HRSA-WHO USAID WHO MCHB Maternal Health Webinar
July 21, 2022, 11:00 AM -1:00 PM EST
[Audio] Transcript

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CARLA: Greetings, everyone. Thank you for joining us today to Access to Respectful and High-Quality Maternal Care Webinar. I would like to turn it over to Silia who will share housekeeping rules.

SILIA: Good morning, everyone. A few reminders, only presenters will be on camera to support better functionality throughout the webinar. There will be no audio or visual for the audience. Please ask any questions through our Q&A at HRSAGHForum@hrsa.gov. I will share that information in our Chat room. We are asking participants to introduce themselves in our Chat room by stating your names, roles, and organizations that you represent. If anyone needs logistical support, please let me know.

Please respond to the polling questions that we will be provide at the end of the webinar to ensure we gain feedback from you on today's session. All our slides, recordings and documents will be shared following this webinar. Thank you and I would like to turn it back over to Carla.

CARLA: Thanks so much, Silia. Hi again, I am Carla Haddad, Director of HRSA's Office of Global Health. I am pleased to welcome you to our Global Health Forum webinar on Access to Respectful and High-Quality Maternal Care Webinar.

Today's event is a true collaboration between HRSA's Maternal and Child Health Bureau, along with partners at the World Health Organization and USAID, building on previous efforts to unite our approach to address improved access to maternal health. More broadly, the forum aims to foster a bidirectional communication among staff and international and domestic community with Subject Matter Experts helping to provide information exchange and to address global health challenges: such as maternal mortality and HIV, mental health, gender-based violence, border health, inequities and so forth. Just last month in June of 2022 the White House stated that the United States is facing maternal health crisis and the U.S. maternal mortality is higher in the world and double in other countries.

Most pregnancy related deaths are considered preventable. Beyond mortality, maternal morbidity affects far too many families. Each year, thousands of women experience unexpected outcomes of labor and delivery that result in significant short- or long-term consequences to their health such as heart issues, the need for blood transfusion, eclampsia, and blood infections. Systemic barriers, together with a failure to recognize, respect and really listen to patients of color has meant that Black and American Indian and Alaskan native women regardless of income or education, experience a greater share of these grave outcomes as do rural women.

In this light and given the great impact of maternal mortality and morbidity in the U.S. and abroad, we must continue to explore now more than ever ways to improve access to high quality maternal care. I am so pleased that the Global Health Forum can serve as an additional platform for us to exchange, strategize, brainstorm, and build around these important global health issues like this one to help achieve and improved health outcomes.

So first a bit about our agency – and as you get to know us, please help us get to know you too by adding to the chat: your name; organization; and where you are joining us from – as I know we have an international audience for today's event. . Next slide.

In terms of the Office of Global Health at HRSA, it is within the Office of Special Health Initiatives within HRSA, and our office provides leadership and technical expertise to create collaboration and facilitate a bidirectional linkage in the U.S. and globally.
We achieve our mission through a broad range of activities across several key areas including 1) implementing the U.S. President's Emergency Plan for AIDS Relief program and 2) coordinating HRSA wide global engagement activities such as this webinar session today. Next slide please.

Office of Global Health works closely with our federal partners and other key stakeholders to provide expertise into broader initiatives, discussions, policy, and position papers.

We also have established relationships with multi-lateral organizations including the WHO and the Pan American Health Organization (PAHO); leveraging those partnerships to enhance the work that we do. In addition to our global diplomacy work our team is focused on advancing HRSA's mission in key focus areas which include advancing health across the U.S. Mexico border region, advancing women's health domestically and abroad and managing global dialogue in telehealth practices. More broadly, our overarching objective is to do our best to leverage HRSA's successes for outcomes globally and vice versa as there is so much to learn on both ends. Next slide.

So here are a few examples of our recent global health efforts as part of the forum. On the left is an image of the HRSA border health report which acts to inform and coordinate efforts and works across all the HRSA programs and with other federal partners to help reduce disparities in the border region. Each year we collate HRSA investments in the U.S./Mexico Border Region to better understand our work in the communities as well as pinpoint the gaps and opportunities that are moving forward. I want to highlight a webinar in collaboration with our Office of Women's Health regarding cervical health innovations to encourage knowledge exchange bidirectional learning in global and domestic programs.

The picture on this slide, on the top here, is from the HRSA Maternal Mortality Summit held back in 2018. Our office led this effort in partnership with HRSA's Maternal Child Health Bureau and the Office of Women's Health as well.

In this we invited technical and health professionals from many places and the WHO participated as well. The purpose of this summit was to develop solutions to lower maternal mortality and morbidity rates, and it resulted in many advances to HRSA's maternal health programs, congressional briefings of all sorts on the topic, among many other outcomes. I talk about this HRSA Maternal Mortality Summit because it has particular synergy with today's effort. Several of the collaborators and many of the initiatives that we will hear from today continue to work with us to help advance maternal health. Next slide.

I will now turn it over to the acting team lead for Office of Global Health Engagement Team who leads the Global Health Forum initiative with great support from Silia, Alberta as well as other colleagues at HRSA.

TANCHICA: This is a collaborative effort.

Our goal is to highlight and exchange strategies and ideas on the important issue of maternity care. We hope to do this in a two-way conversation, one that takes into perspective maternal health through the lens of quality and respectful care principles and also addresses the related issues and the lack of access inequities and inequalities that so many women faces arrange the world.

We are careful to note that this not just a joint conversation between global and national experts and representatives but an inclusive effort to illuminate the real-world application of our programs on the ground. So, next slide, please.

As context to this webinar, we consider quality care as encompassing effective, safe patient centered, timely, equitable, integrated, and efficient care. So, most importantly, quality health care systems are accountable and responsive, they listen to the patients and families, and voices and communities' needs and wants but don't take it from me let's hear directly from our partners at WHO. [Video plays next]

Everyone needs access to health care but just because a patient has been treated it doesn't mean their condition will improve. In fact, when care is not sufficient quality treatments might not work or may even cause harm. Around the world more deaths are due to poor quality care than lack of access to health services. 15 percent of that in low- and middle-income countries are caused by poor quality care and in high income countries, one in ten patients are harmed while receiving hospital care. The need for action is clear to make sure that health services provide quality care that improves people's health. Care should be effective, so you accurately diagnose and receive treatment that works. So, the health care that you receive doesn't harm you.

People centered decisions made about your care are tailored to your needs and you are treated with compassion. And timely so you receive care when you need it. It should also be equitable; so, all people receive the health care they need. Integrated so different health workers and facilities work together to improve your care and efficient so available resources are used more effectively to improve your health and avoid waste.

TANCHICA: Thank you WHO for that careful reminder on respectful care. So, the White House also considers quality of care so important to maternal health services it declared their increase to high quality maternal health services as goal number one in its newly released Blueprint for addressing the maternal health crisis. Similarly, the Blueprint explains to us that every person having access to comprehensive health care coverage and high-quality health care services regardless of where they live or how much they earn, is critical to ending the maternal health crisis. Also, to achieve high quality health care we must eliminate inequities and inequalities, the WHO, the White House Blueprint, and the President Emergency Plan for AIDS Relief prioritizes health equity. Next slide.

So now it is my pleasure to introduce Dr. Allisyn Moran. Dr. Moran leads the maternal health team in the Department of Maternal, Newborn, Child and Adolescent Health and Ageing at the World Health Organization. She has over twenty-five years of experience in research, country implementation,

monitoring, and evaluation of maternal, newborn, and child health programmers working with a variety of academic, non-governmental, and donor organizations, as well as extensive field experience with work in over 15 countries worldwide.
Next slide**.**

ALLISYN: Thank you very much and to HRSA and all our colleagues today, for including me in this important webinar. It is important for us to be here and share with you today and learn from each other about this important topic. Next slide please.

Just to remind everyone I think it was talked about a little, but we do have a sustainable development target reducing maternal mortality ratios. Our most recent global estimate showed 295,000 maternal deaths in 2013. From this chart we projected out trends to achieve SDG or the sustainable development target in 2030. Globally we are off target, and we really need to increase our average annual aide rate of reduction so we can do that.
Next slide, please.

We know what the major causes of death are globally, and we estimate them to still be the leading cause of maternal death followed by hemorrhage and other causes. But we also have this huge category of, indirect no obstetric cause, which comprises almost 28% of deaths so it is essential that we try unpacking and look at some of these deaths as well and think about how we address them in an equitable way. Next slide, please.

In addition, I want to remind people that stillbirths are still also a big issue. We estimate about 2 million stillbirths per year in 2019. You can see where they are occurring from this map. Many stillbirths aren't visible, and half occur during labor and childbirth so very closely related to maternal death. Next slide, please.

As was mentioned, maternal mortality is the tip of the iceberg. For every woman or baby who dies with childbirth related causes, many will suffer from morbidity disabilities and long-term ill health. Next slide, please.

We also know that this chart shows the trends in global coverage for key intervention, during the maternal and newborn period. We have other information on essential services for improving maternal health and survival. We have seen changes over time between the gray and the blue bars representing change. We have good coverage on maternal care information. There are births that mostly 100% in facilities. But there are huge inequities in which women can have better skilled care. This shows the disparity between the poorest and the richest, for different countries. These data are mostly from lower- and middle-income countries. But important to note as other colleagues have already talked about this issue of equity and better tracking of equity especially national vulnerable groups is essential. Next slide, please.

As I mentioned, almost all women give birth in a facility. We know that inequity. But the focus is how we look at improvement of quality of care as well as equity of that care. Poor quality care is the biggest barrier to reducing mortality. You can see there a picture on the right where care is provided in a high end versus rural setting.

We know that with quality of care you can prevent about 50% of deaths for women and more than 50% of deaths for babies. This analysis comes out of the Lancet Commission on quality of care. WHO has been working hard with United Nations' agencies and partners on how to address this issue and has come up with this framework published several years ago on the framework for quality for maternal and newborn care? In addition to the elements that were highlighted in the prior presentation I wanted to note that from our perspective, quality of care is essential in terms of looking at the provision of the care or the quality of the clinical care provided, as well as the supporting systems for information and referral as well as the experience of care. How do women experience the childbirth experience to ensure respectful care? Next slide, please.

We have been looking at how we adopt this framework and implement it across a continuum. We have a similar framework for newborn, pediatric care as well as newborns. You do have standards that outline different elements for improving quality of care within each of those domain's provision and experience of care, resources as well as health workforce. Next slide, please.

To really address the issue of experience of respectful care, in 2014 WHO came out with a statement for women. Working collaboratively with many partners including colleagues at USAID. Published in 16 languages and endorsed by more than zero organizations. Support from governments on research; looking at improving quality care and with a greater emphasis on the rights of women. Generating data and ensuring all stakeholders, including women and women's voice are included in these efforts. Next slide, please.

As a follow up to this WHO worked with partners to conduct some research to really look at disrespect and abuse and respectful care. A two-phased multi-country study of qualitative and quantitative components to evaluate tools to measure development. And from that effort we clearly documented that there are significant issues around care within these countries and many other countries. In terms of observing labor as far as following up and talking to women afterwards, we found very high rates of disrespectful care which you can see on this slide. Next slide, please.

In addition, women were at increased risk of disrespect, physical and verbal abuse 15 minutes prior to delivery. That seems to be the time from the labor observation when most of the abuse peaked. Next slide, please.

We have also looked at factors associated with mistreatment during pregnancy and childbirth based on data from a community survey from women themselves, which found that young women are really at increased risk for mistreatment compared with those who are older, those who do not experience mistreatment, as well as were more likely to experience verbal abuse compared to those who do not experience it. Next slide, please.

We really want to emphasize that within WHO respectful care is a human right. It is included in many U.S. documents and parliamentary documents and so we're all working together to ensure that we can really engage with systems to share their experiences; to make systems and governments accountable; and those women are active and informed individuals with the unique expectation and needs. Next slide, please.

There was a large global survey done by the White Ribbon Alliance. We asked women what they wanted during pregnancy childbirth. This was a global survey, included 114 countries, 359 partners and so about 1.2 million unanimous or requests came, and number one was dignity and respectful care during labor and birth. This is what women are demanding and we need to be able to respond to what they want and need. Next slide, please.

The White Ribbon Alliance has also worked with partners to update respectful maternity care,
Next slide, please.

I will talk a little about intrapartum care guidelines. WHO recommends six interventions for respectful care: effective communication, continuity of care, companionship during labor and birth, maternal mobility and upright position, oral fluid and food intake and pain management whether pharmacological or non-pharmacological? I want to highlight the importance as well focusing on the care. So, midwives and other providers of maternal care as well as immediate newborn care need respect and an enabling environment in which they provide respectful and quality care.

WHO did quite a bit of work for training materials, we have a toolkit and course on essential childbirth, and are finalizing a course on respectful care? We are also working on this framework for action to strengthen strengthening quality midwifery education. We are working in several countries. Next slide, please.

Just to remind everybody I think this is my last slide to wrap that up. Safe and respectful childbirth goes beyond service delivery we must work at systems and societies and really think about how we work together to challenge harmful gender stereotypes: eliminate intersectional discrimination, disrupt power dynamics, and address health system conditions and constraints my colleagues have finished their supplement on this work. The information is there if you want to look at the strategies documented to achieve this worldwide aim. Next slide please.

I am sorry if I spoke very quickly; it was a lot of information to get through. But really appreciate your attention and look forward to working with you as we think as a global community on how to address this issue that affects all countries, all women, so that we can ensure not only to healthy, happy babies, but also women who are able to thrive and have very successful future pregnancies. Thank you.

Now I am going to turn it over to my colleague from the USAID.

ROBYN: I want to acknowledge our partnership over maternal care over the past decade. The work is done on the ground by USAID. Nurses' midwives, community health workers and other people who work to make childbirth safe and respectful to everyone. As a midwife and global health advocate, we link between global and domestic maternal health issues. Next slide, please.

Many women face disrespect and abuse during childbirth at government and private health facilities. Women face overt violence, like being slapped and abused during labor. They are left unattended, lack privacy and a birth companion. Some face discrimination because of religious or social economic status. In response, hospitals blame overloading, inadequate infrastructure, and workplace stress. Given these constraints we can help facilities be committed to providing respectful maternal health care. Maternal care is listening to what clients are saying and incorporating these into our programming. Next slide, please.

This slide before you start it is a short video from the White Ribbon Alliance describing Malawi country findings of survey for women clients receiving maternal health and child services. Go ahead.

ROBYN: Thanks. As I hope you have seen from our first videos. I try to get as many videos as possible because I think those voices are important. But second, is shows how consistent the findings have been. This is an issue that truly crosses countries and regional borders.
USAID has been working for over a decade to advance respectful maternity care at a global policy level and through country programming developing the evidence base around maternity care and abuse across all reproductive and maternal newborn child health services. Respectful care is looked at from the U.S. experience as well as from across the globe. Disrespect and abuse disproportionately affect groups and communities that do not have social or political power, and this creates problems for maternal and newborn outcomes so all our work must include and focus on these communities. Next slide, please.

In most of the USAID supported countries, patient experience of care is acknowledged as part of 2016 WHO Quality of Care Framework presented earlier and incorporated the being experienced of privacy and respect. In 2022, we are in a stock taking phase to understand what has been accomplished over the past decade where there are persistent gaps and how USAID can expand the maternal health care globally. We had a stock taking effort over the work and achievements over the past decade across 20 countries. This exercise identifies implementation successes and gaps and provided some framing for how to move forward. Next slide.

This is our draft framework for respectful care because time is short, I am going to skip this slide, but it will be shared and you're welcome to look at it.
Next slide.

The learning from the 20 countries surveyed provided direction forthcoming years. We recognized the need for iterative learning and scale across programs with practical and evidence-based solution. The four main buckets of findings are these: Beginning with the orange box, top right, moving counterclockwise: National and policy systems while many countries you include intermittent training on respect for care, USAID feels the health system is needed to support the workforce as well as making sure there are good policies in place to help support this work.

At the community level we must move away from not just awareness raising, but also meaningfully raise communities in design of health services becoming active consumers rather than passive recipients of health care where they understand rights and agencies and processes in place, as an example: USAID is exploring the contractibility approaches in the co-design of solutions which are context specific. The glue is sub-national and facility level activities where the rubber hits the road coordination components of care, budgeting for integration for maternal care policy is where it is translated into practice. Where good ideas become meaningful. And finally, measurement, the green box to strengthen any of this work requires further advances in data collection, analysis and data use and we're engaged with partners who work with promoting a compendium, harmonized measures for respectful care including partnerships with WHO our implementation partners as well as our flagship momentum projects. Next slide.

As you know I think that whatever we do we have to recognize that measurement is important, but it really is the lived experience that matters. So, I will let the last word go to someone in India. As I said before, our work is really done on the ground and we have with us Suzanne Stalls, who is one of our long-term implemented partners.

Suzanne over to you. Thanks very much.

SUZANNE: I would like to both acknowledge and thank colleagues all over the world who have spent this past decade and prior to that investing so much effort with so much passion in promoting this aspect of quality day. We see from Allisyn's and WHO's framework without a policy of care we don't have a quality care overhaul. So good morning, good afternoon, good evening to everyone. Very quickly: On our agenda will be able to look at what as a program or a project Momentum Country and Global Leadership are attempting to do in this field both in knowledge and implementation. We are working at a global level to advance global thought leadership and again to reinforce respectful care is a key aspect of quality care; conduct national policy initiatives looking at this health system; and generate learning in measurement of sub-national implementation and community engagement. Next slide, please.

These next several slides I think are the ones that I will focus on most specifically. We know now that this field has been flourishing the past ten years with quite a bit of the attention. There are still many unanswered questions and deeply entrenched behaviors that will continue to need attention. Some of the questions that we continue to need to ask: How do we integrate respectful care principles and programming throughout all levels of the health care system as an essential aspect of the quality of care? Next slide, please.

From the perspective of the Momentum Country and Global Leadership, we have gained our approach and programming to look at development, integration, and implementation of respectful care policies through a process designed to create personal and institutional commitment. Also, looking at multiple programmatic approaches. Based on the context. I think one of the things that we understand is that the drivers, the manifestations of mistreatment and what is perceived as respectful care is highly determined by sociocultural contexts. So, again, looking at national level policy and advocacy, district level linkages with quality-of-care initiatives, very sustained meaningful challenges of collaboration between facilities and communities. We feel this is key. Utilizing and implementing a variety of mechanisms engaging both the communities and the facilities to address these issues. And recognizing this is really a systems issue that impacts providers and the beneficiaries of the health system. Some of these examples are values clarification for providers, community action cycles and scorecards, open maternity cases, accountability strategies and defined errors of RMC measures. We also look at how we can help to understand both the measures and how to integrate the measurements routinely within health systems so that we can track what it is that we're able to learn about. Then lastly, as Robyn mentioned this pattern closely follows the USAID framework, to understand the experience of care not only intrapartum but in antenatal and postnatal care and affects different segments of women of reproductive age also infants, newborns, and children. Next slide, please.

Under Momentum Country and Global Leadership, we are engaged, in fact, I am leaving in a few days for Rwanda to begin a dialogue process. We were requested by the Ministry of Health to help them develop a policy for respectful care integrated into their strategy. As you can see, I won't dive into the details of this slide, but, again, they will be available to you. We are looking at developing, creating, and evaluating a very specific process to highly engage key stakeholders to ensure the success of the implementation of this policy. Next slide, please.

In Kenya, we'll be collaborating closely with the White Ribbon Alliance who will be working at community and county levels to really engage stakeholders, women, and communities, in a listening exercise. To understand their perceptions of quality of care of respectful care and we will be helping to create those links between that local level, the county level and then to reinforce the existing respectful care policy. Next slide, please.

We have several deliverables that will be available, certainly once all these activities are completed. A lot of what we'll be looking at is what is the adaptive learning and how can we learn to best support the development of policies and their implementation. Next slide, please.

At the sub-national level and the community engagement, we are utilizing an operational guidance that we developed under the maternal care and child survival program the predecessor to this program now. We have developed a process that can be utilized at a sub national level, conducting a situational analysis that explores women's, newborns, health workers experience and perceptions of care during the continuum of case, looking at the findings to co-design between the facility and the community. The prioritized interventions that the community and facility feel best address the situation within their context and then lastly, the implementation of the co-designed activities accompanied by routine monitoring.
Next slide, please.

As you can see, we are looking at implementing this in several countries, Trinidad, and Tobago and subsequently Jamaica. Into each we have a focus on antenatal and postnatal care. In Ghana, we are looking very closely at newborn experience of care as well in Guatemala not a part of the Momentum program but a bilateral program where we are actively engaged. We are using quality of care standards within the facility and very strong community efforts to create those avenues and channels of communication. Next slide, please.

We are collaborating with AlignMNH initiative funded by Gates to bring together the maternal and newborn world to continue driving with a very concerted effort toward the SDGs in 2030. As you can see, we created a graphic. One of the things that we really tried to be very clear about at a global level is terminology because there are all sorts of different terms that people are using to describe the experience of care and we felt that it would be helpful to illustrate that. We are looking at a landscape analysis to really see the policy and the extent to which it has been implemented within our priority countries and then supporting White Ribbon Alliance in several countries as well. Next slide.

Now I would like to turn it over to another colleague, Alpa Patel-Larson from HRSA's Office of Global Health and over to you Captain Patel-Larson.

ALPA: Thank you Suzzane for your kind introduction.
I have led many MCH projects as well: 1) use of multidisciplinary maternal mortality review committees to reduce the impact of social determinants of health on racial disparities in pregnancy-related complications and outcomes, 2) co-lead for a special American Journal of Ob/Gyn issue highlighting campaigns to eliminate mother-to-child HIV transmission, 3) review of surveillance data for each missed opportunity for preventing HIV along the clinical cascade of services, 4) the ways assumptions made by providers about risk of HIV exposure among foreign-born pregnant women contributed to late HIV diagnosis resulting in delayed treatment and worse health outcomes, 5) importance of early pediatric disclosure for children and adolescents in Thailand for better adherence to prevent transmission and adolescent health outcomes, and 6) use of CQI for the addressing challenges of HIV early infant diagnosis (EID) lab networks in Kenya, Tanzania and Botswana – as several examples.
It is my pleasure and honor to share a brief introduction of HRSA's global maternal health programs supported by PEPFAR with a specific example in Zambia. Next slide, please.

HRSA's Division of Global Programs has country and regional operational plans and equity, and maternal care are two key components and pillars of the HRSA's global programs. It collaborates closely with communities, governments, and other key partners to improve HIV/AIDS intervention for adolescent girls and young women pregnant, breast-feeding women and children globally as a member of PEPFAR in our agency team. Next slide, please.

We have also aligned with UNAIDS goals and strategic vision as an integral part of PEPFAR's support in over 50 countries.
UNAIDS outlines ambitious targets to end the AIDS epidemic by 2030 and prevent nearly 28 million new HIV infections and 21 million AIDS-related deaths, under competing global health challenges including COVID-19 Only if these targets are met, we can then end new HIV infections by 2030 through achieving the 95-95-95 goals (shown in the slide):
95% of people living with HIV knowing their HIV status.
95% of people who know their status on treatment; and
95% of people on treatment with suppressed viral loads.

- PEPFAR programs are also aligned with WHO's Sustainable Development Goals for improved access to health care services and integration of specialized services and public health interventions into primary health care, including for women and children across the life span. Based on HRSA's experience in both domestic and global programs, OGH focuses on supporting HIV/AIDS interventions of pregnant and breast-feeding women in the following six technical areas:
    - Person-centered Care (as written in the slide)
    - Quality improvement
    - Treatment continuity
    - Viral load suppression
    - Human resources for health, and
    - Sustainability and health systems strengthening
- These technical areas are unique opportunities for HRSA to demonstrate our value-added strengths and contributions in the PEPFAR interagency work globally. Next slide.

Here's a list of key strategies to improve continuity of care among pregnant and breast-feeding women supported by PEPFAR across all countries. Previous presenters have highlighted some of the strategies already. HRSA/OGH will continue to support our programs to improve continuity of care for pregnant and breast-feeding women through key strategies in collaboration with our partners.
Next slide, please.

HRSA/OGH currently has six cooperative agreements and three special projects related to global HIV/AIDS intervention. One of them is the partnership with the historically black colleges and universities (HBCUs). This consortium of HBCUs has decades of experience in providing care and services that recognize and address cultural considerations, issues of equity and social determinants of health, for diverse populations including adolescent girls, young women, pregnant women, and breast-feeding women.

For the next 15 minutes, we are going to highlight a HBCU Global Health Consortium program that focuses on maternal child health in Zambia implemented by Meharry Medical College in collaboration with national and local partners.
Next slide.

CYNTHIA: Thank you for that introduction. And thank you to the HRSA team and all the colleagues for this opportunity to share on this very important topic. So, I will take you through Meharry Medical College's global health and HIV clinical services' work regarding access to respectful and high-quality maternal care. Next slide, please.

In terms of background, Meharry is one of the four schools in the historically black colleges and universities health global consortium, we are partnering with the Zambian Ministry of Health to improve the quality of care of people living with HIV and to meet the testing, treatment, and viral suppression targets. As a consortium, we do have great support both from the Zambian government as well as from the U.S. embassy in Zambia. Each of the four schools in the consortium has a different focus area. At Meharry, we are working in the maternal and child health. In the University in Lusaka providing services to pregnant breastfeeding women and babies. Howard University is focusing on differentiated delivery plus services for stable clients.

In 2019, we were working to ensure that all children are diagnosed and are on the best treatment regimens and a virally suppressed. We were working to contribute to the UNAIDS stay HIV free and AIDS free targets which included reducing the number of children newly infected annually to less than 40,000 by 2018 and 20,000 in the future. To reach and sustain 95% of pregnant women living with HIV with lifelong antiretroviral therapy. To provide antiretroviral therapy to 1.4 million children aged 0-14 years living with HIV by 2020. Next slide, please.

To this end, we are providing one stop differentiated-service delivery within the child and maternal health clinics. We certainly believe this is a comprehensive continuum of care beginning with pregnancy through labor and delivery, and postnatal until the children are five years old. So, providing person and family-centered care. With support services such as nutritional psychosocial support through the mentor mother program as well as a pharmacy. So, in all the work that we are doing, we are trying to ensure that the care that we provide is ethical and is also respectful of women's choices and preferences. Next slide, please.

This is a framework of how we are implementing a two-way differentiated service delivery model that focuses on respectful maternal care and this has eight strategic areas. Three of the areas include patient and family centered care, continuous quality improvement for practice trans for nation, and improved care coordination to enable us to listen to client's voices and allows them to meaningful participate in their care. The next four areas within this strategic framework which include improved patient flow, point of care services, improved processing time of samples, and pairing of moms and baby appointments have resulted in us having a more efficient service with a reduction in waiting times in the facilities, so this has enabled moms to spend less time in the facility and more time with their families or at work.

The final area for in this framework, is on building capacity for service, through training of community health workers. So, we have trained mentor mothers, women living with HIV who successfully have gone through a prevention of mother-to-child transmission program. These women willingly walk the walk with of our clients, providing emotional and psychosocial support both in the facility and the community. Next slide, please.

Our program recognizes the importance of respectful maternity care as component of quality of care. Our goal for respectful maternity care includes strengthening practice of care to improve overall maternity care addressing inequities and inequalities including stigma and discrimination. Introducing bidirectional focus on maternal health care strategy, reducing, and eliminating HIV/AIDS in babies under it for wraparound service. Next slide, please.

Our strategies and approaches for respectful maternity care include providing clinical services support in the facility, through the differentiated service delivery model, providing support in the community through the mentor mother program, as well as utilizing better data to track our clients and our indicator. Next slide, please.

We are implementing a one stop clinical care model with our clients' accessing services under one roof, so to speak. So, the services that we provide include diagnosis and initiation of antiretroviral therapy within zero to six weeks of birth for infected infants, dispensation of antiretroviral for moms and under five years children in our clinics, nutritional counseling, as well as strengthening patient and family centered care services, including final outcomes for babies which I will explain in the succeeding slides.

The next few slides are showing some of the impact we have had contributed in part to the holistic and comprehensive care which incorporates maternity care principles that are respectful. This chart reflects trend lines screening of moms and babies for October 2021 to May 2022. These are showing a consistent attendance to clinic appointments by moms and babies, and we noted that respectful client centered care ensures that this consistent compliance has occurred even during COVID 19 surges. Next slide, please.

Part of our framework in implementing a bi-directional module included the use of point of care service for quick turnaround results. This chart shows how 97% of infants in our care are receiving a birth test. This far exceeds the Ministry of Health's Zambia target of 90%. Next slide, please.

In terms of the positivity rates for the infants whom we are testing, these are remarkably low, ranging from as low as 0.16% up to 1.3%. This can be attributed to the comprehensive continuum of care that we are providing in our facilities. For comparison, the UNAIDS estimate for Zambia is currently at 11%. This is how well we are doing reducing mother-to-child transmission in our facilities. Next slide, please.

Retesting of negative, pregnant, and breastfeeding women after their first antenatal visit is important to detect HIV infection early; to provide early treatment; and to prevent mother-to-child transmission. Globally over 50% of women are retested. But what we have noticed in our facilities is that providing respectful maternity care increases the proportion of women coming back to the facility for retesting. In our facilities, 89% of women returned to our clinics for retesting even during COVID 19. What is notable is that over 18,000 pregnant and breastfeeding women retested only 196 or 0.01% tested were found to be infected with HIV and these were all linked to care. Next slide, please.

In terms of viral load suppression in our pregnant and breastfeeding clients, we have found adherence with taking medication as well as attending clinical appointments increased with respectful maternity care. So, in our facilities, the viral suppression rates for pregnant and breastfeeding women are ranging from 93 to 99 percent and we have exceeded the UNAIDS target for this population. Next slide, please.

Postnatally until the children are five years old. We are providing a person and family-centered care psychosocial support through the mentor mom program. We are trying to ensure the care we provide is ethical and respectful of women's choices and preferences. So, this is a framework of how we are implementing a bi-directional differentiated service delivery model that focuses on respectful maternal care.

This framework has eight strategic areas of three of those areas which include patient and family centered care, continuous quality improvement for practice transformation, and improved care coordination. This enables us to listen to our client's voices and allows women to meaningfully participate in their care. The next four areas, which include, improved patient flow; point of care service; improved processing time of samples; and fair treatment have resulted in having a more efficient service with a reduction in waiting times in the facilities.
This enabled moms to spend less time in the facility and more time with their families or at work.

The final area in this framework is on building capacity of service through training of community health workers. So, we have trained mentor mothers, and these are women who are living with HIV who have gone through a prevention of mother-to-child transmission program. And these women willingly walk the walk with our client's, providing emotion and psychosocial support both in the facility and in the community. Next slide, please.

Our program recognizes the importance of respectful maternity care as a component of quality care. Our goals for respectful maternity care include strengthening practice of care to improve overall maternity care, addressing inequities and inequalities. Emphasizing a bi-directional focus for reducing and eliminating HIV in babies and providing differentiated service delivery wraparound services. Next slide, please.

Our strategies and approaches for aligning with respectful maternity care include providing clinical services support in the facility through the differentiated service delivery model; providing support in the community through the mentor mother program; as well as utilizing better data to track our clients and our indicators. Next slide, please.

We are implementing a one-stop clinical care model with our clients' accessing services, under one roof. The services that we provide include diagnosis and initiation of antiretroviral therapy within 0 to 6 weeks of birth for infected infants, and dispensation of antiretroviral therapy of moms. Nutritional counseling, psychosocial support for moms and babies, as well as strengthening patient and family-centered care services including having final outcomes for babies which I will explain in the preceding slides. Next slide.

The next few slides are showing some of the impact that we have had which can be attributed in part to the holistic and comprehensive care which incorporates respectful maternity care principles. So, on this chart is reflecting trend lines of the screening of moms and babies from October 2021 to May 2022. And these are showing a consistent attendance to clinic appointments by moms and babies and client-centered care ensures this consistent compliance, and this has occurred even during COVID 19 surges. Next slide, please.

Part of our framework in implementing a bi-directional differentiated service delivery model included the use of point of care services for quick turnaround time for results. So, this chart is showing how 97% of infants in our care are receiving a birth test. And this far exceeds the ministry of health Zambia target of 90%. In terms of positivity rates for infants we are testing, these numbers are low. Ranging from as low as 0.16% up to 1.3%. And this can be attributed to the comprehensive continuum of care that we are providing in our facilities.
For comparison, the UNAIDS estimates for Zambia. Next slide, please.

The retesting of negative pregnant and breastfeeding women is important to detect HIV infection early, to provide early treatment, and to prevent mother-to-child transmission. So globally over 70% of women are retested. But what we have noticed in our facilities is that providing respectful maternity care increases. In our facilities 89% of women returned to our clinics for retesting even during COVID 19. And what is notable is that of the over 18,000 women tested, only 196 or 0.01% tested were found to be infected with HIV and these were all linked to care. Next slide, please.

In terms of viral load suppression in our pregnant and breastfeeding clients, we have found that adherence with taking medication is increased for respectful maternity care. The viral suppression rates for our pregnant and breastfeeding women are ranging from 93% to 99% and we have exceeded the UNAIDS targets for this population. Next slide.

Our other impact has been improving the proportion of HIV exposed infants who have a known outcome at 24 months of age. So, this is an important measure of success, of a PMCT program and this allows for every child to be accounted for. So, we have had a progressive increase as the graph shows of our children who have a known outcome at 24 months. So successfully documenting this outcome is dependent on us having a good relationship with our clients but also with the communities where they live as well as the community leaders. So, we periodically have meetings with these community leaders to touch base and to exchange ideas and to share information. Next slide.

Our mentor mothers are providing support to various clients who include those who are newly diagnosed, those with a high viral load, those who have children living with HIV and those who have recurring miss appointments. They are providing peer and psychosocial support services to enhance identification, linkage, retention, and adherence for our clients. Next slide, please.

As we conclude these are some of the lessons that we have learned in respectful maternity care, and these include to offer patient and family centered care and deal with every case as the need arises. Listening to moms about their needs and to meet them. Engaging the community to assist us in providing outstanding maternal and child services in low-resource communities. Partnering with other organizations, and community leaders to ensure that patients' needs are met. It is clear from the goals and objectives of the implementation and interventions for overall success for moms and babies. Next slide, please.

This is a short personal account from one of our moms attending one of our MCH clinics on her experiences as a recipient of care. Please play the video.

Feedback like this from our clients is useful for us to tailor our programs and evidence have the bi-directional approach we are taking. These are pictures of our dedicated staff in each of the four flagship facilities who are providing comprehensive care for our clients. Next slide, please.

Our parent organization Meharry Medical College is in Nashville, Tennessee, and the local organization is in Zambia. This is the leadership of our organization with Dr. James Hildreth as well as the chairperson of the board. Dr. Patricia Matthews who is our project director and Dr. Sanika and Dr. Xylina and me and our MD specialists. This is the end of our presentation. Thank you for listening.

ALPA: Thank you Dr. Shava for your excellent summary on one-stop shop respectful maternal care in Zambia. You have shared an inspiring model with some support from HRSA/PEPFAR to strengthen those interventions. These interventions for pregnant women, mothers and children are under a larger umbrella of improving access. And without increasing access to respectful and high-quality maternal care, the progress of these interventions cannot be sustained anywhere including U.S. and other countries.

As we look forward to continuing to strengthen our support in collaboration with our partners, like Meharry Medical College, government agencies and communities too may help improve access to respectful high-quality maternal care in a bi-directional approach. Next slide.

I want to thank you all for contributing across to the Office of Global Health, Division of Global Programs. There has been significant work that's being done.

I would like to introduce Kimberly Sherman from HRSA's Maternal and Child Health Bureau. She serves as the Chief of the Maternal and Women's Health Branch and provides support to the maternal health programs. She has been a HRSA staff member since 2008 and enjoys building cross bureau and agency collaborations that lead to policy and programmatic changes. In 2018, she worked in collaboration with MCHB leads to convene HRSA's Maternal Mortality Summit. This collaboration sparked new funding to support maternal health innovations at state and community levels. Thank you so much.

KIMBERLY: Thank you for the warm introduction, Alpa. If I could have the next slide up on the screen. I am here representing HRSA's Maternal and Child Health Bureau. Our Agency, and our bureau's mission is to support mothers, families, and infants and to improve their health. We are doing that through access to care, increasing access to care. Centering ourselves around equity, building MCH capacity and impact. Next slide, please.

MCHB is focusing its maternal health initiatives from various facets. First from the systems and state level we are looking at innovations and what innovations we can support here in the United States. We also provide programming and funding to support workforce and quality improvement on clinical perspectives of care. And then thirdly on the access bucket, we are focused on direct care and services to women. Next slide.

Today I want to share some of HRSA MCHB's maternal health activities to support respectful care. I want to begin with the AIM program which is one of our central efforts to prevent maternal mortality and morbidity in the clinical setting. The purpose is to reduce maternal death by engaging provider organizations, state-based health and public health systems, consumer groups, key stakeholders within a national partnership to assist state-based teams in implementing safety bundles within hospitals and birthing facilities across the nation. I want to tell you a little bit about these patient safety bundles. They package maternal health services in one seamless process. These core bundles that are listed on the left support specific quality metrics and measures through the AIM data system and address the leading causes of severe they are expressible and available to everyone. You can access them via the web link AIM for maternal safety.org. We have supporting materials that can be found on website as well. Next slide.

For AIM to be successful it is essential that we work at the national, state, and local levels through the establishment of very strong partnerships. Partnerships at the policy level, clinical level, and through the QI movement. The goal of AIM is to enroll all 50 states, the District of Columbia, U.S. territories in this program. As of April 2022, we have 45 states plus the district of Columbia currently enrolled. If I could have the next slide.

I would love to talk to you about what's included in our patient safety bundles. Every patient safety bundle as mentioned on the previous slide are structured around the four Rs listed on your screen. But today we are here centering ourselves around respectful care and so I would like for everyone in the audience to understand that respectful care is incorporated throughout all the bundles. And are really integrating elements into each bundle so that we can focus on the provision of equitable care. All bundles are being revised to incorporate respectful care and to respect the most updated evidence-based practices, so they are taken into consideration for every encounter for every AIM birth. Next slide.

So that was just a high-level overview of the AIM program. In the time that we have remaining I would like to highlight a few other HRSA MCHB initiatives that are centering respectful care. Next, I would like to focus your attention on the healthy start program. It has been in existence for about 30 years and the purpose of this program is to improve the health, outcomes of women, and infants, before, during and after pregnancy and to reduce racial and ethnic differences in death. Next slide, please.

Most recently, the healthy start program has been responding to the needs of women by modifying the program to incorporate Doula care. Doulas serves as advocates for pregnant mothers to see that they receive the best care possible. Next slide.

Our funding through the healthy start program to support community-based Doulas is through a supplement to increase the availability of doulas throughout the healthy start program in areas where in which communities are most affected by poor infant and maternal health outcomes. We are so excited to expand our community doula-based effort. I would like to tell you a little bit about what we're hearing from the field. Next slide.

This work and most of our work is being done through needs assessments and collaborations. We also want to be culturally responsive and use the funding that's available to innovate and to meet women where they are. Next slide, please.

Shifting from the Healthy Start program, I would like to briefly highlight our work to increase access to preventive services. It provides clinical recommendations for preventive services to clinical providers and guidance to the insurance industry on preventive services for women. There are a few that I would love to highlight. If I could have the next slide.

The purpose of this initiative is to improve the adult women's health across the lifespan by engaging a coalition of clinical and professional organizations to recommend updates to the women's preventive service guidelines. One component of this initiative is the well women chart. You can access the chart through the hyperlink below and I will also drop it in the chat at the conclusion of this presentation but there are specific callouts for the pregnancy and postpartum period. What women should be screened for, and we provide clinical guidance to support initiation of these services in the clinical setting. So, I would love for you to reach out and review these well women chart that will highlight some of the services that support contraception counseling. And a host of other recommendations for women during the prenatal and postpartum period. Next slide, please.

I cannot cover everything in this presentation today, but I would love to highlight just a few other initiatives that HRSA MCHB is leading. We have a maternal health learning innovation center that's led by the University of North Carolina which is building capacity across the state. We package needed resources in our resource center, provide national leadership at the state and community level, and spark innovation in the space of maternal health. If I could have the next slide.

I would love for you all to join us at the Third Annual Maternal Health Innovation Symposium that's happening in two weeks in Chicago, Illinois. There are virtual and in-person provisions to attend the Symposium. We are sharing information across states and communities that are supporting maternal health outcomes. Lastly, if I could have the next slide.

In May of 2022, HRSA launched the National Maternal Health Hotline in the caveat of access to care. Our national hotline recently was released and provides available support to women, and services are provided in English and in Spanish via voice text and chat. Interpreters are available to make sure that women who are experiencing a maternal mental health crisis needing services can reach out to a provider and get service in their community.

And with that, I will turn the presentation back over to Ellen for us to talk about opportunities for collaboration and building the bridge for maternal health globally and domestically. Thank you so much for your time.

TANCHICA: Thank you so much to Kimberly and all the other presenters. Wow. What a great and impactful presentation. At this time, I would like to start our moderated question and answer session. Ellen, we are going to pose the first question to WHO. We've heard respectful care expressed in numerous aspects in the presentation. How should we define respectful care and why has it been important to address respectful care through a quality-of-care lens?

ALLYSYN: Thank you so much for the excellent discussions and sharing today of respectful care.
So, I think from the WHO perspective, really defining respectful care as an essential element of quality of care for maternal and newborn health as well as for child and adolescent health as well. So, to really raise a profile, the importance of this essential issue by having it in our framework as equal to the provision of services and respectful care, that's how we are trying to help raise a profile by reshaping and rethinking the definition so that we can ensure respectful care is integrated into everything that we do to improve quality. And I think for the second question in terms of why it is beneficial, I think as today we see some of the examples, we know that women are demanding this. We know that it is possible to provide it. And so, we just need to think together about how to ensure that we can really promote respectful care through all the work that we do to improve maternal and newborn services and outcomes and to really consider the factors around equity. Thank you.

TANCHICA: Thank you, Allisyn. I'll turn it over to Ellen next.

ELLEN: Thanks so much. Our next question is for Kimberly. The lack of respect experienced by patients, families and health care workers in the health care system is not a new challenge. How do we finally get it right and ensure patients and all health workers voices are heard and responded to?

KIMBERLY: Thank you so much, Ellen, for the question and I would love to hear other thoughts on how this work is being done domestically and globally. You are correct that lack of respect is not a new issue. HRSA MCHB has been supporting the work of doulas since 2006 and there is a strong commitment to continue to do that work and move it forward. I think from our perspective we want to make sure that the people that we serve know that their voice is important. And so, making sure that they can utilize their voice that they are working with their community health workers, patient navigators and clinical providers to feel comfortable and to share what things are wrong. We are building out, making sure that we have lived experience on all advisory committees, on all HRSA-funded activities related to maternal health, even down to maternal mortality review committees. Seeing that we are making space to make sure that that there is a seat at the table and their voice is being heard. We are trying to incorporate that and interweave it into everything that we are doing to build that capacity. Thank you.

Thank you. Our next question is for HRSA/OGH. Are there any novel community engagement strategies coming down the pike that you are excited about that show promise at addressing inequities and inequalities?

ALPA: Thank you for the great question. In Malawi, HRSA is implementing a new PEPFAR program that aims to address the vulnerabilities of adolescent girls and that includes early age pregnancy and young marriage in addition to the high community levels and risks of HIV for adolescent young women and girls. This is introducing a pathway to employment through training of community health workers that are responsible for the provision of community level essential health services and the scale up and expansion of these availabilities in communities across the country.

The HBCU Global Health Consortium is supporting this introduction of a new training module that's specific to the health care and social needs of adolescent girls and young women. And when you consider how the population in Malawi are young people, and a large percentage of 18 to 25-year-old mothers are married. So, this is important because health care to address the social needs of adolescent girls and young women to ensure respectful and appropriate high-quality health care. And that's further strengthened by peers delivering this new program. There is great excitement about the prospects for this program, the Ministry of Health has been an active partner. And among female leaders the program is desired for they see great potential for a different more self-driven future by having economic empowerment but also increasing the health care workforce for young mothers.

ELLEN: Thanks so much. That's exciting to hear about that new program. This next question is for Suzanne. From your experience working in the maternity care at the intersection of HIV prevention, care, and treatment, what would you identify as the key elements to promote a culture of respectful person-centered care that can be maintained even when clinic settings are over capacity and understaffed?

SUZANNE: Thanks very much, Ellen, for that question. And many thanks to all the presenters for just extraordinary programs and you have given me lots of great ideas as well. So, thank you for this interchange. I think that I would say that after implementing programs on the ground that probably one of the single most important aspects of this is to humanize both the provider and the client who uses the services. And, you know, almost all the settings where we work are overcapacity and understaffed. It's a reality that probably won't resolve itself soon. So, what I have seen be very useful is for the providers to see their clients as someone who has a place in the community that has desires and needs. Someone who has a family that they are concerned about, and then for the community itself to understand that the providers are under enormous pressure. And that they too experience mistreatment within the system. And I think probably that has been one of the biggest takes aways that we've seen. Thanks for the question.

Thank you for that thoughtful response. And, just for also highlighting the impact to health care workers.

This next question is for Dr. Shava. Are there other real-world experiences or examples of access to high quality care that we can examine or look at further to improve maternal care across the globe?

Thank you for this question and for all the great presentations from all the colleagues who presented today. So, in Lusaka the provincial health office conducted the Save a Life Campaign and involved training of nurses, midwives, and other staff in four hospitals in Lusaka. So, the aim was to reduce maternal and child mortality through quality improvement as well as attitude change. So, in the facilities where the staff were trained, they noted that there was a reduction in maternal deaths in the preceding months and improvement in documentation during labor and delivery. And there was an increase in client satisfaction. So quality improvement in attitude change training is an example of how we can improve access to high quality care across the globe. Thank you.

Thank you so much, Dr. Shava. I appreciate that response. We are going to do one more question? Am I skipping ahead? Go ahead.
Yep, yep. Sorry. Thank you. That's okay. This next question is for Robyn at USAID. What key aspects are we missing when we speak of high-quality care around the world such as mental health and climate change?

ROBYN: Thank you. And I do think that those are exactly the two that I would name. I think that high-quality care has a clinical component and an inner personal component and must address a lot of things. But we know that mental health has been overlooked for a longtime. USAID has funded through our Momentum project a groundbreaking landscape analysis of the impact of maternal mental health and perinatal mental health disorders in low- and middle-income countries. And I can share the link when I'm finished so that you can see that analysis.
And additionally, we are doing some work around addressing maternal mental health issues. Understanding they are contextual to different locations and a lot of work that has been going on in different countries and different settings. I think we need to acknowledge that identify what is successful and how to strengthen the reach of those interventions.

I also think that obviously many of us are sitting in exceedingly hot locations right now. And that the impact of climate change on maternal and newborn health outcomes, there are many, many aspects to what climate change means. We have been focusing along with the White Ribbon Alliance, the Human Rights Watch, and World Health Organization in a growing interest group on impact of heat on maternal and newborn health outcomes. And continuing to advocate and raise voices including sharing some of these voices at the COP26 and now preparing for COP27, making sure this issue doesn't get ignored. Thank you.

TANCHICA: Thank you so much. Thank you again to our presenters. I think currently we have a few questions for the audience. What we want to do is open it up to our Q and A from the audience and I think we have some in the queue. Thank you all for sending them to us at HRSA GHForum@HRSA.gov. First question, this one is geared for Dr. Shava. It says with regards to the MCH project, I wanted to ask if there are any unforeseen or unintended consequences that arose from the project.

CYNTHIA: Thank you very much for this question. We have been conducting this project for over 18 months. And so, one of the things that we have noted was that the space within the MCH is where we have been working was not adequate to meet the demand of our clients. And once we started seeing moms and babies in MCH we also had their partners also wanting to be seen in this maternal and child health clinic. It was a good thing in terms of our service delivery.

TANCHICA: Thank you Dr. Shava. We have one other question and then Ellen, I will turn it over to you to see what you have in the queue. One of the strategies is companionship during labor, how has this been achieved considering the current COVID-19 pandemic as most hospitals have greatly limited patient companions in the hospital settings? Any of our presenters can feel free to address the question?

KIMBERLY: This is Kimberly. I can only speak domestically and from personal experience. It the fluctuation in partner support that has changed with each wave of new COVID-19 variants. And so, we know that in the United States hospitals are testing not only the pregnant individual, any of their support persons, but we have also seen a rise in telehealth services and the use of doulas. You may not be able to have your doula and additional partners there. So, making sure that that partner support has been available through other modes of communication and we're learning a lot about the use of telehealth services at least domestically in making sure that women get the care they need. And just pivoting. So, it is how can we make this happen for pregnant and postpartum individuals. Anyone else have anything to add?

I can speak to it from the global perspective. And what we know is that despite WHO's leadership and emphasis on companionship during birth it oftentimes is a very difficult situation to achieve just primarily because of lack of privacy and overcrowding. And we also know that during the pandemic that you know this emphasis has been deemphasized even further. So, I think as much as anything that we have done is spent quite a bit of time trying to document as best we can basically the lack of access to this respectful care intervention. So that as we see the pandemic subsides, we can begin to advocate once again for this extraordinarily important aspect of respectful care. So, thank you.

Thank you both Kimberly and Suzanne. I will turn it back to you, Ellen.

ELLEN: Thanks so much. The next question is for Robyn and Suzanne. For those of us who don't work on issues globally can you describe what the White Ribbon organizations do? And what does the name stand for?

ROBYN: It is the White Ribbon Alliance. Suzanne you might want to speak more to this because you have a longer history working with them. They are working in mostly every country in the world. It is not just internationally. I think one of the potentially missed opportunities is getting engaged with them a little bit more domestically. They focus on listening to women and raising the voices of women. They have done work over a long period of time and identified what the challenges are. They describe what the disrespect and abuse situations have been and then organize campaigns to raise the voices and address the issues. They were also the organization that led the charge in the creation of The Universal Rights of Women & Newborns charter of the rights and childbirth. Suzanne I'm going to let you speak to it. So, fill in all the gaps that I have.

SUZANNE: Thanks, Robyn. I think first, just acknowledge that this movement was really spearheaded by a nurse midwife here in the U.S. And, you know, given that Robin and I are both nurse midwives, we must acknowledge that and be proud and supportive of it. I would describe the White Ribbon Alliance primarily as an advocacy organization. They have employed any number of different strategies to heighten awareness of maternal mortality and the inequities. And they have developed a lot of strategies, for example, citizen journalists and health care provider journalists. One of their primary pathways for understanding what needs to be done in terms of advocacy is by conducting what they call listening to groups, listening sessions. I think it was Allison earlier that referenced that extraordinary survey that they undertook, I think it has been four years ago that was entitled What Women Want. Over 1.3 million women throughout the world responded and as Allison rightly noted the No. 1 request from women was that they be treated with dignity and respect.

Every time I hear that, it just brings me to my knees. It just shows you how critical that is in terms of women's access and experience of care. And what an important right it is to as a human being to be able to have that experience during pregnancy childbirth and postpartum. It is not confined to that period in a women's life. At any point, and any person is deserving of that respect and dignity. So, thank you.

ELLEN: Thanks so much. It looks like Robyn dropped a link in the chat to the White Ribbon Alliance. Our next question may be answered by any of our presenters. What are the two main existing gaps you currently see in improving respectful maternity care?
SUZANNE: Thanks, Ellen, for that question. I think having a reduced number of trained health care workers we certainly see a high patient to staff ratio in the communities where we work. So, I think one of the gaps is in terms of human resources for health and we need to optimize the health workforce numbers in and include training on respectful maternity care principles within the training curricular. Over.

ROBYN: Thank you. Suzanne, I would like to piggyback on to that and I feel like one of the things that we oftentimes see and particularly in global health programs I cannot address domestic programs with as much knowledge. But we oftentimes see the programming for human resources for health, rather separate from for example from maternal and newborn program implementation. And I think, you know, in terms of funding streams and focus, those two areas need to be joined at the hip. Because at the end of the day we are talking about a health system that's simply does not have, you know, the number of health care workers that as needed to provide quality services. When I say quality services it clearly is inclusive of both the provision of clinical care and respectful care.

SUZANNE: I mean health care providers are human beings. When you look out, I had someone in Malawi tell us this one day, how we estimated gestational age which is a very critical aspect of clinical care and very challenging oftentimes in our settings. And he looked at me and he said Suzanne, I look out the door in the morning and there are 200 people in line to see me that day in four hours. Do you really expect me to ask all those questions? I realized we must talk about increased focus, increased emphasis on quality education for providers.
It is just an essential element. We cannot ignore it. Thank you. Over.

ROBYN: Actually, to build on that, I think, you know, in the U.S. when I was a midwife, I used to have one hour for the initial intake for an obstetric visit. I'm sure I think that COVID-19 has highlighted that attention that doesn't get acknowledged which is with COVID-19 health care establishments decided that the risk was to the health worker, and that the community was the source of the risk. Whereas the community has seen well, the risk to themselves as the community lies in going to the hospital. So, they don't trust going to the hospital. While that's in a COVID-19 specific situation, I think there is a little bit of a mistrust and a little bit of an othering of rather than recognizing that health care workers are in fact, part of the community. We have a shared concern and shared desires from different perspectives. I feel like that tension is big. If we don't address it head on, it continues to divide. I live in Boston. I think it is interesting to see what the obstetric community did here. We are the last birth center in the Boston area was just shut down. Whereas in other communities there was an increase to unburden the hospitals and do what could be safely done in birth centers. The responses to this tension are different but I do think the tension exists. Over.

SUZANNE: Maybe can I just add one thing on top of all that? The gaps that others have raised is important and the other gap is how do we measure and capture the respect for care elements as we capture the provision of services or the clinical care. We track lots of information about the quality of the clinical services provided. We do audits and we don't often very well capture many settings. I can speak more to the low-to-middle income settings than the high-income setting, but capture how many births during labor and childbirth, how many had adequate communications between the woman and her provider. So, I think we need to think about how to track that because once there are measures, then it is easier to hold systems accountable for that performance as well. Thank you.

DR. SHAVA: Thank you. I would like to add, too, as well about the as much as the tragedy in ongoing exposure to COVID-19 and the pandemic, it is done both it is done several things where it is accelerated innovations. That we are lagging in implementation. One key aspect of a lot of the work that we are doing for in Zambia and many countries, there wasn't enough health care workforce as well as infrastructure, structural that allowed confidential respectful care when it needed. And so, a lot of efforts to decongest the clinics without changing or affecting the quality of services or access to services was necessary through the acceleration of other interventions. So multi-month dispensing of regular medications instead of once a month where you would have to come back to the clinic where you would lose which was quite burdensome to the client but also burdensome to the health care workers and clinics to have that many people around. A lot of the techniques to decongest the ongoing waves of COVID-19 as Kimberly mentions also changed how we implement standard and routine care. Those are some advantages in increasing the use of telehealth and telemedicine for both the training of health care workers to expand the accessibility without it being in person but still increasing the quality of those materials and the use of technology.
Dr. Shava, if there is an opportunity later to provide some other examples of how the mother and baby clinics had to change their care models to address how COVID-19 impact practice, if possible, sorry, let me know.

TANCHICA: We are coming up on our next time. We can take questions from the audience, please send questions to HRSAGHForum@hrsa.gov. And we will make sure that they have get your questions. At this point we do want to get you all out on time. We do have one burning question from one of the audience members: can we get this recording slide deck? We will make sure we make it available to you after we go through the appropriate clearance processes, but we do plan to share the slides as well as the recording. At this point in time, we just again wanted to thank our presenters. Next slide.

One of the things we hoped to highlight with today's Global Health Forum is that quality health care -- is respectful, patient-centered care and equitable, and that the implementation of RMC principles followed by exemplary programming can help us to keep front and center patient, family, and community needs for improved maternal health outcome. This Forum envisions that operationalizing RMC must encompass the full complement of the health care workforce. In addition to physicians, nurses; midwives; doulas; and community health workers; and anyone caring for an expected parent, must receive the same respect and engagement by the health system. We would be remiss if we didn't point out the overlapping concerns, aligned programs, and opportunities from HRSAs Office of Global Health, Maternal Child Health Bureau, the World Health Organization, the U.S. Agency for International Development, and our noteworthy program implementers, Jhpiego and Meharry Medical College.

From WHOs stark reminder from the Global Health Commission's declaration, "poor quality is now a bigger barrier to reducing mortality than inefficient care." To the White House's recognition that "addressing the maternal health crisis in the United States requires immediate action." We understand that we must continue to act globally and internationally and be unified in our approach to ensure quality health care for all women and families regardless of race/ethnicity, gender, income, or geography.

Yet, with these challenges, there is hope. We heard about USAID-MCGLs integration of RMC principles into the health system in Rwanda and Kenya to achieve patient-centered care including the application of operational guidance to design, implement, and monitor interventions to improve women and their newborn's care and patient experience in selected facilities.

There is also promise in our HRSA/OGH-HBCU Global Health Consortium efforts on-the-ground in Zambia to provide a one-stop maternal care model to strengthen and infuse numerous support services. This includes mom-baby pairing; a MCH pharmacy; psychosocial support; mentoring of moms; continuum of care; and continuous quality improvement to address respectful maternity care goals. For HRSA/OGH this is an especially important model as since the inception of PEPFAR at our agency, quality, patient-centered care has been the primary focus.

As we reflect on what is occurring on a global stage, nationally HRSA/MCHB is leading the charge and has made incredible progress since the Maternal Mortality Summit in 2018. They have launched a plethora of new programs to uphold HRSA/MCHB goals of access, equity, capacity, and impact. For example, doula-community based funding, women's preventive services, an innovation center, and a maternal mental health hotline are among their numerous programs.

CARLA: Thank you so much for the thoughtful summary and reflections that you just provided as we near the end of this webinar session. And I just want to echo what everyone else has said and just let what an outstanding group of presenters today. Your work and efforts are truly inspiring. I'm so eager and excited to build on the insights and experiences that were discussed today by the presenters and the discussion that unfolded. The Global Health Forum is a larger effort to have inclusive and poignant conversations and exchanges on key health issues across the spectrum and in a bidirectional manner. We will have this dedicated space for the experts and key stakeholders and the public to engage and learn from each other to refine and incorporate themes, ideas, and strategies that can help improve clinical practice, and behavior.
We do also will plan to continue our discussion on maternal health and related matters. Stay tuned for more information on this in the future.

I just want to give a very special thank you to all our collaborators. HRSA's Office of Global Health, Division of Global Programs, Maternal and Child Health Bureau, Office of Women's Health, USAID, and Meharry Medical College. And our very own Global Health Engagement Team for coordinating this extremely thoughtful and laid out event on HRSA's behalf. So next you will see on the screen or should see on the screen a brief poll that allows you to share some of your feedback with us on today's session.

We encourage you to take just a moment to complete the poll. Your input is very much appreciated as we continue to move the global health forum in the months and years to come.
Please reach out to HRSA's Office of Global Health if you are interested in learning more about anything we've discussed today. You can reach us again at hrsaghforum@HRSA.gov. And I just want to take a moment to thank all of you for joining us today. We hope you have found this session to be informative and useful. Take care and we will see you at the next global health discussion forum. Thanks all.
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