



# CPIPE

Caring for Providers, Improving Care



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**Caring for Providers to Improve  
Patient Experience:  
Emerging Lessons from the Field**

# Outline

## Background

- Formative research
- Intervention description

## Pilot

- Methods
- Results

## Trial

- Design
- Progress update

# Study team

## UCSF

- Dr. Patience A Afulani, *MBChB, MPH, PhD (left, outer) Principal Investigator*
- Monica Getahun, *MPH, Research Program Director,*
- Jackie Odiase, *MS (not pictured)-Research Analyst,*

## Kenya Medical Research Institute

- Dr. Linnet Ongeru *MBBS, MMed, Site Principal Investigator*
- Kinyua Joyceline, *MPH,- co-Investigator Kenya*

## Global Programs for Research and Training, Kenya

- Akinyi Beryl, *BA, Study coordinator,*
- Edwina Ndhine, *BA, Research Assistant*

## Migori County

- Dr Iscar Oluoch, *PhD, CAB chair*
- Dr. James Odour, *MBChB, Deputy CAB chair*



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# Background

- PCMC sub-optimal globally
- Poor PCMC contributes to poor maternal health outcomes
- Disparities in PCMC drive disparities in the use of health services and health outcomes.
- Little empirical research on effective interventions to improve PCMC

## Person-centered maternity care (PCMC) is

- Responsive,
- Compassionate, and
- Respectful care



# Research program and study goals

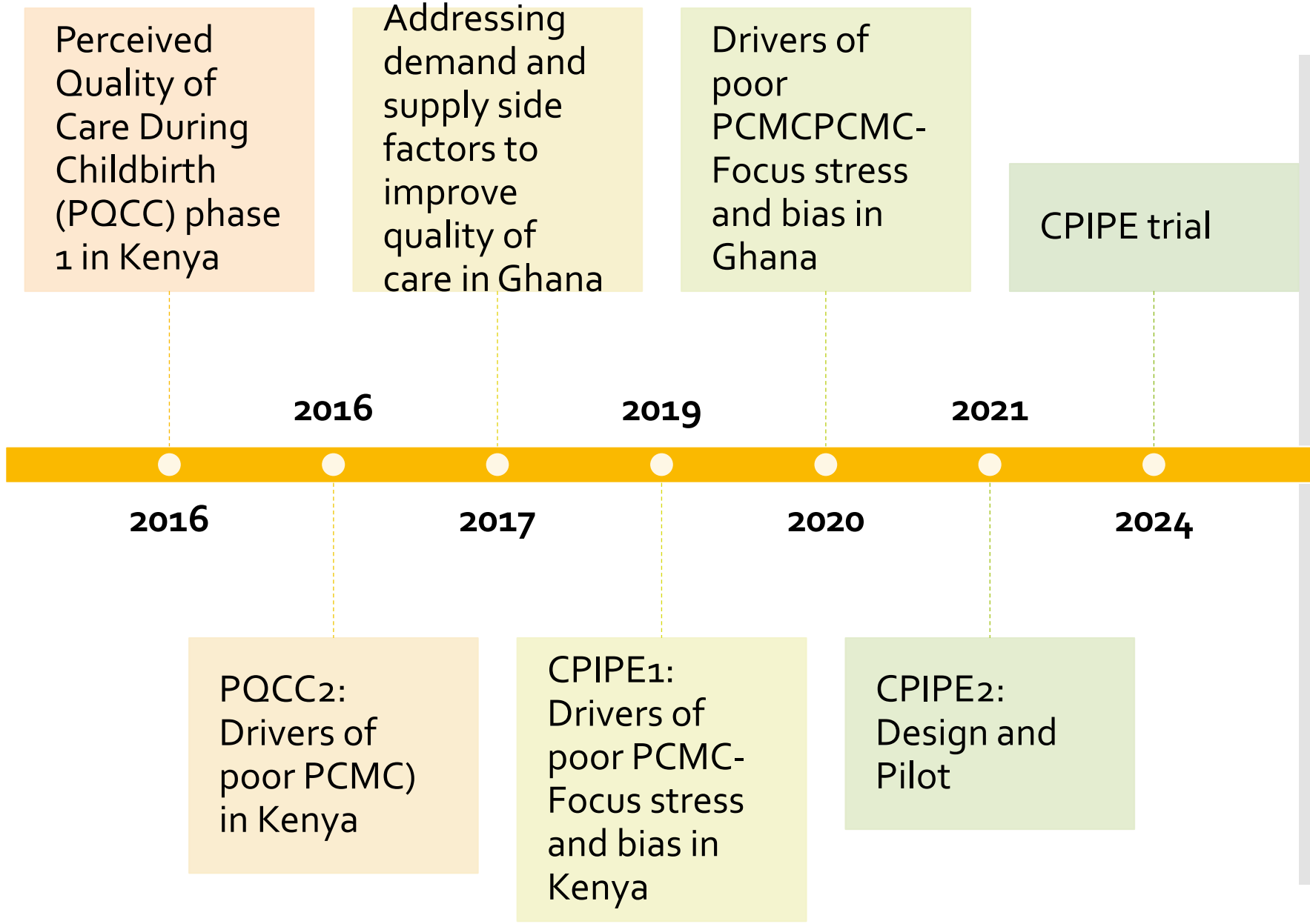


Develop, implement, and evaluate interventions to improve PCMC that address key drivers of poor PCMC through an equity lens

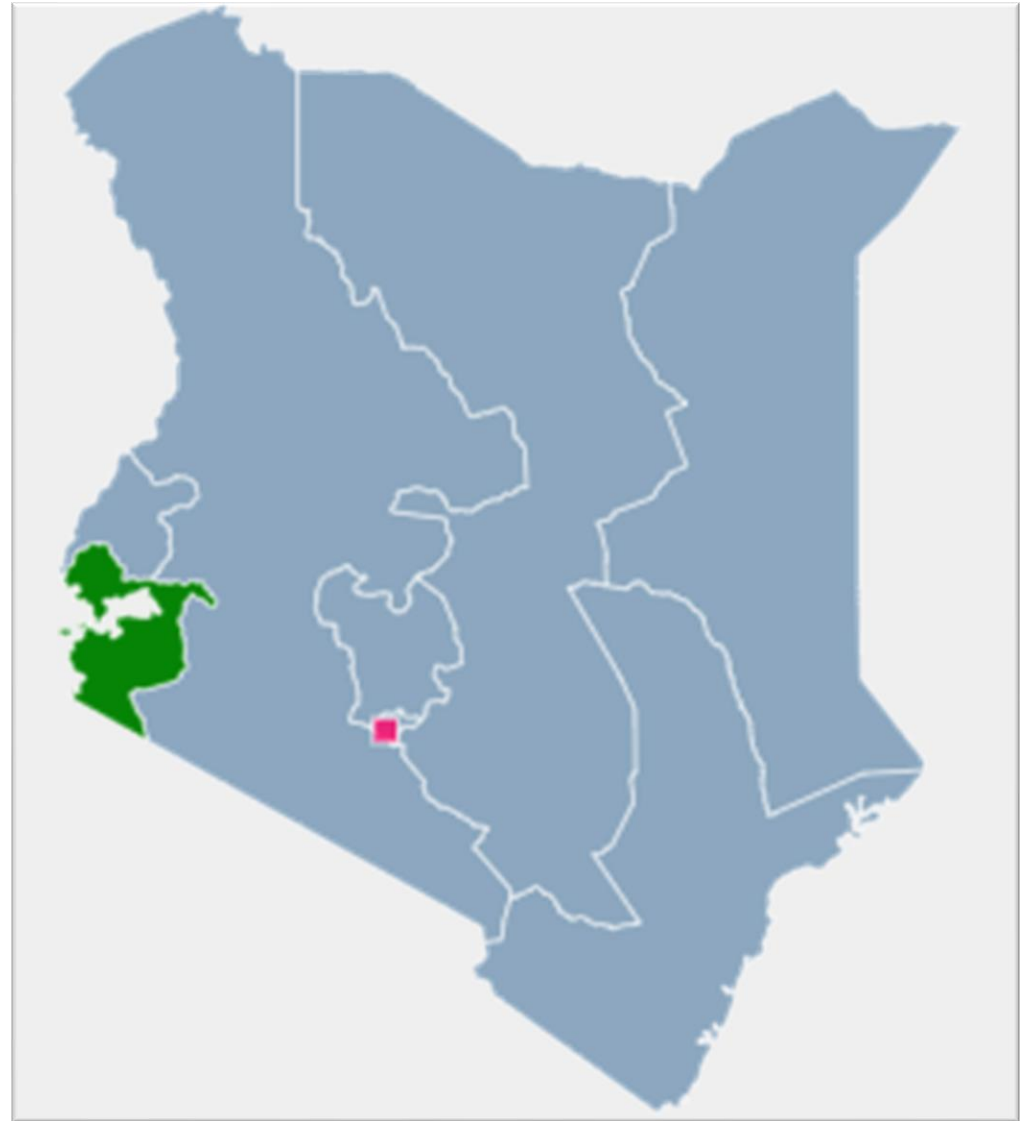


CPIPE focuses on two drivers—**provider stress and bias**—to improve **both provider and patient experience**, with a focus on the **experience of disadvantaged groups**

# Historical context of CPIPE Study in Kenya and Ghana



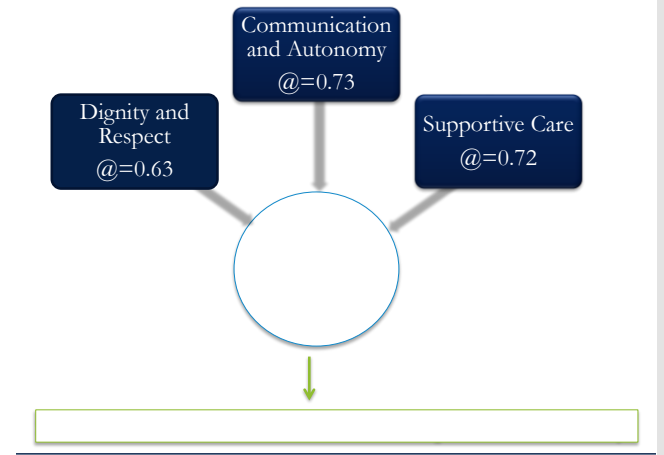
Setting:  
Migori county, Kenya



# Findings from PQCC<sub>1</sub>: Women's experiences

- Gaps in PCMC during childbirth, manifesting as disrespect and abuse, poor communication, little respect for their autonomy, and lack of supportive care.
- Disparities in PCMC with the most vulnerable receiving the lowest quality care

Person-centered maternity care scale



- Afulani PA, Diamond-Smith N, Golub G, Sudhinaraset M. **Development of a tool to measure person-centered maternity care in developing settings: validation in a rural and urban Kenyan population.** *Reprod Health.* 2017;14:118.
- Afulani PA, Kusi C, Kirumbi L, Walker D. **Companionship during facility-based childbirth: results from a mixed-methods study with recently delivered women and providers in Kenya.** *BMC Pregnancy Childbirth.* 2018;18:150.
- Afulani PA, Phillips B, Aborigo R, Moyer C. **Person-centered maternity care in low- and middle-income countries: Analysis of data from Kenya, Ghana, and India** *Lancet Glob Health.* 2019;7(1):e96-e109.
- Afulani PA, Sayi TS, Montagu D. **Predictors of person-centered maternity care: the role of socioeconomic status, empowerment, and facility type.** *BMC Health Serv Res.* 2018;18(1):360.
- Afulani PA, Kirumbi L, Lyndon A. **What makes or mars the facility-based childbirth experience: thematic analysis of women's childbirth experiences in western Kenya.** *Reprod Health.* 2017;14.



## Findings from PQCC<sub>2</sub>:

## Drivers of poor PCMC

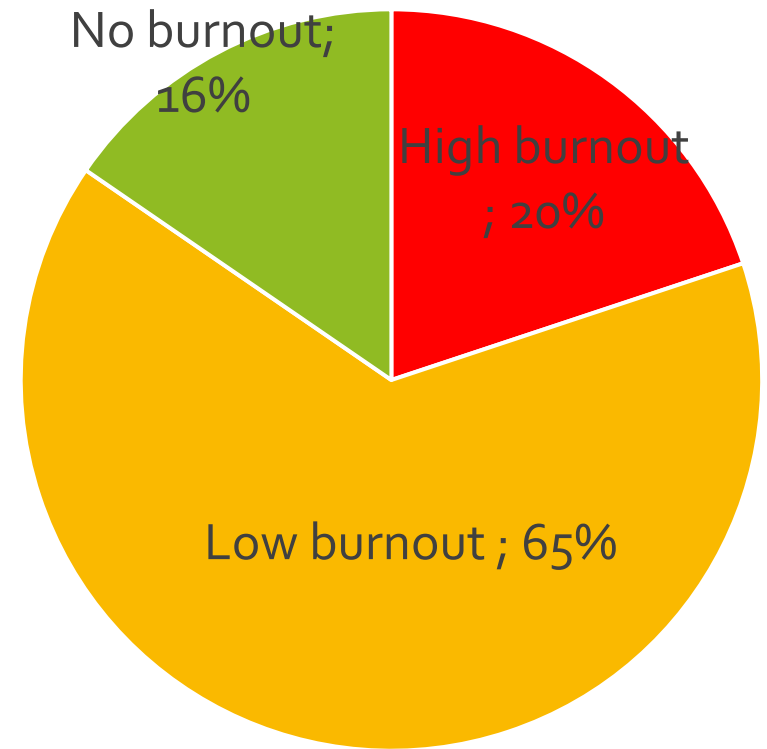
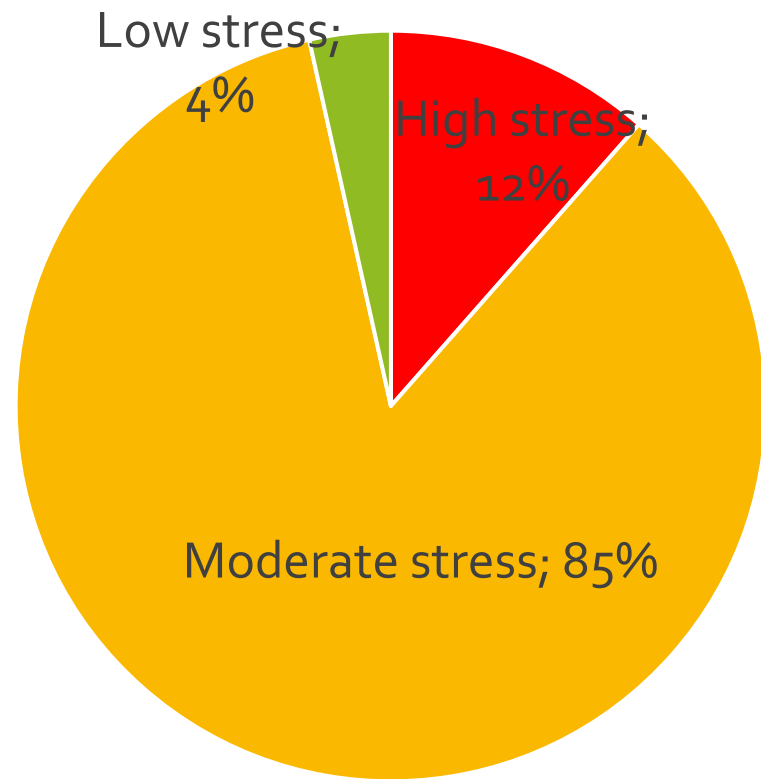
### Burnout

- *Maybe you call the doctor, this is an emergency, and she/he has come with some stress from wherever she/he comes from, when they come, they start to **pour the anger on the patient by shouting** (C<sub>10</sub>).*
- *Whenever there is burnout then you just find yourself not giving the clients the best that you should, you just find yourself **treating the patients as if they are the cause of the burnout** (C<sub>11</sub>).*

### Bias

- *"... a person who is well off sometimes when they are coming to deliver and the other mother coming with one cloth...which is torn, they are not treated like the mother who has come with blankets and other things. Sometimes this mother has not bathed there is just that humanity, you just feel that this woman, **they don't treat them equally.**" (C<sub>38</sub>)*
- *"It would be different like somebody is from high class or well informed, **you will find yourself doing the right thing even when you are straining.** Because when I said we have shortage of staff, at times you try to run around but when we know this individual is informed, we will tend to **come to that room in most occasions without knowing.**" (C<sub>32</sub>)*

## Findings from CPIPE<sub>1</sub>: Provider experience



Afulani PA, Ongeru L, Kinyua J, Temmerman M, Mendes WB, Weiss SJ. **Psychological and physiological stress and burnout among maternity providers in a rural county in Kenya: individual and situational predictors.** BMC Public Health. 2021;21:453.

# Findings from CPIPE<sub>1</sub>: Sources of stress and burnout

## *High workload*

- *"You find in a shift you can be one nurse, you need to attend to MCH and ANC mothers, then probably there is a mother in labor, then there are those mothers who are post-natal requiring discharge and you are one person.....all these departments having one person manning at times can lead on to burnout and end-up not giving somebody that respectful care."*

## *Lack of work resources*

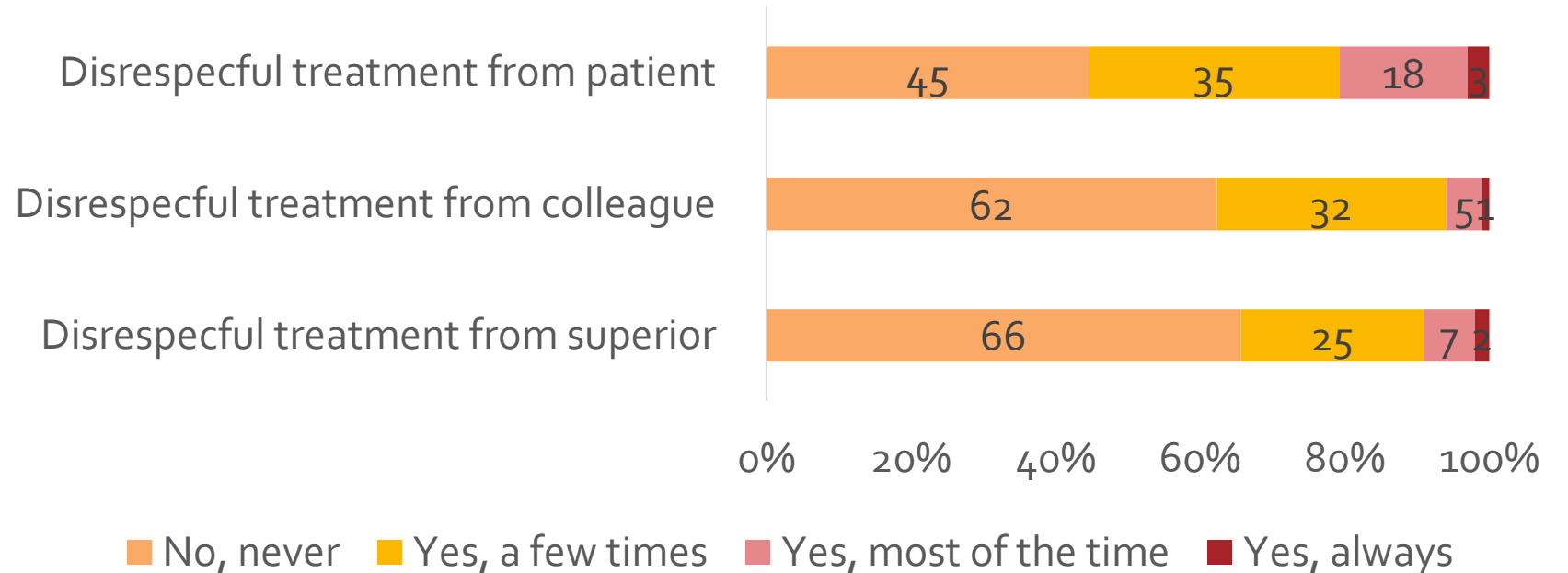
- *"Sometimes problems are as simple as reagents, water, other times they are as big as lack of oxygen and drugs...."*

## *Avoidable deaths*

- *"Sometimes the electricity goes off when a mother has delivered a preterm and there is no source of heat. So the baby ends up dying - a death that could be avoided"*

# Findings from CPIPE<sub>1</sub>: Sources of stress and burnout

## Attitudes of patients, colleagues, and superiors



# Findings from CPIPE<sub>1</sub>: Support for providers



86% never received stress management training, although almost all (98%) would like such a training.



84% had no access to workplace peer support, although almost all (92%) wanted such support.



88% had no access to psychological and emotional support, although almost all (94%) would like such support.



36% had no mentor in the county, although all wanted to have a mentor in the county.

# Findings from CPIPE<sub>1</sub>: Explicit bias in PCMC disparities

## Attraction based on women's appearance

*"Maybe the one who is dirty and carelessly dressed, you will just look at her unlike the one who is well kept, clean and well dressed . . . even if you don't know her but she is well dressed, then you will treat her well. Mostly you will find yourself not treating them equally. You will see the clean one to be special than the other one."*

## Assumptions about who is more likely to understand and be cooperative

*"There are patients less likely to cooperate in the sense that some have good understanding; it depends on the environment where the client has come from. If a client is properly educated . . . the understanding level is good, but the one from village, under- standing level is low and [they] take long to understand so will make them not cooperate well (CP1041)."*

## Expectations, ability to advocate for oneself and accountability

*". . . because you know that this person knows. . . you want to try and do what is ideal. But when handling someone who doesn't know, you seem not to care, so it does contribute (CP2172)."*

# Findings from CPIPE<sub>1</sub>: Implicit bias in PCMC disparities



## **Positive average Implicit Association test (IAT) score**

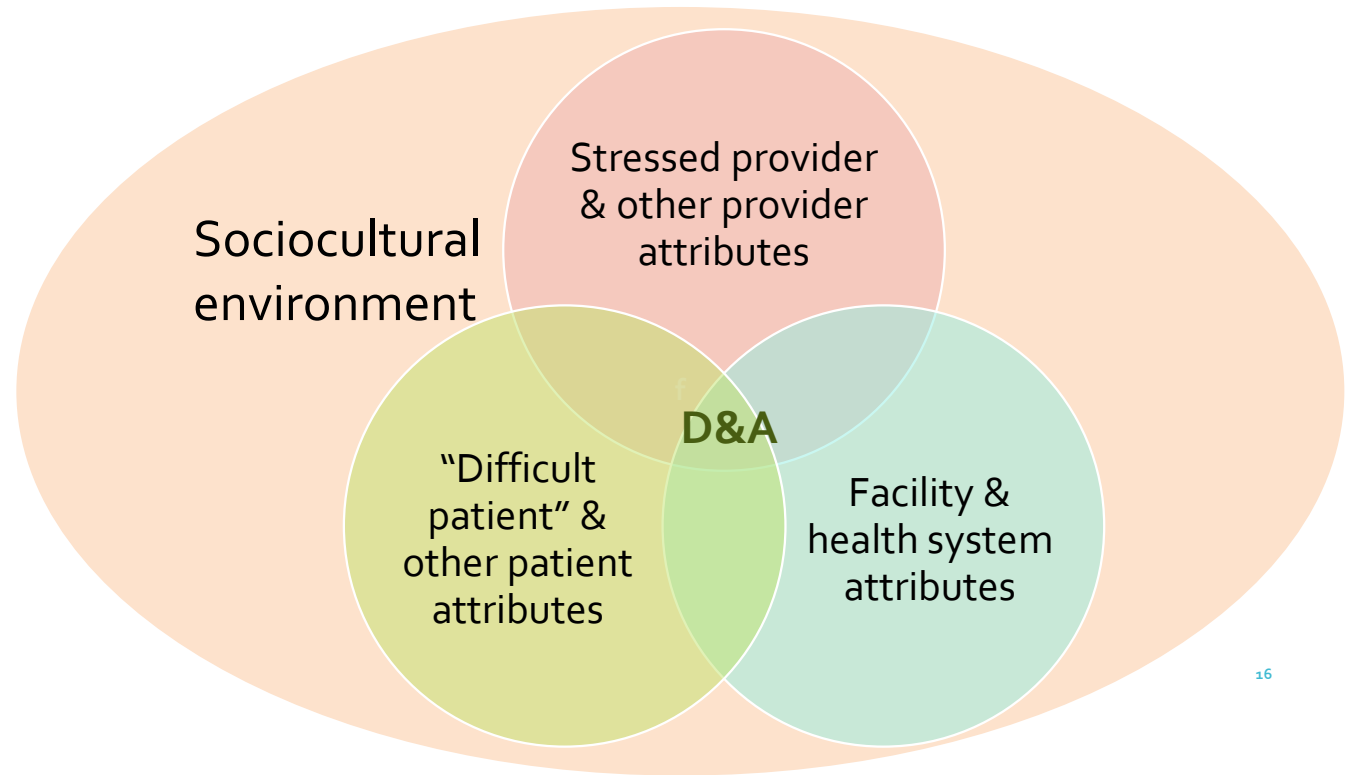
More likely to implicitly associate good patient with high SES characteristics and difficult patient with low SES characteristics than the reverse.



## **Differential care does not imply preference for such patients**

Prefer patients who do as they are told and don't challenge them

# Summary of Drivers of poor PCMC



16

## Provider bias reinforces patterns of poor PCMC

Afulani PA, Kelly AM, Buback L, Asunka J, Kirumbi L, Lyndon A. **Providers' perceptions of disrespect and abuse during childbirth: a mixed-methods study in Kenya.** *Health Policy Plan.* 2020;35:577–86.

Afulani PA, Buback L, Kelly AM, Kirumbi L, Cohen CR, Lyndon A. **Providers' perceptions of communication and women's autonomy during childbirth: a mixed methods study in Kenya.** *Reprod Health.* 2020;17(1):85.

Buback L, Kinyua J, Akinyi B, Walker D, Afulani PA. **Provider perceptions of lack of supportive care during childbirth: A mixed methods study in Kenya.** *Health Care Women Int.* 2021;0:1–22.



# Summary of CPIPE<sub>1</sub> and Integration with literature



**High stress and burnout among providers, with little institutional support.**

Burnout out leads to numbing, reactivity, and depersonalization



**Both implicit and explicit bias contribute to PCMC disparities.**

Most disrespect and abuse of patients is reactive and unconscious



**Deeply felt biases are more likely to emerge when people are stressed.**



**Stress and bias hardly discussed in context of QI in Africa.**

## CPIPE<sub>2</sub> objective 1



Design intervention to improve PCMC by addressing two intermediate factors—provider stress and bias

- Iterative intervention design process informed by
  - Formative research
  - Existing literature
  - Behavior change theory
  - Continuous feedback in consultation with key stakeholders.

# Guiding Theories

## Social cognitive Theory

- dynamic process in which environment and human behavior exert influence upon one another (reciprocal determinism)

## Trauma informed systems framework

- recognizes stress as a source of trauma to the system, which if not addressed leads to numbing, reactivity, and depersonalization.

## Ecological perspective



## CPIPE Intervention Strategies



TRAINING

Initial 2-day training followed by monthly refreshers



PEER SUPPORT

Monthly cadre specific peer support groups



MENTORSHIP

Onsite in-person peer driven mentorship



EMBEDDED CHAMPIONS

Champions in each facility who lead intervention activities



LEADERSHIP ENGAGEMENT

Health system leaders as community advisory board

# CPIPE<sub>2</sub> objectives 2 & 3



Pilot the  
intervention to  
assess feasibility

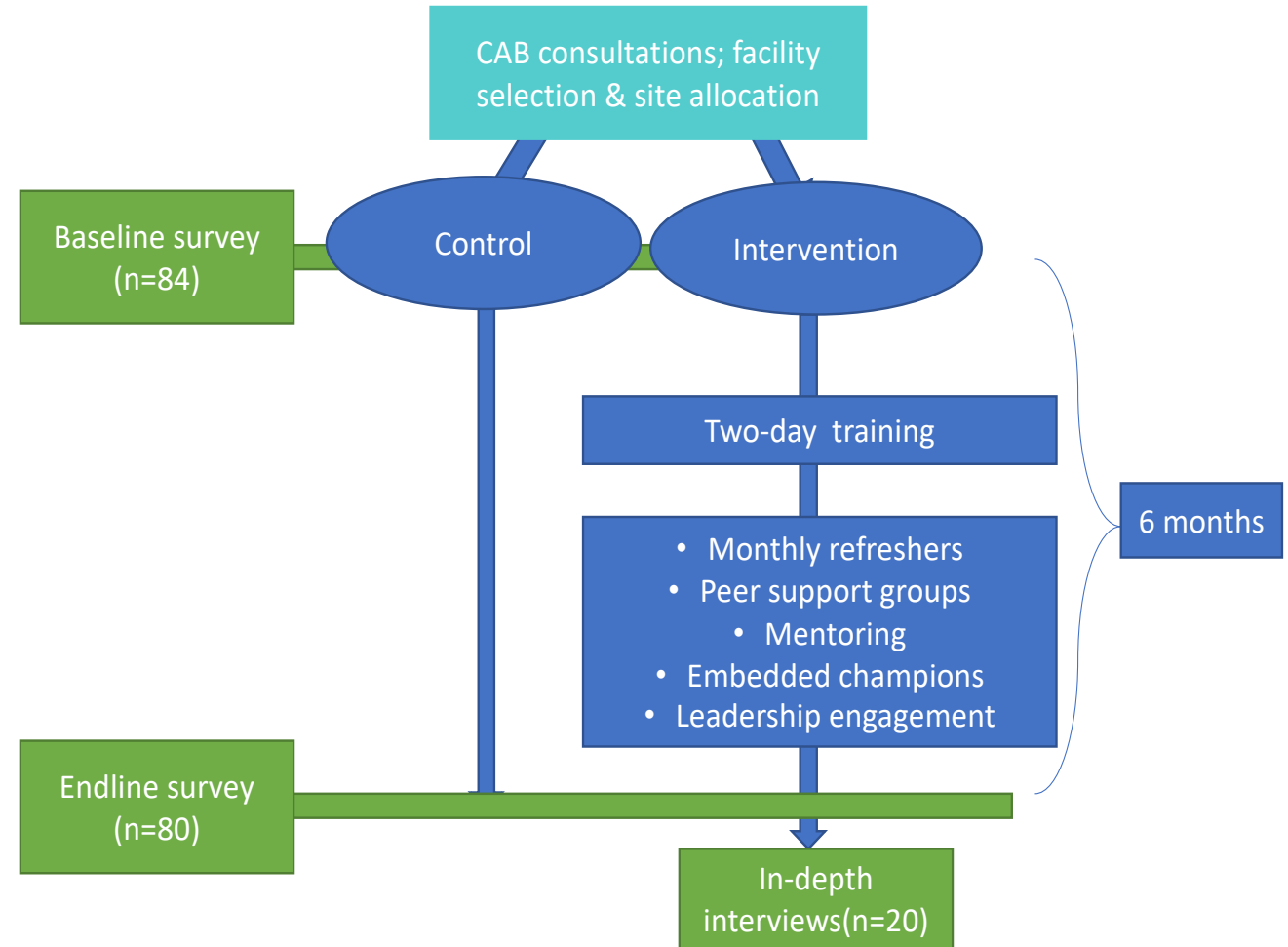


Evaluate to assess  
acceptability and  
preliminary effect

# Pilot implementation and evaluation

- **Pretest-posttest** non-equivalent control group coupled with a **convergent mixed-methods** design.

Figure 2: Flow diagram of study activities



# Quantitative Study Measures

## Stress knowledge

- A 13-question knowledge of stress and stress management assessment adapted from existing questions.

## Implicit bias knowledge

- A 15-question assessment of unconscious bias adapted from existing questions

## Perceived Stress

- The 10-item Cohen Perceived Stress Scale (PSS) on people's feelings and thoughts in the past month.

## Burnout

- The 14-item Shirom-Melamed Burnout Measure (SMBM) on feelings at work in the past month.

## PCMC

- The 9-item provider reported PCMC measures care provision in the last month.

## Explicit bias

- Two situationally specific vignettes assessing providers' perceptions of women's PCMC expectations and behaviors based on SES.

## Implicit bias

- SES-PCMC Implicit Association Test (IAT) which measures associations between women's SES and providers' perceptions of women as 'difficult' or 'good.'

# Qualitative: In-depth interviews

Using a semi-structured interview guide

Probed on the following:

- Experiences with the CPIPE intervention
- Perceptions about various strategies
- Impact on them
- Application in daily activities
- Successes and challenges
- Suggestions for improvements



# Analytic approach



## Quantitative

Descriptive statistics  
psychometric eval of composite  
measures  
Bivariate analysis  
Multivariable linear regression  
Difference in difference analysis



## Qualitative

Codebook thematic analysis  
approach

**Joint interpretation and presentation of data**

# Baseline characteristic of the study participants, N=80

| Characteristics                    | Category                 | Control (N=40) | Intervention (N=40) | P     |
|------------------------------------|--------------------------|----------------|---------------------|-------|
|                                    |                          | Frequency (%)  | Frequency (%)       |       |
| Gender                             | Male                     | 14 (35.0)      | 8 (20.0)            | 0.133 |
|                                    | Female                   | 26 (65.0)      | 32 (80.0)           |       |
| Age                                | 30 or below years        | 9 (22.5)       | 12 (30.0)           | 0.632 |
|                                    | 31-40                    | 20 (50.0)      | 16 (40.0)           |       |
|                                    | 41 or above              | 11 (27.5)      | 12 (30.0)           |       |
| Current marital status             | Single                   | 2 (5.0)        | 11 (27.5)           | 0.003 |
|                                    | Currently Married        | 34 (85.0)      | 29 (72.5)           |       |
|                                    | Divorced/Widow/separated | 4 (10.0)       | 0 (0.0)             |       |
| Position                           | Doctor                   | 2 (5.0)        | 1(2.5)              | 0.287 |
|                                    | Clinical officer         | 3(7.5)         | 0(0.0)              |       |
|                                    | Nurse/Midwife            | 25(62.5)       | 31(77.5)            |       |
|                                    | Support staff            | 10(25)         | 8(20.0)             |       |
| Years of work as a health provider | 0 to 5 years             | 12 (30.0)      | 15 (37.5)           | 0.169 |
|                                    | 6 to 10 years            | 19 (47.5)      | 11 (27.5)           |       |
|                                    | More than 10 years       | 9 (22.5)       | 14 (35.0)           |       |

Prior training experience at baseline of the study participants, N=80

| Characteristics                              | Category | Control (N=40) | Intervention (N=40) | P    |
|--|----------|----------------|---------------------|------|
|  |          | Frequency (%)  | Frequency (%)       |      |
| Training on how to deal with stress          | No       | 39 (97.5)      | 39 (97.5)           | 1.00 |
|  | Yes      | 1 (2.5)        | 1 (2.5)             |      |
| Ever had training on unconscious bias (n=79) | No       | 38 (97.4)      | 34 (85.0)           | 0.11 |
|  | Yes      | 1 (2.6)        | 6 (15.0)            |      |
| Training on interpersonal interactions       | No       | 38 (95.0)      | 34 (85.0)           | 0.26 |
|  | Yes      | 2 (5.0)        | 6 (15.0)            |      |

# Quantitative results summary

- At endline, statistically significant ( $p < 0.05$ ) changes from baseline in the intervention group
  - Increases in stress and bias knowledge scores
  - Decreases in perceived stress and burnout
  - Decrease explicit bias scores
  - Increase in self-reported PCMC
- Smaller or no significant changes in the control group except for implicit bias



# Multivariate analysis of primary outcomes stratified by study group

| Study period/Group             | Control               |       | Intervention         |           |        |
|--------------------------------|-----------------------|-------|----------------------|-----------|--------|
|                                | Coefficient (95 % CI) | P     | Coefficient          | (95 % CI) | P      |
| <b>Stress knowledge</b>        |                       |       |                      |           |        |
| Baseline                       | Reference             | -     | Reference            |           |        |
| End line                       | 0.66 (-0.23,1.55)     | 0.144 | 1.59 (0.75,2.43)     |           | <0.001 |
| <b>Implicit bias knowledge</b> |                       |       |                      |           |        |
| Baseline                       | Reference             | -     | Reference            |           |        |
| End line                       | 0.28 (-0.63,1.18)     | 0.543 | 1.64 (0.82,2.45)     |           | <0.001 |
| <b>Perceived stress</b>        |                       |       |                      |           |        |
| Baseline                       | Reference             | -     | Reference            |           |        |
| End line                       | -0.76 (-2.99,1.47)    | 0.498 | -2.50 (-4.70, -0.30) |           | 0.026  |
| <b>Burnout</b>                 |                       |       |                      |           |        |
| Baseline                       | Reference             | -     | Reference            |           |        |
| End line                       | -0.48 (-0.95,-0.02)   | 0.041 | -0.82 (-1.24, -0.41) |           | <0.001 |
| <b>IAT</b>                     |                       |       |                      |           |        |
| Baseline                       | Reference             | -     | Reference            |           |        |
| End line                       | -0.25 (-0.49,-0.01)   | 0.042 | -0.05 (-0.27,0.17)   |           | 0.652  |
| <b>Low SES vignette score</b>  |                       |       |                      |           |        |
| Baseline                       | Reference             | -     | Reference            |           |        |
| End line                       | -1.55 (-3.01,-0.08)   | 0.039 | -2.09 (-3.59,-0.58)  |           | 0.007  |
| <b>High SES vignette score</b> |                       |       |                      |           |        |
| Baseline                       | Reference             | -     | Reference            |           |        |
| End line                       | -2.79 (-4.78,-0.79)   | 0.007 | -3.14 (-5.15,-1.12)  |           | 0.003  |
| <b>PCMC</b>                    |                       |       |                      |           |        |
| Baseline                       | Reference             | -     | Reference            |           |        |
| End line                       | 1.71 (-5.40,8.82)     | 0.633 | 8.07 (1.29,14.84)    |           | 0.02   |

# Qualitative results: Themes align with theory of change

## Individual

- Increased knowledge and competence in stress management
- Increased competence in managing clinical complications and difficult situations.
- Improved provider wellbeing and experience
- Increased bias awareness and mitigation behaviours

## Interpersonal

- Improved provider-provider interactions: Supportive work environment
- Improved patient-provider interactions: Improved PCMC

## Institutional

- Increased accountability: Facility culture change
- Collective action and advocacy to address sources of stress.

# Individual -level Impacts

Increased knowledge and competence in stress management

"I now know how to calm down. Am not the bitter nurse I was before. I know how to cope with the stresses that we are going through in the maternity. I can handle difficult cases. The way I use to freeze when I got emergencies, I no longer freeze. I just breath in and out then I quickly do what is expected of me" FB-CP0107

Increased bias awareness and mitigation behaviors

"...before we attended this training, we had discrimination when we looked at an individual, like, maybe this is a nurse or even a doctor then we want to give them the best attention compared to the other class of mothers who are dirty without anything. At least we can now give them equal service (with) no discrimination. If everybody can get to the seminar, we can change like me. Ever since I went to the training, I have changed." FB-CP0107

Improved provider wellbeing and personal experience

"...sharing my stresses with my colleagues now made me to enjoy coming to work and my anger towards the patients was also delt with. Before, I could shout at the mothers so much in the maternity without bothering that the mothers are in pain and that is why maybe they are not cooperating. But nowadays, it's not easy to find me shouting at them..I no longer insult the mothers." FB-CP0106

# Interpersonal -level Impacts

Improved  
patient-  
provider  
interactions  
→ improved  
PCMC

".. it has come to a point where community people have started saying that Kehancha is good, and they no longer go to private facilities. They are saying that 'here we are treated well, nobody is becoming rough'." FB-CP0106

Improved  
Provider-  
provider  
relation →  
Supportive  
work  
environment

"...previously, we the providers never had time to laugh but after the training, and when we were going on with our refresher training, we would vent our stress and share your experience and you feel good about your work..... It made me more open to my colleagues." FA-CP0201" FA-CP-0201



# Facility- level Impacts



## Increased accountability

“[The] training on unconscious bias, the way somebody appear, you could attend to somebody based on how they look but with time, now that everybody was trained, now when unconscious (comes-up), then your colleagues are able to remind you of the unconscious training and then you get back to your conscious [self]; you think that I should treat everybody the same. The training has really helped.” FA-CP-0201



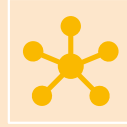
## Increased advocacy

“If it were not for us sitting in this peer support group meetings and putting pressure on our nursing officer as a team who is also putting pressure on the top leadership...we saw miracles happen... The essential commodities we have complained about them for a long time. Nothing was done about it until when you [CPIPE] came in.” FA-CP-0104



*CPIPE training in Migori*

## Discussion



The CPIPE intervention outcomes are a result of the synergistic effects of the different intervention strategies.



Findings are expected and align with theory of change except that for implicit bias



Limitation: Self-reported measures; No patient reported measures



Strength: first to show the effect of an integrated provider targeted intervention on stress, burnout, implicit and explicit bias and provider reported PCMC.

# Summary

CPIPE is feasible and acceptable to providers



Preliminary effectiveness in

increasing stress management and bias knowledge;

decreasing stress, burnout, and bias levels;

and increasing self-reported PCMC.



Need to to generate robust effectiveness data in larger sample and include PCMC outcome from patient perspective



# CPIPE Trial

# CPIPE trial objectives

Aim 1

Assess the effectiveness of the CPIPE intervention on PCMC

Aim 2

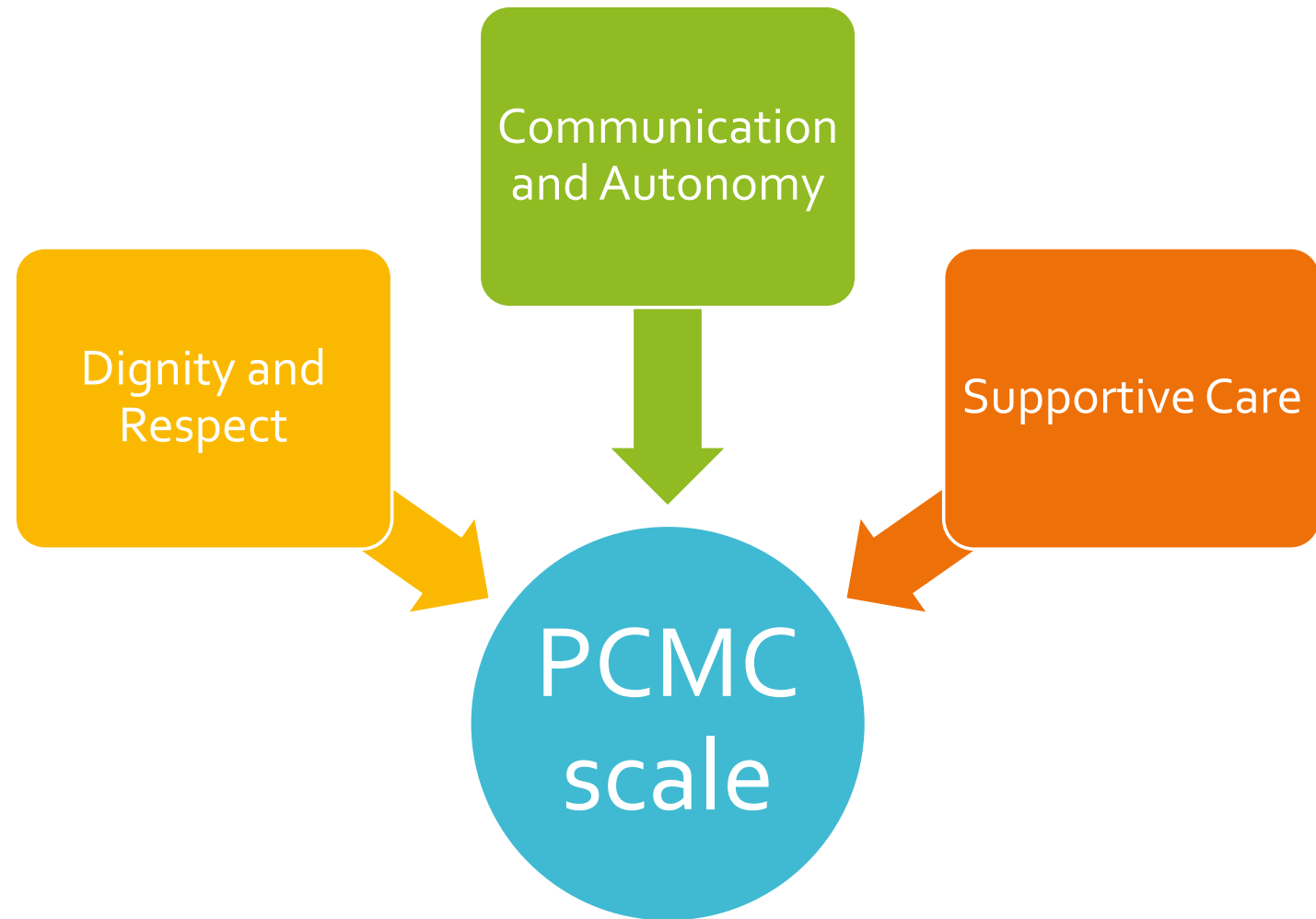
Examine the mechanisms of impact of CPIPE on PCMC

Aim 3

Assess impact of the CPIPE intervention on distal outcomes impacted by PCMC

Primary  
outcome

## Person-centered maternity care (PCMC)



# Intermediate outcomes

## Stress knowledge

- A 10-question knowledge of stress and stress management assessment adapted from existing questions.

## Implicit bias knowledge

- A 10-question assessment of unconscious bias adapted from existing questions

## Perceived Stress

- The 10-item Cohen Perceived Stress Scale (PSS) on people's feelings and thoughts in the past month.

## Burnout

- The 14-item Shirom-Melamed Burnout Measure (SMBM) on feelings at work in the past month.

## PCMC

- The 9-item provider reported PCMC measures care provision in the last month.

## Explicit bias

- Two situationally specific vignettes assessing providers' perceptions of women's PCMC expectations and behaviors based on SES.

## Implicit bias

- Implicit bias awareness and mitigation scale

# Distal outcomes

Postpartum health seeking behavior

- Postnatal care timing, breast feeding

Postpartum mental health

- Postnatal depression

Newborn health

- Vaccinations, illness

Facility outcomes

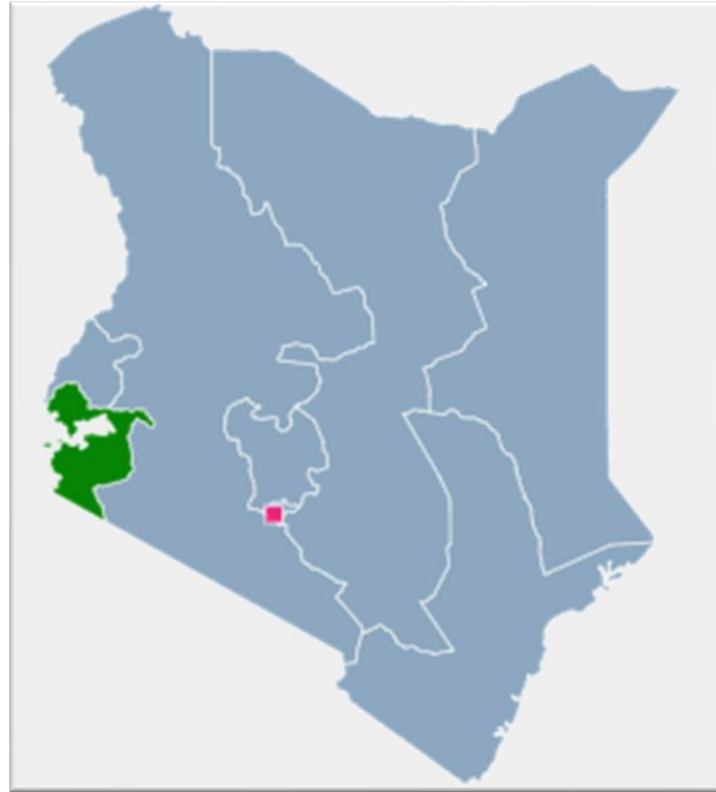
- facility service utilization and morbidity and mortality data



# Setting:

Western Kenya: Migori and Homabay Counties

Northern Ghana: Upper East and North East regions



*Study Regions in Kenya*



*Study Regions in Ghana*

# Investigator team

| Name and Qualifications           | Role  | Institutional Affiliation |
|-----------------------------------|---|---------------------------|
| Patience Afulani, MBChB, MPH, PhD | Principal Investigator                      | UCSF                      |
| Linnet Ongeru, MBChB, MMed, PhD   | Site Principal Investigator- Kenya          | KEMRI                     |
| Raymond Aborigo, PhD              | Site Principal Investigator- Ghana          | NHRC                      |
| Jerry John Nutor RN, PhD          | Co-Investigator                             | UCSF                      |
| Dilys Walker MD                   | Co-Investigator, Simulation Training Expert | UCSF                      |
| Joyceline Kinyua, MPH             | Co-Investigator                             | KEMRI                     |
| Tor Neilands, PhD                 | Co-Investigator- Study Statistician         | UCSF                      |
| Maxwell Dalaba PhD                | Co-Investigator-Health Economist            | UHAS/NHRC- Ghana          |
| Wendy Berry Mendes, PhD           | Co-Investigator- Psychologist               | Yale                      |
| Dr Iscar Oluoch, PhD              | Co-Investigator- Social Scientist           | Independent Consultant    |

# Partner Institutions



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**UCSF**

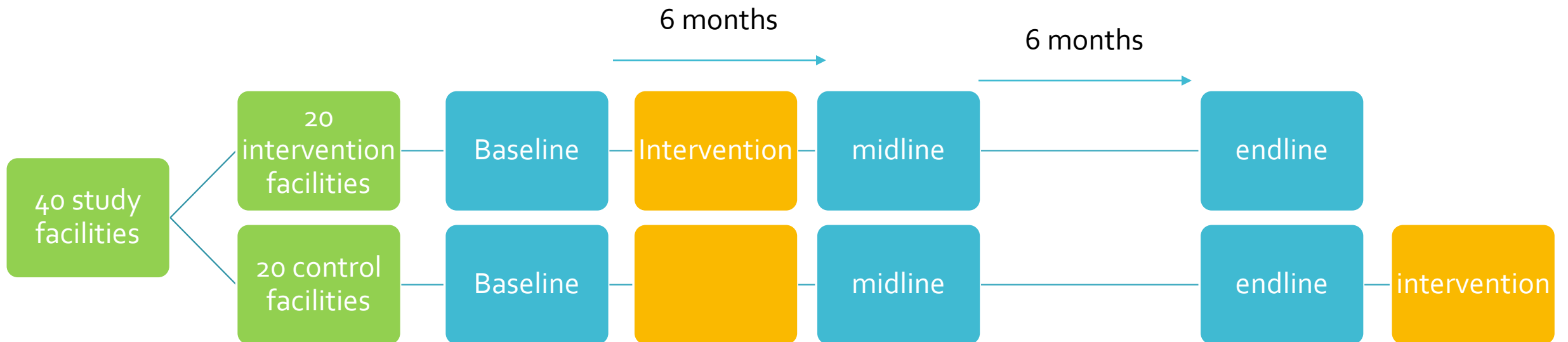
University of California  
San Francisco



Migori and Homabay County,  
and Upper East and NorthEast  
Region Health Directorates

# Study Design

- Cluster randomized-controlled trial in 40 high-volume delivery health facilities in Kenya and Ghana (20 in each country)



# CPI PE Intervention Strategies



TRAINING

Initial 2-day training followed by monthly refreshers



PEER SUPPORT

Monthly cadre specific peer support groups



MENTORSHIP

Onsite in-person peer driven mentorship



EMBEDDED CHAMPIONS

Champions in each facility who lead intervention activities



LEADERSHIP ENGAGEMENT

Health system leaders as community advisory board

# Study Participants

## Provider cohort:

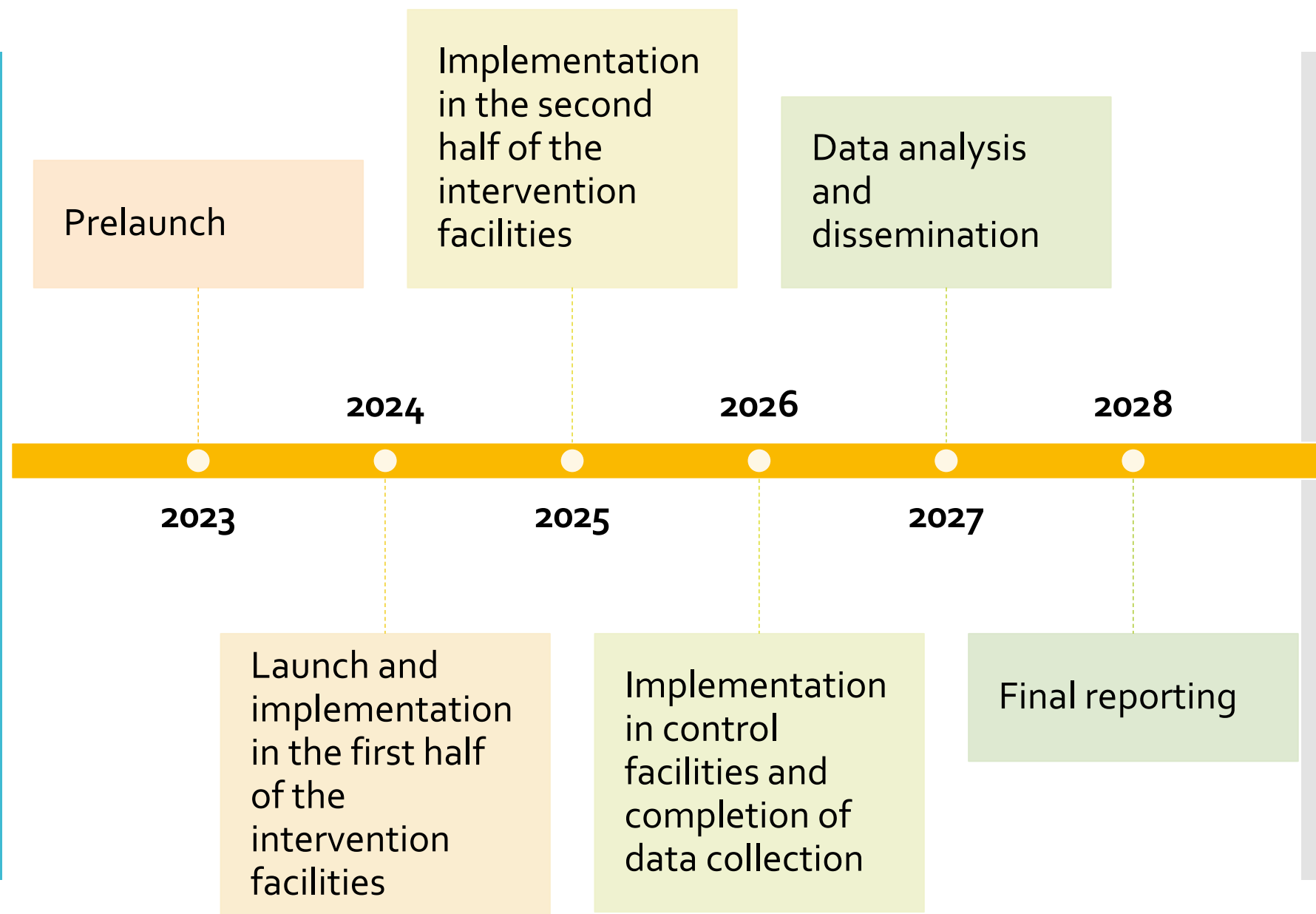
- 400 Healthcare workers who provide MCH services; at least 6 months of experience
  - N=200 in each country; **followed longitudinally** with data collection at 3 time points over 12 months
  - Receive intervention

## Women:

- 6000 women who have given birth in prior 2 weeks in the study facilities,
  - N=1000 in each country at each timepoint; **multiple cross-section** at baseline, midline, and endline
  - No intervention but primary beneficiaries

# Study Timeline and Progress

Five-year project from July 2023 to June 2028



## Psychological and physiological stress and burnout among maternity providers in a rural county in Kenya: individual and situational predictors

Patience A. Afulani<sup>1,2\*</sup>, Linnet Onger<sup>3</sup>, Joyceline Kinyua<sup>3</sup>, Marleen Temmerman<sup>4</sup>, Wendy Berry Mendes<sup>5</sup> and Sandra J. Weiss<sup>6</sup>



> [Glob Health Action](#). 2023 Dec 31;16(1):2147289. doi: 10.1080/16549716.2022.2147289.

### Caring for providers to improve patient experience (CPIPE): intervention development process

Patience A Afulani<sup>1,2</sup>, Edwina N Oboke<sup>3</sup>, Beryl A Ogolla<sup>3</sup>, Monica Getahun<sup>2</sup>, Joyceline Kinyua<sup>4</sup>, Iscar Oluoch<sup>5</sup>, James Odour<sup>6</sup>, Linnet Onger<sup>7</sup>

Affiliations + expand

PMID: 36507905 PMCID: PMC9754039 DOI: [10.1080/16549716.2022.2147289](https://doi.org/10.1080/16549716.2022.2147289)

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### A cluster randomized controlled trial to assess the impact of the 'Caring for Providers to Improve Patient Experience' intervention on person-centered maternity care in Kenya and Ghana: Study Protocol

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Affiliations + expand

PMID: 38766153 PMCID: PMC11100884 DOI: [10.21203/rs.3.rs-4344678/v1](https://doi.org/10.21203/rs.3.rs-4344678/v1)

## Sources of stress and coping mechanisms: Experiences of maternal health care providers in Western Kenya

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### Understanding disparities in person-centred maternity care: the potential role of provider implicit and explicit bias

Patience A Afulani<sup>1,2,\*</sup>, Beryl A Ogolla<sup>3</sup>, Edwina N Oboke<sup>3</sup>, Linnet Onger<sup>4</sup>, Sandra J Weiss<sup>5</sup>, Audrey Lyndon<sup>6</sup> and Wendy Berry Mendes<sup>7</sup>

DOI: 10.1002/ijgo.15301

### Mixed methods evaluation of the *Caring for Providers to Improve Patient Experience* intervention

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#### Additional information

- Clinicals trials # **NCT05019131**: <https://clinicaltrials.gov/ct2/show/NCT05019131>
- <https://personcenteredequitylab.ucsf.edu/>

# Acknowledgements

Team; Mentors

Participants; Advisory Board; County leadership

Funding

The research reported in this presentation is supported by the Eunice Kennedy Shriver National Institute Of Child Health & Human Development of the National Institutes of Health [K99/R00 HD093798 and R01HD110370-01]. The content is solely the responsibility of the authors and does not necessarily represent the official views of the National Institutes of Health.



*CPIPE training in Migori*



Thank you!  
Questions?  
Comments?

