



Health workforce governance for compassionate and respectful care: a framework for research, policy and practice

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ABSTRACT

The progressive realisation of universal health coverage requires that health services are not only available and accessible, but also that they are rendered to the population in an acceptable, compassionate and respectful manner to deliver quality of care. Health workers' competencies play a central role in the provision of compassionate and respectful care (CRC); but health workers' behaviour is also influenced by the policy and governance environment in which they operate. The identification of relevant policy levers to enhance CRC therefore calls for actions that enable health workers to optimise their roles and fulfil their responsibilities. This paper aims at exploring the health workforce policy and management levers to enable CRC. Through an overview of selected country experiences, concrete examples are provided to illustrate the range of available policy options. Relevant interventions may span the individual, organisational, or system-wide level. Some policies are specific to CRC and may include, among others, the inclusion of relevant competencies in preservice and in-service education, supportive supervision and accountability mechanisms. Other relevant actions depend on a broader workforce governance approach, including policies that target health workforce availability, distribution and working conditions, or wider system-level factors, including regulatory and financing aspects. The selection of the appropriate system-wide and CRC-specific interventions should be tailored to the national and operational context in relation to its policy objectives and feasibility and affordability considerations. The identification of performance metrics and the collation and analysis of required data are necessary to monitor effectiveness of the interventions adopted.

FRAMING THE ISSUE OF COMPASSIONATE, RESPECTFUL CARE

Universal coverage with quality services requires that these are not only available and accessible, but also that they are provided to the population according to optimal standards and that they are acceptable.¹ Despite the

WHAT IS ALREADY KNOWN ON THIS TOPIC

⇒ Compassionate and respectful care is a neglected topic, with most evidence referring to interventions targeting individual health workers' capacity, such as training.

WHAT THIS STUDY ADDS

⇒ Addressing the underlying determinants of workforce performance, however, requires broader policies at organisational or system-wide level.

HOW THIS STUDY MIGHT AFFECT RESEARCH, PRACTICE OR POLICY

⇒ A framework for research, policy and practice is presented.

recognition of the importance of delivering care that is respectful and compassionate,² relevant policy options are not often adopted in practice. Definitions of compassion in the provision of health services emphasise the importance of cognitive and emotional responses, including empathy, by care providers and their subsequent actions to contribute to provision of quality healthcare.³ Challenges in providing respectful care have been documented in several clinical areas, ranging from the treatment and care for HIV,⁴ to mental health,⁵ sexual and reproductive health, and obesity,⁶ among others; there have also been similar challenges related to specific population groups, such as ethnic minorities, and stigma and discrimination on the basis of sexual orientation.

Shortcomings in the provision of compassionate and respectful care (CRC) can be categorised according to different types of abuse and inappropriate behaviours that patients may be exposed to. A landscape analysis outlined the issue of disrespectful



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and abusive care women experienced during childbirth in health facilities.⁷ Quality of care for maternal and newborn health requires eliminating mistreatment of women and promotion of respectful care during childbirth.^{8,9}

A 2015 systematic review identified six main types of mistreatment during childbirth, categorised according to the perspectives of women, community members, health workers and administrators:¹⁰

- ▶ Physical abuse.
- ▶ Verbal abuse.
- ▶ Stigma and discrimination.
- ▶ Poor rapport between women and providers.
- ▶ Providers' failure to meet professional standards.
- ▶ Health systems conditions and constraints.

Respectful maternity care emphasises the fundamental rights of women, newborns, and families, to equitable access to evidence-based quality care, while recognising the unique needs and preferences of both women and newborns.¹¹ Achieving this requires taking into account the perspectives of users (women and their families), and devising interventions by policy-makers and managers to enhance the capacity of health workers to improve quality of care, including through appropriate communication and respecting women's choices.¹²

Tools have been developed to measure compassionate care in clinical settings,¹³ and metrics exist on mistreatment of women through community surveys and labour observation;¹⁴ for instance, a multicountry study found that younger, less-educated women were most at risk of mistreatment, which can include physical and verbal abuse, stigma and discrimination, medical procedures conducted without their consent, use of force during procedures, and abandonment or neglect by health workers.¹⁵

While a substantial part of the respectful care evidence originates from maternal and childbirth services, the

challenges encountered in these contexts are mirrored by similar issues in other clinical areas. Mistreatment can occur at the level of interaction between the service user and the health workers, as well as through systemic failures at the health facility and health system levels.

Despite the growing importance of this topic, it is still relatively neglected in the health workforce literature; moreover, the prevalent policy responses and their analyses have been often fragmented and largely verticalised according to individual service delivery areas.

This paper intends to go beyond a narrow service-specific lens and aims instead to explore the evidence base and articulate policy options for health workforce governance and management in support of CRC, adopting an analytical lens rooted in a health workforce conceptual framework.

UNDERSTANDING THE DETERMINANTS OF HEALTH WORKER BEHAVIOUR

Health worker behaviour is a key driver of quality of care; multiple frameworks exist to identify determinants of health workforce performance, ranging from labour market forces and other system level elements to organisational and work environment factors underpinning motivation at the individual level (see figure 1).

Various health labour market factors impact on the motivation and job satisfaction of the health workforce,¹⁶ for instance, it may be necessary to address the root causes of health workers' burnout by ensuring a reasonable workload in a conducive and supportive work environment; reducing occupational diseases and injuries by adequately investing in occupational safety measures in the workplace; dealing adequately with secondary traumatic stress conditions putting in place support and counselling services; and reducing abuse of health workers by ensuring a safe and protected work

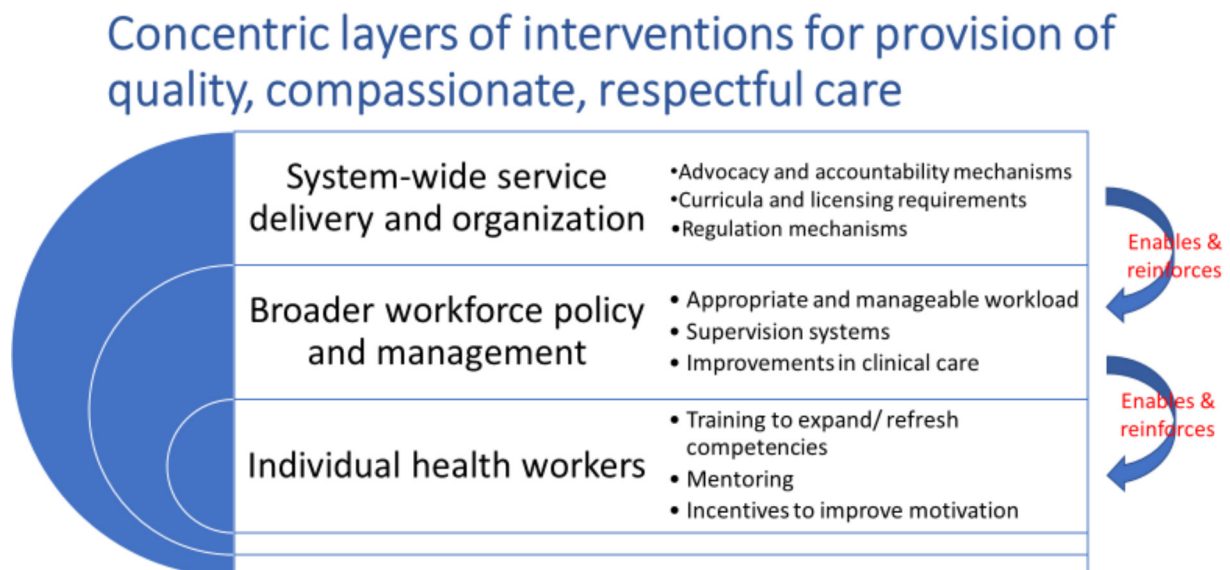


Figure 1 A policy framework for multilayered interventions towards CRC. CRC, compassionate and respectful care.

environment, coupled with sensitisation of communities. Conversely, evidence from a 2018 systematic review shows that strategies to improve the performance of the health workforce focusing exclusively on training and advocacy materials have very limited impact.¹⁷

The working environment, adequacy of workload and decent work of health workers are closely related to compassionate care and quality of care: occupational burnout and overburdening of health professionals are major causes of medical errors and poor quality of care; lack of patient handling equipment is an obstacle for compassionate care of patients with reduced mobility; violence and harassment in healthcare affect both workers and patients.¹⁸

Health workers' individual motivation is affected by the environment in which they operate: upholding health workers' rights is linked with the fulfilment of their roles and responsibilities. Compassionate care may be compromised when health workers suffer from psychological, physical and sexual harassment and violence, excessive workload and occupational burnout. The duty of care of employers and facility managers is to both workers' safety and patient safety; in turn, the duty of care towards health workers influences directly health workers' duty of care towards their patients.¹⁹ Fulfilment of the rights and responsibilities of health workers, by addressing the contractual framework for health workers' employment, fair pay, equal treatment, safe and conducive working environment, professional representation, and complaint mechanisms, can ensure that the positive roles that health worker play are amplified, and potential negative ones mitigated,²⁰ contributing to the delivery of CRC.

Established frameworks for quality of care and Integrated People Centred Health Services²¹ recognise that multiple health services and health workforce factors are necessary for quality of care. For example, action is required to plan, assure and improve quality,²² reflecting the need for coherent and aligned national planning and policy formulation to set direction, accompanied by operational methods to ensure that the critical processes of health service delivery are designed to work and that the target levels of performance are being achieved and sustained. Attention is also needed across four areas of intervention to enhance quality: shaping the system environment, reducing harm, improving clinical care, and engaging patients, families and communities.²³

At the system-wide level, health workforce strategies geared to the development of a compassionate, caring and respectful workforce require quality standards and regulation systems to uphold them. These can in turn be reinforced by appropriate management and governance mechanisms, and compassionate leadership.²⁴ Evidence-based approaches to CRC emphasise the importance of embedding in management systems attitudes that support attending to, understanding, empathising with and helping others.²⁵ Compassionate leadership is

inherent in cultures that provide psychological safety—as opposed to blame or undue punishment.²⁶

An integrated and comprehensive framework for CRC should centre, but at the same time go beyond, its workforce dimensions, recognising the multiple layers of determinants of health worker behaviour described above (figure 1).

Applying this framework can lead to the identification of complementary strategies and targeting them at the appropriate level: some policy levers will be effective if addressed to individual health workers, whereas others will require interventions at the level of the organisation, facility or employer; and yet others will necessitate governance interventions of a policy, management or regulatory nature,²⁷ either focusing on the health workforce more broadly, or on the organisation and delivery of health services at large. Identifying the right targets can lead to defining the most appropriate implementation strategy: for instance, interventions targeting individual health workers can include training, mentoring, incentives etc; conversely, those targeting the broader workforce management (eg, to reduce burn-out due to overburdening) depend on action at the aggregate level, including management strategies adopted by health facilities or reforms to curricula and licensing requirements; and those requiring an even broader approach (eg, investments in health labour markets to ensure adequate numbers and distribution of health workers, adopting broader quality of care approaches, or the regulations to sanction disrespectful behaviour by health workers) should be targeted to policy-makers.

In the context of the framework above, selected examples from contexts at different levels of socio-economic development are presented, drawing from a selective literature review, to illustrate application in real world settings of the policy levers for CRC.

SELECTED EXPERIENCES ON CRC POLICIES

To date, only few studies have examined the impact of specific policies to enhance CRC, either as a single component or package of measures. A 2018 systematic review with data from five studies showed that CRC in the context of maternal care reduces experiences of disrespectful or abusive behaviours and of physical abuse by health workers.²⁸ However, the evidence on reductions in non-dignified care, lack of privacy, verbal abuse, neglect and abandonment, and reduction in episiotomy rates was less certain. The review suggests that a multicomponent CRC policy could increase women's experiences of good-quality maternity care.

A broader range of illustrative country examples, collated through the authors' experience supplemented by a snowballing approach, is provided to summarise the evidence on interventions which either focused primarily on CRC or included this policy objective (table 1).

Table 1 Selective overview of 20 initiatives and studies focusing on CRC workforce

No	Lead author and year	Policy objective	Study context	Target scope of policy interventions			Type of study and certainty of evidence*	Summary of reported results or outcomes
				Individual health workers	Employer/ organisation and work environment	Entire health system		
1	Hansen <i>et al</i> ⁴² 2021	Decreasing psychological distress in informal caregivers of people with mental illness	Two different community settings in Denmark involving mental health caregivers.	Compassion cultivation training intervention			Waitlist-controlled randomised clinical trial involving 161 caregivers of people with mental illness. Moderate certainty	reduction in psychological distress in caregivers of people with mental illness
2	Larmar ⁴³ 2020	Providing compassionate care for people living with HIV	Private clinic providing outpatient services to people living with HIV and their families at subnational level in India.	Improve health workers' relations with patients	Improve clinicians' attitude towards clients of HIV clinic through participation of beneficiary group		Qualitative study on health workers' perceptions Very low certainty	None
3	Afujani <i>et al</i> ⁴⁴ 2019	Training on delivering respectful maternal care	Pilot project undertaken in East Mampurus District in northern Ghana training 43 providers of obstetric and newborn care.	Integrated emergency obstetric simulation trainings for health workers providing care to pregnant women			Before and after study Very low certainty	Average person-centred maternity care score increased by 43%; improvements of 15% for dignity and respect, 87% for communication and autonomy, and 55% for supportive care
4	Flores <i>et al</i> ⁴⁵ 2018	Developing compassionate community care models	Large-scale study developed through a centrally run network of international non-governmental organisations and implemented in Spain, Colombia and Argentina	Training and development of intervention protocols for community promoters for the delivery of compassionate palliative and end of life care	Implementation of networks of care raising social awareness and adopting community charters		Descriptive study Very low certainty	42 organisations involved. Awareness and training workshops benefiting 16 077 members of the public, 270 students, 1420 caregivers, 95 trained health professionals.
5	Tompkins ⁴⁶ 2018	Developing compassionate communities	National level initiative in Canada s led by not for profit organisation through it work on strengthening education and building networks for compassionate care.	Training and education on providing compassionate palliative and end of life care	Compassionate Communities Charter connecting all stakeholders.	Medical assistance in dying legislation. Curricula adaptation.	Descriptive study Very low certainty	None
6	Department of Health and Human Services, Government of Tasmania ⁴⁷ 2017	Developing a policy framework to guide the delivery of compassionate care	Sub-national policy and training initiative in Tasmania adopting a whole of community approach and builds on the National Strategy of Australian Government.	Training and capacity building of the health workforce on compassionate care elements	Strengthening community approaches, transitioning from hospital-based to community and family level care	Adoption of new policy framework for palliative and end of life care.	Descriptive study Very low certainty	None
7	Villamil-Salcedo ⁴⁸ 2017	Sharing experiences with a collaborative care model in mental health	Six primary care centres that provide mental health services to marginalised populations in Mexico City, Mexico.	Collaborative care model for the diagnosis and treatment of depression and anxiety disorders.			Mixed methods, cross-sectional study Low certainty	general practitioners were more aware about mental health problems and they were more interested in the identification of these conditions

Continued



Table 1 Continued

No	Lead author and year	Policy objective	Target scope of policy interventions				Type of study and certainty of evidence*	Summary of reported results or outcomes
			Study context	Individual health workers	Employer/ organisation and work environment	Entire health system		
8	Correa ⁴⁸ 2016	Strengthening palliative care at community level	Primary healthcare establishment in the state of Rio Grande do Sul, Brazil. The team was composed of community health workers, nurses and a family physician providing services with the involvement of the local community.	Training and awareness of health workers on holistic care, including physical, social, psychological and spiritual support	Strengthening of primary care networks	Palliative care policy development	Descriptive study Very low certainty	None
9	Federal Ministry of Health, Ethiopia ^{50 51} 2016, 2020	Incorporating compassionate respectful care as a pillar in national health strategy and in development of sub-sectoral strategy on CRC	Strategy documents developed by the ministry of health at national level in Ethiopia outlining multilayered interventions targeting number, skills mix, competencies and quality of health workforce to deliver CRC.	Mainstreaming of CRC principles and ethics in pre-service education and in-service education	Establishment of regional CRC councils and health professional consortiums. Mainstreaming CRC in integrated supportive supervision and person-centred care. Community engagement and feedback mechanisms.	National CRC policy. Policies and incentives for better health workforce motivation. Recognition mechanisms. Legislative framework on patients' rights and responsibilities. ^{52 53}	Descriptive study (baseline assessment) Very low certainty	Over 30000 health workers trained on CRC.
10	Pulerwitz et al ⁵⁴ 2015	Reducing HIV-related stigma.	Operations Research conducted in high HIV prevalence areas using four district hospitals (two in the south and two in the north) in Vietnam	Arm 1: training on HIV/AIDS basic knowledge and universal precaution Arm 2: Stigma and discrimination training in addition to interventions in Arm 1	Hospital policy development, and supplies provision	Quasi-experimental controlled study on 797 health workers Low certainty	Reduced fear-based stigma, social stigma, and enacted stigma	
11	Vesel et al ⁵⁵ 2015	Increasing psychosocial support and resilience building among health workers	Intervention in context of Helping Health Workers Cope project implemented in Kono district in the Eastern province of Sierra Leone. Neighbouring Tonkolili district was selected as the control site. 80 primary health units and approximately 300 health workers were involved in total.	Stress-management intervention		Mixed methods study including interviews; Pre-post, control design; Very low certainty	Improved self-reported relationship with patient. Change in health workers' behaviours and attitudes towards their clients.	
12	WHO, ⁵⁶ 2015	Improving survivor-centred care for gender-based violence (GBV)	National level policy and protocol developed under the auspices of the Ministry of Public Health of the Islamic Republic of Afghanistan.	In-service training of health workers.	Implementation of a treatment protocol for the survivors and sufferers of GBV outlines the signs and symptoms, minimum requirements and scope of treatment for the management of cases.	Descriptive study Very low certainty	Improvement of competencies of approximately 6500 health workers to provide CRC. ⁵⁷	

Continued

Table 1 Continued

No	Lead author and year	Policy objective	Target scope of policy interventions				Type of study and certainty of evidence*	Summary of reported results or outcomes
			Study context	Individual health workers	Employer/ organisation and work environment	Entire health system		
13	Adamson ⁵⁸ 2014	Improving learning on compassionate care through reflection and the use of story	Intervention in practice settings in the UK with podcasts and online discussion mediums used to exchange and share reflections on compassionate care.	Use of reflective learning stories for student nurses		One group of 37 nursing students; post-test (qualitative) Very low certainty	Improved reflective learning	
14	Dewar ⁵⁹ 2014	Developing compassion through a relationship centred appreciative leadership programme	Intervention set within the context of a year-long Leadership Programme. A total of 86 nurses across one acute hospital in a rural part of Scotland, UK, were invited to take part.	Communities of practice, action learning sets, workplace-based activities		One group; qualitative longitudinal study Very low certainty	Improved culture of compassionate care among 86 participating nurses, though some reported institutional barriers to providing compassionate care	
15	Department of Health, England ⁶⁰ 2013	Delivering high quality and compassionate care	Policy directives developed at national level under the guidance of the Government of England and the mandate of Health Education England.	Pre-service education and in-service training of health workers, including on behaviours and values for compassionate care	Increasing workforce flexibility Inclusion of patient feedback in the provision and assessment of care	Descriptive study Very low certainty	Over 10000 health workers trained. 4000 health visitors recruited. Improved reported awareness of compassionate care elements. ⁶¹	
16	Shih <i>et al</i> ⁶² 2013	Delivering compassion-focused training programme in palliative care education for medical students	Intervention delivered to fifth-year medical students at the National Taiwan University.	Palliative care training course		One group of 251 preclinical students; before and after study Very low certainty	▲ Mixed results on perception of compassionate care ▲ Improved knowledge of clinical management ▲ Improved attitudes about ethical decision-making in palliative care	
17	Bertakis ⁶³ 2011	Implementing patient-centred care to enhance the utilisation of health services	Intervention targeting outpatient attendees receiving care from primary care physicians at a university medical centre in the USA.	Use of the modified Davis Observation Code patient-centred care interaction analysis system		Mixed methods; Low certainty	Significantly decreased annual number of visits for specialty care hospitalisations (p=0.0033), and fewer laboratory and diagnostic tests (p=0.0027). Total medical charges for the 1 year study significantly reduced (p=0.0002).	
18	Betcher ⁶⁴ 2010	Improving effective and compassionate communication with palliative care patients	An educational project set at a 208-bed private hospital in the southwest of the USA	Compassionate communication workshop with simulation for in-patient nurses.		One group of 8 nurses; before and after study Very low certainty	Improved confidence in conveying a caring attitude, improved developing caring relationships and increased satisfaction with care provided	

Continued

Table 1 Continued

No	Lead author and year	Policy objective	Target scope of policy interventions			Summary of reported results or outcomes	
			Study context	Individual health workers	Employer/ organisation and work environment		Entire health system
19	Uook <i>et al</i> ⁶⁵ 2006	Understanding the impact of anti-stigma education on the attitudes of general practitioners regarding schizophrenia	Intervention targeting 106 GPs working in 71 primary healthcare centres in Istanbul and Ankara, Turkey.	Stigma intervention addressing attitudes towards schizophrenia.	Employer/ organisation and work environment	Pre-post study design involving 106 general practitioners in 71 primary health care centres. Very low certainty	Statistically significant, positive changes on five outcomes, including items about the treatability of schizophrenia, harmfulness and untrustworthiness of schizophrenic patients.
20	Williams <i>et al</i> ⁶⁶ 2006	Implementing HIV/AIDS educational programme for nurses.	Intervention led by a national Chinese nursing agency and a US NGO conducted in four provincial centres in China.	Workshop comprising didactic lectures to engage participants on their values and feelings about HIV/AIDS	Employer/ organisation and work environment	Pretest, post-test experimental design with 208 nurses. Very low certainty	Improved attitude on HIV/AIDS and, willingness to carry out nursing activities for PLHIV

*GC and OKA assessed the certainty of the evidence through the GRADE methodology. CRC, compassionate and respectful care; GPs, general practitioners; GRADE, Grades of Recommendations, Assessment, Development and Evaluation.

The experiences summarised in [table 1](#) illustrate some of the strategies adopted to enhance CRC, ranging from training and community engagement, to integrated approaches spanning several aspects of service delivery reform and health workforce management. However, the paucity of evidence and the fact that is largely focused on training activities require that a broader set of possible strategies be considered. Considering broader existing policy frameworks and indirect evidence from other domains of workforce governance and management, it is possible to identify a wider range of policy options, both generic and more specifically geared towards CRC.

Interventions to improve performance of the health workforce at large

Some interventions with the potential of contributing to CRC require being implemented as part of broader health workforce strategies. Examples of these systemic interventions include:

- ▶ Ensuring adequate overall workforce numbers in relation to workload to avoid overburdening, so that health workers can dedicate appropriate time and attention to the qualitative and interpersonal aspects of CRC; this calls for action by national Government at the planning and financing stage.
- ▶ A more sustainable and responsive skills mix, harnessing opportunities from the education and deployment of a primary care-oriented workforce; this depends on action when planning the education and deployment of health workers.
- ▶ Adoption of more effective and efficient strategies and appropriate regulation for health workforce education, including licensing of individual health workers and individual health facilities, as well as accreditation of training institutions; this requires action by regulators and professional councils.
- ▶ Selection of trainees from, and delivery of education in, rural and underserved areas, financial and non-financial incentives, and regulatory measures or service delivery reorganisation.²⁹
- ▶ Improved deployment strategies and working conditions, inclusive of occupational safety, high-quality infrastructure, a positive practice environment, merit-based career advancement, the elimination of gender-based discrimination, a working environment free from any type of violence, discrimination and harassment, appropriate incentive systems; this can be enabled by action by employers (both public and private) and the public sector bodies (eg, civil service commissions) which set terms and conditions of employment.

Conversely, other interventions can be implemented in the context of existing policies and governance mechanisms. Examples of these interventions include:

- a. Enhanced social accountability mechanisms, whereby the public can provide feed-back on health workers performance and quality of the services rendered;³⁰

this can be operationalised by employers and by local health authorities.

- b. Interprofessional collaboration to embed since the preservice education stage a collaborative attitude among health workers, which can result in more respectful relationship within healthcare teams and, as a reflection of that, has the potential to also improve the quality and responsiveness of care rendered to the population; this can be operationalised by health education institutions.³¹
- c. Job security, a manageable workload, supportive supervision and effective organisational management;³² these elements can be operationalised by employers.
- d. Continuous professional development opportunities and career pathways tailored to gender-specific needs;³³ this can be operationalised by employers, professional councils and professional associations, or national and subnational bodies responsible for continuous medical education.

These strategies are proven to optimise health worker motivation, satisfaction, retention, equitable distribution and performance;³⁴ while specific evidence on their effectiveness in improving CRC may only be starting to emerge, they should be regarded as policy options to be explored also in the context of pursuing CRC objectives.

Specific policy levers for CRC

Identifying CRC-specific policy options requires recognising the complex interplay among expectations, human rights, individual action and systemic conditions.³⁵ A CRC menu of options should be a multipronged approach focusing on three levels:

1. Individual health workers and patients.
2. Structures and functioning of the organisations employing health workers.
3. Health system governance.³⁶

An integrated approach at these three levels can help mitigate the drivers of mistreatment, improve the CRC policy environment and community awareness on rights.³⁷ Globally, there is also an emerging move towards operationalising a human rights approach to address this issue at all three levels.³⁸

Interventions targeting the individuals in the system

Activities targeting either patients or the health workers themselves have been shown, for instance, to address mistreatment during childbirth. Further, identifying human rights norms and standards related to mistreatment is a first step towards addressing violations of human rights during facility-based childbirth, ensuring respectful treatment and improving the overall quality of maternal care.³⁹ Raising awareness and generating demand for CRC rights is essential. Examples of relevant intervention areas include:

- a. Establishing mechanisms to ensure that all patients and service users are made aware of their rights.
- b. Providing service users a medium for raising and addressing complaints; this for example can be

Box 1 Key elements to consider in competency-based training on compassionate and respectful care⁶⁷

- a. Demonstrating compassion, empathy and respect for all people irrespective of age, sex, race or ethnicity, economic status, health status, disability or vulnerability to ill health, sexual orientation, gender identity and expression, nationality, language, asylum or migration status, or criminal record.
 - b. Reinforcing the rights of all people to be treated with respect and free from stigma, discrimination, violence, coercion, disrespect or abuse.
 - c. Adapting practice to respond to people's needs, ability to access care, preferences and aspirations.
- In addition, soft skills relating to effective collaboration with other health workers has the potential to result in an improvement in the overall quality of care in facilities, specifically in both the quality of interaction between patients and health workers and in relations among health workers. These include:
- d. Teamwork.
 - e. Effective communication.
 - f. Problem-solving
 - g. Leadership, decisiveness.
 - h. Time management and flexibility.
 - i. Staff values, motivation and behaviours.

operationalised through an audit and feedback mechanism that is responsive to users.

- c. Developing curricula and implementing training programmes for in-service training and preservice education to develop competencies that meet the social, cultural and linguistic needs of users (box 1).

Interventions targeting the structure and functioning of the organisations

CRC requires not only specific knowledge, behaviours and attitudes by health workers, but also conducive management and operating environments created by the organisations and health service facilities employing them. CRC can be negatively affected when the conditions of infrastructure deviate greatly from quality of care standards. Examples of relevant interventions include:

- a. Addressing infrastructure and work environment deficiencies that can contribute to disrespectful care (eg, conditions (or absence) of toilets and washing facilities, lack of privacy, overcrowded birth spaces).
- b. Organisational and structural shifts to redirect towards CRC (eg, reorganisation of workflow processes, re-engineering of management and quality assurance systems, upgrading or repurposing of health facilities).
- c. Monitoring and evaluating the feasibility, effectiveness and sustainability of CRC interventions in the context of individual institutions and health facilities.
- d. Appointing dedicated facility leadership, management support and health workforce engagement to enhance staff well-being and morale.⁴⁰

Interventions targeting health system governance

Health system governance can also contribute to CRC through appropriate policies, oversight capacity and

accountability mechanisms in place. Examples of relevant interventions include:

- Establishing and implementing protocols for CRC detection, reporting and response in the event of reported mistreatment.
- Creating formal mechanisms for civil society to engage in an advocacy and accountability role at the community level or to feed into policy development.
- Embedding CRC in the national policy and governance frameworks, strategic documents, legislation, and resource allocation processes and mechanisms.

TOWARDS A RESEARCH, POLICY AND PRACTICE AGENDA

Limitations of the evidence base and research gaps

This paper presents some specific evidence on enablers of CRC. Policy options contributing to CRC were discussed and categorised using a health workforce framework. The evidence of effectiveness of different strategies is, however, of variable depth and maturity. In particular, most of the available literature is descriptive and often originates from retrospective analysis of policy documents; only occasionally are the results of these initiatives reported, and typically these have been confined to process or at best output indicators, rather than outcomes; as a result, most of the studies identified were of low or very low certainty; firm indications of demonstrable and attributable results arising from these initiatives are largely lacking.

More research, ideally mixed-methods studies originating in implementation research contexts, should be conducted to expand the range of policy options to be considered, as well as to assess their relative effectiveness, cost-effectiveness and optimal implementation modalities, going beyond process measures and assessing performance of CRC initiatives through output and outcome indicators. The framework that was presented provides a structure to categorise health workforce interventions for which specific metrics should be identified in the monitoring and evaluation of CRC initiatives.

A policy and practice agenda

Notwithstanding the limitations above, the evidence and country examples presented illustrate the range of issues that should inform health workforce policy and management when pursuing CRC as a health system objective.

Translating the limited evidence base and the policy options outlined in this document into a policy agenda requires the identification of context-specific challenges (including which groups are at higher risk in each setting to receive disrespectful and non-responsive care), health system architecture and most appropriate implementation modalities.

An effective strategy to enhance the health workforce role in the provision of CRC should be rooted in the broader context of determinants of health workforce availability, accessibility, acceptability, quality and performance. It should also recognise that upholding health

workers' rights has a positive effect on ensuring that they, in turn, adequately fulfil their roles and responsibilities.

While some interventions may be highly specific to health worker knowledge, skills and attitudes towards CRC, others will have to tackle more systemic issues at the organisational, institutional or health system level.

While it is individual health workers who provide services to the population, the challenges may reside at the level of health facility infrastructure, or regulation, governance and financing of the health system at large.

Accordingly, the appropriate policy responses may include interventions targeting: the citizens and communities themselves; health workers; health facilities, employers or other health sector institutions; or the health sector policy and governance environment.

The interventions outlined in this document are of a variable level of complexity and feasibility; while the full range of interventions, and particularly the ones requiring some re-organisation of the health system or addressing underlying health workforce shortage, can represent long-term objectives, taking action on the most direct interventions at the operational level, such as workload monitoring and management, can be feasible with a more limited level of investment, resulting in tangible improvements in a shorter time frame.

The framework presented in this paper can assist in categorising relevant health workforce and health systems interventions for CRC, recognising their interdependence and providing a tool to inform their prioritisation and sequencing.

The identification of clear and objectively verifiable performance metrics, and the collation and analysis of required data, from both the health system and health worker perspective and that of end-users of services, can enable assessing and tracking over time the effectiveness of the interventions adopted. In the context of large-scale programmes, embedded implementation research can contribute to the stewardship of a CRC strategy, by identifying and resolving bottlenecks at programme and health systems level, based on the priorities identified by planners and managers.⁴¹

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