treatment.** No one is allowed to physically hurt you or your newborn. You should both be taken care of in a gentle and compassionate way and receive assistance when experiencing pain or discomfort. **2. Everyone has the right to information, informed consent, and respect for their choices and preferences, including companion of choice during maternity care and refusal of medical procedures.** No one is allowed to force you or do things to you or your newborn without your knowledge or consent. Every woman has the right to autonomy, to receive information, and provide informed consent or refusal for care. Every parent or guardian has the right to receive information and provide informed consent or refusal for their newborn's care, in the newborn's best interests, unless otherwise provided by law. **3. Everyone has the right to privacy and confidentiality.** No one is allowed to share your or your newborn's personal or medical information, including all records and images, without your consent. Yours' and your newborn's privacy must be protected, except as necessary for healthcare providers to convey information for continuity of care. **4. Everyone is their own person from the moment of birth and has the right to be treated with dignity and respect.** No one is allowed to humiliate, verbally abuse, speak about or touch you or your newborn in a degrading or disrespectful manner. You and your newborn baby must be cared for with respect and compassion. **5. Everyone has the right to equality, freedom from discrimination and equitable care.** No one is allowed to discriminate against you or your newborn because of something they think or do not like about either one of you. Equality requires that pregnant women have the same protections under the law as they would when they are not pregnant, including the right to make decisions about what happens to their body. **6. Everyone has the right to healthcare and to the highest attainable level of health.** No one may prevent you or your newborn from getting the healthcare needed or deny or withhold care from either one of you. You and your newborn are entitled to the highest quality care, provided in a timely manner, in a clean and safe environment, by providers who are trained in current best practices. **7. Everyone has the right to liberty, autonomy, self-determination and freedom from arbitrary detention.** No one is allowed to detain you or your newborn in a health- care facility, even if you cannot pay for services received. **8. Every child has the right to be with their parents or guardians.** No one is allowed to separate you from your newborn without your consent. You and your newborn have the right to remain together at all times, even if your newborn is born small, premature or with medical conditions that require extra care.	60 mins

	9. **Every child has the right to an identity and nationality from birth.** No one is allowed to deny your newborn birth registration, even if they die shortly after birth, or deny the nationality your newborn is legally entitled to. 10. **Everyone has the right to adequate nutrition and clean water.** No one is allowed to prevent you and your newborn from having adequate nutrition, clean water or a healthy environment. You have the right to information and support on child nutrition and the advantages of breastfeeding. Ask participants to reflect on each of the 10 rights. ○ How will you ensure the other providers in your facilities learn about the RMC charter? ○ What will you do, as an OIC to ensure that the rights of women and newborn are respected in your facility?	
Action plan for translating evidence into action **25 mins**		
Materials needed	Planning template for step-down activity at facility Reporting template for step-down activity done	
Activity	**How can you make RMC a part of everyday routine in your facility?** ● Distribute planning template to participants ● Talk them through each part of the template ● Using the planning template, participants should develop an action plan with do-able points that they will implement at their individual facilities. ● Conclude the session by emphasizing the importance of continuous engagement on the group WhatsApp forum ○ Participants select point persons to initiate discussions as they choose	25 mins
Post-test/evaluation and closing **15 mins**		
Materials needed	Post-test forms	
Administer post-test	● Distribute copies of the post-test ● Say you will read the questions out loud. They should quietly fill in their answer. ● Read each question out loud. ● Collect the forms at the end.	10 mins
Next steps and closing	● Share next steps ○ Step down orientation at facility ○ Step down report submitted to MCH coordinator ○ Continuous engagement on WhatsApp ○ Weekly SMS blasts ● Closing remarks	5 mins

Pre and Post Cluster Meeting Evaluation Forms

Name of provider_____ **Cluster** _____

Facility name_____

S/N	QUESTION	ANSWER (TICK AS APPROPRIATEI)
1	Age	25 – 30 years 31 – 35 years 36 – 40 years 41years and above
2	Gender	Female Male
3	Cadre	Nurse/midwife CHEW Other (Specify)_____
4	Years of experience	1 – 5 years 6- 10 years 11- 15 years 15- 20 years 21 years and above
5	Years of service in current facility	
6	Have you attended training on Maternal and Child Health within the last 2 years?	YES NO
7	Have you attended training on Respectful Maternity Care within the last 2 years?	YES NO
8	Have you provided labor and delivery services to women in the last 6 months?	YES NO
9	Have you attended this cluster meeting before?	YES NO If YES, how many times?_____
10	Are you the OIC of your facility?	YES NO
11	Are you the maternity focal person?	YES NO

S/N	QUESTION	I AGREE	I DON'T AGREE	I DON'T KNOW
1.	A pregnant woman who refuses care because of a health worker's attitude is not serious about her health and that of her baby.			
2.	A woman in labor or immediately after birth should never be left alone.			
3.	Fear of disrespect and abuse may prevent a woman from facility delivery even more than financial problems.			
4.	Confidentiality is important in family planning and reproductive health care, but not in maternity care.			
5.	Abusive and disrespectful care occurs in all countries, including Nigeria.			
6.	The parents of a pregnant unmarried adolescent should be present during consultation and counselling because she is a minor.			
7.	Pregnant women with HIV or other infectious diseases should be attended to using a separate room and tools for their delivery.			
8.	Illiterate women cannot understand the explanations about their health conditions.			
9.	I feel that it is sometimes necessary to shout at stubborn clients to make them cooperate when you tell them what to do during childbirth.			
10	It is okay for a woman to have a male relative with her during labor and childbirth.			
11	All service providers in a facility have the right to know the HIV status of every client in the facility to prevent infections.			
12	Our facilities should attend to every pregnant woman whether they have money to pay or not.			
13	Having a companion of choice in the labor ward during labor and delivery can help ensure continuous support for the woman in labor.			
14	I believe that women in the community should be able to report to the authorities when they are treated badly during labor and delivery.			
15	It is difficult to provide respectful maternity care when a pregnant woman comes without any money or maternity items.			

Follow-up activities

- Take note of the WhatsApp facilitator names and topics, as well as other action points.
- Submit the pre and post assessment forms for data entry
- Submit the activity forms for data entry
- Monitor if the WhatsApp discussions are happening. Provide encouragement and reminders to the volunteers.

Facilitator Resources

Sample List of Attitude Statements for the Attitude Cards

****Facilitators are encouraged to adapt the cards and/or develop additional ones. However, please make sure that you do not write on any card statements like "provider should encourage/discourage this attitude". The aim of the activity is not for trainers to impose their views. The role of the trainers is to ask questions to help the participants reflect on how any of the attitudes selected for discussion may impact access to and quality of RMC and especially client-centered RMC services.*

Please note *it is not necessary to use all the cards. Use your discretion to select by picking the attitudes that would challenge participants to think and reflect on their own values and beliefs and how they bring such values and beliefs in their counselling through their attitudes.*

1. In a couple, it is only the woman who is responsible for issues related to ANC, labor and childbirth.
2. A pregnant woman who refuses care because of a health worker's attitude is not serious about her health and that of her baby
3. Pregnant unmarried adolescents should be attended to separately during ANC.
4. Illiterate women cannot understand the explanations about their health conditions
5. Women understand that pinching and hitting them during childbirth or delivery is for their own good and helps to make them cooperate with the provider.
6. Some clients are very stubborn and will not cooperate when you tell them what to do during childbirth
7. A woman in labor or immediately after birth should never be left alone.
8. Abusive and disrespectful care occurs in all countries, including Nigeria.
9. It is okay for a woman to have a relative with her during labor and childbirth.
10. Some clients want to wait till they are almost due before they come for ANC.
11. If a woman wishes to have her husband with her during delivery or childbirth, he should be allowed into the labor room.
12. Fear of disrespect and abuse may be a more powerful deterrent to the use of skilled birth care than financial obstacles
13. It is unusual for a man to accompany his wife to the ANC clinic
14. Service providers have the right to know the HIV status of their clients.
15. Providers should reduce the frequency of vaginal examination in pregnant women with HIV or other infectious diseases to avoid the spread of infection
16. Pregnant women with HIV or other infectious diseases should be attended to using a separate room and tools for their delivery.
17. It is safer to withhold information from less educated women who may not understand or become confused and distressed
18. Women with HIV should be discouraged from getting pregnant, so they don't pass on the infection.
19. Our facilities should be made friendly regardless of their social economic status.

20. Community structures should provide platforms for RMC enlightenment for women in the community.
21. It is difficult to provide respectful maternity care when a pregnant woman comes without any money or maternity items
22. Pregnant women should be taught about prevention of HIV and other STI during ANC
23. The mother-in-law of a pregnant woman has a right to know about her health information in case of an emergency.
24. Confidentiality is important in family planning and reproductive health care, but not necessary in maternity care
25. Some clients do not want to pay for delivery services in the facility.

Respectful Maternity Care Charter: The Universal Rights of Women and Newborns

1. **Everyone has the right to freedom from harm and ill-treatment.** No one is allowed to physically hurt you or your newborn. You should both be taken care of in a gentle and compassionate way and receive assistance when experiencing pain or discomfort.

2. **Everyone has the right to information, informed consent, and respect for their choices and preferences, including companion of choice during maternity care and refusal of medical procedures.** No one is allowed to force you or do things to you or your newborn without your knowledge or consent. Every woman has the right to autonomy, to receive information, and provide informed consent or refusal for care. Every parent or guardian has the right to receive information and provide informed consent or refusal for their newborn's care, in the newborn's best interests, unless otherwise provided by law.

3. **Everyone has the right to privacy and confidentiality.** No one is allowed to share your or your newborn's personal or medical information, including all records and images, without your consent. Yours' and your newborn's privacy must be protected, except as necessary for healthcare providers to convey information for continuity of care.

4. **Everyone is their own person from the moment of birth and has the right to be treated with dignity and respect.** No one is allowed to humiliate, verbally abuse, speak about or touch you or your newborn in a degrading or disrespectful manner. You and your newborn baby must be cared for with respect and compassion.

5. **Everyone has the right to equality, freedom from dis-crimination and equitable care.** No one is allowed to discriminate against you or your newborn because of something they think or do not like about either one of you. Equality requires that pregnant women have the same protections under the law as they would when they are not pregnant, including the right to make decisions about what happens to their body.

6. **Everyone has the right to healthcare and to the highest attainable level of health.** No one may prevent you or your newborn from getting the healthcare needed or deny or withhold care from either one of you. You and your newborn are entitled to the highest quality care, provided in a timely manner, in a clean and safe environment, by providers who are trained in current best practices.

7. **Everyone has the right to liberty, autonomy, self-determination and freedom from arbitrary detention.** No one is allowed to detain you or your newborn in a health- care facility, even if you cannot pay for services received.

8. **Every child has the right to be with their parents or guardians.** No one is allowed to separate you from your newborn without your consent. You and your newborn have the right to remain together at all times, even if your newborn is born small, premature or with medical conditions that require extra care.

9. **Every child has the right to an identity and nationality from birth.** No one is allowed to deny your newborn birth registration, even if they die shortly after birth, or deny the nationality your newborn is legally entitled to.

10. **Everyone has the right to adequate nutrition and clean water.** No one is allowed to prevent you and your newborn from having adequate nutrition, clean water or a healthy environment. You have the right to information and support on child nutrition and the advantages of breastfeedi

Malaria in Pregnancy Pre and Post Evaluation Answer Key

1. Many pregnant women who have malaria parasites in their blood may not show any symptoms.	**TRUE**	FALSE	DON'T KNOW
2. Intermittent preventive treatment in pregnancy (IPTp) protects the placenta from malaria parasites.	**TRUE**	FALSE	DON'T KNOW
3. SP is safe to give in the last month of pregnancy.	**TRUE**	FALSE	DON'T KNOW
4. Providers should avoid giving a pregnant woman quinine because it can cause abortions.	TRUE	**FALSE**	DON'T KNOW
5. SP is no longer effective due to drug resistance.	TRUE	**FALSE**	DON'T KNOW
6. Women should receive a maximum of 3 doses of SP during a pregnancy.	TRUE	**FALSE**	DON'T KNOW
7. ACTs or quinine can also be given for IPTp.	TRUE	**FALSE**	DON'T KNOW
8. Directly Observed Therapy is far more effective in protecting women from malaria than giving SP by prescription.	**TRUE**	FALSE	DON'T KNOW
9. SP is the recommended treatment for malaria in pregnant women in the first trimester.	TRUE	**FALSE**	DON'T KNOW
10. I should wait for the woman to feel the baby move before I can give her IPTp.	TRUE	**FALSE**	DON'T KNOW
11. I feel confident that I can ensure that my clients take their SP in front of me during ANC consultations.	TRUE	FALSE	DON'T KNOW
12. I am confident that I can counsel my clients about the importance of returning for their next dose of IPTp.	TRUE	FALSE	DON'T KNOW
13. Most of the ANC clients in my facility receive IPTp.	TRUE	FALSE	DON'T KNOW