"SMART"—specific, measurable, accurate, reliable, timely; 3) Measuring outcomes, sustainability, surprises; 4) Optional comments section for lessons learned and open issues; 5) Invite content input from all stakeholders, including hosts; 6) Modify the assessment tool based on regional or cultural features, new priorities, new complexities, and insights. By including input from all stakeholders and scoring the project or program based on all checklist submissions, a "quality rank" of each specific project/mission could be calculated. This assessment can be done at various times after project completion, for added insights.

Results (Scientific Abstract)/Collaborative Partners (Programmatic Abstract): The design of an objective, quantifiable HA project evaluation tool is simple to use and encourages compliance and data gathering. All stakeholders, especially those in the host nation, participate in customizing measurement indicators and in the scoring and assessment. The product of this evaluation tool can be utilized for education of political leadership, for impact assessment, and for improved resource and budget decisions. This tool is ready for pilot study and implementation.

Summary/Conclusion: Using the lessons learned by international humanitarian organizations, the author found that the DoD should first determine the relative value of its vast array of projects/programs by engaging all stakeholders—host nation, US embassy, interagency US government, and military—and by better measurement of the long-term impact of the programs. The value of assessment can inform non-military humanitarian work also.

It's for the greater good: Midwives' perspectives on maltreatment during labor and delivery in rural Ghana

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Background: Encouraging women to deliver in facility settings is one strategy to improve maternal and neonatal outcomes in the developing world. However, in much of sub-Saharan Africa, less than half of pregnant women deliver their babies in health facilities. Fear of maltreatment during labor and delivery has been shown to be a major barrier to facility delivery, yet previous studies have focused solely on reports from women, rarely seeking insights from practicing midwives' about their thoughts and reported behaviors regarding maltreatment during labor and delivery.

Structure/Method/Design: All seven practicing midwives from a rural hospital in Ghana were recruited to participate in in-depth interviews regarding their perceptions of care during labor and delivery. Ten pregnant women with at least one previous delivery were also recruited from the same hospital. We utilized a semi-structured interview tool and a qualitative field interviewing approach. All interviews were audiotaped, transcribed, and entered into Nvivo 9.0 for analysis.

Results (Scientific Abstract)/Collaborative Partners (Programmatic Abstract): Several themes were identified during data analysis: Theme 1) The interaction between midwives and their patients is analogous to a mother/daughter relationship, including the need for disciplinary action when necessary; Theme 2) There is a knowledge imbalance between midwives and patients, whereby patients don't always know what is in their best interest; Theme 3) Midwives feel a strong sense of accountability and responsibility for the labor and delivery outcomes. As a result, they will do whatever it takes to deliver a live baby to a healthy mother. Hitting, yelling, and neglecting women during labor and delivery were reported as not uncommon occurrences in the labor and delivery ward. However, each was undertaken in an effort to encourage women to do what was needed to deliver safely.

Summary/Conclusion: The research findings suggest that the issue of patient maltreatment in low-resource labor and delivery settings is complex and may be undertaken in what is perceived to be the laboring woman's best interest. Midwives feel a strong sense of responsibility over birth outcomes, and even pregnant women interviewed agreed that midwives have to do "whatever it takes" to help them deliver a healthy baby. The exploration of alternative strategies to facilitate labor and delivery is warranted, as well as the provision of adequate support and resources for practicing midwives in rural settings.

Medicine in a hostile environment: Chinese medical providers' fear of retaliation from patients

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Background: Tension looms over the patient—physician relationship in China despite concerted reform efforts to improve access and the standard of care. Dissatisfied patients often resort to aggressive means to solve disputes over diagnosis, treatments, medical errors, and costs. In the past decade, the incidence of physical violence by patients against medical providers tripled to over 17,000 cases per year nationwide, including 34 murders that have gathered immense media attention. We wanted to assess the medical providers' perception of the practice environment in China, including their encounter with violence and the associated emotional impact.

Structure/Method/Design: An anonymous survey was distributed to medical students, trainees, and staff at three academic hospitals in Hunan Province. Respondents were asked to rate their fear of retaliation from patients, and disclose whether they have been involved in medical disputes or been a victim of physical violence by patients and/or family members. The answers were tested for statistical association with professional and personal backgrounds.

Results (Scientific Abstract)/Collaborative Partners (Programmatic Abstract): Among the 380 providers (62 attending physicians, 80 residents, 128 students, 110 nurses), 65.7% admitted to being somewhat or very afraid of retaliation from patients. Only 17.9% have been involved in medical disputes, and 1.84% have been a victim of patient-afflicted violence. However, 17.1% personally know someone who has been a victim, and another 48.2% are aware that this type of violence is happening near where they practice. Personal experiences with medical disputes or patient-afflicted violence did not significantly affect the extent of fear, nor did education, marital status, income, or religious beliefs. Nurses and physicians experienced similar degrees of fear but physicians were more likely to have been involved in a dispute (OR, 3.81; 95% CI, 1.94-7.49) and know someone who has been a victim of violent retaliation (OR, 4.45; 95% CI, 2.49-7.93). Providers under age 35 are more likely to harbor fear for patient retaliation (OR, 1.95; 95% CI, 1.06-3.60) but less likely to have been involved in a dispute (OR,0.11; 95% CI, 0.06-0.21). Intriguingly, the majority (74.5%) of the providers considered themselves in the bottom or lower-middle socioeconomic classes, and only 1.1% considered themselves in the upper-middle or elite classes.

Summary/Conclusion: Our results show that Chinese medical providers feel vulnerable in the current practice climate. Their fears may originate from the widespread incidence of retaliation from patients, media reports highlighting the violence, as well as financial insecurity. Whether this emotional backdrop negatively affect the providers' mental health and impede on their daily interactions with patients and decision making awaits further elucidation.