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2022

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IMPROVING READINESS FOR CHANGE TO RESPECTFUL MATERNITY CARE PRACTICE IN PUBLIC HEALTH FACILITIES, IBADAN, NIGERIA

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A thesis submitted to the

Faculty of Health Sciences, University of the Witwatersrand, Johannesburg,

in fulfilment of the requirements for the degree of

Doctor of Philosophy

Johannesburg, March 2022

DECLARATION

I, Oluwaseun Taiwo Esan hereby declare that this PhD Thesis titled '**Improving readiness for change to a respectful maternity care practice in public health facilities, Ibadan, Nigeria'** is original and my unaided work. It is being submitted for the degree of Doctor of Philosophy at the University of the Witwatersrand, Johannesburg, South Africa. It has not been submitted in part or in full for any degree or examination to this or any other university.



Oluwaseun T. Esan

30th day of March, 2022

DEDICATION

This work is dedicated to

My pillar of strength: God Almighty

My devoted husband and friend: Dare Esan

My lovely children: Toluwani, Morohunfoluwa and Boluwarin

My dutiful father: Simeon Kehinde Ajayi

And in loving memory of my dear mother:

Mrs Comfort Morohunfola Ajayi

Your labours were not in vain

PRESENTATIONS ARISING FROM THIS STUDY

1. **Esan, O.T**. Readiness to address "*wicked problems*". Global Implementation Society 5th Biennial Global Implementation Conference, Scottish Event Centre, Glasgow, Scotland. Oral Presentation. September 15-17, 2019.

2. **Esan, O.T.** Respectful Maternity Care: The way forward in Nigeria. 2nd Quarter National Reproductive Health Technical Working Group Meeting. Hawthorne Suites, Area 11, Abuja. Oral Presentation. June 11, 2021.

3. **Esan, O.T.,** Maswime, S. Blaauw, D. A qualitative inquiry into pregnant women's perceptions of respectful maternity care during childbirth in Ibadan Metropolis, Nigeria. 22nd Medical Women's Association of Nigeria (MWAN) National Biennial Conference, International Conference Centre, University of Ibadan, Nigeria. Oral Presentation. September 16, 2021.

4. **Esan, O.T.,** Maswime, S. Blaauw, D. Organisational and individual readiness for change to respectful maternity care practice and its associated factors in Ibadan, Nigeria: a cross-sectional study. The Consortium for Advanced Research Training in Africa (CARTA) 8th Annual Joint Advanced Seminar (JAS 4) Conference (Virtual). Oral Presentation. September 23, 2020.

PUBLICATIONS ARISING FROM THIS STUDY

1. **Esan, O.T.,** Esan OT, Maswime S, Blaauw D. A qualitative inquiry into pregnant women's perceptions of respectful maternity care during childbirth in Ibadan Metropolis, Nigeria. Sex Reprod Heal Matters. 2022; 30(1):1–17. https://doi.org/10.1080/26410397.2022.2056977 (Published)

Submitted for publication

2. **Esan, O.T.,** Maswime, S. Blaauw, D. Directly observed and reported respectful maternity care received during childbirth in public health facilities, Ibadan Metropolis, Nigeria. *PloS One.*

3. **Esan, O.T.,** Maswime, S. Blaauw, D. Organisational and individual readiness for change to respectful maternity care practice and associated factors in Ibadan, Nigeria: a cross-sectional study. *BMJ Open.*

Planned submission

4. **Esan, O.T.,** Maswime, S. Blaauw, D. "Theory-informed strategies to improve readiness for change to a respectful maternity care practice in Ibadan, South-west, Nigeria. *SSM- Qualitative Research in Health.*

ABSTRACT

Background: Women's mistreatment during childbirth which may result from the negative attitudes of health providers, has contributed to the low utilisation of health facilities for delivery. The global community endorsed respectful maternity care (RMC) as a way to improve women's childbirth experiences. However, transiting from mistreatment to RMC requires a change effort. Organisational and individual readiness for change are known precursors of successful change implementation, such as to RMC practice. However, most RMC interventions in the literature did not assess providers' readiness for a change to RMC practice before implementation. There are also no theory-informed strategies in the literature to address the barriers of readiness for change to RMC practice. My study aims to bridge these gaps.

Objectives: To explore women's perceptions of RMC and how it aligns with the global standards; determine the proportion of women experiencing RMC during childbirth using two methodologies; evaluate health providers' perceived organisational and individual readiness for change to RMC practice and associated factors; and identify the barriers and potential strategies that would improve readiness for change to RMC practice in Ibadan Metropolis, Nigeria.

Methods: This was an analytical cross-sectional study using a mixed-method sequential exploratory design. It was conducted in 5 selected primary and 4 secondary health facilities across the 5 local government areas in Ibadan Metropolis in three phases. A two-stage probabilistic cluster sampling technique was used to select the health facilities, the women and health care providers studied. The first qualitative phase was 8 focus group discussions (FGD) conducted with pregnant women in their 1st and 2nd trimester about their perceptions of RMC. In the second quantitative phase, 269 women were observed during childbirth using an RMC observational checklist and then interviewed using the 15-item RMC scale more than 12hrs postpartum, to determine the proportion who received RMC during childbirth. A quantitative survey of 212 health providers was also done to determine their perceived organisational and individual readiness for change to RMC practice and the associated factors. The third qualitative phase included 4 FGDs with homologous groups of 35 health providers selected from the 9 study health facilities. This phase concluded with 17 in-depth interviews with facility heads, reproductive health program managers at the Primary Health Care Board and non-governmental organisations in the state, to identify strategies that may improve readiness for change to RMC, guided by the Theoretical Domains Framework and the Behavioural Change Wheel. Quantitative data were analysed using Stata 15. The main outcome variables were observed and reported RMC and both organisational and individual readiness for change to RMC. Descriptive and inferential statistical analysis was done. Simple and multiple linear regression were used to

identify significant predictors of the study outcomes. The audiotaped qualitative data were transcribed verbatim. Deductive and inductive coding was done using a thematic or framework analysis with NVIVO 11. Triangulation of the quantitative and qualitative findings was done in the concluding chapter of the thesis. Ethical approvals were obtained from the Health Research and Ethical Committees of the University of the Witwatersrand, and the Oyo State Ministry of Health. The respondents also gave written informed consent for participation.

Results: Women's definitions of RMC may vary based on their cultural and social differences. In the FGDs, the women's definitions of RMC aligned well with seven of the defined 12 RMC domains, even though they had mixed perceptions for two of these. Their perceptions however deviated for four of the domains, and they never mentioned one (enhanced physical environment). No woman received 100% of observed RMC items assessed. There were wide disparities in the observed versus reported evaluations of RMC. The least observed RMC sub-category was informed consent (loss of autonomy), then privacy. Women's employment status and birthing facility influenced the RMC scores received. The pregnant women's perceptions about RMC were also related to the categories of observed RMC they received during childbirth. Healthcare providers' perceptions of women's rights were related to the mistreatment women received, and to observed RMC. The health providers had high mean scores for organisational and individual readiness for change to RMC practice, and the measures were positively correlated. They did value a change to RMC highly but had low perceptions of resource adequacy for RMC implementation. Both of these significantly influenced organisational and individual readiness for change to RMC practice. Key barriers of readiness for change to RMC practice were identified as being provider, leadership, health systems, and patient-related. Training and environmental restructuring were the preferred of nine strategies for addressing the barriers. The nine strategies can be achieved using fifty-five identified techniques. Five of the techniques were applicable to >1 strategy. It was advised that the strategy implementation be led by committed leaders to it and using a combination of strategies.

Conclusion: Women's expectations of RMC and providers' perception of women's rights influenced what women received during childbirth. The normalisation of mistreatment and abuse may explain the disparities between the observed and reported RMC received. Socio-cultural factors, and the delivery site and workplace contexts significantly influenced women's perceptions of RMC, the extent of RMC received, and providers' perceived organisational readiness for change to RMC practice. Training and environmental restructuring in combination with other strategies could address the identified barriers of readiness for change to RMC, and improve health providers' readiness for change to RMC practice.

ACKNOWLEDGEMENTS

I sincerely appreciate God, the Alpha and Omega for starting with me and bringing me this far. I am forever grateful to God for His strength and, for life.

I deeply appreciate the respondents for their patience and cooperation, and my research team, for their dedication and diligence.

I acknowledge the immense support of my supervisors, Dr Duane Blaauw and Professor Salome Maswime, for their contributions and support to this work. I had the opportunity to learn many new things. They had a goal- quality PhD work. Sometimes, it was rough, but we were able to weather it together to a successful end. I remain grateful to them. May God bless all they do.

I sincerely appreciate the Consortium for Advanced Research Training in Africa (CARTA) for the support which made my PhD programme a reality and one with financial ease. I appreciate the Directors, the team at the Secretariat, all facilitators and the focal persons at my home and host institutions. I appreciate Prof. Jude Igumbor for his encouragement and support, Dr Melvin Agunbiade and Prof. Otuyemi for being there for us. I am deeply grateful to Mr Paul Bohloko for his support and ability to handle all issues raised.

I also appreciate all the assessors who reviewed the work across all levels. I sincerely appreciate Drs Tunde Adedokun, Stephen Wandera, Kudus Adebayo, Joshua Akinyemi, Olujide Arije, Tosin Ayeni, and Innocent Maposa. Also, Professors Oladapo Olayemi and Foluso Owotade for their support with the data analysis, and manuscript reviews. For the many consultations, not minding the inconveniences. I remain grateful.

I sincerely appreciate all my CARTA Cohort 8 friends. Dr Adeleye Adeomi painstakingly supported my preparation for the interim presentation. Dr Femi Popoola provided guidance. Catherine Kafu supported my qualitative data analysis. I appreciate them all for their kindness. I sincerely appreciate all my teachers and colleagues at the Department of Community Health, Obafemi Awolowo University, Ile-Ife for their tolerance and support.

I am indebted to my husband, Dare Esan and children- Toluwani, Morohunfolu and Boluwarin. Words fail me to express my sincere appreciation for their sacrifices and understanding. They remain my pillar of support. I appreciate my parents- Mr Kehinde Ajayi, Mrs Alice Esan, and Mrs Biola Ajayi. I appreciate all my siblings- Peter, Lola, Segun, Funke and Ife. Also, Tope, Ayodeji, Toba, Titilayo, Ayokunle, Folake, Seun, Sumbo, Busuyi and Temilolu. Thanks to Kemi Akinola for all the help. I thank them all for their prayers and encouragement.

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ABBREVIATIONS

ANC	Antenatal Clinic
APHRC	African Population and Health Research Centre
BCC	Behavioural Change Communication
BCW	Behavioural Change Wheel
CARTA	Consortium for Advanced Research Training in Africa
CBO	Community-Based Organisation
CC	Chief Consultant
CHEW	Community Health Extension Worker
CHO	Community Health Officer
CI	Confidence Interval
CNO	Chief Nursing Officer
COM-B	Capacity, Opportunity, Motivation on Behaviour Model
DAC	Disrespectful and Abusive Care
DELTAS	Developing Excellence in Leadership, Training and Science
DPHC	Director of Primary Health Care
Dr	Doctor
DT	Daytime
EI	Emotional Intelligence
FG	Federal Government
FGD	Focus Group Discussion
HA	Health auxiliary
HREC	Human Research Ethics Committee
ICA	Inter-coder Agreement
IDI	In-depth Interviews
IQR	Inter-quartile Range
IRC_{RMC}	Individual Readiness for Change to Respectful Maternity Care
KMO	Kaiser-Meyer Olkin
LGA	Local Government Area
LL-UL	Lower level – Upper level
LMICs	Low and Middle-Income Countries
MADM	Mothers' Autonomy in Decision Making
MCH	Maternal and Child Health
MCHIP	Maternal and Child Health Integrated Program
MMR	Maternal Mortality Ratio
MOH	Medical Officer of Health
MORi	Mothers on Respect Index
MP	Multiparous
NE	North-East
NGO	Non-Governmental Organisation
Nrs	Nurses
NT	Night time
NW	North-West
OAU	Obafemi Awolowo University
OECD	Organisation for Economic Cooperation and Development

ORC_{RMC}	Organisational Readiness for Change to respectful maternity care
ORIC	Organisational Readiness for Implementing Change
PBoR	Patient's Bill of Rights
PCA	Principal Component Analysis
PCC	Person-centred Care
PG	Primigravida
PHC	Primary health care facilities
PHCMB	Primary Health Care Management Board
PhD	Doctor of Philosophy
QoC	Quality of Care
REDCAP	Research Electronic Data Capture
RfC	Readiness for Change
RH	Reproductive Health
RMC	Respectful Maternity Care
SDG	Sustainable Development Goals
SE	South-East
SERVICOM	Service Compact for Nigeria
SG	State Government
SHF	Secondary health facility
SIDA	Swedish International Development Agency
SMOH	State Ministry of Health
SOPs	Standard Operating Procedures
Suppl.	Supplement
SVY	Svy commands (in Stata)
SW	South-West
TBA	Traditional Birth Attendants
TDF	Theoretical Domains Framework
UHC	Universal Health Coverage
UK	United Kingdom
USD	United States Dollar
VIF	Variance Inflation Factor
WHO	World Health Organization

CHAPTER ONE: INTRODUCTION

1.1. Background

Childbirth has been described as an intense psychological experience in a woman's lifetime[1]. This experience could influence women's future reproductive health choices including place of birth[2]. Healthcare workers contribute to making the childbirth experience more positive by providing physical, emotional, and social support during the process[1]. This can be achieved through the provision of high quality respectful women-centred childbirth care by health care providers which has become known as respectful maternity care.

This chapter provides an overview of the key concepts in this research and elicits the gaps in the literature. The chapter started with a brief introduction to what respectful maternity care (RMC) and readiness for change (RfC) entail. The underpinning theories, frameworks, and models for the research were discussed next. This was followed by a review of the existing literature on related concepts of RMC and RfC, and the findings were summarised in a paragraph highlighting the research gaps. The statement of the research problem and research questions were discussed next, followed by the research aims and objectives.

1.2. Literature Review

1.2.1. What is respectful maternity care?

Several terms have been used to describe women's negative experiences during childbirth. Bowser and Hills[3] described it as disrespectful and abusive care. In their landscape analysis conducted in 2010, disrespectful and abusive care (DAC) was characterised as consisting of seven categories. These are physical abuse, non-consented care, non-confidential care, non-dignified care with verbal abuse, discrimination in care delivered, abandonment of care, and detention in health facilities for inability to pay[3]. Several studies have been done, tools developed, and interventions proposed based on the Bowser and Hills criteria[4].

Freedman *et al*[5,4], later argued that the seven categories of disrespect and abusive childbirth experiences by Bowser and Hills did not sufficiently differentiate the individual level factors of abuse from the structural and policy level factors, due to health system deficiencies. Bohren *et al*[4,6] also claimed the seven DAC categories lacked operational definitions and comparability when measured across investigations. Bohren *et al*[4,6] proposed a typology of seven categories for mistreatment of women during childbirth with identification criteria of events for each of the categories[6] as shown in Table 1.1. Mistreatment was then described as a more inclusive term with broader categories that include health system factors[4]. The WHO Research Group on the 'Treatment of Women During Childbirth[7] also adopted the term mistreatment rather than

DAC. Obstetric violence is another term used[8], particularly in the Caribbean and Latin American literature. DAC and mistreatment have a more global use[4]. The emphasis has however shifted in the literature from describing the prevalence of abuse or mistreatment to identifying interventions that best promote respectful maternity care.

Table 1.1: Typology of the mistreatment of women

Third-Order Themes	Second-Order Themes	First-Order Themes
Physical abuse	Use of force	Women beaten, slapped, kicked, or pinched during delivery
	Physical restraint	Women physically restrained to the bed or gagged during delivery
Sexual abuse	Sexual abuse	Sexual abuse or rape
Verbal abuse	Harsh language	Harsh or rude language
		Judgmental or accusatory comments
	Threats and blaming	Threats of withholding treatment or poor outcomes
		Blaming for poor outcomes
Stigma and discrimination	Discrimination based on sociodemographic characteristics	Discrimination based on ethnicity/race/religion
		Discrimination based on age
		Discrimination based on socioeconomic status
	Discrimination based on medical conditions	Discrimination based on HIV status
Failure to meet professional standards of care	Lack of informed consent and confidentiality	Lack of informed consent process
		Breaches of confidentiality
	Physical examinations and procedures	Painful vaginal exams
		Refusal to provide pain relief
		Performance of unconsented surgical operations
	Neglect and abandonment	Neglect, abandonment, or long delays
		Skilled attendant absent at time of delivery
Poor rapport between women and providers	Ineffective communication	Poor communication
		Dismissal of women's concerns
		Language and interpretation issues
		Poor staff attitudes
	Lack of supportive care	Lack of supportive care from health workers
		Denial or lack of birth companions
	Loss of autonomy	Women treated as passive participants during childbirth
		Denial of food, fluids, or mobility
		Lack of respect for women's preferred birth positions
		Denial of safe traditional practices
		Objectification of women
		Detainment in facilities
Health system conditions and constraints	Lack of resources	Physical condition of facilities
		Staffing constraints
		Staffing shortages
		Supply constraints
		Lack of privacy
	Lack of policies	Lack of redress
	Facility culture	Bribery and extortion
		Unclear fee structures
		Unreasonable requests of women by health workers

Source: Bohren *et al*[4,6]

According to the World Health Organisation (WHO), respectful maternity care (RMC) refers to "*care organised for and provided to all women in a manner that maintains their dignity, privacy, and confidentiality, ensures freedom from harm and mistreatment, and enables informed choice and continuous support during labour and childbirth*"[9] RMC is described as a universal human right due to every childbearing woman in health systems globally[10]. It has generated global interest in the quality of patient-provider relationships[10] among stakeholders

involved in maternal health, public health and human rights activities[11]. Shakibazadeh *et al*[12], developed a typology for RMC from a qualitative synthesis of the literature. As shown in Table 1.2 below, RMC practices entail more than reducing disrespectful and abusive care or mistreatment of women.

Table 1.2: Typology of respectful maternity care practice

	The Twelve Domains of Respectful Maternity Care		
1	Being free from harm and mistreatment	7	Providing equitable maternal care
2	Maintaining privacy and confidentiality	8	Engaging in effective communication
3	Preserving women's dignity	9	Provision of efficient and effective care
4	Provision of information and get informed	10	Availability of competent and motivated
5	Ensuring continuous access to family support	11	Continuity of care
6	Enhancing the quality of the physical environment and resources	12	Respecting women's choices to strengthen their capabilities to give birth

Source: Shakibazadeh *et al*, 2017[12].

A health facility practising RMC would allow the woman a companion during birth, freedom of movement during labour, intake of oral food when classified as low risk, ensure one private cubicle per woman in labour, and support her to deliver her child squatting or standing if she so wishes[9]. In some settings, lack of RMC is more prevalent for unmarried adolescents, women with higher parity and those with poorer, socioeconomic status[13].

1.2.2. What is readiness for change?

Readiness for change has been defined as "the extent to which an individual or a collection of individuals are cognitively and emotionally inclined to accept, embrace, and adopt a particular plan or change which will purposefully alter the status quo" (page 326)[14]. It is a process and not an event. It is also a multilevel and multifaceted construct - multi-level because it could refer to the individual or organisational readiness for the expected change, and multi-faceted because it addresses the cognitive (attitudes, beliefs and intentions)[15], behavioural (institutional capabilities and resources), and motivational (acceptability and willingness) components for implementing the planned change[16].

Preparedness refers to setting in place the activities needed to implement change[17], while *readiness* measures the state of being both prepared and capable to implement change. Preparedness may imply the provision of needed infrastructure to implement a change to RMC practice. While readiness would imply a commitment to the change, a belief in the ability to implement the change, and the motivation and willingness to implement the change. Readiness for change is measured before the introduction of a change and therefore considered a precursor for the successful implementation of change in implementation science[18]. If the implementers

are not ready for the change, then limiting factors can be identified and addressed. This prevents wastage of resources invested in implementing interventions. The 'readiness for change' concept has been applied in health[19–21] and non-health disciplines[22–24]. In an implementation science approach, the levels of readiness for change should be determined before attempting a full-scale implementation of interventions to promote a change to RMC practice. However, there is no documented evidence in the literature on readiness for change assessments before implementing RMC-promoting interventions to date.

1.3. Relevant Theories, Theoretical Frameworks and Models

1.3.1. Organisational readiness for change

Weiner had proposed a theory of organisational readiness for change[18]. He focused on the readiness for change at the organisational level because he believed approaches to improving health care delivery must commence at the organisational level with system re-design. This includes re-design in work processes and workflows, quality and quantity of the staff, the management decision-making systems, and mode of communication in the organisation. Organisational readiness for change also addresses the psychological and behavioural forms of readiness which imply the willingness and ability to implement the change respectively[16]. This must be a shared psychological readiness amongst the employees and addresses their commitment to the change[16]. The structural form of readiness for change was also described by some authors as consisting of the financial, material, and human resources for such a change to be implemented[16,18,25]. However, Weiner argued that the structural form of readiness addresses organisational capacity more than organisational readiness for change[16].

Figure 1.1 shows a schematic representation of the organisational readiness for change theory. Weiner defined organisational readiness for change as consisting of the collective resolve of members of an organisation to implement a change called the '*change commitment*' and the belief they have in one another as being capable of implementing such a change termed as the '*change efficacy*'[16,18]. The commitment to the change must be collective and simultaneous[16].

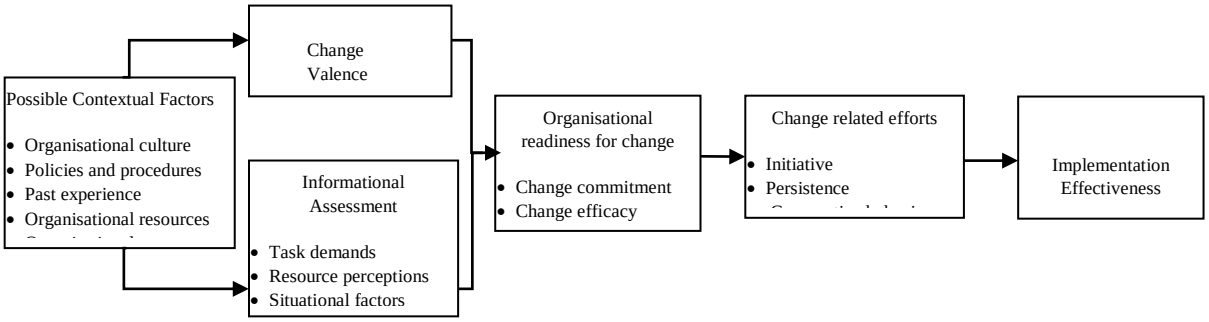


Figure 1.1: Weiner's theory of organisational readiness for change[16]

The collective commitment to change is important as service delivery is heterogeneous, involving different categories of people at different levels working together as teams. Lack of commitment at any of these levels or within a team can adversely affect the change implementation. This commitment to change should be because the organisational members value the change '*change valence*' and not because they have been ordered to and hence have no choice other than to comply with the change implementation. Their change valence may be influenced by various reasons, and these reasons may also vary among members. All these aspects contribute to the effectiveness of the change implementation[26].

According to Weiner[16], change efficacy is not measured by assessing the skills or knowledge level of individual organisational members, Rather, it is the collective confidence they have in their capability to implement the change. Their change efficacy is determined by their informational assessments which consist of organisational members' appraisal of the demands the change will make on them and the possibilities of resource availability to continually implement the change. Others are situational factors such as the internal and external political environments in the organisation as it favours the change to be implemented[16].

The contextual factors presented in the theory that could influence organisational readiness across settings include the organisational climate, structure and resources. Others include existing policies and procedures in the organisation and past experiences with implementing change. Organisational cultures that support innovation and risk-taking, with flexible policies and procedures which are evident in good working relations and a positive previous experience of implementing new change would record higher organisational readiness[16]. However, Weiner argued that these contextual factors influence organisational readiness for change by first influencing the employees' change valence and their informational assessments[16].

1.3.2. Individual readiness to change

Figure 1.2 shows the schematic representation of individual readiness for change. It is believed that changes occur in organisations through their members[27]. Hence, individual readiness for change is as important to measure as organisational readiness for change[28]. Regarding individual readiness for change, Vakola *et al*[28] defined it as individuals' (providers) confidence in their ability to manage the change and their willingness to accept new roles or adopt new practices[29]. It is said to be influenced by employees' characteristics[16], their job satisfaction, and core self-evaluation[28,30]. Core self-evaluation is a personality trait that encompasses traits such as self-esteem, locus of control, emotional stability, and generalised self-efficacy[30].

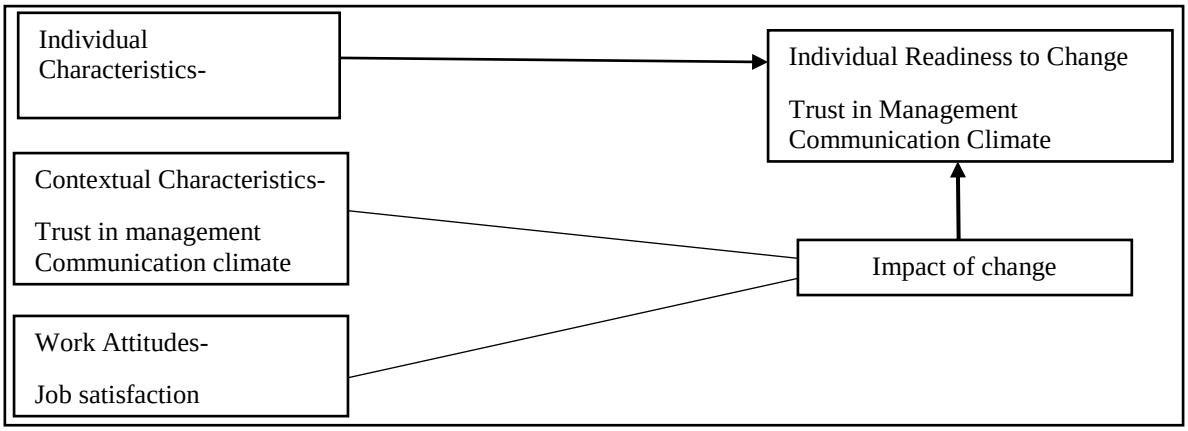


Figure. 1.2: Vakola's theory on individual readiness for change [28]

Vakola *et al*[28] proposed a hypothesis of possible contextual factors that could explain the differences in individual readiness for change within an organisation. These contextual factors could include increased trust in the employees' facility management and their managers' leadership style, and regular payment of wages with fair wage structures across professional types. A good communication climate as regards the change with no information asymmetry amongst the employees will also increase the employees' organisational readiness for the change[15].

The components of organisational readiness- change commitment and change efficacy of organisational members can be interdependent as a lack of confidence in members' capabilities to implement a change may hinder them from committing to that change[18]. Individual and organisational readiness for change are also interrelated. According to Weiner, organisational readiness for change is highest when there is a high level of individual readiness[16].

1.3.3. Measuring readiness for change

There had been challenges with measuring the readiness for change concept, either at the organisational or individual level. Holt *et al*[31] reported that the available instruments for assessing organisational readiness for change were limited in their psychometric assessments of validity and reliability after they reviewed 32 instruments for their quantitative assessment[31]. A content analysis of readiness assessment tools showed that the Texas Christian University organisational readiness for change (TCU-ORC) tool was lengthy with 18 scales and 115 items in all[32]. Other tools such as the organisational readiness to change assessment (ORCA) tool had 3 primary scales and 19 subscales with 77 items overall[33]. Many of its subscales had ≥0.8 reliability tests, however, three of them had poor reliability tests[33].

Miake-Lye *et al* had concluded that there was no gold standard assessment for organisational readiness for change and that many of the existing instruments were intervention-specific[32].

Most recently, a 12-item measure of organisational readiness to implement change (ORIC) tool was developed in 2014 by Shea et al[34]. This tool was based on Weiner's theory of organisational change, measuring change commitment and change efficacy. Psychometric assessments found it valid and reliable[34]. The tool passed the content adequacy test. The reliability tests at individual levels scales for the change commitment and change efficacy subscales were 0.92 and 0.98 respectively. The tool may be easier to use in a busy health service setting because it is brief. It could be readily adapted to the intended change[34], as was done in this study to evaluate readiness for change to RMC practice.

1.3.4. Factors influencing readiness for change to RMC practice

There have been several factors in the literature that could influence organisational and individual readiness for change as earlier stated. These include change valence and informational assessments which are known factors influencing organisational readiness for change[16]. Job satisfaction and the employees' core self-evaluation are also known to influence individual readiness for change[28]. There have also been reported patient and provider-related factors found to be associated with the delivery of RMC during childbirth. In a study where RMC was defined as receiving no item measuring disrespect in their 15-item tool[35], the patient factors associated with women receiving RMC included delivering at private health facilities[35]. It also included women aged 30 to 39 years versus 15 to 19 years[13], women with planned pregnancies, who had an antenatal follow-up, attended to by male providers, and had normal delivery outcomes[35]. While provider-related factors associated with the receipt of RMC from linked data obtained from women and providers included providers' perceived receipt of fair pay/remuneration, being a nurse versus a clinician, and attending to a higher volume of monthly deliveries[13]. However, there has been no documentation of factors associated with readiness for change to an RMC practice.

1.3.5. Theoretical Domains Framework

The Theoretical Domains Framework (TDF)[36] is a theoretical framework that provides a lens to assess the factors that influence human behaviour related to change. It is a type of determinant framework in implementation science[37]. Determinant frameworks in implementation science are types of frameworks that describe the determinants of implementation outcomes[37]. Determinant frameworks will help identify the facilitators and barriers to implementation. The TDF was developed to simplify the plethora of behavioural change theories into one framework to make them more accessible for use[38]. It is an evidence-based approach to systematically identify the practice gaps needing change, the barriers and facilitators to change, and the selection of evidence-based strategies to address the required behavioural change. Another

application has been to evaluate the effects of implementing a change –a process evaluation[36]. Thereafter, these strategies are combined into a deliverable intervention, tested for acceptability and feasibility, and may be evaluated in a randomised control trial[36]. The TDF was adopted in this study because a change to RMC by maternal care providers requires a change in their behaviour. The TDF will be used to identify strategies to improve readiness for change to RMC practice.

In Table 1.3, the 14 domains of the TDF are presented. Each has a definition construct describing the different aspects of the domains that may influence the implementation outcome. The 14 TDF domains and their definition constructs can be found in Appendix 1.1. The TDF was developed by a team of behavioural scientists and implementation researchers first in 2005, with a revised version in 2012. It consists of 14 domains representing 84 theoretical constructs extracted from 33 theories of behaviour and behavioural change[36]. The initial version consisted of 12 domains which excluded optimism, reinforcement and intention but had the nature of the behaviour as the 12th domain[39].

Table 1.3: The Theoretical Domains Framework

The 14 Domains of the Theoretical Domains Framework			
1	Knowledge	8	Intention
2	Skills	9	Goals
3	Social and professional roles and identity	10	Memory and decision-making processes
4	Beliefs about capabilities	11	Environmental contexts and resources
5	Optimism	12	Social influences
6	Beliefs about consequences	13	Emotion
7	Reinforcements	14	Behavioural regulation

The steps in using the TDF, which were also followed in my study, include:

1. Identification of the target behaviours that need to change.
2. Specifying what needs to change as regards the targeted behaviour.
3. Prioritisation of the target behaviours using prioritisation criteria such as; if it is modifiable, prevalent, central to bringing about a change, has a spill-over effect on other behaviours, and if the change will be measurable.
4. Mapping of the prioritised target behaviours to the 14 Theoretical Domains Framework and their 84 constructs.

These 4 steps may suffice, however, if the research aims to identify behavioural change strategies, then one can proceed to the fifth step.

5. Identification of strategies that can best change these target behaviours, guided by the mapped TDF domains to the Capacity, Opportunity and Motivation on behavioural model (COM-B Model), and the potential strategy categories in the Behavioural Change Wheel[36,38,40,41].

1.3.6. The Behavioural Change Wheel and the COM-B model

The Behavioural Change Wheel (BCW) was developed from 19 existing frameworks of behavioural change interventions[42]. These 19 intervention frameworks were evaluated using three usefulness criteria. The first usefulness criterion was comprehensive coverage which meant that the intervention framework could be applied to all existing behavioural change interventions in the literature. The second criterion was coherence. This means that there should be consistency when similar intervention frameworks are grouped. The third criterion was that the intervention frameworks either individually or grouped should be linked to an overarching behavioural model. None of the 19 existing behavioural change intervention frameworks met all three usefulness criteria[42]. A new framework was then developed to make up for the deficiencies in the previous frameworks. This new framework is the Behavioural Change Wheel (BCW) which has nine potential intervention categories, 7 policy strategies, and a hub that consists of the COM-B model. The linkage between the COM-B model, intervention categories and policy strategies was identified and tested for reliability[42]. These were then developed into a final 3- layered wheel[42] as shown in Figure 1.3. The COM-B model was also mapped to the 14 TDF domains[36] as shown in Figure 1.4. The TDF was recently integrated into the BCW to give a 4-layered wheel[41] as shown in Figure 1.5. In this study, the TDF was mapped to the COM-B model and the nine potential intervention categories in the BCW. The intervention categories are referred to as strategy categories for the rest of the thesis.

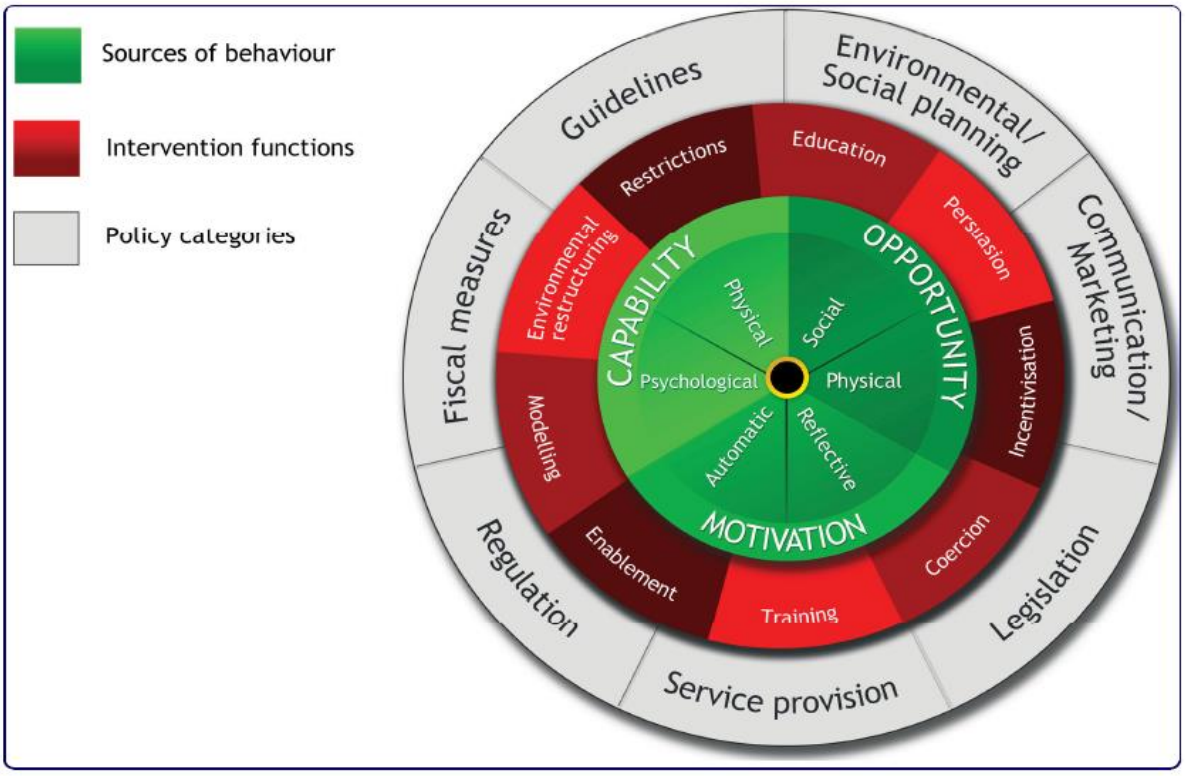


Figure 1.3: The 3-layered Behavioural Change Wheel

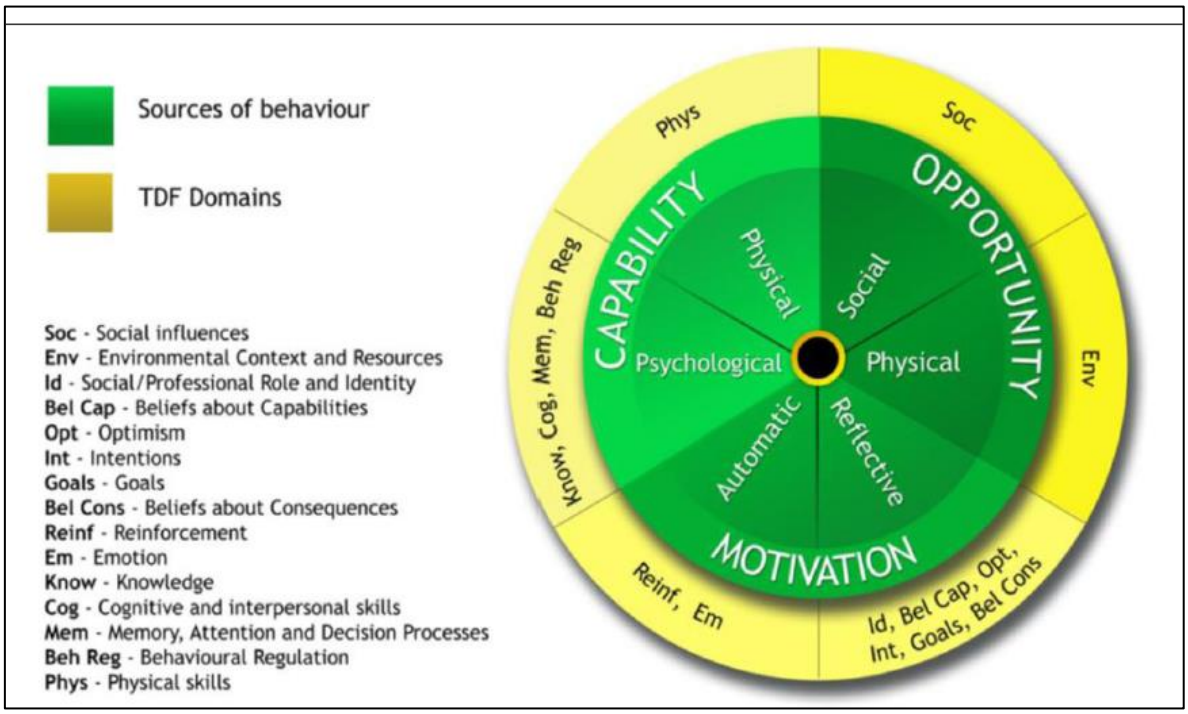


Figure 1.4: The Theoretical Domains Framework mapped to the COM-B Model

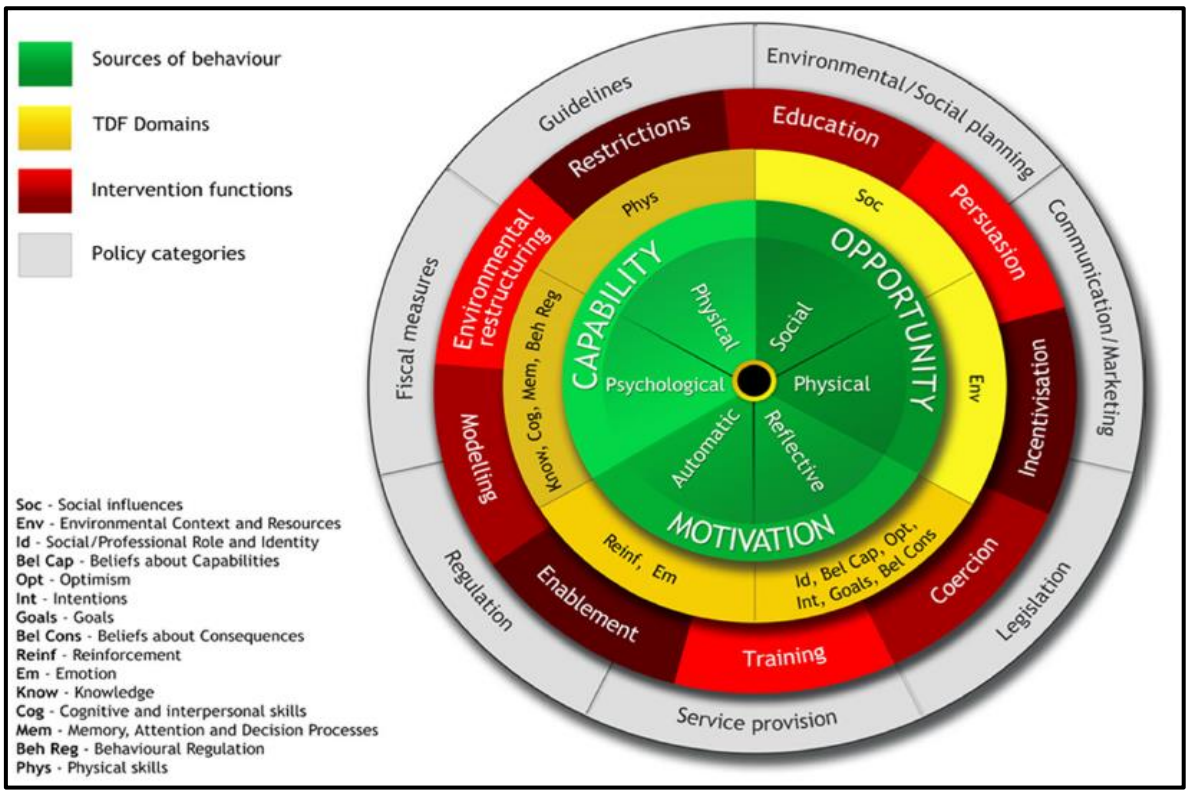


Figure 1.5: The Theoretical Domains Framework and Behavioural Change Wheel

To aid in making sense of the theoretical approaches used in implementation science, Nilsen[37] delineated these into five categories. One of these is the implementation theories category. The implementation theories were described as those that were developed by implementation researchers either from scratch or by adapting or improving existing theories or concepts[37]. Examples of implementation theories according to this publication were organisational readiness theories, the COM-B model in the BCW, and the normalisation process theory[37] which is used to normalise implemented complex interventions into routing work[43].

The COM-B model- a type of implementation theory, has the capability ("C") which addresses employees' (providers') psychological and physical capacity to engage in the strategies to improve the target behaviour. Opportunity ("O") refers to all the external factors that could propel or prompt the change in the employees (health providers). Motivation ("M") concerns the analytical decision-making processes within the employee (provider) that drive the targeted behaviour change ("B")[42]. The COM-B model is important as it helps to identify which components need to change for the target behaviours to occur, after identifying the factors that influence these target behaviours in the TDF[40]. The TDF and BCW have been used to develop a tailored intervention aimed at breaking or reducing excessive sitting habits in the workplace[41]. The TDF and BCW were also used to synthesise the findings from three interconnected systematic reviews- which were a combination of quantitative and qualitative reviews. They

helped to identify potential interventions or strategies that target the likely determinants of self-care behaviour for the management of minor ailments[40].

There are several strategies in the BCW designed to address readiness for change barriers in organisations, but none of these had been developed to improve readiness for change to RMC practice using a theory-informed approach. From the Behavioural Change Wheel, there are nine potential strategy categories. These include training, enabling, and coercion which all enhance self-motivation for the change. Restriction, environmental restructuring and modelling enhance employees' physical and psychological capabilities. Persuasion, incentivisation and education help to create opportunities for external motivation for the change. The Behavioural Change Wheel also has the seven policy interventions that could be employed to influence readiness for change to RMC[42]. However, for this study, we focused on the nine potential strategy categories.

1.4. Study conceptual framework

The theories, theoretical frameworks and models that underpin this research were used to develop the conceptual framework for this study and are presented in Figure 1.6. This conceptual framework demonstrates that to change from a current childbirth practice that may be devoid of RMC, (measured by assessing women's expectations, the actual observed and self-reported experience of childbirth), there must be a high level of individual and organisational readiness for change. However, these may be hindered by barriers (for example provider-related, leadership-related, health systems and patient-related), influenced by current organisational contextual factors. Application of the TDF, mapped to the COM-B model, can be used to identify potential strategies from the BCW which would help shift the providers' state of readiness positively towards the desired RMC practices.

A culture of respect for the fundamental rights of childbearing women is however essential for this to occur. Also, the provider's awareness of the occurrence of mistreatment in their health facilities and perceived availability of resources for RMC practice are deemed necessary to improve their readiness for a change to RMC practice. The organisational contextual factors, or more specifically, maternal care practice environment contextual factors vary and are presented below. Strategies were identified to address only the provider and leadership-related barriers, excluding the health systems and patient-related barriers, hence the demarcating broken lines. Also, the study aimed at improving the provider and their organisation's readiness for change to an RMC practice and not to make RMC practice happen, hence the demarcating broken lines in Figure 1.6.

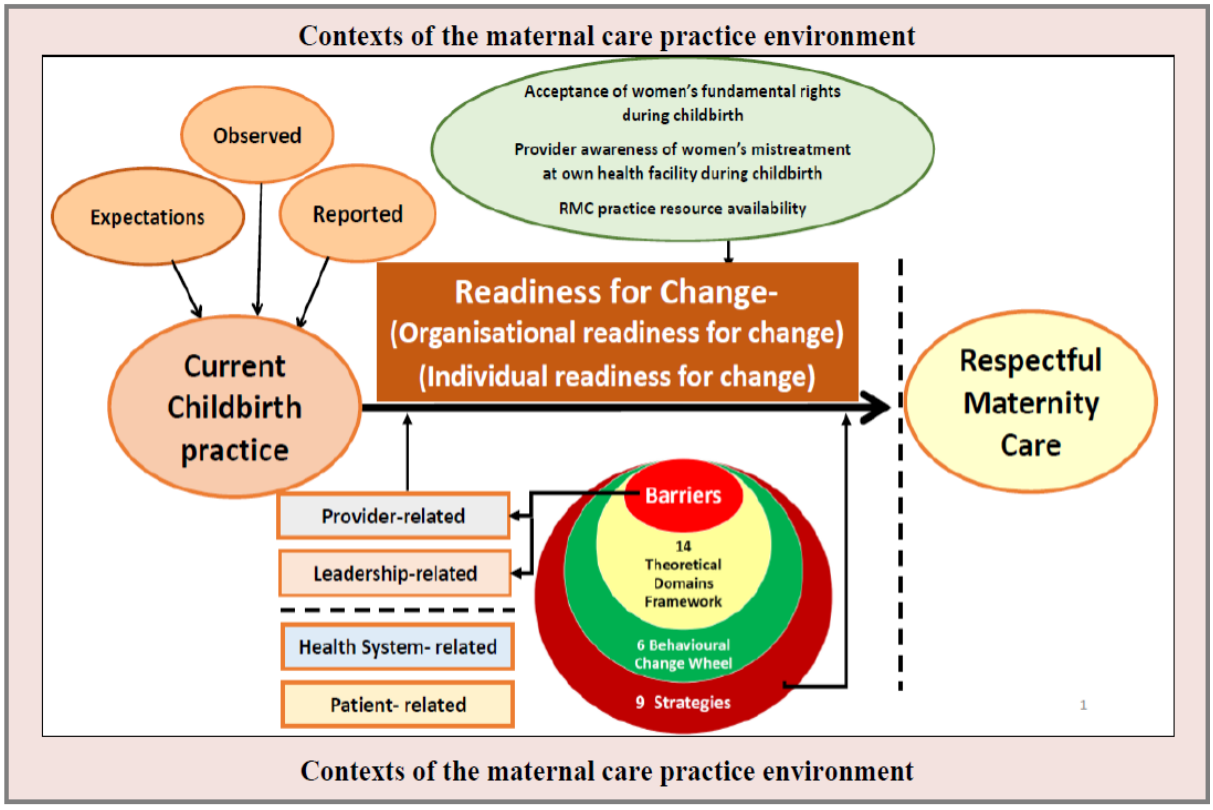


Figure 1.6: Conceptual framework for readiness for respectful maternity care practice study

1.5. Concepts Related to Respectful Maternity Care

1.5.1. Evidence of women's mistreatment during childbirth and its implications

Health care providers have been reported to mistreat women during childbirth by shouting, scolding, eliciting rude behaviour, ridiculing clients, authoritarian and threatening attitudes, lack of communication, and occasional physical abuse including slapping and pulling of hair[44]. A high prevalence of mistreatment of women has been reported in Kenya, Malawi[45], Ethiopia[46], Tanzania[47], Jordan[48], Peru[49], Kenya, Rwanda and Madagascar[50], Pakistan[51], South Africa[52], and also Nigeria[53,54]. But there are also reports from high-income countries such as the United States of America[55]. In South-East, Nigeria, the proportion of women accessing immunisation clinics who experienced at least one form of disrespectful and abusive care during childbirth was reported as 98% in 2012[56]. In South-West, Nigeria, 93.1% of women attending antenatal clinic had experienced at least one form of disrespectful and abusive care during previous pregnancies and childbirth as published in 2017[57]. For Nigeria as a whole, a range of 11-71% prevalence of women's mistreatment during childbirth was reported in a systematic literature review covering 2004 to 2015, and published in 2017[53].

Mistreatment has been found to have direct and indirect effects on maternal and newborn health. The direct effects result from the abandonment of care by providers. The indirect effects are the complications resulting from avoidance of health facility delivery due to a previous experience of mistreatment[58]. Both of these could contribute to increased morbidity and death of the woman and/or her baby. Negative childbirth experiences may also increase the risk of postpartum post-traumatic stress disorder[59,60] following supposed abandonment of care by health providers. Mistreatment during childbirth is a human rights violation that may lead to distrust in the health system[61], and preference for unsafe alternative options with possible dire consequences. Some reported that negative childbirth experiences were associated with the decision not to have another child, delay a subsequent birth, or request for a Caesarean section[2].

1.5.2. Respectful maternity care and person-centred care: components of the WHO quality of care framework

The World Health Organisation (WHO) defined quality of care as "*the extent to which health care services provided to individuals and patient populations improve desired health outcomes*" (page 14)[62]. People-centred care is one of the seven characteristics indicative of quality health care delivery. Others include effectiveness, efficiency, integration, equity, safety and timeliness[63,64]. People-centred care also referred to as person-centred maternity care or person-centred reproductive health care, has been defined as the "*provision of reproductive health care that is respectful of and responsive to individual women and their families' preferences, needs and values, and ensuring that their values guide all clinical decisions*" (page 3)[64].

The Quality of Care (QoC) Framework was developed by the World Health Organisation (WHO) in 2015 to guide the improvement of quality maternal and newborn health services [63,62]. It covered both the provision and experience of care while recognising that they are interrelated as shown in Figure 1.7. Under the experience of care, it addressed effective communication, respect and dignity, as well as emotional support. Improved maternal quality of care is expected to yield positive health and patient-centred outcomes[63,62]. Sudhinaraset in 2017 [64] developed the patient-centred care (PCC) framework with 8 essential components. The PCC components are presented in Table 1.4 and compared with the 12 RMC domains. Six of the eight components in the PCC are directly related to six of the RMC domains. While the remaining two components of the PCC (supportive care and trust), may be implied in the remaining six RMC Domains. Hence, one sure way to deliver people-centred care in maternal health services is through the delivery of RMC.

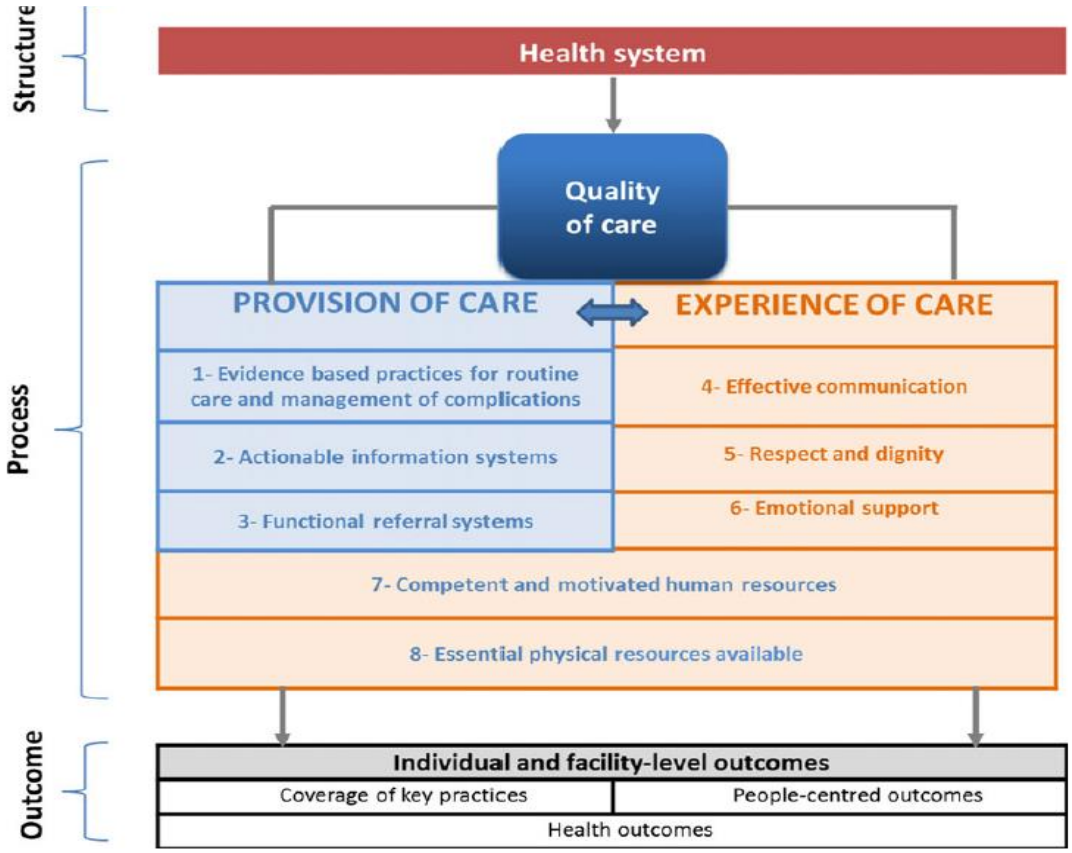


Figure 1.7: WHO Quality of Care framework for maternal and newborn health [63]

Table 1.4: The components of person-centred maternal care versus the 12 RMC domains

	Components of Person-centred Care		12 Respectful Maternity Care Domains
1	Dignity and respect	1	Preserving women's dignity
2	Autonomy	2	Respecting women's choices to strengthen their capabilities to give birth
3	Privacy and confidentiality	3	Maintaining privacy and confidentiality
4	Communication	4	Engaging in effective communication
5	Social support	5	Continuous access to family support
6	Supportive care	6	Continuity of care
7	Trust	7	Provision of efficient and effective care
8	Conducive health facility environment	8	The enhanced quality physical environment
		9	Being free from harm
		10	Provision of information and informed consent
		11	Providing equitable maternal care
		12	Availability of competent and motivated staff

1.5.3. The Human Rights Approach to Respectful Maternity Care

The concept of human rights in reproductive health is not new. The sexual and reproductive health rights of women to control their fertility were reaffirmed and adopted at the 1994 International Conference for Population and Development in Cairo[65]. The fundamental human

rights of dignity, autonomy, equality and safety are all addressed within the RMC context[66]. To this end, the White Ribbon Alliance developed the seven universal rights of childbearing women termed the RMC Charter[10]. It was based on the seven criteria of DAC by Bowser and Hills[3]. This preceded the development of the 12 domains defining RMC. The RMC Charter presented in Appendix 1.2 has been adopted in many countries, Nigeria included[10].

Health care providers' ability to respond to the RMC concept may depend on what they perceive as women's fundamental human rights during childbirth. Evidence in the literature has shown that women's fundamental human rights are violated repeatedly during childbirth[67,68]. This has been attributed to the health providers' lack of information on women's legal rights[69]. Some believe these rights are not clear or inadequately operationalised, leading to violations by healthcare providers[66]. The process of childbirth is also a very delicate time, where the woman is very vulnerable[70,71]. Some believe this vulnerability could make women's decision-making at such times one that should not be reckoned with because of the pain and the stress they go through[72]. This perceived vulnerability during childbirth may thus inadvertently deny these women their rights to autonomy, informed consent, and even dignity[72]. All women have the right to RMC. Women need to know their rights during childbirth[73] and demand it. The health providers also need to accept the rights of women during childbirth, and not violate them.

1.5.4. Efforts at promoting respectful maternity care uptake globally

In 2015 the WHO released a statement emphasising the right of every woman to a respectful and dignified care[74]. In response to this statement, several efforts have been documented aimed at promoting RMC globally. These include the conceptualisation and definition of RMC[6]. Bohren *et al*[6] synthesised findings from quantitative, qualitative and mixed-method studies across all geographical and income settings. They did this to inform an evidence-based typology for women's mistreatment during childbirth in health facilities. They organised the typologies into 7 categories and defined 1st, 2nd and 3rd order themes for the categories of mistreatment[6]. However, the absence of mistreatment may not constitute RMC[75]. How RMC should be framed was also proposed[76]. The author presented RMC as both a human rights and a gender equity issue[76]. The rationale for this is yet to be substantiated by other studies. The author also stated that beyond the interpersonal facets of health care delivery, RMC extends to the meso-level and macro-level health systems. The need for concerted efforts in the health system to ensure the delivery of RMC was stressed by concluding that without a well-functioning health system, RMC practice is not feasible[76]. The 12 domains of RMC were also defined[12].

Respectful maternity care was also defined from the provider perspective through a systematic review of 54 documents[75]. The definitions of RMC identified from the provider perspectives were then related to the rights in the RMC Charter and the WHO International Human Rights and Mistreatment of Women during Childbirth. Most of the articles reviewed had the provider perspectives rallied around three rights in the RMC[75]. These include- *"rights to being free from harm and ill-treatment, dignity and respect, and information with informed consent or refusal and respect for women's choices and preferences"* (page 12)[75].

In measuring RMC, indicators have been identified[77], while tools for measuring it have been developed and validated[78,79,80]. These tools include the MCHIP RMC observational checklist with a Yes and No response[81], and the 15-item RMC 5-point Likert scale[80]. The WHO also recently developed and validated a tool to measure the receipt of RMC through observation of childbirth, and a postpartum community survey[82]. Mixed-method research has been recommended as well as the use of observational studies in measuring RMC received[4]. However, there is no consensus on the tools or the measurement design.

Interventions to promote RMC have also been recommended[83], developed and tested[84,85,86,87]. A review of what interventions have worked in promoting RMC has also been done[88]. Sixty studies on RMC were reviewed, with three cross-cutting issues found. The majority of the papers addressed capacity building of providers on RMC and clinical service quality. These were followed by interventions addressing clinical audits and feedback, then improving provider performance and others which addressed community engagement for example. The lack of standardised definitions, measurements, and study methods to quantify RMC received challenged the study[88]. RMC training and advocacy guides have been developed[89,90] and implemented[91].

In measuring the receipt of RMC quantitatively, several instruments had been developed such as the 14-item Mothers on Respect (MORi) Index to measure quality, safety and respect during childbirth using a 6-point Likert scale [78]. Another is the Mothers' Autonomy in Decision Making (MADM) scale also on a 6-point Likert scale[79]. The 15-item Respectful Maternity Care scale is also measured on a 5-point Likert scale of agreement[80]. The Maternal and Child Health Integrated Program (MCHIP) by Jhpiego also developed the 28-item RMC observational checklist[46,92]. All of these instruments were based on the 7 categories of the Bowser and Hills criteria for disrespect and abuse, rather than the 12 domains of RMC. Some of the instruments were used as observational checklists, others were used for client exit interviews.

There has been a call for a mixed-method approach to measure the receipt of RMC, especially during childbirth[4]. The need to conduct observational studies to measure the receipt of RMC has also been emphasied[4,88] since fewer observational studies had been done to assess it[82]. Many of the published observational studies used varying number of items from the MCHIP RMC observational checklist[35,50]. For a few, the checklist was used for an exit interview[46,93,94] Most survey studies conducted postpartum interviews at the postnatal wards, postnatal clinics or immunisation clinics, or as an exit interview post-delivery using the 15-item RMC scale[35,95,96].

The observational studies are challenged by the possibility of an Hawthorne effect[1], while the postpartum interviews may be influenced by social desirability bias[2], courtesy bias[3], and recall bias[4] depending on the duration since delivery[82]. There could also be attrition of the respondents if the postpartum interview is conducted in their homes as a community survey, especially in low- and middle-income countries[82]. There may be a need for a consensus on the standard instruments and research design for measuring RMC received during childbirth to ensure comparison across settings.

Observational studies had been considered the gold standard for clinical quality assessment in a study validating an index for measuring the quality of labour and delivery processes[97]. Observational study and not self-reported was the preferred in understanding the work tasks of ward-based nurses. The observational study gave a more accurate reflection and the concern about the Hawthorne effect was not substantiated[98]. In 2018, WHO designed and validated an instrument to measure women's childbirth experience of RMC[82]. They conducted observational studies and community surveys. A higher prevalence of women's mistreatment, 40% was observed compared to the 35% reported by the women themselves during the community surveys[99]. For my study, both the MCHIP RMC observational checklist and the 15-item RMC scales were used to assess the observed and reported RMC received respectively.

1.6. Health care in Nigeria

1.6.1. The Nigerian health care delivery system

1.6.1.1. Guiding policies

According to the Nigerian National Health Policy, health care is delivered by the three tiers of government in Nigeria which are the local, state and federal tiers of government[100]. Since the First National Health Policy and strategy to achieve health for all Nigerians in 1988[101], Primary

[1] The process where human subjects change their behaviour in an experiment because they are being watched.
[2] The tendency to underreport or over report undesirable attitudes or more desirable behaviours respectively.
[3] The reluctance to give negative feedbacks for fear of offence.
[4] A systematic error from inaccurate and/or incomplete recollection of previous events

health care services were to include preventive, curative, promotive and rehabilitative health services. It should be the population's entry point into the health system and should largely be the responsibility of the local government. This level of care also accommodated private medical practitioners. Collaboration with traditional medical practitioners was encouraged only for practices of proven values. The secondary health services were to be referral centres for the primary level of care and to provide out-patient and in-patient medical, surgical, paediatric and community health services. They were also to administratively supervise health care services at the peripheral primary health facilities. The tertiary health facilities were to provide highly specialised health services as referral centres. The National Health Policy also provided for community involvement in the planning and implementation of health services. All these were to be offered within a coordinated system[101].

These delineated roles of the local, state and federal government in health care delivery were retained in the revised Nigerian National Health Policy in 2004[102]. However, by 2016, the roles of the local, state and federal government in health care delivery became blurred. As stated in the Revised National Health Policy in 2016, the federal government now provides care at the primary and secondary levels of care in addition to its primary responsibility at the tertiary level. This is to support the health service delivery at the primary and secondary levels of care under the jurisdiction of the local and state governments respectively[103].

According to the National Health Policy, the National Council on Health provides the overarching oversight for the Nigerian health system and they are the highest policy-making body for it. The National Council on Health consists of the federal health ministers and the Commissioners for Health for the 36 states in Nigeria as well as other invited agencies. They meet once a year. The National Council on Health has adopted RMC as the standard of care for all Nigerians and a policy brief was developed to disseminate this decision[10,104].

Reproductive, maternal and neonatal health are priority public health issues to be addressed in the 2016 revised National Health Policy[103]. One of the objectives for addressing this as a priority problem was to increase awareness and access to comprehensive reproductive health services. The formulation and implementation of policy initiatives were a few of the mechanisms to ensure access to quality reproductive health services in Nigeria[103]. One such policy is the National Reproductive Health Policy published in 2001[105] and revised in 2010[106]. The 2001 National Reproductive Health Policy listed the reproductive health rights of women in its annexe, and these included the women's rights to privacy, dignity, information and education. To this end, the federal government aimed to "protect the rights of all people to make and act

on decisions about their reproductive health free from coercion or violence and based on full information" (page 14)[105]. The revised National Reproductive Health Policy, in 2010 has a '*rights-based approach to the highest standard of health*' as its first key underlying values[106].

In 2018, the Patient's Bill of Rights (PBoR) was produced by the Consumer Protection Council, an agency of the Federal Government of Nigeria and launched by the Vice President of the Federal Republic of Nigeria[107]. A summary of the PBoR is presented in Table 1.5. The PBoR reflects five of the rights expressed in the RMC Charter. These include the women's rights to dignity, privacy, information and informed consent, equitable care, liberty, autonomy, self-determination and freedom from coercion. All of these emphasise that policy backup exists for the delivery of RMC to women during childbirth in Nigeria.

Table 1.5: The Nigerian Patients' Bill of Rights (in summary)

Patients' Bill of Rights		
1	Access to information	These include access to all relevant information regarding their health in a language they understand
		They are also to fully participate in the plans and decision-making regarding their management
2	Access to patient-related information	This includes access to their hospital records
		They are to have the right to know the identity and qualifications of their managing health professionals
3	Fee-related information	Rights to full disclosure of cost for their treatment plan and transparent billing
4	Right to confidentiality	They are to be managed in privacy and with the utmost confidentiality per the prevailing law
5	Right to quality care	They are to have access to a clean, safe and secure healthcare environment.
		They are to receive equitable care and caregivers
6	Access to care with dignity	They are to be treated with respect and dignity without prejudice to gender, religion, race or socioeconomic status or geographical location.
7	Access to emergency care	They should receive urgent, immediate and adequate intervention and care in case of an emergency. Prioritising such actions over cost and payments
8	Access to visitation	The patients are to have access to visitors including for religious purposes according to the rules of the facilities. organisation
9	Right of refusal of care	The patients must always retain control of their person and at all times be informed of their power to decline care upon full disclosure of the consequences of such decisions by the patients
		They have the right to consent or decline participation in medical research
10	Right to be informed of interruption of	The right to be informed of impending interruption of services by the attending health professionals
11	Complaints	The patients have the right to express dissatisfaction regarding the service and/ or the providers including personnel charges or abuse

1.6.1.2. Maternity care services offered

Antenatal care, normal labour and delivery, newborn resuscitation, emergency obstetric care services and post-natal care are services expected to be delivered across the primary, secondary and tertiary levels of health care. The stakeholders involved in the provision of maternity care across these levels are specialist consultants in obstetrics and gynaecology, doctors, nurses, nurse-midwives, community health officers, community health extension workers and health assistants. Their roles and responsibilities vary across the professional cadres as well as by the levels of health care delivery.

The specialists, doctors, nurses and nurse-midwives are termed skilled health care providers according to the World Health Organisation[108,109]. The CHOs and CHEWS are the community health workers in Nigeria. The majority of doctors work at the secondary and tertiary levels of care; the community health workers work mainly at the primary level of care; while the nurses work across all the levels of care. According to the National Health Policy in 2016, Nigeria had one of the largest stock of human resources for health in Africa[103], comparable only to Egypt and South Africa[110]. Nonetheless, Nigeria still suffers from a shortage of health professionals across the various cadres.

Persistently low and inequitable distribution of health professionals has been consistently reported in the literature[110]. This has been worsened by the emigration of health workers to high-income countries, known as *'brain drain'*[111]. There has been a reported 1.5 million shortfall of health workers in Africa, the majority of which is said to have been contributed by Nigerians who had emigrated to high-income countries[112]. This shortage of health workers cuts across the levels of health care delivery. The primary health care system is badly affected with shortfalls of health workers reported at this level of health care delivery in a state in Northern Nigeria[113]. This has led to women receiving poor quality maternal care contributed by work overload, and a possible transfer of aggression to their clients[113,114].

1.6.2. State of maternal health in Nigeria

According to the Nigerian National Demographic Health Survey, the country's maternal mortality ratio (MMR) increased from 545/ 100,000 live births in 2008[115], to 576 per 100,000 in 2013[116] but declined to 512/100,000 live births in 2018[117]. However, the maternal mortality estimation inter-agency group (MMEIG) gave it an estimated 978/100,000 live births in 2010 and 917/100,000 live births in 2017[118]. The MMEIG consist of representatives from the World Health Organisation, United Nations Children Fund, United Nations Population Fund, the World Bank Group and the United Nations Population Division[118]. There has been a fall in the

global MMR[119] and Nigeria. However, the decline is at a very slow rate in Nigeria. The MMEIG puts the annual rate of reduction from 2010 to 2017 as 0.9% (-2.1 – 3.4 95% Confidence Interval)[118]. Nigeria failed to meet the targets for the Millennium Development Goal 5 in 2015[120,121]. Nigeria was ranked 163 of 188 countries in the baseline Sustainable Development Goals (SDG) health-related index (ranging from 0 to 100 as best) with a poor score of 28 for the maternal mortality indicator[122,123].

1.6.3. Contextual factors in maternal care practice environments

Several environmental factors may influence the quality and practice of maternity care in the Nigerian health system. There is the overarching political and policy environment which is expected to guide or inform the type of practice to be delivered. For example, if maternity care will be respectful or not and if it will be evidence-based or not. Without a policy backup, many new interventions or new ideas may not be accepted or implementable.

There is also the socio-cultural environment. The socio-economic status may determine the type of maternity care received. There are very strong cultural beliefs across different ethnic groups. Some of which may be protective or harmful. And may facilitate or hinder the practice and uptake of respectful maternity care as globally desired. The socio-economic environment also speaks to women's economic power to access care as well as the effects of the financial regulations in the country on their affordability of care[83].

The partnering organisations on childbirth care delivery services in Nigeria at international, national, and local levels are external environmental factors with a strong influence on the type, manner and scope of services delivered. The internal environments in health institutions are also important. Task-shifting, multi-tasking, inter-professional rivalry, poor health worker motivation, low job satisfaction, and overworked workers are a few of the internal environmental factors limiting respectful maternity care practice and uptake.

1.6.4. Respectful maternity care in Nigeria

The prevalence of mistreatment during childbirth in Nigeria had been reported in the literature using both quantitative and qualitative measures. Okafor *et al*[56] found a 98% prevalence of disrespect and abuse during childbirth in a study with 446 women who brought their infants to immunisation clinics in Enugu. Ogunlaja *et al*[57] also found a 93.2% prevalence of disrespect and abuse in previous deliveries among 438 antenatal clients in Ogbomoso. However, Ijadunola *et al*[95] reported a 19% prevalence among 384 women at post-natal and immunisation clinics in Ile-Ife. Focusing on RMC rather, 69.9% of postnatal women reported receiving RMC from tertiary and secondary health facilities in Calabar, Nigeria[124].

Qualitative assessments were done in Abuja and Benue states[125,126] supporting the evidence of mistreatment during childbirth. A systematic review of 14 studies from 2004-2015 described the prevalent types of mistreatment and its associated factors in Nigeria[53]. The prevalence of mistreatment ranged from 11% to 71%. The most prevalent type was non-dignified care which was influenced by personal characteristics of the women such as low socioeconomic status[53]. Okafor *et al*[56] identified recall bias as a limitation to their study while Ijadunola *et al*[95] identified selection bias. The authors also identified the need to obtain health provider perspectives on disrespectful care during childbirth and to conduct formative qualitative research on women's understanding and expectations for RMC

The White Ribbon Alliance and JHpiego Maternal and Child Health Integrated Program, have worked to promote RMC uptake in Nigeria since the global call in 2010. Their activities include an adaptation of the RMC training guide to a Nigerian-focused version, conducting pre-and in-service training, and community mobilisation[127]. They introduced hotlines for victims of mistreatment to call and facilitated the adoption of the RMC Charter by the National Council on Health, a policy-making body in Nigeria. They adapted the RMC Charter to the Nigerian language and cultural context and supported the production of the Nigerian customised RMC training guide [10,104].

1.7. Study Problem Statement

The utilisation of maternal care services especially during childbirth is still low in Nigeria. The proportion of women who had been delivered in a public health facility by a skilled birth attendant in 2013 was 22.6% and 35.8% for both public and private facilities[116]. This has slightly increased to 43% in 2018 following several global efforts[128]. Several reasons have been postulated as explaining the increasing but yet low proportion of women delivering in health facilities[61,129]. One of the reasons is disrespectful and abusive maternity care practice[129,130].

Health workers' attitudes influence women's health-seeking behaviour[44]. Poor health-seeking behaviour implies women may present late at health facilities for antenatal care or delivery, while some may opt-out of health facility delivery altogether[94,131]. These decisions may increase the risk of maternal complications and death[132]. Negative health worker attitudes have been expressed as mistreatment, particularly during childbirth, which has been reported frequently, both globally and in Nigeria. RMC practices have been prioritised as a means to improve patient-provider interactions and the quality of maternal care experienced.

This study intends to address some important research gaps. There are a few studies assessing women's perceptions about respectful RMC. However, none has aligned these with the 12 domains of RMC. Studies documenting the RMC experiences of women in Nigeria have mostly relied on interviews with women and not by direct observation of childbirth[4,77]. However, Bazant[77] and Savage *et al*[4] recommended the use of observational studies when assessing women's RMC experience. They proposed that it will provide a bridge between the objective (true experience) and subjective experience (reported experience) of the women. Also, the reported childbirth experiences in Nigeria were obtained from postpartum women at immunisation and post-natal clinics of health facilities with possible recruitment bias. This is because the abused women during childbirth may not return to the same health facility to access another service[56,57,95]. The challenge of recall bias and social desirability bias could also influence the quality of data collected during postpartum interviews. However, by conducting observational studies, such biases will be excluded as events observed will be recorded as they occur.

Several maternal interventions have been implemented in Nigeria, with minimal effect on Nigeria's maternal mortality ratio[133]. Many countries have pushed for the implementation of interventions to promote RMC[85,134]. A transition from the traditional routine childbirth care with the reported occurrences of women's mistreatment to a respectful maternity care practice would require change efforts[10,18]. However, if the stakeholders are not ready for the change, resources invested in the implementation may be wasted[10]. Warren *et al*[135] confirmed the importance of employee readiness at multiple levels in promoting the uptake of RMC practices in Kenya. However, this reported employee readiness for RMC uptake was not measured quantitatively.

Assessments of readiness for change have been done for implementing change in the demand for care in acute care hospitals[21], and for reporting quality and patient safety indicators[19] but none has yet been done for a change to RMC practice. An assessment of readiness for change to RMC practice has not been published in Nigeria. Few studies have assessed both organisational and individual readiness in the same population. Assessing both together may help to objectively measure the influence of one on the other.

There are possible barriers that may limit health provider readiness for change to RMC practice. These barriers will need to be addressed using systematic, evidence-based theory-informed strategies. These strategies can be derived using a systematic process such as the Theoretical Domains Framework (TDF) and the Behavioural Change Wheel (BCW)[40]. Strategies to

improve readiness for change have been documented in the literature but none had employed a theory-informed process such as the use of the TDF and BCW, and none had been developed for readiness for change to RMC practice.

1.8. Study justification

The World Health Organisation (WHO), World Bank and Organisation for Economic Cooperation and Development (OECD) have jointly reiterated in their 2018 publication that without the delivery of quality health care, there cannot be Universal Health Coverage (UHC)[136]. The WHO has also called for a five-point action plan toward preventing and eliminating disrespect and abuse during facility births[74]. These include a need for more research in measuring disrespectful and abusive care in all contexts and the effects of such mistreatment on women's future choices for birthplace. The Nigerian government also recently published the Patient's Bill of Rights. This is an indication that this PhD research which addresses a maternal care approach from a human rights perspective is topical and relevant to addressing the policy direction in Nigeria. The call to emphasise women's rights, make health systems more accountable, and support health systems to focus on RMC-driven quality care has been made[74]. It is hoped that findings from this study would contribute to achieving that.

1.9. Contribution to knowledge

This study is novel in providing stronger evidence on women's RMC experiences through a triangulation of two methods, observation, and a structured interview. The contributions of this research to knowledge also include providing evidence on the organisational and individual readiness for change to RMC within the context of public health facilities in a developing country, and the relationship between the two constructs. The factors that may facilitate or hinder readiness as well as the strategies that may improve the state of readiness for RMC change have also been identified. Application of the findings on the health providers' state of readiness for change to RMC, and the associated factors may contribute to the sustainability and institutionalisation of interventions promoting RMC practice in developing countries.

1.10. Research Questions

1. What is the current status of RMC and provider readiness for change to RMC practice?

2. What strategies are necessary for improving readiness for change to a patient-centred approach among healthcare providers and programme managers in the labour ward?

1.11. Aim and Objectives

1.11.1. Aim

To evaluate the extent of respectful maternity care (RMC) practised during childbirth, and improve readiness for change to its practice in primary and secondary public health facilities in Ibadan, Nigeria.

1.11.2. Specific objectives

1. To explore the perceptions of pregnant women about RMC during childbirth in Ibadan.
2. To determine the level of respectful maternity care (RMC) experienced by women during childbirth in Ibadan, and its determinants.
3. To evaluate the organisational and individual readiness for change to RMC and determine its associated factors in public health facilities, Ibadan, Nigeria.
4. To identify the barriers and potential strategies to improve the readiness for a change to RMC practice in public health facilities, Ibadan, Nigeria.

1.12. Structure of the doctoral thesis

This doctoral thesis follows the divided block format as approved by the Faculty of Health Sciences, University of the Witwatersrand. It consists of 7 chapters with chapter references. Chapter one presented the introduction and literature review sections. Chapter two gives the expanded methodology used in the research. It also described the funding support received. Chapters 3 to 6 present the findings of the research according to the objectives. They were developed as complete manuscripts either submitted or already accepted for journal publication. Brief background information on the study facilities not captured in any of Chapters 3 to 6 is presented in the appendices. Chapter 7 integrates the findings across the result chapters, and presents the key findings with conclusions and recommendations. The bibliography and other appendices are also presented.

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CHAPTER TWO: OVERVIEW OF STUDY METHODOLOGY

Detailed methods for each component of the study are provided in each paper. This chapter provides an overview of the methods used. More detailed methodology specific to each chapter has been addressed in the methodology section of each chapter in the result section of the thesis.

2.1. Study Design

This was an analytical cross-sectional study that used a mixed-method sequential exploratory design.

2.2. Study Setting

The study was conducted in public primary and secondary health facilities across the five Local Government Areas (LGA) in Ibadan Metropolis, Oyo State, Nigeria. Ibadan land is the capital, and most populous city, in Oyo state, South-West, Nigeria. It is the third largest city in Nigeria and the 7th in Africa[1] with a population estimate of 3,756,000 with a 2.93% growth rate[2], and a land mass coverage of 3,080 km2 (1,190 square metres) in 2022[1]. It is the city with the largest geographical area in Nigeria. The estimated population of pregnant women in Ibadan is 187,822 based on the assumption that pregnant women represent 5% of the total population[3]. Yoruba is the local language of the residents of Ibadan land. Ibadan land has 11 LGAs, but the Ibadan Metropolis which is a sub-set of Ibadan land consists of five LGAs. Figures 2.1 and 2.2 show the maps of Nigeria and Ibadan Metropolis respectively.



Figure 2.1: Map of Nigeria showing Oyo state and Ibadan

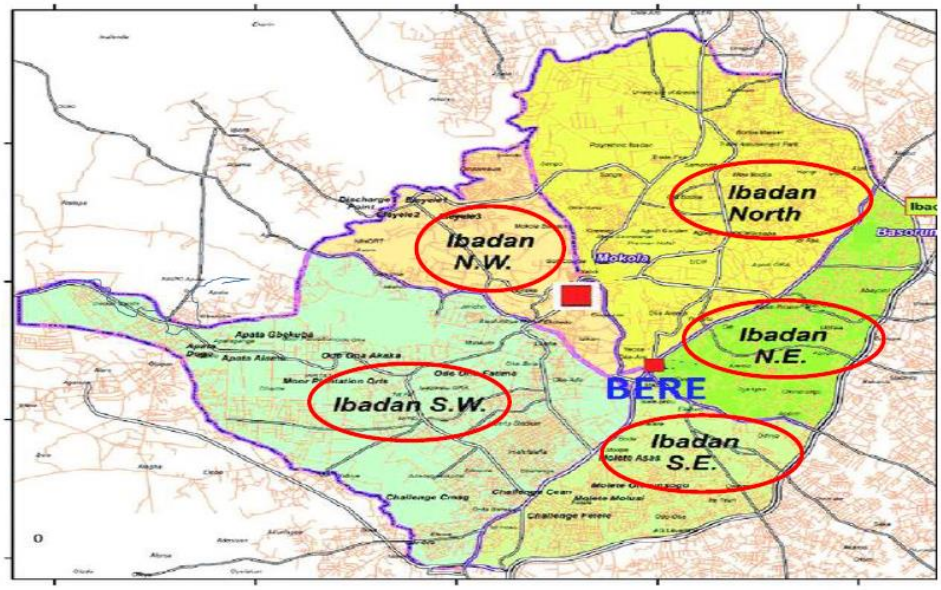


Figure 2.2: The map of Ibadan Metropolis showing its five LGAs

The LGAs in Ibadan Metropolis are Ibadan North, Ibadan North-East, Ibadan North-West, Ibadan South-East and Ibadan South-West. Ibadan North East and North West have the largest and smallest projected population sizes respectively. The LGAs, their headquarters, estimated population size and area land mass are provided in Table 2.1. All the LGAs in the Ibadan Metropolis are urban according to the Nigerian thresholds for defining urbanisation[4], and all the five LGAs have slums[5]. However, the LGAs with the largest slums in Ibadan Metropolis are Ibadan North-East, South-East and South-West[5]. The North-West LGA is located in the centre of the city, surrounded by the other LGAs[6]. The main occupation of the residents of Ibadan Metropolis are traders, artisans, and civil servants.

Table 2.1. Population size, area square metre and headquarters of study LGAs [7]

S/n	LGA	Headquarters	Est. Population size in 2016	Area/ sq. metre
1	Ibadan North	Agodi	432,900	19.43 km
2	Ibadan North-East	Iwo Road	465,700	19.94 km²
3	Ibadan North-West	Onireke	216,400	14.31 km²
4	Ibadan South-East	Mapo Hall	374,400	15.14 km²
5	Ibadan South-West	Aleshinloye	397,700	25.13 km²

Figure 2.3 depicts the health systems governance structure in Oyo state, which includes the Ibadan Metropolis. The Commissioner for Health heads the health system and reports to the Executive Governor. The Executive Secretary of the Primary Health Care Board oversees the delivery of primary health care activities in the state and works with all those reporting to him as shown in the figure. The Permanent Secretary of the Hospital Management Board oversees the operations and human resource management in the secondary health facilities. However,

the Director of Secondary Health Care in the state Ministry of Health addresses issues like accreditation of secondary health facilities. The non-governmental organisation engages with both the primary and secondary levels of care.

The Chief Consultants head the secondary health facilities and are supported by the Chief Nursing Officer and other unit heads in each facility. The Medical Officer of Health (MOH) (a doctor with a postgraduate degree in public health) or the Director of Primary Health Care (DPHC) (if not a doctor or has no postgraduate degree in public health) oversees all the PHC facilities and public health activities in the LGA. The primary health care facilities are managed by the Officers in Charge at the facility. These could be a nurse/ midwife, a CHO or a CHEW.

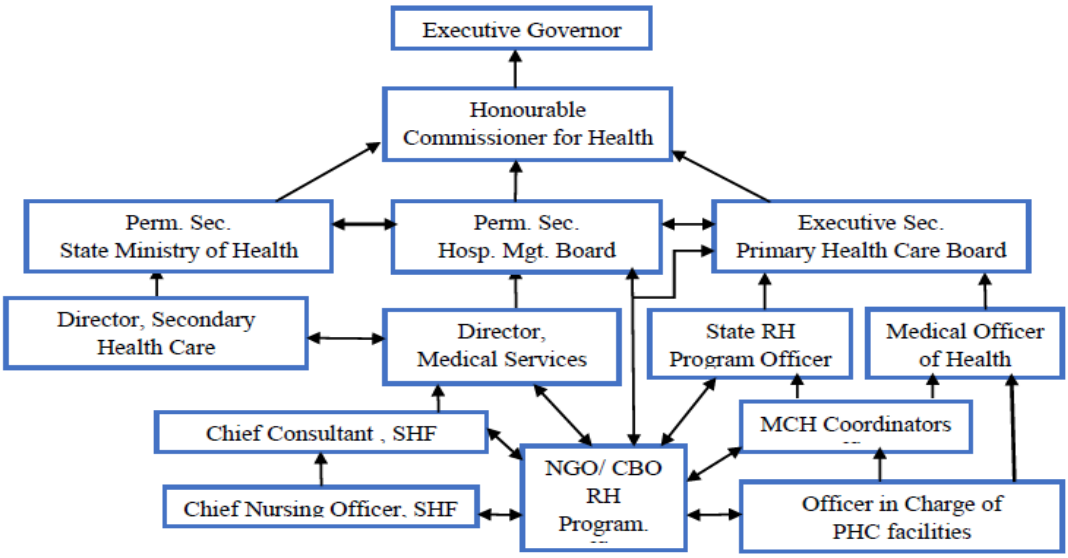


Figure 2.3: Health systems governance structure in Ibadan Metropolis, Oyo state

2.3. Study Population and Sampling

There are private and public health facilities in Ibadan Metropolis. There were 40 public primary and 6 secondary health facilities that offer maternity care services in Ibadan Metropolis at the inception of my study, according to the state's health management information system. These services include antenatal, normal delivery, postnatal, newborn resuscitation and family planning. However, only 26 (65%) of the primary but all the secondary health facilities could be defined as functional. Functionality in this study was defined as those that reported ≥12 deliveries in a year, (an average of 1 delivery per month). The average monthly delivery rates in the functional 26 primary and 6 secondary health facilities in the preceding year to the onset of the study were 10.5 and 26.0 respectively. Appendix 2.1 presents the monthly delivery rates in the functional primary and secondary health facilities across the five LGAs. The scope of this study excluded tertiary health facilities.

According to the State's Health Management Information Unit, there were 187 healthcare providers across the 26 primary health care (PHC) facilities. These consisted of 86 (46.0%) community health extension workers (CHEW), 55 (29.0%) nurse/midwives, 36 (19.0%) community health officers (CHO) and 10 (5.0%) doctors. These gave an average of 7 providers per primary health care facility. The secondary health facilities are located in four of the 5 LGAs in Ibadan Metropolis. Ibadan South-East LGA had no secondary health facility. There were 503 health providers across the 6 secondary health facilities, comprising 410 (82.0%) nurses/midwives and 86 (18.0%) doctors, with an average of 84 providers/facility. This gave a total of 690 health providers at both types of health facilities. Data on health auxiliaries were not available from the state health management information unit. Appendix 2.2 shows the distribution of health providers across the functional primary and secondary health facilities in the five LGAs (Ibadan Metropolis inclusive) according to the database obtained from the relevant agency in the Oyo State Ministry of Health[5]. The doctors mainly work at the tertiary and secondary health facilities, the nurses work across all three levels of health care delivery, and the community health workers work at the primary PHC facilities. All the providers studied attend to deliveries at their designated health facilities.

2.4. The Processes for Data Collection

In Figure 2.4, the data collection methods are presented in three phases. The first and third phases used qualitative research methods while the second phase was quantitative. All the research assistants (this includes the external observers who observed women during childbirth) were trained over three days on the rationale for the study, use of the tools, and ethics of data collection.

[5] Department of Planning, Research and Statistics

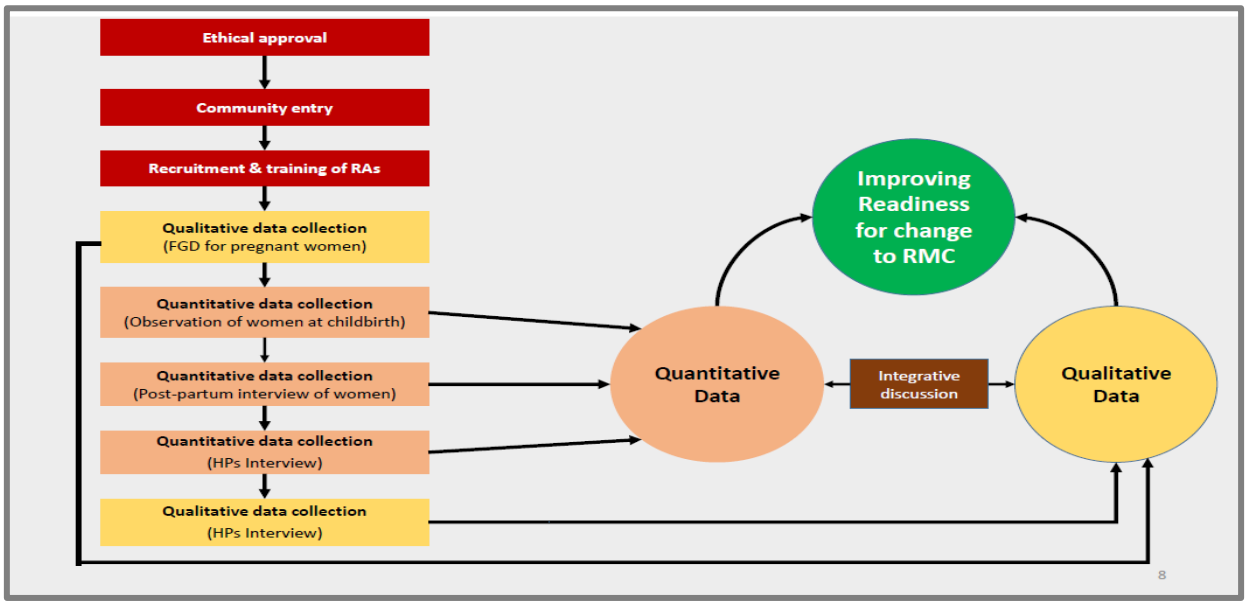


Figure 2.4: The flow of the study

2.5. Methods of Data Collection

Data for objective 1 were collected qualitatively. The quantitative data collection method was done for objectives 2 and 3 while objective 4 was addressed using a qualitative study. See Table 2.2 for the summary of the data collection and data analysis.

Table 2.2: Summary of data collection and management plan

Objective	Study population	Data collection tools /method	Analytical outcomes
1. To explore the perceptions of pregnant women on RMC during childbirth in Ibadan	Pregnant women in the 1st and 2nd Trimester	Four Focus Group Discussions using the FGD Guide	-Perceptions of pregnant women (primigravidas and multiparous) on RMC and their rights during childbirth
2. To determine the level of respectful maternity care (RMC) experienced by women during childbirth in Ibadan, and its determinants	1. Pregnant women presenting at any stage of labour 2. Same women at ≥24hrs post-delivery in the post-natal ward	Observational study: 29-item MCHIP RMC Observational checklists[8], with a short comment section. Structured Interview: 15-item RMC scale tools.	-Mean observed and reported RMC scores received and their sub-categories - Proportion of women who received each item in the observed and reported RMC sub-categories - Predictors of observed and reported RMC received identified from simple and multiple linear regression
3. To evaluate the organisational and individual readiness for change to RMC and determine its associated factors in public health facilities, Ibadan, Nigeria.	Maternal health care providers at the primary and secondary health facilities.	Quantitative method Tools on Likert scales 1-5 (a) 12-item Organisational Readiness for Implementing Change (ORIC) tool[9] (b) 6-item individual readiness tool[10] (c). Change valence tool (6-item) (d) Information assessments (8-item) (e). Perception on available resources for RMC (18-item) from WHO recommendation for IPC[11] (f). 12-item employee core self-evaluation tool[12] (g) Job satisfaction (10-item)[13] Tool with Other response types (h) Perception on Women's Rights at childbirth (13-item) (i) Awareness of DAC practices in facility (12 items, Yes/No)	Quantitatively -Mean (95%CI) scores of individual readiness and organisational change efficacy and change commitment -Mean (95%CI) scores of predictor variables. -Predictors of individual and organisational readiness for change to RMC practice identified from simple and multiple linear regression models -Association between individual and organisational readiness mean scores using the Pearson's correlation test
4. To identify the barriers and potential strategies to improve the readiness for a change to RMC practice in Ibadan.	-Health providers Relevant stakeholders-Facility heads, MCH program managers and decision makers	Qualitative methods. 4 focus group discussions (FGD) amongst providers using FGD guide.17 In-depth Interviews (IDI) using IDI guide among stakeholders. Barriers were mapped to TDF and BCW	-Strategies to identified barriers of readiness for change to RMC practice. This was through the process below: -For the FGDs, coded deductively with the FGD guide, then inductively, using a thematic framework analysis -For the IDI, coded deductively using the a priori TDF and BCW themes, then inductively to explore practical applications of the strategies, used framework analysis.

Note: DAC-Disrespectful and abusive care, MCHIP-Maternal and Child Health Integrated Program, TDF- Theoretical Domains Framework, BCW- Behavioural Change Wheel

2.5.1. Focus group discussions (FGDs) with pregnant women (Objective 1)

Facilities: One primary and secondary health facility each with the highest volume of clients were purposively selected from two LGAs (Ibadan North-West (predominantly urban) and South-West (has some slums) giving a total of four health facilities for this objective. The LGAs were selected purposively.

Study population: Six pregnant women primigravidas and another six with previous birth experience (multiparous women) were recruited from each primary and secondary health facility. This gave a total of eight FGDs. There were seven respondents in two of the FGDs giving 50 women overall.

Recruitment: They were selected by the research assistants with support from the nurses or the Head of the facility who introduced the research assistants to the women.

Eligibility criteria: Being in the 1st and 2nd trimester of pregnancy.

Data collection: The FGD sessions were moderated by the PhD candidate using an FGD guide. Written informed consent was obtained from each respondent. See Appendix 2.3 for the data collection instrument[6].

2.5.2. Evaluation of current RMC practice (Objective 2)

This included both observations of women during childbirth and then post-partum interviews with the same women.

2.5.2.1. Background information on the health facility

A basic data extraction tool was used to collect data on the health facilities visited for this study on their monthly delivery rate, available and functional maternity beds, and available maternal service providers to mention a few through observation and review of hospital records. This was to give a background overview of the health facilities. It was not addressing any specific objective. The clinical observers who were at the facilities for over a month collected the data at each facility. Refer to Appendix 2.4 and 2.5 for the study facility instrument and background information for the facilities presented.

2.5.2.2. Observational study of the childbirth process

Study population: Consenting women from the antenatal clinic who were admitted at any stage of labour.

[6] More details on the methodology are provided in the result chapters

Recruitment: All pregnant women at term or near term at the facility's antenatal clinic were approached for consent to participate in the observational study during childbirth and the questionnaire-based study from 12 hours postpartum. Consent was obtained from un-booked women at presentation in labour.

Eligibility criteria: Women admitted for elective Caesarean sections were excluded.

Sample size: Calculated using the power analysis for a one-sample test of proportion in Stata[14] where the assumed proportion (p) of women who received RMC during childbirth was=81%, based on a study from Ile-Ife, Nigeria[15]. For a ±10% precision around the required confidence interval (71% to 91%) and for 90% power, the calculated sample size=129. For cluster sampling with an assumed design effect of 2[16], the required sample size was then 258 women. Given a total of 275 deliveries across the selected facilities in the previous 1-year just before the commencement of observation at each facility, a decision was made to observe all the women presenting at each facility within the one-month duration of data collection for this objective. Appendix 2.5 gives the breakdown of the total number of deliveries per facility in the previous 1-year before the commencement of observations. The data were obtained directly from the facility's delivery register.

Sampling: The studied health facilities were sampled from the functional 26 primary and 6 secondary health facilities in Ibadan Metropolis at the time of conducting the study. A two-stage cluster sampling technique was employed. A list of the functional primary and secondary health facilities in each of the 5 LGAs in Ibadan Metropolis was generated. One primary and 1 secondary health facility were selected per LGA by simple random sampling. However, one of the LGAs has no secondary health facility. This gave a total of nine health facilities. In the results presented below the study health facilities are represented by numbers (Facility 1 to 9) to ensure confidentiality. The odd-numbered health facilities represent the primary health facilities, while the even-numbered represent the secondary health facilities. Consecutive facilities belong to the same LGA.

A total sample of all the earlier consented booked women, and newly consented un-booked women who arrived in labour at any time of the day was done until the allotted sample size to that health facility was reached. The first of two women who arrived at about the same time was observed. The same women observed were also interviewed postpartum but by different research assistants.

Data collection instruments: The instrument had one section which was the adapted K4health and Maternal and Child Health Integrated Program (MCHIP) RMC standard checklist[8] 29 items describing 6 of the 7 categories of mistreatment based on the Bowser and Hills criteria. The 7th category (illegal detention of women unable to pay their bills) was not included because it was outside the observation period. The checklist had a Yes or No response and a short comment section to describe specific scenarios informing the selected response. The observational checklist was completed by research assistants and supervised by the PhD candidate. The women were allotted an identification number on their hospital file to facilitate linking the women's observational data with their interview data at postpartum. (The tool is in Appendix 2.6)

Duration of observation: The women were observed from time to admit in the labour room till they were discharged out of the labour room, irrespective of the childbirth outcome. The reason for discharge from the labour room may include a successful normal vaginal delivery of live birth or still birth baby (foetus), a decision to proceed for an emergency Caesarean section or a referral to another health facility.

The observers were six newly graduated nurses, external to the facilities and trained over one week. Each covered the health facilities on a 12-hour or 8-hour shift for a low or high-volume facility respectively, guided by a schedule. There was one high-volume facility amongst them. The health facilities were covered for 24 hours each day over 1 month. The research assistants had days off when they were not scheduled to be at the facilities. Two facilities were covered each month, and the data collection spanned over 5 months (November 2019 – March 2020) for this objective.

2.5.2.3. Interview of post-partum women

The same woman observed in the observational study was interviewed post-partum. Hence, the same study population, eligibility criteria, recruitment process, sampling technique, and sample size calculation were applied. The survey was conducted 12 hours post-delivery. This was because the women were often discharged early at postpartum. The research assistants were graduates with Master of Public Health degrees and experienced in data collection

Data collection instrument: This had three sections namely the women's characteristics such as their socio-demographic and obstetric history (14 items), the RMC 15-item scale, and the current pregnancy outcome (6 items). The 15-item RMC scale was developed by Sheferaw *et al*[17] in 2016, and used by Moussa and Tunrigan[18] in Egyptian health facilities in 2018. Responses were on a Likert scale of 1-5 from 'strongly disagree' to 'strongly agree'. There are

four sub-categories in the tool. The first 7 items of the 15 RMC scale addressed the friendly care sub-category, the next three addressed abuse-free care, the next three described timely care, and the last two addressed discrimination-free care. Overall, there were 35–items on the tool and each interview lasted about 20 minutes. (Appendix 2.7)

2.5.3. Structured interview with health care providers (Objective 3)

Study population: Health care providers who attend to deliveries in the study health facilities.

Eligibility criteria: Physicians, nurses, nurse-midwives, and community health workers namely (community health officers (CHOs), community health extension workers (CHEWs), and health auxiliaries) who consented to participate in the study.

Sample size: This was calculated using the power analysis for a one-sample mean test[14] for readiness for change, at 90% power with an assumed mean of 3.64±0.61 standard deviation. This was the nurse-reported mean score on change commitment (organisational readiness) for implementing change in acute care hospitals in Switzerland[19] and it was the closest study that gave the mean score on change commitment and change readiness using the same instrument. Estimating the confidence interval or range of precision, (delta) around the mean as ±5% of the mean. This gives (3.64 ± 0.05*3.64= 3.82 and 3.46), a standard deviation of 0.61 and a finite population of 690 health providers, approximated to 700, this gave a sample size of 105 providers. In a cluster sampling with an assumed design effect of 2[16], the minimum sample size was therefore 210 providers.

Sampling method: The health providers of the same health facilities selected for the observational study were interviewed. The number of health providers and the professional type of providers to be interviewed per facility was allotted proportionately to the total number of providers per facility by professional type. Simple random sampling using the 'balloting selection method with replacement' was used to select the available providers after generating the sample frame per professional type per facility.

Data collection instrument: The tool consisted of 9 sections (see Table 2.3) measuring organisational and individual readiness for change to RMC practice and the associated factors. The data were collected by two research assistants who were post-graduate students in Public Health and experienced in field data collection. They were supervised by the PhD candidate. The health providers' interview was done immediately after concluding the allotted sample of women for the observation of childbirth and postpartum interview.

Table 2.3: List of tools in the health provider structured questionnaire

	Name of Tool and Sections	Source	Items	Response type	Alpha coeff.
1	*Organisational readiness for implementing change (ORIC)	Shea *et al*[9]	12	Likert scale 1-5	0.949
2	*Individual readiness for change	Vakola *et al*[10]	6	Likert scale 1-7	0.733
3	Socio-demographic characteristics	Adapted from the literature	15		
4	Perception on women's rights during childbirth	Childbirth Connection[20]	13	Likert scale 1-5	0.575
5	Provider awareness of mistreatment in their own facility	Maternal & Child Health program[21]	12	Likert scale 1-5	0.638
6	Change valence	Shea *et al*[9]	6	Likert scale 1-5	0.902
7	Informational assessments	Phillip[22]	8	Likert scale 1-5	0.648
8	Perception on RMC resource availability	WHO Recommendation for labour[11]	18	Likert scale 1-5	0.669
9	Core self-evaluation tool	Judge *et al*[12]	12	Likert scale 1-5	0.598
10	Employee job satisfaction tool	Management Sciences for Health[13]	10	Likert scale 1-5	0.603
	Total		112		

*Outcome variables. ORIC- Organisational readiness for implementing change; RMC- Respectful maternity care; WHO- World Health Organisation

In all, there were 112 items assessed. (Appendix 2.8). The Organisational Readiness for Implementing Change tool assessed 5 items on change commitment and 7 on change efficacy. Organisational readiness for change was assessed by asking individual employees using words such as 'we' or 'people who work here'. Readiness for change to RMC practice for this study was defined as 'maternal care providers' readiness to integrate the content of the RMC charter and its interpretations into their routine childbirth services'.

2.5.4. Focus group discussion with maternal care providers (Objective 4)

The respondents were probed for their perceived facilitators, barriers and contextual factors of organisational and individual readiness for change to RMC in their facility. Four FGDs were conducted.

Study population: They were homogenous groups of nurses/midwives, community health workers and doctors. They were made up of two representatives each of the nurses and community health workers across the 5 PHCs, and two representatives each of nurses and doctors from the 4 SHFs. Some of the participants for the FGD were also interviewed quantitatively for objective 3.

Recruitment: The participants were selected purposively by the heads of their facility.

Eligibility criteria: Health providers with ≥2 years of work experience

Data collection: The FGD sessions lasted about one hour and were moderated by the PhD candidate, and supported by two research assistants who served as the note taker and observer. (Appendix 2.9). The FGD's were conducted after concluding the quantitative interview of the health providers and preliminary data analysis for Objectives 1 and 2 and the quantitative part of Objective 3. Before each interview, the preliminary findings were presented to the providers.

2.5.5. In-depth interviews (IDI) with stakeholders (Objective 4)

Study population: The stakeholders interviewed are presented in Table 2.4.

Table 2.4: Breakdown of stakeholders interviewed

S/no	Stakeholder's role	Level of administration	Number
1	Head of the Reproductive health program, State Primary Health Care Board	State	1
2	Decision maker, State Primary Health Care Board	State	1
3	Head of the Nursing Team at the state secondary health facilities	State	4
4	Head of the doctor teams at the secondary health facilities	State	4
5	Medical Officers of Health/ Directors of Primary Health Care	LGA	5
6	Reproductive health program managers at Non-governmental organisations	Non-governmental	2
	The total number of stakeholders interviewed		17 persons

Recruitment of NGO representatives: The names of the NGOs supporting the state in reproductive health and maternal health services were obtained from the state Ministry of Health. Registered NGOs with an official website were selected. One of the NGOs had attempted implementing RMC in the state and was purposively selected, even though their project closed up before the completion of the implementation process. They are implemented both at the primary and secondary levels of care. The other NGO selected is a multilateral agency that is actively supporting the state in its maternal and child health services, especially at the secondary and tertiary levels of care. Their implementing technical staff who interacted directly with the facilities and the health providers were interviewed for both NGOs.

Eligibility criteria: All the respondents working in the government-owned establishments interviewed were selected purposively as they would play key roles in integrating RMC practice into the routine childbirth services in the state.

Data collection: The IDIs were conducted after concluding the FGD sessions and a preliminary analysis of the data to extract the identified barriers. The interviews were moderated by the PhD candidate using an IDI guide and supported by one research assistant as the note-taker. The

respondents' bio-data such as their age and years of experience in service and the position were obtained. The summary of the preliminary findings on Objectives 1 to 3 was presented in bullet form on a one-page document and their opinions on these findings were sought. The IDI guide also covered the barriers of readiness for change to RMC extracted from the FGD sessions with health providers. The IDI respondents were asked about their opinion on each of these barriers and other barriers if they agreed they were truly barriers or not, and the reasons for their responses. They were then taken through the steps in using the Theoretical Domains Framework: (1) Identification of the barriers (target behaviours) that will need to change. (2) Prioritisation of the target behaviours using prioritisation criteria. (3) Mapping of the prioritised target behaviours to the related domains in the TDF.

The PhD candidate then mapped their selected TDF domains to the capacity, opportunity, and motivation components (COM-B) model in the hub of the Behavioural Change Wheel (BCW), and then to the nine potential strategy categories in the BCW. (4) The respondents' perceptions of the applicability of these potential strategy categories were then explored. (Appendix 2.10 for the IDI guide)

The interviews were conducted in private rooms within the health facility for confidentiality, and at the time allotted by the respondents. The interviews were conducted in English. About 60% of the interviews were conducted in two separate sessions, each interview lasting about 90 minutes.

2.6. Data Analysis

2.6.1. Quantitative data analysis:

Analysis was done using Stata version 15. The key outcomes were determined at a 95% confidence interval, and the level of statistical significance was defined as a p-value <0.05. Adjustment for the cluster sampling and weighting was done using the Stata survey commands (svy estimation commands).

2.6.1.1. Objective 2: Determine the proportion of women who received RMC during childbirth

The unit of measurement was women who received RMC as observed during childbirth and reported at post-partum. Numeric variables included the RMC scores from observation and interview. Descriptive statistics of the mean and standard deviation were used to summarise the numerical data. From the observational study, a positive response to the items on the checklists was scored 1, and a negative response scored 0. These scores were summed up for all the categories of mistreatment assessed and scores were converted to percentages. The higher the

percentage, the more respectful the care received. Proportions (95%CI) of women with RMC experience from observation were determined. Any woman observed to have received at least one category of mistreatment had not experienced an RMC. However, no woman received 100% of the items on the checklist. The observed RMC scores received were thus analysed on a continuous scale.

The overall reported RMC mean scores (95%CI) with those for the sub-categories were obtained from the postpartum women survey. The mean scores were standardised and converted to percentages using the formula (Mean-1)/4*100.

The predictors of both the observed and reported RMC received were identified using simple and multiple linear regression models.

2.6.1.2. Objective 3: To evaluate the organisational and individual readiness for change to RMC and explore their associated factors in public health facilities, Ibadan, Nigeria

The mean scores for organisational and individual readiness for change and their 95%CI were determined. The change commitment (5-items) and change efficacy (7-items) measures were determined and the correlation between them was evaluated using Pearson's correlation test. The 95%CI mean score of the summed 12 items in the ORIC tool was used to determine the organisational readiness for change mean scores. The maximum mean score obtainable was 5^{9}. The 7-point Likert scale for the individual readiness for change was converted to 5 for better comparability with the organisational readiness for change. The 95%CI mean score for the individual readiness for change was determined. The 95%CI mean scores for all their quantitative predictors were also determined.

Simple and multiple linear regression models were each built for organisational readiness (ORC_{RMC}) and individual readiness for change (IRC_{RMC}) to RMC. The known predictors of organisational readiness for change include change valence and informational assessments (perceived resource adequacy which describes the adequacy of available resources equipment, expertise, skills, and time, needed to implement the change). Additional factors for individual readiness for change included providers' job satisfaction, core-personality evaluation and their characteristics such as their age and years of work experience. Additional variables as predictors of both ORC_{RMC} and IRC_{RMC} included their awareness of mistreatment in their health facilities, perceived resource availability and perceived rights women should always have during childbirth. Their perceived resource availability differed from resource adequacy as this assessed the availability of specifically identified resources needed to implement the change to RMC practice. Table 2.5 presents the quantitative data analysis plan for Objectives 2 and 3.

Table 2.5: Quantitative data analysis

Objective	Outcome variables	Predictor Variables	Data analysis methods
Objective 2 **To determine the proportion of women experiencing respectful maternity care (RMC) during childbirth in public health facilities, Ibadan, Nigeria.**	• Overall mean score of the ***observed** & **reported** RMC experienced • Mean score by type of **observed** & **reported** RMC experienced • Maternal outcome of current pregnancy • Types of complications experienced • Foetal outcome of current pregnancy • Future intention to deliver in health facility • Intention to recommend health facility for delivery	• Gestational age at presentation (in weeks) • Cervical dilatation at presentation • Status of foetal heart sound on arrival in labour room • Level of education • Ethnicity • Number of pregnancies ever had • Number of deliveries ever had • Number of children alive • Ever delivered in this health facility • Place of last birth • Outcome of last pregnancy • Familiarity with health providers in this facility	• Descriptive statistics of mean and standard deviation were used to summarise the numerical normally distributed data and median and interquartile range were used to summarise numerical skewed data. • Frequencies and percentages were used to summarise categorical variables. • 95%CI of mean RMC scores and proportion of women who experienced RMC (observed/reported) • Pearson's correlation coefficient was used to determine the relationship between observed and reported RMC received • Predictors of observed and reported RMC scores received using a simple and multiple linear regression
Objective 3 **To evaluate the organisational and individual 'readiness for change' to RMC and determine their associated factors in public health facilities, Ibadan, Nigeria (quantitative assessments only)**	• Mean score on change efficacy and change commitment • Overall mean score of *organisational readiness • Mean score of *individual readiness	• Mean score of change valence • Mean score of informational assessments • Proportion of type of abuse providers are aware had ever or never been done to women in their health facility (always, very frequently, occasional re-grouped as ever done, rare & never regrouped as rarely done) • Proportion of rights providers perceive women should ever or never have rights to (always, very frequently, occasional re-grouped as should ever have, rare & never regrouped as never have) • Mean score of available resources needed to implement RMC in facility • Mean score on core self-evaluation personality traits • Mean score on provider job satisfaction	• Descriptive statistics of mean and standard deviation were used to summarise the numerical normally distributed data and median and interquartile range were used to summarise numerical skewed data. • 95%CI of mean scores of organisation and individual readiness for change • 95%CI of mean scores of predictor variables • Regression models were built separately for organisational and individual readiness for change • Bivariate and multiple linear regression were used to determine the relationship between the dependent variables and the independent variables. • Determined association between individual and organisational readiness mean scores using the Pearson's correlation coefficient

Note; * (asterisk) indicates outcome variables

The size of the influence of these predictors on organisational and individual readiness for change to RMC practice was determined from the beta coefficient, the confidence intervals and the p-value. Association between the overall organisational readiness and individual readiness to change scores were determined using Pearson's correlation coefficient. This gave the direction and magnitude of the relationship. (See Table 2.5)

2.6.2. Qualitative data analysis

2.6.2.1. Objectives 1 and 4: The qualitative inquiry into women's perceptions of RMC, the exploration of facilitators, barriers and contextual factors and identifying strategies for achieving a positive shift in readiness for change

All the interviews were audio-taped after obtaining the respondents' consent. Audio recordings were transcribed verbatim. The recordings in the Yoruba language were translated to the English language by language experts. All transcriptions were imported into the NVIVO software. Coding was done by the PhD candidate. A research assistant who is also an expert at qualitative data analysis coded a few of the interviews and inter-coder agreements determined. From the codes, broader concepts were generated and themes emerged. Thematic framework analysis with initial inductive then deductive coding was used to analyse Objective 1, however a framework analysis with a priori themes and initial deductive, then inductive coding was used to analyse Objective 4.

2.7 Data Triangulation

Methodological and data triangulation approaches were employed in this research[23]. This was done in the integrative narrative in Chapter 7. Methodological triangulation of observational and interview-based determination of RMC experienced by women was done. Data triangulation of qualitative and quantitative data collected on different themes identified such as respectful maternity care, perceived women's rights during childbirth, facilitators, barriers and contextual factors of readiness for change to RMC practice was done. The integration of these different methodological and data triangulation approaches was done using a convergent and holistic triangulation method[24]. The convergent aspect sought to seek for agreements across different methods and sources of data collection methods, while the holistic approach then identified the unique perspectives contributed to the results by the different methodological and data triangulation approaches.

2.8. Ethics

Ethical clearance was obtained from the Human Research Ethics Committee of the University of the Witwatersrand, the Health Research and Ethics Committees of the Institute of Public Health, Obafemi Awolowo University, Ile-Ife, and the Oyo State Ministry of Health. (Appendix

2.11-2.13). The observational studies could challenge the need to ensure privacy and confidentiality that is advocated in RMC, hence clinical observers (registered nurses) were engaged and all observations were done with the full consent of participants. The research assistants were also re-trained on research ethics. The clinical observers were given a uniform and name tag from the research project for proper identification, and so they could appear like any other staff on duty to prevent further distress for the women. The health providers were informed of the purpose of the observation, and permission to observe their clients was obtained from the head of the labour wards.

In obtaining written informed consent, the details on the purpose of the study, how the results will be used, the duration of the interview, and their freedom to withdraw from the study were explained to all the respondents. (See Appendix 2.14-2.17 for samples of the informed consent forms used for each stage of the research). The informed consent forms were prepared in both the English and Yoruba languages. (the Yoruba language is the local dialect for the study location). The preferred language of the respondents was used for the qualitative study.

The quantitative data were stored digitally in a repository managed by the research electronic data capture (REDCap) administrators at Wits University and password protected on the researcher's computer. To protect their anonymity and confidentiality, names were not required during data collection. In the occurrence of physical abuse of the woman, the observers were instructed to calm down the provider and report it to the PhD candidate. If a life-threatening complication should arise such as excessive bleeding or intrapartum convulsions, the observers were instructed to stop the observation, and document the reason for same. However, this never occurred.

2.9. Funding Details

This research was funded by the Consortium for Advanced Research Training in Africa (CARTA) which is jointly led by the African Population and Health Research Centre (APHRC) in Nairobi and the University of the Witwatersrand, South Africa. CARTA is funded by the Carnegie Corporation of New York (Grant No--B8606.R02); SIDA (Grant No:54100029); the DELTAS Africa Initiative (Grant No:107768/Z/15/Z). The DELTAS Africa Initiative is an independent funding scheme of the African Academy of Sciences' Alliance for Accelerating Excellence in Science in Africa and is supported by the New Partnership for Africa's Development Planning and Coordinating Agency with funding from the Wellcome Trust (UK) and the UK government.

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CHAPTER THREE: A QUALITATIVE INQUIRY INTO PREGNANT WOMEN'S PERCEPTIONS OF RESPECTFUL MATERNITY CARE DURING CHILDBIRTH IN IBADAN METROPOLIS, NIGERIA

Journal information and publication status for paper 1

Journal	Sexual and Reproductive Health Matters
Manuscript ID	ZRHM-2021-0213
Manuscript type	Research article
Authors	Oluwaseun Taiwo Esan; Salome Maswime; Duane Blaauw
Corresponding author	Oluwaseun Taiwo Esan
Publication status	Published
Keywords	Respectful maternity care, perceptions, pregnant women, qualitative study, low resource settings, deviations, similarities, global norms, Respect, Women Cantered-Care
Citation	**Esan, O.T.,** Maswime, S. Blaauw, D. A qualitative inquiry into pregnant women's perceptions of respectful maternity care during childbirth in Ibadan Metropolis, Nigeria. Submitted to Sexual and Reproductive Health Matters. 2022. (Published) See Appendix 3.0 for the published manuscript
doi	10.1080/26410397.2022.2056977

Abstract

Background: Women's perceptions of respectful maternity care are critical to its definitions and measurements globally. We evaluated these in relation to globally defined respectful maternity care norms.

Methods: We conducted a descriptive study involving eight focus group discussions with 50 pregnant women attending antenatal clinics at one primary and secondary health facility each in the North-West and South-West local government areas of Ibadan Metropolis, Nigeria. One focus group each with primigravidas and multigravidas was held per facility. The 12 domains of respectful maternity care by Shakibazadeh served as the thematic framework for data analysis using NVivo 11 software. Ethical approvals were obtained from relevant authorities.

Results: The women's perceptions of respectful maternity care resonated well with seven of its domains, emphasising provider-client interpersonal relationships, preserving their dignity, effective communication, and non-abandonment of care but with mixed perceptions for two domains. However, their perceptions deviated for four domains namely maintaining privacy and confidentiality; ensuring continuous access to family support such as birth companions; obtaining informed consent; and respecting women's choices about mobility during labour, food and fluid intake, and birth position. The physical environment was not mentioned as contributing to a respectful maternity care experience.

Conclusion: Whilst the perceptions of the Nigerian women studied about respectful maternity care were similar to those accepted internationally, there were significant deviations which may be related to cultural differences and societal disparities. Different interpretations of respectful maternity care may influence women's demand for it in different settings and challenge strategies for promoting it as a universal standard of care.

Keywords: Respectful maternity care, perceptions, pregnant women, qualitative study, low resource settings, deviations, similarities, global norms, Respect, Women-Centred Care.

3.1. Background

Childbirth has been described as an intense psychological experience in a woman's lifetime that leaves her with vivid memories which may be positive or negative[1]. Women have described a positive childbirth experience as having control of their birth process and having trustful and supportive relationships during birth[2,3]. Being treated disrespectfully or over-medicalisation of the birth process may result in negative experiences[4]. Negative childbirth experiences may affect a woman's health and well-being long after childbirth, influencing the bonding period post-delivery and her future reproductive health decisions. Complications such as post-traumatic stress disorder have also been reported[5,6].

Respectful maternity care (RMC) received during childbirth can enhance a woman's positive experience. In addition to ensuring the clinical requirements of a safe childbirth process, the delivery of RMC helps to meet a woman's psychological and emotional childbirth needs. It is a rights-based approach to maternal care[7]. Emphasis has been placed on RMC as a global priority in the last decade because it contributes to the overall quality of childbirth care experienced, and may be the missing link in ensuring continuous health facility delivery[8]. Unfortunately, the basic rights underlying the global RMC norms may not be universally accepted. Local expectations of RMC may be lower due to cultural differences, low self-perception, and structural power imbalances[9]. These factors would negatively affect women's demand for RMC as currently defined.

There has been no agreed global definition of RMC because it is not simply the absence of mistreatment[10], and women's voices should contribute to defining it[11]. The World Health Organisation defines RMC as "care organised for and provided to all women in a manner that maintains their dignity, privacy and confidentiality, ensures freedom from harm and mistreatment, and enables informed choice and continuous support during labour and childbirth[12]. Shakibazadeh et al[13] defined the 12 domains of RMC from a qualitative evidence synthesis of 67 eligible papers from 32 countries, including 6 from sub-Saharan Africa. By exploring women's perceptions of RMC, this study thus contributes to its global definitions.

The current global norms around RMC should meet women's demands and expectations. They should be continuously reviewed as women's demands and expectations change and as women and girls continue to challenge the normalisation of their mistreatment during childbirth in healthcare settings. It is assumed that women's expectations of birth should be to receive respectful and dignified care that gives a positive birth experience and can be used to define RMC or improve its current definitions. Evaluating if this assumption is correct is important

for the conceptualisation and measurement of RMC as well as informing the demand for RMC in different settings. If women's expectations deviate negatively from respectful and dignified care, their claim of a positive childbirth experience may not have been optimal, and this also challenges their ability to define an RMC. This would be a challenge for policymakers and program implementers promoting RMC as the standard of care for all women during childbirth. Understanding the reasoning behind these deviations is also important.

Several studies have explored women's and providers' perceptions of disrespectful and abusive care[14]. Of recent, there has been a shift in the literature to rather focus on RMC as a broader more positive concept beyond the absence of mistreatment or disrespect. Women's perceptions and expectations of RMC during childbirth have been less studied, especially for women in low-resource settings such as Nigeria. Thus, this study investigated Nigerian pregnant women's perceptions about RMC, and how these relate to the globally defined RMC domains.

3.2. Methodology

3.2.1. Study design and setting

This was a cross-sectional exploratory qualitative study conducted in Ibadan's North-West and South-West local government areas (LGAs) within the Ibadan Metropolis, South-western Region, Nigeria. There are six public primary health care (PHC) facilities and one secondary health facility (SHF) offering maternal and child health services in the North-West LGA, while there are three public primary and three secondary health facilities in the South-West LGA. The SHFs facilities serve as referrals to the PHCs. The features of the LGAs determine the characteristics of pregnant women accessing the health facilities in each LGA. The South-West LGA is one of the LGAs with the largest slums (socially undesirable residential areas) in the Ibadan Metropolis[15], and the main occupation of the people is trading[16]. The North-West LGA is located in the centre of the city and is predominantly urban. The population were also traders, artisans and civil servants[17].

3.2.2. Sampling, study participants and recruitment

Two LGAs (Ibadan North-West and South-West) were selected purposively (one predominantly urban and one with more slums, though urban). One secondary and one primary health facility were selected in each of these two LGAs, giving a total of 4 health facilities. There was only one SHF in the North-West LGA but other primary and secondary health facilities were selected based on their relatively large volume of clients.

The study participants were pregnant women in their first or second trimester who were registered at these health facilities. They were selected by the research assistants with support

from the nursing staff who introduced the research assistants and explained the purpose of the research to them. Pregnant women, who were not in any form of distress, had completed their antenatal clinic (ANC) routines for the day and were willing to participate were recruited until predetermined quotas for primigravidae and multiparous women, respectively, were reached. Two Focus Group Discussions (FGDs) were conducted per facility, one with six multiparous women (women who have delivered before) and another with six primigravidae (women with their first pregnancy). This gave a total of eight FGDs. There were however seven participants in two of the FGDs. The FGDs were conducted the same day as recruitment. Pregnant women who were ill or in any form of discomfort were excluded.

3.2.3. FGD guide

The guide explored the women's perceptions of RMC and how these are commonly demonstrated during childbirth. Probing questions include, '*what do you understand by the word respect, and how should this be demonstrated by health providers when you come to deliver?* The FGD guide was translated into Yoruba and back-translated to English. The FGDs were conducted in English or Yoruba depending on the preferred language per group. Five FGD sessions were conducted in Yoruba. The FGD guide was pretested for length, adequacy and comprehensibility among separate groups of multiparous pregnant women and primigravidae recruited at the ANC of a primary health facility in Ile-Ife, a neighbouring town.

3.2.4. Data collection

Respondents' socio-demographic data obtained consisted of their age, level of education, occupation, number of pregnancies and deliveries, and their current gestational age. For the multiparous women, we asked if they had ever delivered in that facility, at home, in a church or mosque or in a Faith-Based Organisation (called Mission Homes).

The FGDs were conducted in a separate and secluded room away from the nurses and other staff within the facility, during one of their regular antenatal clinic days and after all health education activities had been concluded. The health providers introduced the research team to the women. The principal investigator is a Community Health Physician with expertise in conducting qualitative interviews and a deep understanding of the RMC concept. The FGDs lasted about 50 minutes on average. The researchers involved in the FGDs were all female, which helped to prevent gender and social desirability bias. Interesting responses were probed. All the FGDs were audio-recorded using a digital voice recorder.

3.2.5. Data management and analysis

The audio-recorded discussions were transcribed verbatim. The FGDs conducted in Yoruba were translated into English. Thematic content analysis[18] was done using the NVIVO 11 software. The transcribed FGDs were imported and initially coded using deductive coding guided by the 12 domains of RMC by Shakibazadeh et al[13] as the thematic framework used. Coding was primarily done by the principal investigator and also by a research assistant and compared with those of the Principal Investigator.

3.2.6. Ethics approval and consent to participate

Ethical approvals were obtained from the Human Research Ethics Committee (HREC) of the University of the Witwatersrand (clearance Number M190658), as well as the Oyo State Ministry of Health (Ref. Number AD/13/479/1386). Written informed consent for participating and recording of their voices was obtained from each participant. The researchers had no prior relationship with the pregnant women interviewed. They were introduced as researchers; details about their qualifications and positions were not disclosed to minimise a power imbalance that could coerce the women into participating. There were no inducements given before participation. A stipend of ₦500 (1.4 USD) was given for transportation.

3.3. Results

3.3.1. Description of the study participants

Six women participated in six of the groups and seven women in two groups to give a total of 50 women which consisted of 26 primigravidae (PG) and 24 multiparous (MP) (Table 3.1). The majority of the women were of the Yoruba ethnic group with only two who were Ibo and Hausa. Their ages ranged between 18 and 41 years. The multiparous women were older in both health facilities. Only 1 (2%) of the women did not have at least a secondary education. There were more artisans and traders among the primigravidae interviewed at the PHC facilities but more skilled professionals among those at the SHFs. A higher proportion of the multiparous women at the SHF's had previously delivered at the same facility while three at the PHC facilities had previously delivered at home or a faith-based organisation (Table 3.2).

Table 3.1: Socio-demographic characteristics of FGD participants

Socio-demographic characteristics	Primary Health Facility		Secondary Health Facility	
	Primigravida (n=14) Freq (%)	Multipara (n=12) Freq (%)	Primigravida (n=12) Freq (%)	Multipara (n=12) Freq (%)
Age (in years)				
18 – 24	9 (64.3)	0 (0.0)	2 (16.7)	0 (0.0)
25–35 years	4 (28.6)	9 (75.0)	10 (83.3)	7 (58.3)
>35 years	1 (7.1)	3 (25.0)	0 (0.0)	5 (41.7)
Age in years (median, IQR)	23.5 (20-29)	31 (29-36)	28 (26-31)	34 (33-37)
Highest level of Education				
Primary	1 (7.1)	0 (0.0)	0 (0.0)	0 (0.0)
Secondary	10 (71.4)	9 (75.0)	4 (33.3)	3 (25.0)
Tertiary	3 (21.4)	3 (25.0)	8 (66.7)	9 (75.0)
Marital status				
Single	3 (21.4)	0 (0.0)	0 (0.0)	0 (0.0)
Married	11 (78.6)	12 (100.0)	12 (100.0)	12 (100.0)
Occupation				
Student	0 (0.0)	0 (0.0)	0 (0.0)	1 (8.3)
Artisan (tailor, hairdresser, etc.)	8 (57.1)	4 (33.3)	2 (16.7)	1 (8.3)
Trading/ Business	4 (28.6)	4 (33.3)	3 (25.0)	7 (58.3)
Civil servant / Private employee	2 (14.3)	4 (33.3)	7 (58.3)	3 (25.0)

Table 3.2: Obstetric history of multiparous women

Birthing Facility History	**Primary Health Facilities (n=12)**	**Secondary Health Facility (n=12)**
Ever delivered at same facility		
Yes	9 (75.0)	11 (91.7)
No	3 (25.0)	1 (8.3)
Ever delivered at:		
Home	1 (8.3)	0
Church/Mosque/ TBA	2 (16.7)	0

3.3.2. Women's perceptions of RMC with similarities and deviations from the current RMC definition

The twelve domains of respectful maternity care (RMC) as defined by Shakibazadeh et al and how they compare with the study participant's perceptions of RMC are highlighted in Table 3.3.

Table 3.3: Relating the 12 domains of respectful maternity care with the women's perceptions

	Global 12 Domains	Domains' definitions from the literature	Relationship with women's perceptions
1	Being free from harm and mistreatment	Not using loud voice, have a warm and measured manner, give professional treatment	Similar to the norms A few normalised disrespect to women
2	Maintaining privacy and confidentiality	Privacy during examinations and procedures; shield from visitors, other women and men; limit number of attending staff; maintain secrets about their health	Perceptions significantly deviated from the norms. Only a few insisted on ensuring privacy
3	Preserving women's dignity	Positive labour ward atmosphere; make woman feel welcomed, kind attitudes'', calm, tactful, warm, smiling, caring, treat woman as an individual with preferences and differences, respect their cultures, values and beliefs.	Women's perceptions on RMC related mainly to ensuring this domain
4	Provision of information and getting informed consent	Provide information ask permissions before procedures, obtain consent	Agreed with provision of information. Obtaining consent was not always seen as necessary
5	Ensuring continuous access to family support	Have birth companions, physical structure should enable companions	Majority didn't see this as necessary
6	Enhancing quality of physical environment and resources	Provide comfortable, clean and calming birth environment; adequate beddings; regular water supply and electricity with medical & non-medical technologies	There were no RMC perceptions relating to this domain
7	Providing equitable maternal care	Availability of services regardless of age, ethnicity, sexuality and religion	Perceptions were similar to the norms
8	Engaging with effective communication	Give verbal praise and encouragement; provide emotional support; talking to & listening to the women; show empathy; practice effective non-verbal communication; provide interpreters	Perceptions were similar to the norms
9	Provision of efficient and effective care	Minimal delays/prompt attention; minimal interventions (episiotomy; vagina examination, urinary catheter)	Perceptions were similar to the norms
10	Availability of competent and motivated staff	Have adequate and proficient staff; competent and supportive supervision.	Perceptions were similar to the norms
11	Continuity of care	Cared for by familiar staff, available on demand with no abandonment	Perceptions were similar to the norms
12	Respecting women's choices that strengthens their capabilities to give birth	Respecting women's decision on birth positions, mobility during labour and fluid intake during labour.	Women's perceptions deviated from the norms for all the issues raised

We found that most of the women's perceptions of RMC, across the focus groups, mostly related to the domains defined as 'preserving woman's dignity'; 'engaging with effective communication'; and 'continuity of care'. The women's perceptions however deviated from the globally defined RMC norms for health providers' 'ensuring continuous family support'; 'maintaining privacy and confidentiality'; 'getting informed consent'; and 'respecting women's choices' on mobility during labour and birth position. The women made no mention of the "quality of the physical environment and resources" about RMC.

3.3.2.1. Being free from harm and mistreatment

The women's perception of respectful childbirth was one devoid of verbal abuse or being hit or slapped. This was common to all the groups. They denounced providers who shout at women in labour or are rude to them. They mentioned their disappointment with the sudden change in behaviour of providers who had been pleasant at the antenatal clinic but became hostile when they presented in labour. They deemed as unnecessary, providers who tell women, "*was I there when you were conceiving?*", thus blaming the woman for getting herself pregnant. They explained that this abuse of women prevents them from making their complaints known to the providers' for fear of being shouted at, and some not coming to the hospital when in labour.

> *"The manner in which some people will be harsh, you will regret ever going to the hospital" (Multipara, PHC)*

Professional treatment was categorised under the 'being free from harm and mistreatment' domain. The women described this as receiving proper attention and quality care resulting in a safe birth for both them and their baby.

> *"I believe they need to give that woman proper attention…. when you came to deliver, some people will be shouting when some will be bringing different attitude, so I think the health attendants they don't need to be shouting, 'why did you do this!?', they need to give us proper attention". (Multipara, SHF)*

For a few, receiving proper attention and quality care is what they are most concerned with. They would not mind if it was delivered to them under abusive conditions.

> *I will not mind if they abuse me, since I came to seek their assistance. What can prevent me from returning to the facility to deliver is if they don't take proper care of me and my baby. (Multipara, PHC)*

However, in four of the FGD sessions, they believed that women in labour would determine the extent of RMC they received. Two of the groups stated further that some women may deserve

to be beaten during childbirth. The women perceived to deserve being beaten include teenage mothers and those who have not cooperated well with the providers in opening their thighs for vaginal examination or delivery. The teenage mothers were referred to simply because they are teenagers and not because they had done anything wrong to deserve such. These perceptions were more from the FGDs with multiparous mothers who were much older. This deviates from global definitions which stipulate that all women deserve RMC. The statements below signify perceptions that normalise disrespect for some women.

"beat someone! (laughs), when one is not a child, but maybe those girls with unwanted pregnancy can be beaten". (Multipara, SHF)

"So, if there are some you cannot allow the baby to die, so if it's slapping you will have to slap the woman, that 'oya' you must open your thighs" (Multipara, PHC)

And when asked if the slapping of the woman was disrespectful, she replied by saying:

"It is not disrespect, that process is not disrespect". (Multipara, PHC)

3.3.2.2. Maintaining privacy and confidentiality

Ensuring privacy as an approach to providing RMC was a controversial issue across the focus groups. In six of the groups, most women believed that ensuring privacy by not unduly exposing their body parts during labour was not a necessity, especially in the presence of other women in labour and attending health professionals.

"There is nothing like privacy, when you are in labour, the woman will labour to a stage, the nurses will call the doctor to come, as in male doctor, is he not going to do his work and attend to the patient? So that doesn't have any meaning, and even at that time, nobody cares who is watching…" (Multipara, SHF).

There was also a health system perspective to ensuring privacy. All the women in one FGD group conducted at a secondary health facility chorused that privacy cannot be achieved at the public hospitals for women and the lack of this was not perceived as a lack of RMC. This was because of the unavailability of space and if a woman desired privacy, she should be ready to pay for it.

"if you want private, pay for private suite" (Primigravida, PHC)

Even though there were only a few arguing for privacy, they maintained their stance on the need to respect them and their body by ensuring privacy during labour. One of the women was content with covering her body with a wrapper if the screens were not available, while another would not mind going to pay exorbitant fees at private hospitals to ensure the privacy of her childbirth process. The women's idea of privacy was having a private room or private space with screens. The women did not describe privacy in terms of confidentiality.

3.3.2.3. Preserving women dignity

Overall, the women prioritised this RMC domain relating to dignity as the most important way providers should demonstrate respect during childbirth. The women's expectations were about health providers' being caring, showing them love, giving them time and attention, being cheerful with them, treating them as humans and not looking down on them. When probed on how providers' can treat a woman in labour as a human being, the response given was:

> *"This had happened to me before when I went to the clinic for treatment. The way the medical personnel reacted to me, it was like I do not exist. If a patient should arrive, and you, the first treatment is that you smile to the patient, and see her as a human being, she will be relaxed that I am in the right place" (Multipara, PHC).*

The women emphasised how they are received in the labour ward, and how this contributes to their respectful childbirth care experience. The manner of greeting, smiling and welcoming them helps to relax them and they believe it aids their labour process.

This domain includes the idea that health providers should respect women's cultural beliefs during labour. However, the women in the focus groups never mentioned respect for their cultural beliefs and values as part of the demonstration of RMC. This is probably because there are not many cultural differences between the providers and patients in the study setting, so it was taken for granted. However, many did express demands about meeting their spiritual needs. For example, in one of the FGDs, the women wanted their health providers to pray for them during labour as part of demonstrating RMC as shown in these quotes:

> *"prayers, they should speak blessings" (Primigravida, SHF)*
>
> *"they should be saying by God's grace, you will deliver safely, and the woman should be saying amen…amen…," (Primigravida, PHC)*

One aspect compromising the dignity of women is the common practice of detaining women after childbirth when they are unable to pay their childbirth services bill. The women's

perceptions relating to this were explored but they were divided on the issue. This was discussed in 6 of the FGDs, with two of them insisting that the woman needs to pay her hospital bills and that if she is detained at the facility it is no disrespect.

> *"It's a type of disrespect [detaining women for not paying their bills], but they [the health providers] have to receive their money too" (Primigravida, PHC).*

The other focus groups however were sympathetic to the plight of such women insisting that they should be pardoned or should benefit from a welfare purse that supports women with limited resources for childbirth fees and they should never be detained. We did not probe participants' understanding of national laws relating to detention for non-payment of childbirth fees.

3.3.2.4. Provision of information and getting informed consent

The majority of women in four of the FGD groups felt that obtaining informed consent was not necessary. They didn't see the need to question a provider's judgement on conducting a procedure on them but understood this as part of the provider's job. If this was because they trust providers, or because of established power imbalances between providers and women in labour, or because they do not want to be seen as uncooperative was not probed. A few didn't need information or consent, while most wanted information but thought that obtaining informed consent or permission was not always necessary, as shown in this quote.

> *"It's not like permission in a way, it's not like they need your permission, but they just want you to know that….so that you will cooperate. See I want to go through a procedure and you take your time to explain to me, yes, even if it's going to be painful, but because you've taken your time, and ehm, maybe they approach you and you are calm with me, it will prepare my mind ahead and then I will be able to cooperate with you. That is just my own kind of person"*
> *(Primigravida, SHF)*

Even for doing an episiotomy, women in two FGD groups felt there was no need for consent.

> *"They should do it now, whatever that is right" (Primigravida, SHF)*
>
> *"Ha! but they will stitch it back. I don't think one needs any permission"*
> *(Multipara, SHF)*

3.3.2.5. Ensuring continuous access to family support

The need to have a birth companion was only expressed by a few women in one of the FGDs, and not everyone in the FGD agreed with them. The majority of women across the FGDs did not identify being allowed to have a birth companion during labour as demonstrating RMC. Rather they even queried the role of the companion with comments such as these:

> *"There is no need for someone to stay with me, when all they do is just watch someone…. I don't think so oh, is she the one to hold my legs?"(Primigravida, PHC).*

> *"It's not compulsory for someone to be present in the labour room when it's not the person that will deliver the baby" (Primigravida, SHF).*

Some women dismissed health providers' encouragement of having a birth companion as "*spoiling the woman*", and were concerned that this would result in the woman being lazy and no longer cooperating with the health providers. They also felt it could be safer for some spouses not to be near a woman in labour. The quote below explains why.

> *"Apart from yiyo [being spoilt], because some women, we are like the way we talk or the way we behave to our husband at home. A woman was like 'I want to see my husband! I want to see my husband!' when the husband came, she just grabbed him and start cursing him during the labour. So because of such experiences, that is why they don't allow." (Primigravida, SHF).*

Others who encouraged their spouses to be present in the labour room wanted it to be brief, and their main motivation was for the spouses to appreciate the rigours of childbirth that they had to endure. All these ideas deviate from the global RMC norm of not barring women access to a birth companion of their choice if they so wish.

3.3.2.6. Engaging with effective communication

This domain was the second most commonly identified by study participants as part of RMC. The women wanted health providers to listen to them, show them empathy, give them words of encouragement such as, "you can do it", crack jokes with them, and try to make them happy. The women repeatedly expressed the desire that providers should show them, love. In response to a question on how providers can demonstrate love to a woman in labour, a respondent said:

> *"The way they talk with someone, and are cheerful towards one, saying things like 'come over here, let us examine you', and not say things like, 'why is your*

pant like this, why are you like this'? Many do not like them talking to them anyhow. But when they behave well towards her, she also will cooperate, she will be happy that next time, if I want to deliver, I will come back here, so to show love to us is good" (Multipara, PHC).

These requests show the women's need for emotional support from providers during labour. However, some women noted that uncooperative women and primigravidas should be given both love and a bit of harshness:

"They need to be harsh, at the same time, they need to show love. The reason why I said they need to be harsh is because most of us, how will I put it? "A maa n ke ara", [like to be indulged] they will say 'open your legs' some will be doing the way they like, so they need, at that point, they need to be harsh on us. At the same time, they will still pet us, so", "yes, small harsh, small love", "if there is love in their harshness, we will see it" (Multipara, SHF)

3.3.2.7. Provision of efficient and effective care

The women in the FGDs did not mention any contradictions to the global definitions for this domain. Their emphasis was on being attended to promptly on arrival. They also stated the consequences of not being attended to promptly as reported in this quote.

"I once lost a baby and this was very painful. I was coming from church and felt I was having labour pains. I branched at the health facility to tell them I am feeling labour pains. They just looked at me and said, "see the person who is in labour smiling" is it possible that the pregnant woman should just be shouting for no reason? Well I lost the baby and I have vowed that I will never go back there. There are no charms that they can give to make me go back there" (Multipara, PHC).

Effective pain management during labour was not mentioned by the women as a perceived component of RMC. However, the majority of the women in one FGD lamented the pains they experience during vaginal examinations and would prefer that this be reduced to a minimum. One participant even explained this as a reason for women presenting late in labour. They seemed not to know that they can refuse the procedure rather than presenting late in labour to avoid it. The quote below corroborates this.

"You see that insertion of fingers during vaginal examination? It is worse than delivering the child. This is because, when someone has delivered the baby, you

will now be passing through the pain of the vaginal examinations. Especially with all those nurses in training that are using you to learn their practice (laughs). In your life, you won't consider presenting too early. The best is you have labour pains and the child comes out the moment you get to the hospital". (Multipara, PHC).

3.3.2.8. Providing equitable maternal care

The women in my study agreed with equitable care being part of RMC during childbirth. The FGD respondents recounted provider discriminatory behaviours towards teenage mothers. They also reflected that women who were known to providers, such as friends, relatives or colleagues, would get better treatment than those without such connections. They further reported that some women 'buy' preferential treatment by giving larger tips to health providers. Some also commented on the need for equitable care irrespective of women's socioeconomic status (for example, those who present in labour without all the required delivery materials).

It's disrespect, you don't know anybody in the hospital, maybe you don't have money, you are not a kind of person that gives out something to them, the way they will treat you, you won't even like it. (Multipara, SHF).

Inequitable care based on ethnicity and religion was not prominent among the issues raised.

3.3.2.9. Continuity of care

The women's perceptions of RMC were often related to this domain, focusing mainly on neglect or abandonment of care. They described the abandonment of care during childbirth by providers as being common, especially by public health facility providers. One woman described it as the most important RMC issue to address.

"Hmm negligence of duty, in most general hospitals, negligence of duty is much. They will just abandon, even if someone is at the point of delivery, in some general hospitals, I am a civil servant, but within the same general hospital, you see them, negligence of duty is the most important thing they should work on" (Multipara, SHF).

3.3.2.10. Availability of competent and motivated staff

The perceptions of the participants on having competent and motivated staff to ensure RMC was not mentioned directly but could be inferred from some of the discussions. For example, they mentioned the heavy workload of health providers as a reason for their being disrespectful.

"Sometimes ehn, work load. Because WHO say one nurse to four patients. But when you see one nurse taking care of twenty patients, and the nurse is a human being with her own problems too and her own family issues too". (Primigravida, SHF)

They also stated the need for well-motivated staff and the government to ensure that salaries get paid and that staff are provided with the equipment needed to do their work. They stressed that a nurse who is paid performs differently from one who has not been paid.

A few believed that more competent staff would attempt vaginal deliveries rather than referring the woman for surgical deliveries even when there are indications for it.

"What I will like is for example a situation where the woman has been 'condemned' to delivery by operation, but we see some nurses with lots of experience of what one is passing through at that moment, and they come and help the woman to deliver by herself. So, such a situation where the nurse can help, one will be happy to come back again." (Multipara, PHC).

3.3.2.11. Respecting women's choices that strengthen their capabilities to give birth

The FGDs explored participants' perceptions about their intake of fluids or foods, mobility during labour, and choice of birth position. The majority of participants felt that all these decisions should be left to the health provider, and being denied their own choices or preferences did not constitute disrespect.

Not being allowed to walk around during labour was justified by most women, across the FGDs. They felt women need to conserve energy to push the baby out.

"I'm just saying that if you are fit to walk about and the nurses agree with you that you can, you can walk about. But if they say that it is not good for you for now, you just follow their instruction because that is their duty they know better, they know why" (Primigravida, SHF)

As for the choice of birth position, they felt that this is entirely the prerogative of the health provider. A few mentioned that the presenting part of the baby during delivery may not even allow for such a birth. They stated that anyone who desires an alternative birth position, besides lying on one's back with both knees bent, should rather go to a private hospital to deliver. Only one of the women was familiar with squatting to deliver or other alternative birth positions, and

she had booked at a private hospital alongside the public to ensure she got it if she eventually wants it during childbirth.

> *"They won't accept, I've not seen it happen, you will have to lie down to deliver your baby" (Multipara, SHF)*

Similarly, none of the women thought it was disrespectful to deny access to oral fluid or food during birth. The general response to this domain is captured in this quote:

> *"In my own opinion, the summary of it is cooperate with your health professional because they are the ones taking care of you and the success of your delivery, they are also a part" (means the providers are also interested in a successful delivery outcome) (Primigravida, SHF)*

3.3.2.12. Enhancing the quality of the physical environment and resources

There was no reference in any of the FGDs that related to this domain as part of RMC. The women were more interested in the actual service delivery than in the infrastructure when discussing respectful care during childbirth.

We further qualitatively analysed their perceptions as it relates to their parity and the type of health facility where the FGD participants belonged. More primigravidae would prefer their opinions be respected for the RMC domains regarding ensuring mobility during labour, obtaining informed consent, preserving their dignity, having access to family support and ensuring their privacy compared with the multips. The FGD participants at the primary health care facilities expressed most perceptions on ensuring continuity of care, being free from harm and mistreatment, provision of efficient and effective childbirth services and providing effective communication. Those at the SHFs expressed most of the perceptions about maintaining their privacy or not, providing equitable care, providers obtaining informed consent, and pregnant women's choices being respected as regards mobility during labour and their birth positions.

3.4. Discussion

This study explored the perceptions of women in Ibadan Metropolis, South-west, Nigeria about respectful maternity care (RMC) and evaluated how these corresponded with the 12 domains of RMC defined by Shakibazadeh et al[13]. The study participants' perceptions about RMC deviated for four of the defined RMC domains, namely: maintaining privacy and confidentiality; ensuring continuous access to family support; obtaining informed consent; and respecting women's choices about mobility during labour, food and fluid intake, and birth

position. The women's perceptions resonated well for seven of the RMC domains, though there were mixed perceptions for two of these seven domains. The physical environment domain was not mentioned as contributing to RMC.

3.4.1. RMC domains where women's perceptions deviated from globally defined norms

The study participants seemed more concerned with the outcome of their delivery than their privacy or comfort. From their perceptions, having a private cubicle or a private space during childbirth is a luxury, accessible at extra cost by registering at private hospitals, and was not a basic requirement for RMC in public hospitals. Being exposed during labour and not enjoying privacy has become a norm for them. This is unusual especially as the women may not be comfortable if unduly exposed elsewhere, outside the childbirth process. This normalisation of lack of privacy during childbirth has also persisted because the structural design of local health facilities does not allow for individual private space.

This finding differs from those of other studies, such as those from Abuja (Nigeria)[19], Guinea[20] and Mbale in Uganda[6], where women criticised the violation of their privacy resulting from hospital structural deficiencies. The lack of privacy did contribute to the negative childbirth experience for the respondents in those studies. One possible explanation for the different perceptions of women in this study may be that the FGDs were held with pregnant women whereas the other studies interviewed postnatal women. Pregnant women may be more anxious about the delivery and the well-being of their babies, and less concerned about issues such as privacy. Even though the women in my study did not feel that privacy and confidentiality were essential to RMC, these are established ethical and human rights principles[21], that should not be violated even if women don't demand them.

Health providers obtaining informed consent from women during childbirth is also a universally-accepted medical ethical principle and ensures that women maintain some control over their birth process[3]. It was surprising that the pregnant women in the FGDs I conducted seemed content with receiving information only, did not regard giving informed consent as essential, and trusted healthcare workers to make the right decisions for them. Their disinterest in granting informed consent may also be linked to not wanting to be perceived as a difficult or uncooperative patient, as these may have untold consequences such as abandonment of care or abuse. These perspectives are evidence of the entrenched power imbalance between health providers and clients, particularly in low-resource settings[22]. In contrast, Swedish women described their childbirth process as respectful when they were fully engaged and participated

in the decisions regarding their birth[2]. A study of post-partum women in Nigeria reported that many had not given consent for episiotomy during labour and they judged this as mistreatment[23].

Having a birth companion has been linked to better pain management, shorter births, lower levels of mistreatment of women during childbirth, more satisfaction during labour, and early breastfeeding initiation[24,25]. The World Health Organisation has emphasised that global efforts at reducing maternal morbidity and mortality should not end with increasing health facility delivery. Rather, women's preferences during childbirth must be known and supported, such as having a birth companion of their choice[26]. Despite these established benefits, my study participants across the groups did not consider allowing birth companions during labour an essential component of RMC, thus deviating from the global definitions. The implication of this is that women may not demand birth companions, and stand to lose the associated benefits.

Spousal participation during labour is low in Nigeria, attributed to low education levels, and cultural and religious beliefs that see labour as a woman's affair[27]. Poor male involvement during the pregnancy[28] may also explain why their presence during labour seemed unnecessary to the women in my study. Study participants who supported having a birth companion opted either for their mother or their spouse for that role. This is similar to the perceptions of women receiving ANC at a tertiary health facility in Ibadan, Nigeria[28]. In addition, the design of many facilities has no provision for private cubicles which prevents birth companions, either male or female in the labour room. If not addressed, these challenges may limit the implementation of this RMC domain in low-resource settings.

The study participants seemed largely unconcerned about their lack of birthing choices. Denial of food and fluid intake was not common in their experience. However, not being able to move around during labour and delivering in the lithotomy position are routinely enforced. But the women were used to these restrictions and accepted them as normal. Not only were they not aware of the advantages of alternative approaches, such as walking around during the active phase or squatting for delivery, but they viewed these suggestions as strange and even potentially dangerous. I did not probe if delivering using alternative birth positions was culturally acceptable or not, though to the best of my knowledge, there is no evidence to suggest that it is culturally unacceptable. This could be investigated in further research.

3.4.2. RMC domains that resonated well with the women's perceptions but with mixed feelings

The women's perceptions of RMC focused more on the interpersonal skills of healthcare providers than their medical or technical skills. Thus their interpretation of RMC mainly emphasised the preserving dignity domain and wanting to be treated as individual human beings. The women also desired more love and spiritual support from their providers, even requesting prayers. It has been found that one of the reasons women often visit traditional birth attendants (TBA) in Africa is because they pet, pamper and pray for them during labour[29]. This perception of the need for spiritual support for women during childbirth raises other ethical questions, considering the women and health providers alike may have different religious backgrounds and the ethical rights of both must be preserved. Health providers may need to incorporate the concept of 'demonstrating love' in form of compassion and emotional support to women in labour as recommended in the literature[30]. The use of professional doulas as birth companions in health facilities may also be encouraged as these are known to provide physical, emotional (love) and spiritual support to women during birth[31].

The mixed perception in this RMC domain is that a few of the women suggested some form of abuse is acceptable for uncooperative women. This supports the contention that disrespectful and abusive care for women in labour has been normalised[32]. This is a deviation from what an RMC stands for. This is similar to the findings among women who recently delivered and their family members in Ethiopia[33]. Women who had described the abuse of women during antenatal care and delivery as normal behaviour by health providers in government-owned facilities in Nigeria also defended the providers saying those were not intentioned[34]. The normalisation of disrespect by providers and clients alike are critical targets to eradicate through interventions promoting RMC[35].

3.4.3. RMC domains that resonated well with the women's perceptions without exceptions

The continuity of care and effective care domains were strongly supported as critical to the participant's perception of RMC during childbirth. Not being attended to promptly and being abandoned during labour were linked to serious negative outcomes such as loss of the baby or maternal complications. Such consequences would dominate any other considerations of RMC, and would probably result in women not returning to the same health facility for delivery in future, or even avoiding institutional delivery completely[36].

The women in the FGDs I conducted assumed that staff who were not paid well would not be motivated to provide RMC. In a systematic review of disrespect and abuse of women during childbirth in Nigeria, the de-motivation of health workers was attributed to their being understaffed, overworked, poorly remunerated and lacking training on improving quality of care [37]. The FGD participants felt that governments should ensure healthcare workers are paid well and on time to improve their motivation and performance. The role of the providers to ensure that they are competent at what they do, and be intrinsically motivated to provide RMC was however not mentioned by the women.

Ensuring the equitable provision of maternal care is a global health priority for the attainment of Sustainable Development Goal 3[38], but my respondents provided examples of how poorer women in Ibadan received less RMC. The health system should ensure RMC for all women, irrespective of their socio-economic status or demographic characteristics. The costs associated with childbirth, even in the public sector, are not inconsiderable, and the out-of-pocket expenses are not affordable for many women, further worsening inequities. In a recent study, only 10% of 524 pregnant women studied in Lagos had health insurance[39], and 52% of reproductive-aged women in Nigeria had problems accessing health care for themselves, with 46% of these having challenges with getting money for treatment[40]. Hence, there is a need to ensure better financial protection for pregnant women.

The vulnerable group's social health insurance program in Nigeria was meant to cater for pregnant women, however, many have described its gains as poor[41]. Some states in Nigeria provide free maternity care services but poor communication affects uptake[41]. Other maternity health care financing options may include compulsory or voluntary contributory schemes for women in the reproductive age group. Paid maternity leave is also an essential component of a social protection package given to women working in formal settings only. Women could also receive social grants or state subsidies during pregnancy[42], in the form of cash or vouchers, to ensure their financial access to essential healthcare and to cover additional costs associated with caring for themselves and their baby.

3.4.4. RMC domains that were missing from the women's perceptions

The women did not mention the health facility's physical environment, such as having constant electricity, adequate and safe water, or good toilet facilities, as components of RMC. This is contrary to the perceptions of women in Guinea who listed poor physical conditions contributing to mistreatment[20]. This may be because specific questions on these were not asked, rather their perceptions of RMC were related to the RMC domains by Shakibazadeh et al[13].

This implies that the facility's physical environment is not a priority for them. They may also have normalised and accepted the current state of the facilities, either good or bad.

The management of pain during labour is not a separate domain in the Shakibazadeh et al[13] framework but is an important part of providing effective care in RMC. For example, the World Health Organisation has emphasised that proper pain management is crucial for ensuring a positive childbirth experience for women[12]. Pain relief was not mentioned by FGD participants as necessary for the delivery of RMC during childbirth. The reason for this could be that the women saw pain as a natural part of the childbirth process, and not being able to endure pain is interpreted as a sign of weakness[43]. Probably, the women did not imagine childbirth without pain, and so did not identify this as part of RMC.

3.5. Strengths and Limitations of the Study

The study was limited in its spread having been conducted in one geographical region in the country. A more holistic perspective from women across several educational and ethnocultural backgrounds may be needed. The awareness of the health providers' presence within the facility may have influenced the respondents' responses. To ameliorate this, the study was conducted in a separate and secluded room away from possible interference from the providers. Studying pre-pregnant women or women post-pregnancy may have yielded different results. We chose to study pregnant women because we assumed they would have had more reflections on their expected childbirth experiences compared to pre-pregnant women. Women who have recently delivered should be considered as the study population in future research.

This study portends a potential inequity in childbirth experiences across different cultural settings as some strive to attain an RMC while others do not. The findings of this study have implications for the overall quality of care women receive during childbirth and the capacity of the women to define RMC and demand for it during institutional deliveries. The findings also imply that the extent of RMC received during childbirth will be dependent on the woman's interpretations and expectations of RMC. Measurement of RMC received cannot be compared accurately across different settings until women have the right orientation and expectation of an RMC that they should receive during childbirth, and these should not contradict global standards.

3.6. Conclusions and Recommendations

Respectful Maternity Care is a fundamental right of women during childbirth that should be universally accessible to all irrespective of their cultural setting. Pregnant women are critical stakeholders in the implementation of RMC. Their expectations and perceptions about RMC

should inform its definitions. However, when their perceptions do not align with the current globally defined basic RMC standards, it could challenge an effective implementation process. Nigerian women's perceptions of RMC in this study deviated significantly from globally defined norms. Their definitions of RMC may exclude granting of privacy, labour companions, obtaining informed consent, and would include the demonstration of love, trusting health providers solely for decisions on their birth position and mobility during labour. This suggests that local interpretations of RMC are influenced by cultural practices and societal norms in different settings. Additional research exploring how and to what extent these influence the women's interpretations of RMC is required considering various contexts. Quantitative research to measure their perceptions of RMC on a larger scale across settings is also needed.

Nevertheless, pregnant women's human rights, represented by the emerging norms of RMC, need to always be upheld by health providers. These include the right to dignity, privacy, choice, informed consent, and not being mistreated, even though some women believe that violations of some of these are sometimes acceptable. We should promote a nurturing and caring RMC environment in maternity units as this builds trust between patients and healthcare workers. In many low-resource settings, birthing facilities need to be better designed to protect women's privacy and dignity, and support RMC. A strengthened health system with well-remunerated, competent and motivated staff is critical to meeting women's expectations of an RMC during childbirth. A respected health provider, whose needs have been met by the employers should be willing to give the best care and respect to their clients. There is also clearly still much that needs to be done in low- and middle-income countries to inform women about their rights, empower them in their relationships with healthcare providers, and educate them about RMC.

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CHAPTER FOUR: DIRECTLY OBSERVED AND REPORTED RESPECTFUL MATERNITY CARE RECEIVED DURING CHILDBIRTH IN PUBLIC HEALTH FACILITIES, IBADAN METROPOLIS, NIGERIA

Journal information and publication status for paper 2

Journal	PLoS One
Manuscript ID	PONE-D-22-13904
Manuscript type	Research article
Authors	Oluwaseun Taiwo Esan; Salome Maswime; Duane Blaauw
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Publication status	Under Peer-review
Keywords	Respectful maternity care, mistreatment, disrespectful and abusive care, observation, postpartum interview, methodologies, low and middle-income countries

Abstract

Background: Respectful maternity care (RMC) should improve women's childbirth experience and increase health facility delivery. There have been calls for more observational studies assessing RMC. We assessed RMC received by women through observation and self-reporting at postpartum, as well as socio-demographic factors associated with observed RMC.

Methods: This was a cross-sectional study conducted in nine public health facilities in Ibadan, a large Metropolis in Nigeria, selected via two-stage cluster sampling. Observation of 269 women during childbirth was done by external clinical observers using the 29-item Maternal and Child Health Integrated Program RMC observational checklist. The same women observed during childbirth were interviewed postpartum using the 15-item RMC scale for self-reported RMC. We analysed total RMC scores and RMC sub-category scores for each tool. All scores were converted to a percentage of the maximum possible score to facilitate comparison. The correlation between the observed and reported RMC scores was evaluated using Pearson's correlation. Multiple linear regression was used to identify factors associated with observed RMC.

Results: No woman received 100% of the observed RMC items. Higher self-reported RMC scores were weakly correlated with the observed scores (rho=0.164, p=0.007). The lowest scoring sub-categories of observed RMC were information and consent (14%) and privacy (28%). Equitable care was the highest sub-category for both observed and reported RMC. Women's employment status and the de birthing facility were significantly associated with receiving higher observed RMC.

Conclusion: Women reported higher levels of RMC than was observed. Women's birthing facility characteristics influenced the observed RMC received more than their personal characteristics. More standardisation and consensus are required to determine an appropriate cut-off to evaluate the proportion of women receiving RMC.

Keywords: Respectful maternity care, observation, post-partum interview, definition, measurement, childbirth, the experience of maternal care.

4.1. Background

Sub-Saharan Africa with a maternal mortality ratio (MMR) of 542/100,000 live births accounted for two-thirds of global maternal deaths in 2017[1]. Skilled birth attendance (SBA) could reduce maternal deaths by 13-33%[2]. However, only 59% of deliveries in sub-Saharan Africa were attended by skilled birth attendants between 2009 to 2018[3]. Nigeria had the 4th highest MMR in Africa in 2017, based on modelled estimates[4]. Nigeria's MMR for women aged 15-49 years was 512/100,000 live births (95%CI: 447-578) between 2012 and 2018, with a lifetime risk of maternal death of 1 in 34 before the age of 50[5]. Only 39.4% of Nigerian women delivered at a health facility between 2013 and 2018, and this indicator decreased to only 11.6% amongst women in the lowest wealth quintile[5]. For Africa to attain the Sustainable Development Goal (SDG) 3 target of reducing MMR to below 70/100,000 live births, it will require significant improvements in maternal health in Nigeria, one of the largest countries in the region.

Negative health worker attitudes expressed as mistreatment during childbirth are a known deterrent to health facility delivery[6]. A high global burden of women's mistreatment during childbirth has been reported, particularly in low- and middle-income countries, (LMICs)[6]. The burden of mistreatment during childbirth in Nigeria ranged between 11% to 71% of pregnant women in a review of published papers between 2004 and 2015[7]. Respectful maternity care (RMC) has been proposed as a strategy aimed to give women a positive childbirth experience. The World Health Organisation (WHO) had declared it as the standard of care for all women[8]. Unfortunately, receipt of RMC is still seen as a luxury, with few women in LMICs currently accessing it[9], despite the global efforts, research and interventions to promote RMC[10,11].

Respectful maternity care during childbirth is care without physical or verbal abuse, delivered with dignity and respect for women's preferences, providing adequate information and obtaining consent before procedures[12,13]. It is also equitable care delivered regardless of the women's personal characteristics by competent and motivated staff who are available when needed, who do not neglect their clients, and who communicate effectively without language barriers. It entails the provision of quality and effective professional treatment in a comfortable, clean and calming environment that ensures privacy and continuous access to birth companions. In delivering RMC, the women's choices for mobility during labour, intake of fluids or oral foods and alternative birth position are respected[13].

It is necessary to measure to what extent RMC is being received, who receives it, and which components are received, in order to support the planning of RMC-promoting interventions.

This raises the challenge of how to measure RMC[14]. Client or provider interviews are most often reported in the literature[15–18]. However, there have been calls recommending a mixed-method approach, with independent observations, to measure RMC[11,19,20]. To the best of my knowledge, there is only one previous RMC observational study from Nigeria, conducted in three secondary health facilities across two states[21,22]. My study measured RMC received during childbirth using observation and structured interviews across two levels of healthcare delivery and evaluated the factors associated with observed RMC received.

4.2. Methods

4.2.1. Study design and setting

This was a cross-sectional study in design conducted from November 1, 2019, to March 31, 2020. We observed women during childbirth and interviewed the same women ≥12 hours postpartum to evaluate the RMC received during childbirth. The study was conducted in public health facilities across the five local government areas (LGAs) in Ibadan Metropolis. Ibadan is the third largest city in Nigeria and the seventh in Africa[23] The LGAs include the Ibadan North, North-East, North-West, South-East and South-West.

4.2.2. Sampling technique and sample size

This was a two-stage sampling technique. Primary and secondary health facilities across the five LGAs with more than one delivery/month were extracted from the state health information system. This gave a sampling frame of 6 secondary and 26 primary health facilities that met the criterion. One primary and one secondary health facility were selected from each LGA by simple random sampling, except the South-East which doesn't have a secondary facility, giving a total of nine health facilities.

The required sample size of 258 was calculated using the one sample test of proportion in Stata[24] based on a reference proportion of 81% of women who received RMC during childbirth in Ile-Ife, Nigeria through client interview[25]. with a monthly average pf city to the study setting with a population sharing similar characteristics. Other parameters used were a ±10% difference around the reference proportion, (71% to 91%), 90% power and a design effect of 2[26]. The number of women required per facility was allocated proportionately to the monthly average of deliveries in the previous year. However, with a monthly average of 295 deliveries across the nine selected health facilities in the previous year, all consenting women arriving in labour at any time of the day during the observation period were observed. (See Appendix 4.1 for the average monthly deliveries across the selected study health facilities, the number o bserved and interviewed at pospartum)

4.2.3. Recruitment

A research assistant recruited booked pregnant women in their third trimester of pregnancy who were attending the antenatal clinic (ANC) at each of the study facilities. The research assistant did this by visiting each study facility a month before the scheduled data collection period at the facility. Written informed consent was obtained for both the observational and interview components of the study. A tag with the name of the project was attached to the consenting woman's hospital file at the ANC. This was done to avoid obtaining consent from the women while in labour, as they may be more vulnerable at this time[27]. However, the observers also obtained consent from un-booked women presenting in labour. Un-booked women were included to ascertain the effect of booking status on their childbirth experience.

4.2.4. Observation of RMC received during childbirth

Three hundred and twenty-two 322 (97%) women were observed over 5 months (November 1, 2019 - March 31st, 2020) using the adapted MCHIP RMC standard checklist by Jhpiego[28], 29 items describing 7 categories of mistreatment based on the Bowser and Hills criteria[29]. The observed RMC sub-categories are presented in Table 4.1. The variables 'welcomed/greeted the woman' and obtained consent/permission were added to the information and consent sub-category to make 11 items. The 7th sub-category 'assessing the facility's policy on illegal detention of women unable to pay the bills' was dropped as it could not be evaluated during the observation period.

Two groups of three recently qualified registered nurses (as research assistants) conducted the observations as external observers, over 12-hour shifts in low-volume health facilities and 8-hour shifts in high-volume facilities. A high-volume health facility was one with a daily average of at least four deliveries per day or one delivery per shift. Only one high-volume health facility was included in the study. The observers covered two health facilities concurrently in a month, working continuously for 24 hours each day over five months.

Observation of childbirth was commenced for consented women admitted into the labour room at any stage of labour until they were transferred out of the labour room irrespective of the childbirth outcome. The first of two women arriving at the same time in labour was observed. Observation of care delivered was obtained by the type of attending health provider category/type, irrespective of the number of attending health providers by type. Therefore, if three nurses attended to the woman while in labour, only one observational checklist is completed for the nurse professional category. Where a positive and negative observation is obtained for an item on the checklist for attending providers in the same professional category,

the negative observation was recorded. This is because the negative experience could have consequences and should be addressed. A maximum of two attending provider professionals would usually attend to the woman while in labour at both the primary and secondary health facilities. Women admitted for elective Caesarean sections were excluded from the study.

4.2.5. Postpartum interview

A postpartum interview was successfully conducted on 269 of the 322 women observed. Others not interviewed were referred out or withdrew participation. The observed woman was given a study number, that was tagged on her labour room file, and included in the postpartum data to enable linking of the observation and interview data sets. The interviews were conducted from 12 hours postpartum in the same health facility by two postgraduate students in Public Health using a 15-item RMC tool with responses on a 5-point Likert scale of agreement[30]. The sub-categories for the reported RMC 15-item tool are also presented in Table 4.1. The related sub-categories in the observed and reported RMC tools are placed side-by-side, having the same serial numbers. Two of the observed RMC sub-categories were not captured in the reported RMC tool.

Table 4.1: Breakdown of sub-categories for the observed and reported RMC tools.

S/n	Observed RMC sub-categories	Items	S/n	Reported RMC sub-categories	Items
1	Dignified and respectful care	3	1	Friendly care	7
2	Protection from physical harm	6	2	Abuse free care	3
3	Non-abandonment/ neglect	3	3	Timely care	3
4	Equitable care	2	4	Non-discriminatory care	2
5	Care in privacy and confidentiality*	4			
6	Information and informed consent*	11			
	Overall observed RMC tool	**29**		**Overall reported RMC tool**	**15**

The asterisked sub-categories had no related sub-category in the reported RMC tool

Additional information obtained included the women's socio-demographic and obstetric profiles, as well as the maternal and foetal outcomes of the index pregnancy. The postpartum interviewer-administered questionnaire was translated to the local language (Yoruba) and back-translated into English to aid the interviewers. It was administered in the Yoruba language to the majority of the women. All the instruments were pre-tested at a primary and secondary health facility in Ile-Ife, a neighbouring city to the study location. Both the observed and postpartum data were captured electronically using the REDCap software[31]. The PhD candidate supervised the data collection process and monitored the uploaded data daily for correctness and accuracy.

4.2.6. Data analysis

The data were cleaned and analysed using Stata v15. The Stata 'svy' commands were used to adjust for clustering and weighting the data against the proportion of deliveries in each facility in the year preceding the study. The weighting factor was created as the ratio of the proportion of deliveries per facility in the total population to the proportion of deliveries per facility in the sampled population. The observation and interview data sets were merged, but the results presented are confined to the 269 women both observed and interviewed.

For the observation tool, each item was scored 1 for a positive response and 0 if negative, for a maximum score of 29. Observations of care by multiple attending health providers must be positive from all attendants for the woman to be said to have received the observed item. For the interview tool, the Likert responses were entered on a numerical scale from 1 to 5.

All RMC scores were converted to a percentage of the maximum possible score to facilitate comparison, for each sub-category and the total scales. The percentage scores for observed RMC were calculated by finding the average of the summation of all the items per sub-category and the overall items in the checklist. For reported RMC, the mean score was calculated for each category and converted to percentage scores using the formula:

$\frac{mean-1}{4} \times 100$ [‡].

Although these RMC tools have been widely used, there is no consensus in the literature on the cut-off to be used to define which women received RMC, either by observation or when self-reported. We would presume that for a woman to be said to have received RMC, there should be no deficiencies for any of the items. That is, she must have received 100% of the items on the RMC observational checklist or at least agreed with receiving each item in the interview tool.[†] However, none of the women in this study achieved either of those. Hence, the receipt of RMC was considered on a continuous scale using the percent scores for both the observational and interview data.

The relationship between the observed and reported RMC percent scores were assessed using Pearson's correlation statistic. Factors associated with observed and reported RMC received were assessed using simple and multiple linear regression analysis. Predictors with a p-value of

[‡] That is, of course, because the means of the entered Likert responses range from 1 to 5. The calculated percentage scores then range from 0% to 100%, as expected.

[†] Although not exactly equivalent, that could be related to a mean score above 75%, using the converted percentage scores.

≤0.2 in bivariate analyses were added to the final multiple regression model. Only the results for observed RMC are reported here, but the findings for reported RMC are provided in Suppl.1.

4.2.7. Ethical issues

Ethical approvals were obtained from the Human Research and Ethics Committees of the University of the Witwatersrand, Johannesburg (M190658), and the Oyo State Ministry of Health (AD/13/479/1386). We ensured that the selected observers had never worked nor trained at the study health facilities. With regular training, we reiterated the need for the observers to separate their perceptions of women abuse from the study and to remain objective. Observers were rotated between the two health facilities studied each month. The identity of the individual health facilities has been anonymised in the reporting of results. The odd-numbered health facilities represent the primary health facilities, while the even-numbered represent the secondary health facilities. Consecutive facilities belong to the same LGA.

4.3. Results

4.3.1. Women's socio-demographic and obstetric profile

Table 4.2 presents the unweighted and weighted socio-demographic profiles of the 269 women who were both observed and interviewed postpartum. A higher proportion of the women 170 (63.9%) were aged between 25 to 35 years, with an overall mean age of 28.7 ± 5.7 years. The majority of them had formal education. Almost all the women (92.3%) were employed at the time of the study. The facility characteristics are also shown in Table 4.2. A higher proportion of the women 189 (70.2%) were recruited from secondary health facilities. The highest proportion of women was from Ibadan North LGA (47.1%) and facility 2, 112 (41.7%).

Table 4.3 shows the weighted obstetric and labour history of the study participants. A higher proportion of the women 157 (58.7%) were multiparous, and about 50% of them had previously delivered in the same study health facility. However, one-fifth of them 33 (20.9%) did not deliver in a health facility for their previous birth. Nonetheless, 204 (92.5%) of the women had booked at a health facility for their index pregnancy. Only 32 (11.9%) of them were familiar with any of the health providers at the study facilities, though 13 (41.4%) of these were close family relationships. A higher proportion of the women presented during the daytime in labour 164 (60.9%) and at term 217 (81.3%), but 55 (20.4%) presented late in labour with >8cm dilatation. Uncomplicated childbirth was the more common outcome for 230 (86.8%), and 257 (97.2%) had a live birth (97.2%). Figure 4.1. shows the complications experienced. The most common complication experienced was prolonged labour, followed by obstructed labour as reported by the women during the postpartum interview. They either used the exact terms the

health providers told them or they described these using their own words. The majority of the women stated that they would return to the health facility for a possible future delivery 222 (83.8%), and 243 (92.7%) would refer others to the health facility for delivery.

Table 4.2: Women's socio-demographic profile and delivery site characteristics (n=269)

	Unweighted		Weighted	
Socio-demographic variables	**Freq.**	**%**	**Freq.**	**%**
Age in years				
Youths (18–24 years)	62	23.3	60	22.4
Adults (25 – 35 years)	167	62.8	170	63.9
Adults (>35 years)	37	13.9	36	13.7
Mean±SD; median(IQR)	28.6 ±5.8; 28 (25, 33)		28.7 ± 5.7; 28 (25, 33)	
Highest level of education completed				
No formal education	5	1.9	5	1.7
Primary	28	10.4	27	10.0
Secondary	120	44.8	118	44.0
Post-secondary	115	42.9	119	45.0
Employment status				
Employed	249	92.6	248	92.3
Unemployed	20	7.4	21	7.7
Personal Income (US $)				
≤$1.90/day/month (World bank poverty level)	191	74.6	189	73.6
>$1.90/day/month	65	25.4	68	26.4
Mean±SD; median(IQR)	50.1 ±62.3; 39.5 (15.8, 61.8)		50.9 ± 63.6; 39.5 (15.8, 61.8)	
Ethnicity				
Yoruba	252	93.7	251	93.5
Ibo	17	6.3	18	6.5
Delivery facility type				
Primary health facility	87	32.3	80	29.8
Secondary health facility	182	67.7	189	70.2
LGA				
Ibadan North	139	51.7	127	47.1
Ibadan North East	21	7.8	24	8.8
Ibadan North West	37	13.7	38	14.2
Ibadan South East	33	12.3	30	11.2
Ibadan South West	39	14.5	50	18.7
Delivery health facility				
Facility 1	16	6.0	15	5.4
Facility 2	123	45.7	112	41.7
Facility 3	11	4.0	11	4.1
Facility 4	10	3.7	13	4.8
Facility 5	21	7.8	19	7.1
Facility 6	16	6.0	19	7.1
Facility 7	6	2.3	5	2.0
Facility 8	33	12.3	45	16.6
Facility 9	33	12.3	30	11.2

₦380=1US $

Table 4.3: Women's characteristics in labour and obstetric history reported at post-partum (n= 269)

Variables	Freq. (n)	(%)
Obstetric history		
Parity		
Primiparous	111	41.3
Multiparous	157	58.7
Total pregnancies ever had (multips) (Mean ± SD)	2.2 ± 1.2	
Total number of previous live births ever had (multips) (Mean ± SD)	1.8 ± 1.0	
Had previously delivered in the study health facility (multips)		
Yes	79	50.5
No	78	49.5
Mean number of times ever delivered in the focal study facility	1.6 ± 0.5	
Place of delivery for last births (multips)		
Health facility	124	79.1
Non-health facility	33	20.9
Current pregnancy		
Booking status in the current pregnancy		
Booked	204	92.5
Un-booked	16	7.5
Familiarity with providers at the delivery site		
Familiar	32	11.9
Not familiar	237	88.1
Level of familiarity		
Family relations	13	41.4
Non-family relations	19	58.6
Time of presentation in labour		
7:00 am. – 18:59pm (Daytime)	164	60.9
19:00pm – 6:59am (Night/midnight)	105	39.1
Gestational age in labour (weeks)		
Pre-term (<37 weeks)	36	13.6
Term (37 - 40 weeks)	217	81.3
After term/ late term (>40 weeks)	14	5.1
Cervical dilatation at presentation		
<8cm dilated (first stage of labour)	214	79.6
8cm -10cm	55	20.4
No of attending provider		
1 provider	215	80.0
2 providers	54	20.0
Attending providers during childbirth		
Doctor/ Nurse	44	16.2
Nurse/ CHW	4	1.4
CHW/ Health Auxiliary	6	2.4
Nurse only	149	55.3
Community Health Worker only	62	23.3
Health Auxiliary (HA) only	4	1.4
The maternal outcome of the current delivery process		
Complicated delivery	35	13.2
Uncomplicated delivery	230	86.8
The foetal outcome of the current childbirth process		
Live birth	257	97.2
Stillbirth	7	2.8

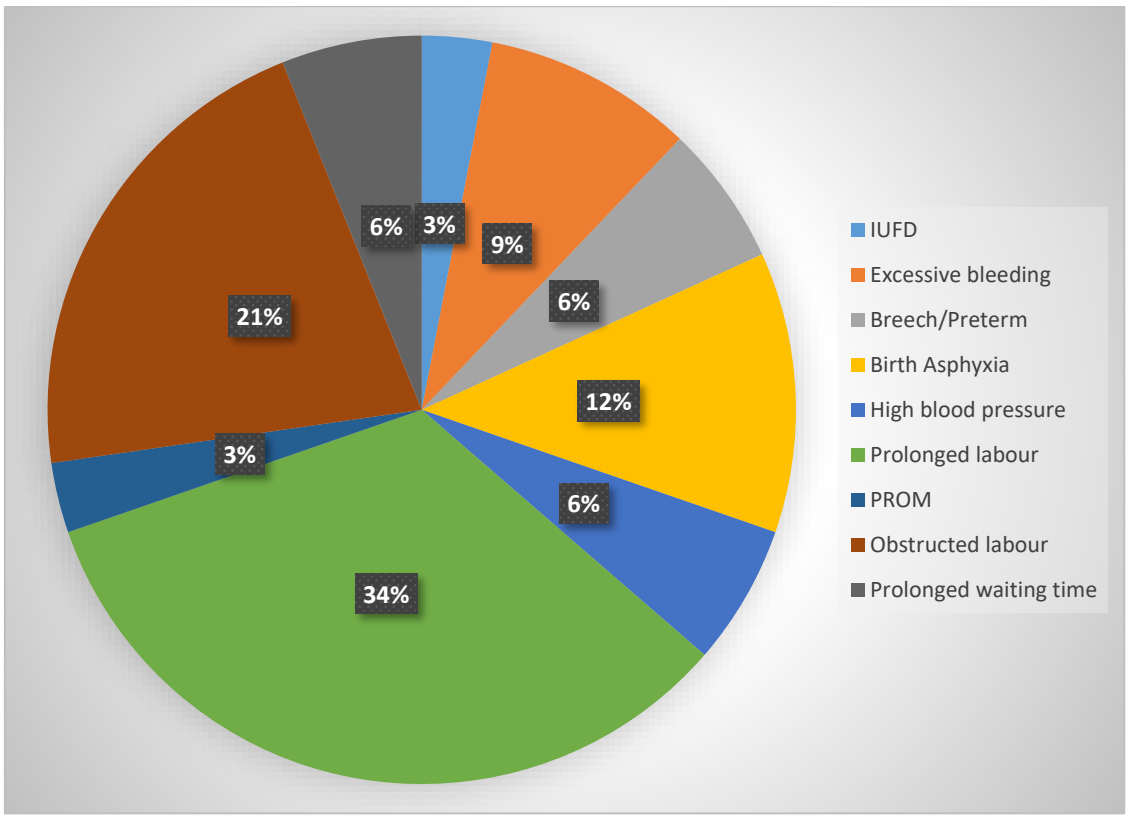


Figure 4.1: Reported causes of birth complications

4.3.2. Observed and reported RMC received

Table 4.4. shows the number and proportion of women who received each of the 29 items in the observational checklist. The mean percent scores for each of the observed RMC sub-categories are shown below the items for each sub-category, and the overall percentage for the entire scale is given at the bottom of the table.

The RMC sub-category with the lowest mean percentage score was the *information and informed consent* sub-category, where the women were observed to receive an average of only 14.0% of the 11 RMC items (Table 4.4). Although 89 (33.2%) were given information about procedures, only 11 (4.0%) were always asked for consent before the procedures were undertaken. In only one case (0.3%) was the provider observed to introduce themselves or encourage the woman to ask questions, and only 5 (1.9%) were allowed to assume the birth position of their choice.

The next weakest RMC sub-category was *privacy and confidentiality* with a mean percent score of 28.2%. Only 4 (1.4%) of the women were properly screened during examinations, though 219 (89.2%) did not have their personal and medical details discussed openly.

The average score for the *being protected from physical harm* sub-category was 60.1% across the 6 items where 246 (92.5%) were never physically restrained and 224 (83.3% were not separated from their babies unnecessarily. However, 28% (95%CI: 65% -76%) of women were observed to be slapped or hit during labour, and only 22 (8.2%; 95%CI: 5% - 8%) received pain relief.

Non-discriminatory care was the highest sub-category of RMC received, with a mean of 90.3% for the two items. Here, 259 (96.1%) of women were spoken to in a language they could understand and 227 (84.4%) were not observed to be disrespected based on their attributes.

Overall, the women were observed to receive an average of 38.2% of the 29 RMC items on the scale. Only 41 (15.2%) of the women received 50% or more of the 29 items in the observational checklist, while no woman received more than 60% of the RMC items.

Table 4.4: Observed RMC items and categories received by women during childbirth (n=269)

	Observed RMC received during labour and childbirth	Freq.	%
	A. Women's right to information and informed consent (Autonomy)		
1	Welcomed/ greeted on presentation in labour	38	14.0
2	Provider(s) introduced themselves to woman (and her companion)	1	0.3
3	Companions encouraged to remain with woman for as long as possible	22	8.2
4	Encouraged the woman to ask questions	1	0.3
5	If asked, responded with promptness, politeness and truthfulness	116	43.1
6	Explained what was being done and what to expect in labour and birth	29	10.8
7	Gives periodic updates on status and progress of labour	87	32.5
8	Allowed women to move about during labour	13	4.9
9	Allowed to assume the birth position of choice	5	1.9
10	Provided with information before conducting procedures	89	33.2
11	Consent or permissions obtained from women before procedures	11	4.0
	Mean (SD) of information & consent received (max:100%)	**14.0 ± 12.3 SD**	
	B. Woman protected from physical harm and ill-treatment		
1	Was never slapped, hit (nor attempted) during labour	194	72.0
2	Was never physically restrained	246	91.5
3	Was touched and caring demonstrated in a culturally appropriate way	67	25.0
4	Was never separated from her baby except medically necessary	224	83.3
5	Was not denied food or fluid in labour unless medically necessitated	217	80.7
6	Was given pain relief and provided comfort as necessary	22	8.2
	Mean (SD) of no physical harm received (max:100%)	**60.1± 20.5 SD**	
	C. Privacy and confidentiality protected		
1	Her file was kept in a locked cabinet and not displayed carelessly	7	2.7
2	Was protected with curtains during all examinations	4	1.4
3	Appropriate drapes or coverings were used to protect her privacy	74	27.5
4	Her personal and medical details were never discussed openly	219	81.2
	Mean (SD) of privacy &confidentiality received (max:100%)	**28.2 ± 16.1 SD**	
	D. Woman is treated with dignity and respect		
1	Woman and/or companion was/were spoken to politely	175	65.0
2	Woman and/or companions allowed to observe their cultural and religious practices	86	31.9
3	Woman and/or companion were never insulted, intimidated, threatened, nor coerced	169	63.0
	Mean (SD) of dignity & respect received (max:100%)	**53.3 ± 30.5 SD**	
	E. Receives equitable care free from discrimination sub-category		
1	Spoken to in a language and at a language level that she understands	259	96.1
2	Not disrespected based on any specific personal attribute of hers	227	84.4
	Mean (SD) of non-discriminatory care received (max:100%)	**90.3 ± 23.9 SD**	
	F. Woman never left without care (Non-neglect of care)		
1	Was encouraged to call providers if needed	28	10.4
2	Provider(s) come quickly when woman calls	171	63.5
3	Was never left unattended to	177	65.0
	Mean (SD) of non-abandonment of care received (max:100%)	**46.6 ± 33.7 SD**	
	Received 50% or more of the 29 items in the MCHIP RMC checklist	**41**	**15.2**
	Received 100% of the 29 items in the MCHIP RMC checklist	**0**	**0.0**
	Mean (SD) Observed RMC percent scores received (max:100%)	**38.2 ± 12.1 SD**	

The results for RMC reported in the post-partum interview are presented in Table 4.5. The table shows the number and proportion of women who agreed or strongly agreed with each of the 15 items on the checklist together with the mean score for each item, calculated as a percentage of the maximum possible score. The mean percent scores for each of the reported RMC sub-categories are shown below the items, and the overall percentage for the entire scale is given at the bottom of the table.

Table 4.5: Reported perceptions of RMC received during childbirth from postpartum interview

S/n	Reported perceptions of RMC received	Freq. (%) agreed/ strongly agreed	Percentage of a maximum score Mean ± SD
A	**Friendly care**		
1	Approached kindly by health care providers (nice and ready to help)	251 (93.4)	78.9 ± 19.1
2	Healthcare workers were friendly (pleasant) in their treatment	253 (94.1)	78.1 ± 18.4
3	Healthcare providers encouraged me positively about pain and its relief.	251 (93.4)	78.4 ± 17.6
4	Healthcare providers were concerned and empathetic	251 (93.4)	77.7 ± 19.4
5	Was respected as an individual (treated like a human being)	246 (91.4)	76.0 ± 21.0
6	Was communicated with in an understanding language	264 (98.3)	81.0 ± 14.5
7	Was addressed by name (not say things like, "eh that woman")	216 (80.4)	67.1 ± 31.2
	Mean (SD) percent score of friendly care sub-category	**76.7 ± 14.9 SD**	
B	**Abuse-free care**		
1	Health needs were responded to appropriately and professionally	251 (93.4)	76.9 ± 20.9
2	Was never hit (pinched, slapped, punched, beat) during labour	234 (87.0)	78.7 ± 29.5
3	Was never yelled at for not obeying provider instructions	224 (83.1)	74.7 ± 32.2
	Mean (SD) percent score of abuse free care sub-category	**76.8 ± 20.9 SD**	
C	**Timely care**		
1	Was given prompt service and never neglected during labour	251 (93.2)	81.9 ± 26.0
2	Was free to practice safe cultural & religious traditions during labour	237 (88.1)	79.9 ± 27.7
3	Problems like many patients never delayed providers' service to clients	257 (95.6)	84.6 ± 22.8
	Mean (SD) percent score of timely care sub-category	**82.1 ± 17.2 SD**	
D	**Non-discriminatory care**		
1	Was never mistreated because of clients' personal characteristics	262 (97.4)	89.5 ± 17.6
2	Clients' companions were never offended due personal characteristics	251 (93.3)	86.1 ± 21.9
	Mean (SD) percent score of non-discriminatory care	**87.3 ± 17.0 SD**	
	Agreed to have received 50% or more of the 15-item RMC scale	**264**	**98.0**
	Agreed to have received 100% of the 15-item RMC scale	**5**	**2.0**
	Mean ± SD score of RMC reported	**79.2 ± 11. 7 SD**	

A high proportion of women agreed that they had received each of the 15 RMC items – the figure was above 90% for most items, and none was below 80% (Table 4.5). The mean scores for each item, expressed as a percentage of the maximum possible score, were slightly lower but most were above 75%. The lowest scoring RMC item was being addressed by name where only 80.4% of women agreed to receive it, for a mean percent score of 67.1%.

The mean percent scores for each sub-category were correspondingly high, ranging from 76.7% for *friendly care* and 76.8% for *abuse-free care,* 82.1% for *timely care* and 87.3 for *non-discriminatory care.*

Overall, the mean percent score for all 15 items was 79.2%. Although almost all of the women (98%) agreed that they had received at least 50% of the reported RMC items, only 5 (2.0%) reported receiving all of the items.

4.3.3. Relationship between observed and reported RMC received at childbirth

There was no agreement between the reported RMC scores and the observed RMC scores from the different tools. The reported RMC scores were significantly higher than the observed RMC scores for most women. However, there was a weak but significant positive correlation between the reported and observed RMC scores (rho=0.164, p=0.007) as shown in Figure 4.2.

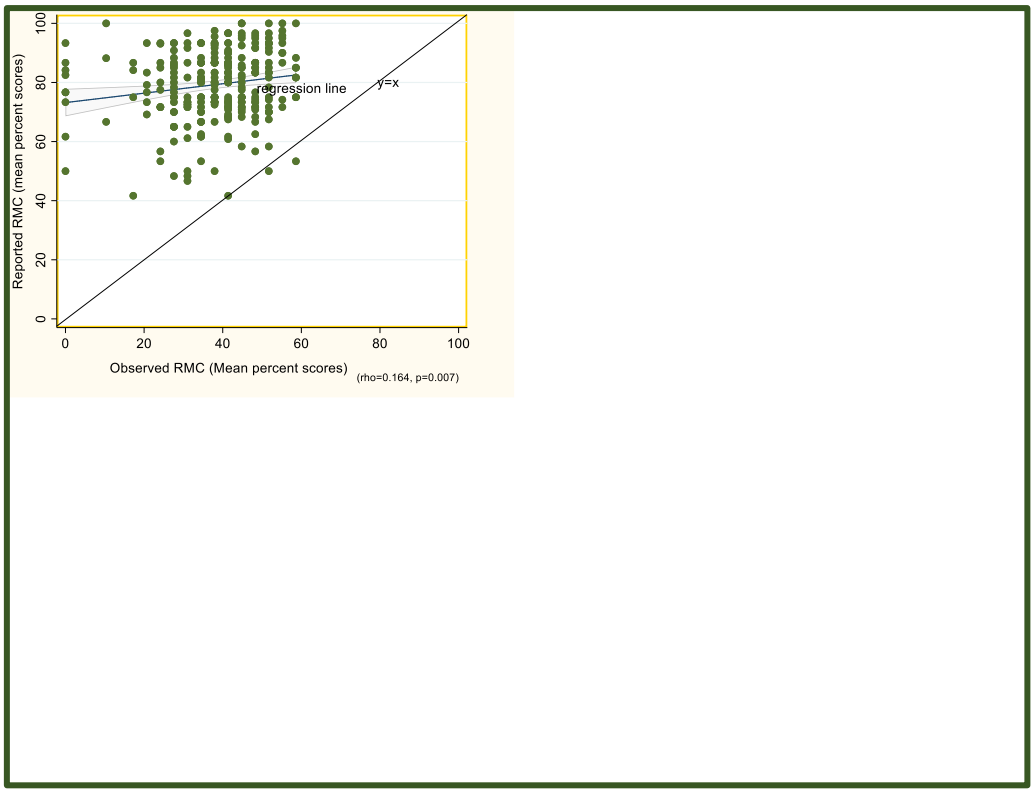


Figure 4.2: Correlation between observed and reported RMC received

4.3.4. Factors associated with the level of observed RMC

Table 4.6 presents the single and multiple regression analysis of the factors associated with the observed RMC score. The available covariates included were the women's personal characteristics, obstetric history, and facility attributes.

Table 4.6: Factors associated with observed RMC received during childbirth

Covariates	Bivariate Analysis			Multiple Regression Analysis		
	Crude Coeff.	95%CI	p-value	Adjusted Coeff.	95%CI	p-value
Age in years						
Youths (17–24 years)	-3.0	-6.3 - 0.3	0.070	-0.8	-4.8 – 3.1	0.637
Adults (25 – 35 years)	Ref	-	-	Ref	-	-
Adults (>35 years)	-1.8	-10.7 – 7.0	0.638	-3.0	-7.9 – 1.9	0.196
Education completed						
No Formal education	Ref	-	-	Ref	-	-
Primary	-4.2	-9.4 - 0.9	0.195	-1.8	-7.8 – 4.2	0.497
Secondary	1.4	-1.0 - 3.8	0.205	1.7	-3.8 – 7.1	0.493
Post-secondary	3.3	-2.1 - 8.7	0.197	4.8	-0.9 – 10.5	0.086
Employment status						
Employed	5.6	-1.530 – 12.8	0.105	4.4	1.4 – 7.3	**0.010**
Not employed	Ref	-	-	Ref	-	-
Income (usd)	0.02	0.004 – 0.026	**0.014**	-0.01	-0.02 – 0.01	0.237
Ethnicity						
Yoruba	-1.8	-8.1 – 4.4	0.510			
Ibo	Ref	-	-			
Delivery health facility						
Facility 1	Ref	-	-	Ref	-	-
Facility 2	11.2	11.2 -11.2	**<0.001**	11.3	10.4 – 12.3	**<0.001**
Facility 3	4.9	4.9 – 4.9	**<0.001**	9.4	6.3 – 12.6	**<0.001**
Facility 4	14.4	14.4 – 14.4	**<0.001**	19.2	15.8 – 22.7	**<0.001**
Facility 5	10.6	10.6 – 10.6	**<0.001**	10.6	9.2 – 11.9	**<0.001**
Facility 6	14.9	14.9 – 14.9	**<0.001**	15.002	13.9 -16.1	**<0.001**
Facility 7	6.4	6.4 – 6.4	**<0.001**	4.6	3.2 – 5.9	**<0.001**
Facility 8	6.4	6.4 – 6.4	**<0.001**	6.7	5.2 – 8.2	**<0.001**
Facility 9	8.3	8.3 – 8.3	**<0.001**	7.6	5.9 – 9.3	**<0.001**
***Facility type**						
Primary	Ref	-	-			
Secondary	3.9	-1.5– 9.4	0.130			
Attending provider						
1 provider	10.4	-1.2 – 22.0	0.071	12.5	3.3 – 21.7	**0.015**
2 providers	Ref	-	-	Ref	-	-
Provider Familiarity						
Yes	3.0	-0.6 – 8.6	0.080	3.3	-0.4 – 7.0	0.076
No	Ref	-	-	Ref	-	-
Parity						
Primipara	Ref	-	-			
Multipara	1.5	-1.4 – 4.4	0.251			
Booking status						
Booked	2.0	-10.4– 14.4	0.713			
Un-booked	Ref	-	-			
Presenting time-labour						
7:00am–18:59pm (DT)	Ref	-	-			
19:00pm– 6:59am (NT)	-0.3	-5.7 – 5.1	0.906			
Constant				12.2	3.0– 21.5	**0.017**
				n=253; R^2= 0.2342; p<0.001		

Significant p values in bold. DT- daytime, NT- Night time. Dropped because of multicollinearity

Employment status was the only socio-demographic characteristic significantly associated with the observed RMC. The score for employed women was 4.4 percentage points higher than for those that were unemployed, (p=0.010). RMC scores did increase with higher levels of education but this was not statistically significant. Women who were attended to by only one category of health provider had significantly higher RMC percentage scores than those attended to by two categories of health providers, (p=0.015). There were also significant differences in the observed RMC at different health facilities compared to the reference facility.

4.4. Discussion

This study measured the level of respectful maternity care received during childbirth using both observation and postpartum interviews and evaluated if any differences in the observed RMC could be attributed to characteristics of the women or delivery facility. By observation, the level of RMC received was low, with an average score of only 38.2% for the observational checklist. No woman was observed to have received 100% of the RMC checklist. However, the interview tool produced much higher levels of reported RMC – the women scored 79.2% of the maximum possible for the self-reported RMC checklist. The observed and reported RMC were positively correlated but only weakly. Employed women were observed to receive significantly more RMC than those that were unemployed, and the level of RMC was noted to vary significantly between individual study health facilities.

4.4.1. Defining the receipt of RMC- a methodological challenge

Also, although the observation and self-reported tools have been widely used to measure RMC, there is no consensus on the benchmark to be used to define who received RMC or not, for either tool[20,32]. Hence, I did not characterise which women received RMC based on a defined cut-off. Different studies in the literature have used varying cut-offs to determine who received RMC, although the rationales for doing so are not always clearly stated. Some studies reported less than the total number of items in the Maternal and Child Health Integrated Program (MCHIP) RMC observational checklist to assess the level of RMC received[33,34]. Others described the proportion who received each item[35,36]. One study observed women during childbirth using all the items on the MCHIP tool but defined women who received RMC as those who received at least the mean score for each of the 7 sub-categories[37]. Overall, a woman who received RMC must have received all the sub-categories of RMC. For the 15-item RMC scale, most studies dichotomised the 5-Likert scale into agreed and disagreed responses to assess the items of RMC received[17,38]. Some transformed the total scores to 100[18], others further defined who received RMC from the mean percent scores[39]. One study determined the self-reported RMC mean scores received and categorised them into very low and very high[16].

I started with the premise that the receipt of RMC is an absolute rather than a relative construct. And that, rather than comparing to some arbitrary cut-off, it should properly be considered as an all or none concept. So that all of the defined components of RMC have to be achieved before women could be said to have received RMC. For example, I would not consider a woman to have received RMC if she received most of the individual RMC items or sub-categories, but was physically beaten during labour. However, none of the women in my study came close to achieving that standard (receiving all items assessed), so I had to resort to measuring the level of RMC on a continuous scale. That metric then reflects progress toward RMC rather than achieving it, which may be necessary given the current levels of RMC in most LMICs.

Another issue I considered in this study on measuring RMC received is the appropriate weighting to be used for different RMC items or sub-categories, and who should determine them. I used the equal weighting of items usually assumed for the existing observation and interview tools but was concerned that some RMC dimensions should perhaps be afforded more importance in evaluating the receipt of RMC (physical harm, for example), and that the relative importance of different RMC sub-categories did not necessarily match the number of items included in the tools for each sub-category.

4.4.2. Levels of the observed and reported RMC in the study site

There was a very poor performance in the observed RMC scores received in my study. The observed RMC mean percent scores (38.2% of 29 items), however, there are no directly similar studies to compare my findings with. The only study that observed the women using all the items on the MCHIP checklist did not determine their overall mean RMC scores received. They however reported that a very low proportion of women, (12.6%) received RMC. This was defined by receiving the mean score or more for each of the 7-sub-categories assessed. The low proportion of women observed to have received RMC and the extent of RMC received is worrisome and describes the level of mistreatment women receive during childbirth in Ibadan.

The mean self-reported RMC scores received among the women studied (79.0%) were higher than the moderate degree (56.0%) reported by postpartum women at a tertiary health facility in Egypt. However, a higher proportion of the women studied in Egypt were in the middle socioeconomic class while 75.0% of ours earned <$1.9/day. This could imply some normalisation of abuse among the women in my study with lower economic power, and with high levels of satisfaction with the care they receive, despite the observed mistreatment and denial of women's fundamental human rights during childbirth.

The best RMC sub-category, received by most women in my study for both observed and reported RMC, was related to equitable/non-discriminatory care. Almost all the 404 women observed (97.0%) during childbirth at public hospitals in the Benishangul Gumuz region in Ethiopia also received non-discriminatory care[40]. Privacy during childbirth was not guaranteed if delivered at the study health facilities. This is corroborated by a previous observational study in four countries that found that privacy measures such as the use of curtains to screen for procedures during childbirth were seldom available in Nigeria[21]. In my study, some women (33.2%) were informed adequately before procedures were conducted and only 4.0% were observed to be properly asked for their consent. This was also similar to the findings in the Ethiopian study earlier described as only 17.5% of the women had their consent obtained before procedures during the observation of their birth[40].

Not obtaining the women's consent denies them the right to autonomy and decision-making, while not protecting their privacy shows a lack of respect for their person. Gaining women's consent is a legal and ethical issue[41]. Valid consent is only obtained when women have been adequately informed of the risks and benefits of procedures during childbirth[41]. Unfortunately, there has always been the challenge of how much information to give[41,42], and the real or perceived safety concerns if consent is not granted during childbirth, for example for episiotomy. The health providers have a responsibility to protect the unborn child without abusing women's rights. This calls for more discussion with health providers about ensuring women's rights to autonomy while yet preserving the safety of the unborn child.

4.4.3. Comparison of observed and reported RMC scores

Another methodological difficulty in measuring RMC is that significantly different results are obtained depending on which method is used. There were higher mean RMC scores reported to have been received (79.2%) than observed (38.2). The gap would be even larger if the proportion of women who agreed or strongly agreed to have received RMC by self-report was used rather than the percent scores as we did in this study. This difference was also noted in the proportion receiving comparable sub-categories in both the observed and reported RMC tools (Table 4.1). For example, the average for the no physical harm sub-category was 60.1% from observation, but 76.8% when reported by women themselves as abuse-free care. The items are not the same in the two tools but this could again suggest some normalisation of mistreatment by the women in the study. This disparity in the observed and self-reported prevalence of disrespectful care was also found pre- and post- an RMC-promoting intervention study in

Tanzania. The prevalence of disrespectful care during childbirth at baseline was 69.8% versus 9.9% and 32.9% versus 7.6% by observation and self-report respectively[43].

Several studies had called for more observational studies to assess the receipt of RMC during childbirth despite the known limitations of such methods, which include the possible Hawthorne effect and high cost[12,16]. Observational studies may be preferred because the events are being measured as they occur and the measurements are more objective, as long as the Hawthorne effect can be controlled. However, social desirability bias may affect the validity of self-reported postpartum interviews when conducted within and without the health facilities[20], and recall biases may interfere when interviews are conducted later in women's homes. Irrespective of the location of the interview, measurement of RMC may be compromised by the halo effect of a successful birth or because women don't clearly understand their rights, leading to under-reporting of mistreatment. Whichever methods are used, the various limitations must always be considered when interpreting the results of RMC evaluations[44].

Although there was no agreement in the absolute levels of RMC recorded in the observational and interview tools in my study, the two measures were correlated and may adequately reflect relative RMC levels. Despite this correlation found, neither of the tools may be used as a proxy for each other, for example using the RMC scale as a proxy when observational studies are not feasible. The wide disparity in the findings, which is consistent with other findings in the literature suggests that the two methods- observational and postpartum interviews are not comparable. Further research may be needed to investigate and bridge the disparity in the gaps.

4.4.4. Factors associated with observed RMC received

The women's personal characteristics had limited influence on the extent of observed RMC received during childbirth besides being gainfully employed. However, their delivery site characteristics and the number of attending providers significantly did. The time women presented in labour (if daytime) and living in an urban area were also the only personal characteristics that influenced the receipt of RMC amongst women studied in the Benishangul Gumuz region in Ethiopia[40]. This shows that the health systems context, that is the setting where birthing services are offered plays a more significant role in the delivery of RMC than the women's characteristics influencing what they receive. This finding also corroborates the high scores in non-discriminatory care received as reported in this study.

4.5. Conclusion

Independent observers found low levels of RMC during childbirth for the women in my study from Ibadan, Nigeria. However, the women themselves reported higher levels of RMC. The

study findings highlight some important methodological issues for the measurement of RMC in LMICs, including the comparability of different methods, the cut-offs to be used in defining the receipt of RMC, and the appropriate weighting of tool items. Self-reported RMC measures are widely used in the literature but may over-report the level of RMC received because of social-desirability bias and the normalisation of abuse and mistreatment in many LMIC settings. I identified problems with certain aspects of delivering RMC during childbirth in the study facilities which include providing adequate information, always obtaining consent before procedures, privacy during examinations, and allowing women to choose alternative birth positions. Health providers did score better in providing non-discriminatory care. This was confirmed by the lack of significant socio-demographic differentials in the multiple regression analysis, although employed women did appear to get more respectful care in my study. RMC delivery also varied between the different study facilities which requires further investigation to support more universal RMC implementation.

4.6. Strengths and Limitations of the Study

My study used two methodologies with separate instruments for the same women revealing the strength and weaknesses of one over the other. I captured practices from both the primary and secondary health facilities, presenting a diversity of contexts. The use of registered nurses as observers with an understanding of the clinical processes was a strength but required extensive training to ensure that their pre-conceptions would not influence their observations.

There are a few study limitations. The likelihood of a Hawthorne effect was mitigated by staying for a relatively long period in each facility (1 month) so that providers got used to the presence of the observers. We used the commonly-used RMC tools for observation and interviews but these do have some limitations. The reported RMC instrument did not capture critical components in the global definitions of RMC which include respect for women's autonomy, and privacy with confidentiality. This hampered the full comparison of both tools. A number of the women observed could not be interviewed because they were referred out and could not be traced at the referral facility. The final sample size for analysis limited the estimable effect size for some comparisons. Lastly, the study excluded public tertiary health facilities and private hospitals which may limit the generalisation of study findings to Ibadan land, and the South-Western region of Nigeria with similar population characteristics as in Ibadan.

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Supplement 1: Multiple regression analysis of factors associated with reported RMC received at birth

	Simple Linear Regression Analysis			Multiple Regression Analysis		
	Crude Coeff.	**p-value**	**LL – UL 95%CI**	**Adjusted Coeff.**	**p-value**	**LL – UL 95%CI**
Age in years						
Youths (17–24 years)	-0.354	0.851	-4.642 - 3.934			
Adults (25 – 35 years)	Ref	-	-			
Adults (>35 years)	0.858	0.676	-3.798 – 5.513			
Education completed						
No Formal education	Ref	-	-	Ref	-	-
Primary	3.003	0.532	-7.813 – 13.819	3.529	0.549	-9.730 – 16.787
Secondary	4.830	0.255	-4.372 - 14.033	5.034	0.372	-7.459 – 17.526
Post-secondary	5.519	0.160	-2.782 - 13.821	4.135	0.452	-8.144 – 16.413
Employment status						
Employed	1.415	0.754	-11.701 – 8.871			
Not employed	Ref	-	-			
Income (usd)	0.004	0.601	-0.012 – 0.020			
Ethnicity						
Yoruba	4.761	0.104	-1.273 – 10.795	3.402	0.050	0.001 – 6.804
Ibo	Ref	-	-	-	-	-
Delivery health facility						
Facility 1	Ref	-	-	Ref	-	-
Facility 2	8.708	<0.001	8.708 – 8.708	8.481	**<0.001**	7.981 – 8.980
Facility 3	-5.066	<0.001	-5.066 – -5.066	-5.063	**<0.001**	-7.230 – -2.897
Facility 4	5.313	<0.001	5.313 – 5.313	4.898	**0.001**	-4.614 – 5.183
Facility 5	-1.394	<0.001	-1.394 – -1.394	-1.418	**0.067**	-2.965 – 0.128
Facility 6	6.875	<0.001	6.875 – 6.875	6.951	**<0.001**	6.575 – 7.327
Facility 7	-0.521	<0.001	-0.521 – -0.521	-1.137	**0.907**	4.094 – 6.917
Facility 8	4.277	<0.001	4.277 – 4.277	4.089	**<0.001**	3.819 – 4.358
Facility 9	5.186	<0.001	5.186 – 5.186	5.506	**<0.001**	-2.806 – 2.532
Facility type						
Primary	Ref	-	-			
Secondary	6.358	0.038	0.480 – 12.237			
Attending provider						
1 provider	-0.530	0.844	-6.655 – 5.595			
2 providers	Ref	-	-			
Provider Familiarity						
Yes	3.614	**0.025**	0.595 – 6.634	2.888	0.015	0.758 – 5.019
No	Ref	-	-	Ref	-	-
Parity						
Primipara	Ref	-				
Multipara	-0.311	0.840	-3.833 – 3.211			
Booking status						
Booked	-0.997	0.617	-5.507 – 3.512			
Un-booked	Ref	-	-			
Presenting time-labour						
7:00am–18:59pm (DT)	Ref	-	-			
19:00pm– 6:59am (NT)	-1.318	0.549	-6.266 – 3.630			
Constant				66.045	<0.001	52.593 – 74.496

CHAPTER FIVE: ORGANISATIONAL AND INDIVIDUAL READINESS FOR CHANGE TO RESPECTFUL MATERNITY CARE PRACTICE AND ASSOCIATED FACTORS IN IBADAN, NIGERIA: A CROSS-SECTIONAL STUDY

Journal information and publication status for paper 3

Journal	BMJ Open
Manuscript ID	bmjopen-2022-065517
Manuscript type	Research article
Authors	Oluwaseun Taiwo Esan; Salome Maswime; Duane Blaauw
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Publication status	Under Peer-review
Keywords	Organisational readiness, individual readiness, readiness for implementing change, respectful maternity care, implementation, change valence, women's rights, informational assessments, change commitment, change efficacy

Abstract

Background: Respectful maternity care (RMC) is underpinned by a human rights approach to maternal health. RMC should be the standard of care for all women but realising that will require a change process in many healthcare facilities. Organisational readiness for change is the collective resolve to implement a change, while individual readiness is members' confidence to manage it. Organisational and individual readiness for change are precursors to successful programme implementation. However, there are no previous studies evaluating readiness for change to RMC practice.

Methods: An analytical cross-sectional study of 212 health providers selected via two-stage cluster sampling was conducted in nine public health facilities in Ibadan, Nigeria. We use a structured questionnaire with standardised instruments adapted from the literature. The organisational readiness for change to RMC (ORC_{RMC}) and individual readiness for change (IRC_{RMC}) scales, as well as other metrics, were scored out of a maximum of 5. We evaluated previously identified predictors of readiness for change including change valence, informational assessments on resource adequacy, self-core evaluation and job satisfaction. Additional proposed predictors were providers' socio-demographic and workplace characteristics, as well as their awareness of mistreatment during childbirth, and perceptions of women's rights and resource availability to implement the change to RMC. Data were adjusted for clustering and analysed using Stata 15. Multiple linear regression was used to identify factors influencing IRC_{RMC} and ORC_{RMC}.

Results: The providers' mean age was 44.0±9.9 with 15.4±9.9 years of work experience. They scored high on awareness of women's mistreatment (3.9±0.5) and women's perceived rights during childbirth (3.9±0.5). They had high ORC_{RMC} (4.1±0.9) and IRC_{RMC} (4.2±0.6). These measures were weakly but positively correlated (*rho*=0.407, p<0.001). Providers also had high change valence (4.5±0.8) but lower perceptions of resource availability (2.7±0.7) and adequacy for implementation (3.3±0.7). Higher provider change valence and informational assessments significantly increased both IRC_{RMC} and ORC_{RMC}. Longer years of work experience (p=0.024), providers' monthly income (p=0.021) and the health facility of practice significantly influenced ORC_{RMC}.

Conclusion: The health providers in the study valued a change to RMC and believed that both they and their facilities were ready for the change to RMC practice.

Contributions to the literature

Organisational and individual readiness for change assessment is relevant in the respectful maternity care literature. High readiness for change to RMC was found amongst maternity care providers.

My findings support existing literature on the positive influence of change valence (value for the change) and informational assessments (perceived resource adequacy) on organisational readiness for change, and also provided evidence on their influence on individual readiness for change to RMC.

Programs targeted at improving providers' perceptions of women's rights during childbirth may help eliminate some forms of mistreatment of women.

5.1. Background

Respectful maternity care has been defined as "*care organised for and provided to all women in a manner that maintains their dignity, privacy and confidentiality, ensures freedom from harm and mistreatment, and enables informed choice and continuous support during labour and childbirth*" (page 3)[1]. It is a human rights approach to maternity care[2] and is recommended as the standard for all women[3]. Several RMC-promoting interventions have been implemented and have shown promising results[4]. For these results to be enduring and sustainable, the health providers will need to embrace and support the interventions. This can be achieved if they are ready for the change to an RMC practice.

Readiness for change measures the extent to which people or organisations are inclined to adopt a change that alters the "status quo"[5]. It addresses the psychological and behavioural forms of readiness for change, that is the state of being willing and able to change[6,7]. The psychological forms must be shared beliefs within the organisation. Readiness for change is also a multifaceted concept as it addresses the cognitive, behavioural and motivational components of readiness for the planned change[6]. Some authors also describe it as having a structural component that addresses the presence or absence of financial, material, and human resources needed for a change, such as RMC practice[7]. However, others argued that the structural component is more related to organisational capacity than readiness for the change[6]. Readiness for change is also a multilevel construct measured at individual and organisational levels. Organisational readiness for change consists of employees' change commitment (their collective resolve) and change efficacy (their perceived shared ability) to implement the change[6]. Individual readiness for change is an employee's confidence to manage the change or willingness to accept new roles and adopt new practices[8].

Readiness for change is a key determinant of implementation success[9,10]. The readiness for change concept has been applied in both health and non-health organisations, however, there are no previous studies on its application to RMC-promoting interventions. Readiness for change to RMC among community, facility and policy stakeholders was mentioned as being responsible for the positive results of an RMC project in Kenya[11]. However, readiness for change was not reported as measured in that study[11]. Many RMC-promoting interventions have been conducted without prior assessment of the individual or organisational readiness for change[12,13]. However, if the readiness is assessed and found wanting, efforts can be directed at improving readiness for change to RMC practice. If found ready, this means there is more

willingness by the providers to accept the change and be willing to change irrespective of the task demands brought by the change.

This study assessed health providers' organisational and individual readiness for change to RMC practice and their associated factors in Ibadan Metropolis, Nigeria. The generally known factors influencing organisational and individual readiness for change have not yet been tested for RMC practice. There is also no published study that has assessed both organisational and individual readiness for change in the same population. Assessing both together will allow an evaluation of the relationship between the two constructs.

5.2. Methods

This was a cross-sectional study conducted from December 1, 2019 to May 31, 2020 among public health care providers from the five Local Government Areas (LGA) in Ibadan Metropolis, Oyo state, Nigeria. In the public sector, there are six secondary health facilities and 26 primary health facilities in the five LGAs. Maternity care services, including birthing services, are offered in all facilities, with more specialised care at secondary health facilities. Doctors and nurses attend deliveries at both primary and secondary health facilities, while Community Health Officers (CHOs), Community Health Extension Workers (CHEWs) and Health Auxiliaries (HA) only attend deliveries at primary health facilities in the study state.

A two-stage cluster sampling technique was employed to select the health facilities and health providers in the study LGAs. One primary and one secondary health facility were selected in each LGA using simple random sampling, except in one LGA without a secondary health facility. This gave a total of nine health facilities in the study (4 secondary and 5 primary health facilities). There were a total of 244 health providers who could attend deliveries in the study facilities (176 in the 4 secondary facilities and 68 in the 5 primary facilities).

A required sample size of 210 health providers was calculated using the one sample mean test[14] in Stata. The parameters used were a change commitment mean of 3.64±0.61 standard deviation (SD), based on a similar study in Switzerland, as a proxy for organisational readiness[15]. The required precision was ±5% about the reference mean, with 90% power, and a design effect of 2[16] for the cluster sampling. The number of health providers interviewed at each facility was allocated proportionately to the total number of health providers per professional type at each health facility within the LGA. All the available and consenting health providers at each health facility were interviewed until the required numbers were reached.

Ethical approvals were obtained from the Human Research Ethics Committees (HRECs) of the University of the Witwatersrand, Johannesburg (clearance Number M190658), the Institute of Public Health, Obafemi Awolowo University, Ile-Ife (HREC No: IPH/OAU/12/1243), and the Oyo State Ministry of Health (Ref. Number AD/13/479/1386). For anonymity, the facilities are referred to by numbers rather than names. The primary and secondary health facilities were designated with odd and even numbers respectively. Subsequent numbers in sequence are located in the same LGA.

Data collection was done using a 112-item tool with 9 sections developed in REDCap[17]. Two research assistants directly administered the questionnaire. The first part of the instrument assessed health providers' perceptions of women's rights during childbirth, their awareness of the mistreatment of women in their health facilities, and their awareness of the RMC concept. A one-page briefing note on RMC and what it entails when integrated into routine childbirth care was then read to each respondent (Suppl. 1). The subsequent sections of the questionnaire evaluated providers' perceptions of individual and organisational readiness for change to RMC practice during childbirth, and other possible associated factors, using standardised tools.

Figure 5.1 shows the analytical framework for the study developed from Weiner[6]. It includes both previously identified predictors of readiness for change and newly proposed ones. The respondents' perceived organisational readiness and individual readiness for change to RMC practice were the main outcome variables. Organisational readiness for change to RMC (ORC_{RMC}) was assessed using a 12-item tool with 5 items measuring their change commitment and 7-items assessing their change efficacy, both on a 5-point Likert agreement scale. The questions assessing organisational readiness were framed as, *"The health workers in this health facility are…"* Organisational readiness was determined as the mean score of the 12 items on the scale with a maximum score of 5. Individual readiness for change (IRC_{RMC}) was measured using a 6-item tool on a 5-point Likert agreement scale. Questions were framed as *"I am willing to…"*. IRC_{RMC} was determined as the mean score of the 6-item scale, also with a maximum score of 5. When reported as percentages, the mean scores were standardised and converted using the formula (Mean-1)/4*100.

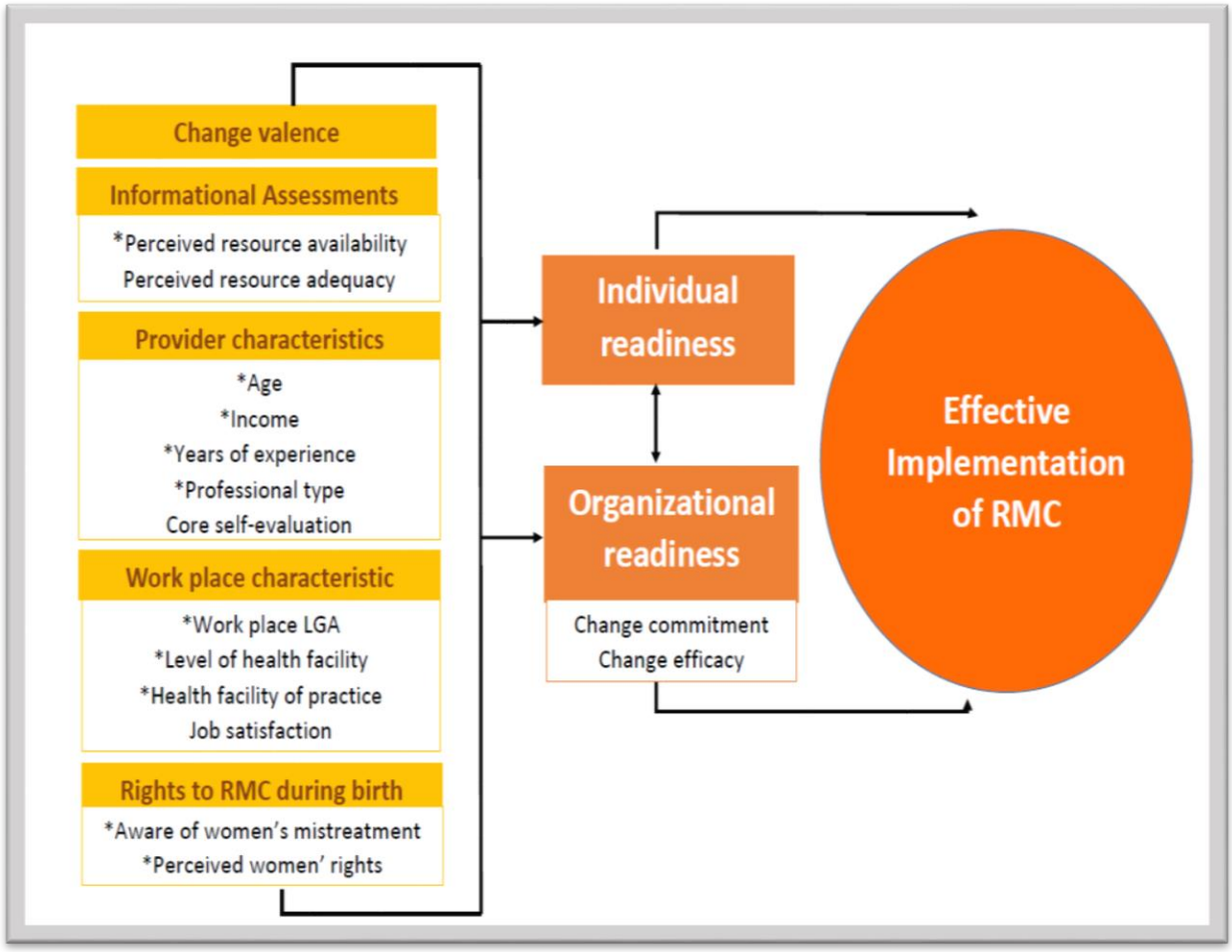


Figure 5.1: Study analytical framework (Note: *proposed as predictor variables)

In terms of predictors of readiness for change, Weiner[6] theorised that employee change valence (how much they value the change) and informational assessments (perceived adequacy of the resources available to implement the change) would positively influence organisational readiness for change. Vakola et al[8] further postulated that employee characteristics such as their job satisfaction and core self-evaluation (which assesses their self-esteem, locus of control, emotional stability and generalised self-efficacy)[18] would positively influence their individual readiness for change. I evaluated the relationship between all of these factors with both IRC_{RMC} and ORC_{RMC} (Figure 5.1). I also included both the perceived availability and perceived adequacy of resources in the analytical framework. I have also proposed that individual provider characteristics such as being younger, having more years of experience, and higher monthly income could positively influence readiness for change. Other factors may be specific to readiness for change to RMC. I suggest that health providers' perceptions about women's rights during childbirth and differences in their workplace contexts might influence IRC_{RMC} and ORC_{RMC}.

Table 5.1 shows the list of the standardised tools used to assess the analytical constructs, together with their reliability statistics in my study. The highest Cronbach's alpha was 0.949 for the organisational readiness for change tool, while the lowest was 0.575 for the tool assessing the providers' perception of women's rights.

Table 5.1: Breakdown of tools in the health provider questionnaire

	Name of Tool and Sections	Source	Items	Response type	Alpha coeff.
1	*Organisational readiness for Implementing change (ORIC)	Shea et al[19]	12	Likert scale 1-5	0.949
2	*Individual readiness for change	Vakola et al[8]	6	Likert scale 1-7	0.733
3	Socio-demographic characteristics	Adapted from the literature	15		
4	Perception of women's rights during childbirth	Childbirth Connection[20]	13	Likert scale 1-5	0.575
5	Provider awareness of mistreatment in their facility	Maternal & Child Health program[21]	12	Likert scale 1-5	0.638
6	Change valence	Shea et al[19]	6	Likert scale 1-5	0.902
7	Informational assessments	Phillip[22]	8	Likert scale 1-5	0.648
8	Perception of RMC resource availability	WHO Recommendation for labour[1]	18	Likert scale 1-5	0.669
10	Core self-evaluation tool	Judge et al[18]	12	Likert scale 1-5	0.598
11	Employee job satisfaction tool	Management Sciences for Health[23]	10	Likert scale 1-5	0.603
	Total		112		

*Outcome variables; WHO: World Health Organisation;

Data analysis was done using the Stata version 15 software. I adjusted for weighting and facility level clustering in all analyses using the Stata 'svy' commands. The mean scores of the outcome and predictor variables were determined. Higher mean scores for the outcome variables indicate higher organisational and individual readiness for change. Pearson's correlation was used to evaluate the relationship between IRC_{RMC} and ORC_{RMC}.

Principal component analysis (PCA) was used to construct separate composite indices for the study-specific tools assessing providers' perceptions of women's rights, their awareness of mistreatment in their facilities, and the availability of resources for RMC practice. Details are provided in Suppl. 2. The first components explained 17.9%, 23.2% and 16.5% of the variance for each of these scales respectively. These PCA scores were then used in the bivariate and multiple regression analysis as potential predictors.

Simple linear regression was done to assess the bivariate relationship between the two numerical outcomes and the postulated predictor variables (Figure 5.1). Predictors with a p-value ≤ 0.2 were included in the final multiple regression models for each outcome variable. All

predictors were added simultaneously. Multicollinearity analysis was conducted after the regressions. Predictor variables with a high variance inflation factor (>10.0) were excluded from the model.

5.3. Results

5.3.1. Socio-demographic profile

Two hundred and twelve health providers completed the survey, with the breakdown by professional groups as shown in Table 5.2. Their overall mean age was 44.0 years. The doctors were the youngest group with a mean age of 38.9 while the health auxiliaries were the oldest with a mean age of 49.3. Overall, the respondents had an average of more than 15 years of post-training work experience, which includes an average of about 6 years working at the study facility. Expectedly, the CHEW/CHOs and auxiliaries were only found at primary care facilities, and the vast majority of both doctors and nurses were from secondary health facilities.

Table 5.2: Providers' socio-demographic profile

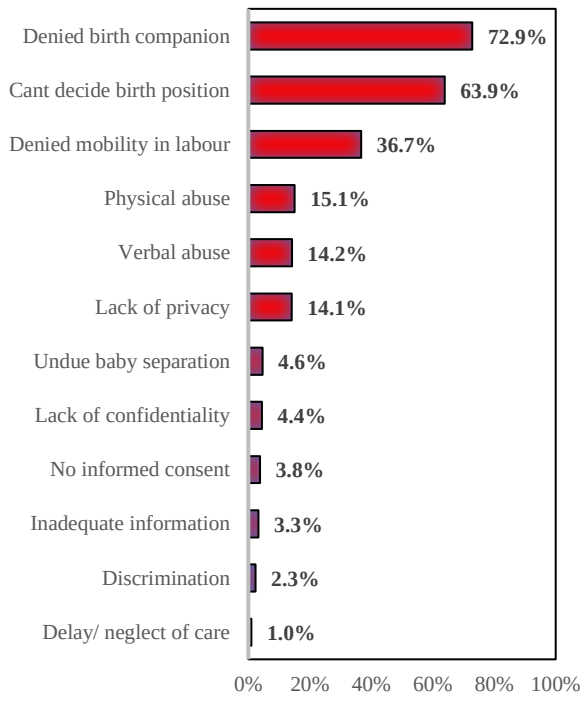
Variables	Doctor n=38	Nurse n=128	CHEW/CHO n=29	Auxiliary n=18	Total n=212
Age					
Mean ± SD	38.9 ±9.9	44.6 ± 9.4	44.5 ± 9.7	49.3 ± 10.5	44.0 ± 9.9
Median (IQR)	40 (31- 46)	44 (39 - 52)	46 (39 - 50)	52 (40 - 56)	44 (38 - 52)
Sex					
Male	20 (52.3)	0 (0.0)	2 (8.5)	0 (0.0)	22 (10.4)
Female	18 (47.7)	127 (100.0)	26 (91.5)	18 (100.0)	190 (89.6)
Type of health facility					
Primary health facility	3 (8.7)	9 (7.1)	29 (100.0)	18 (100.0)	59 (27.9)
Secondary health facility	34 (91.3)	119 (92.9)	0 (0.00	0 (0.0)	153 (72.1)
LGA					
Ibadan North	23 (61.9)	61 (47.8)	3 (12.0)	2 (9.7)	89 (42.2)
Ibadan North East	5 (14.6)	14 (11.2)	5 (16.2)	2 (8.8)	26 12.3)
Ibadan North West	6 (15.6)	20 (15.9)	12 (41.6)	3 (15.0)	41 (19.3)
Ibadan South East	1 (2.9)	1 (0.8)	4 (14.8)	7 (41.8)	14 (6.6)
Ibadan South West	2 (5.1)	31 (24.3)	4 (15.3)	4 (24.7)	42 (19.7)
Study health facilities in LGA					
Facility 1	1 (2.9)	2 (1.4)	3 (12.0)	2 (9.7)	8 (8.7)
Facility 2	23 (59.6)	59 (46.4)	0 (0.0)	0 (0.0)	82 (38.5)
Facility 3	0 (0.0)	2 (1.2)	5 (16.2)	2 (8.8)	9 (3.7)
Facility 4	5 (44.6)	13 (10.0)	0 (0.0)	0 (0.0)	18 (8.6)
Facility 5	1 (3.6)	1 (1.1)	12 (41.6)	3 (15.0)	17 (8.2)
Facility 6	5 (12.0)	19 (14.8)	0 (0.0)	0 (0.0)	23 (11.1)
Facility 7	0 (0.0)	3 (2.6)	5 (15.3)	4 (24.7)	12 (5.7)
Facility 8	2 (5.1)	28 (21.7)	0 (0.0)	0 (0.0)	30 (13.9)
Facility 9	1 (2.3)	1 (1.0)	4 (14.8)	7 (41.8)	13 (6.6)
Years of experience					
Mean ± SD	10.4 ± 7.7	18.2 ± 9.9	10.5 ± 7.5	13.6 ± 11.0	15.4 ± 9.9
Median (IQR)	10 (3 - 14)	18 (11 - 25)	8 (4 - 17)	9 (6 - 190)	14 (7 - 23)
Years working in study facility					
Mean ± SD	3.2 ± 3.5	8.2 ± 6.0	2.7 ± 1.9	3.7 ± 2.0	6.0 ± 5.6
Median (IQR)	2 (0.5 -5)	7 (4 - 11)	3 (1 - 4)	4 (3 - 5)	5 (2 - 10)
***Monthly* Income (in USD)**					
Median (IQR)	658 (526 - 921)	500 (289 – 553)	270 (132 -395)	99 (26 – 191)	463(263 – 605)

Note: IQR – Interquartile range

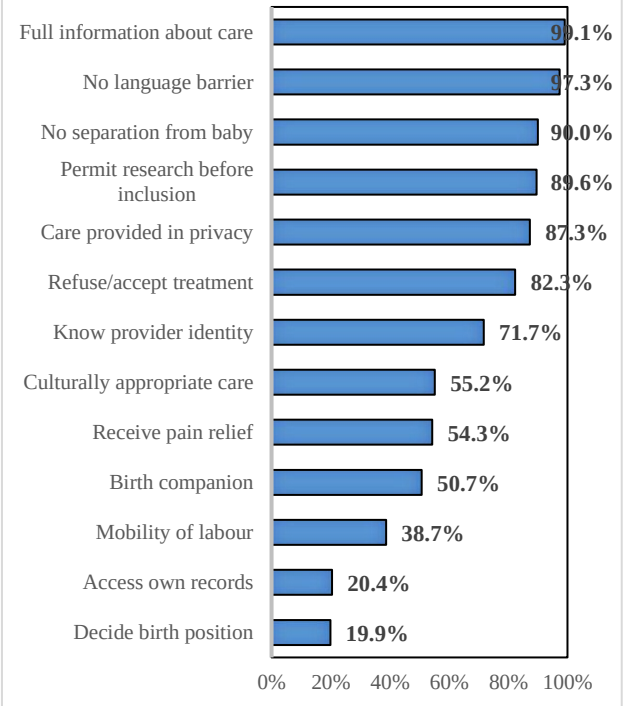
5.3.2. RMC- women's rights and mistreatment and needed resources

Overall, 62 (35.9%) of the providers said they had heard of RMC. Over 60% of the doctors had heard of RMC, while this was true for less than 35% of respondents in the other professions, with the least (19.1%) being the health auxiliaries. Nonetheless, after RMC had been explained to them, 148 (70.0%) of all the providers agreed that RMC could be implemented in their facilities.

As shown in Figure 5.2, 155 (72.9%) of the health providers stated that women delivering in their facility were always denied a birth companion, 135 (63.9%) were aware of women not being allowed to decide their birth position and 78 (36.7%) had witnessed restrictions on mobility during labour. Correspondingly, only 41 (19.9%) of health providers believed that women should always have the right to decide their birth position, 82 (38.7%) agreed that all women could be mobile during labour, and 107 (50.7%) supported women having a birth companion (Figure 5.2). Only 43 (20.4%) accepted that women should always have unrestricted access to their hospital records.



Forms of mistreatment noted by providers in their health facilities



Provider's perceived rights women should always have during childbirth

Figure 5.2: Forms of mistreatment and perceived providers' rights to women during childbirth

Figure 5.3 indicates providers' perceptions of the availability of essential resources for implementing RMC. The least available of the 18 WHO-recommended resources for RMC practice was RMC educational materials (7.7%), followed by guidelines (8.2%).

Approximately 10-15% of the providers agreed to the availability of private spaces to support birth companions, in-service training on RMC, suggestion boxes, and adequately trained staff on RMC. However, 134 (63.0%) of them agreed to have curtains and screens for privacy during childbirth.

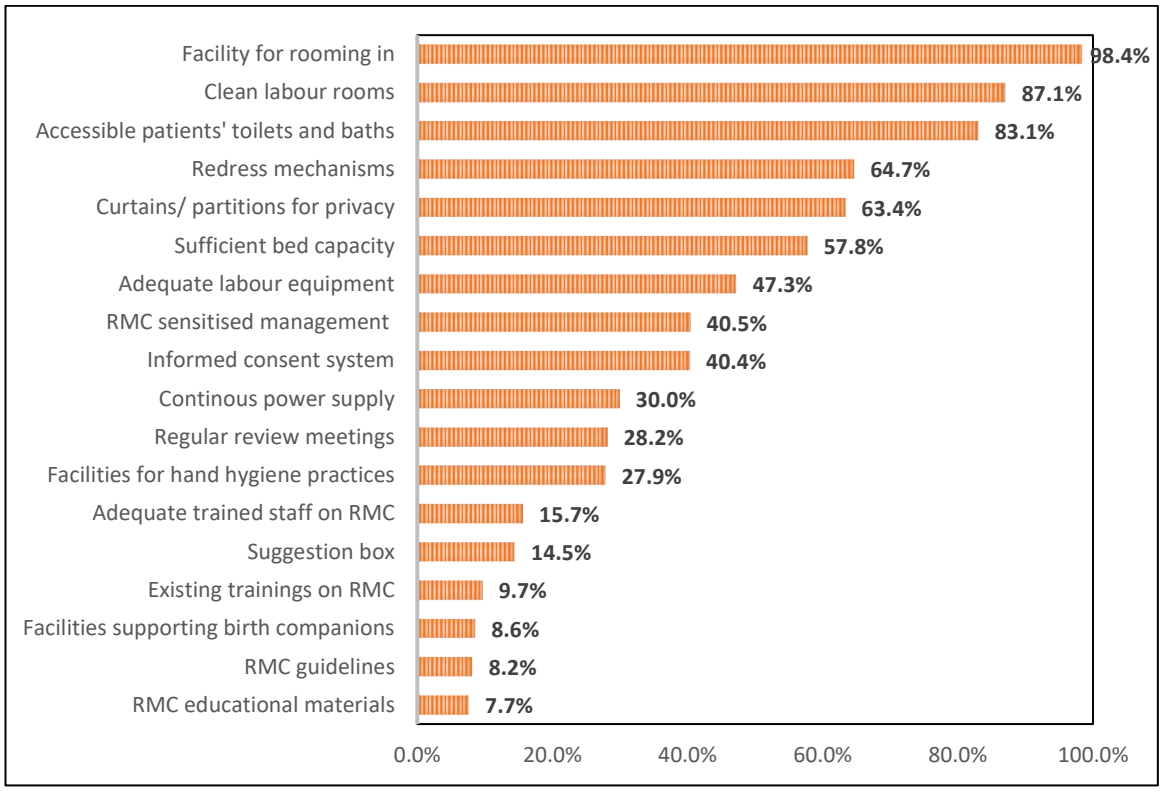


Figure 5.3: Provider perceptions on availability of WHO-recommended resources for RMC implementation

Table 5.3: Average provider perceptions for different study scales (n=212)

Analytical Category	Scale	Mean ± SD	95% CI
Outcomes	Change commitment	4.05 ± 1.0	3.8– 4.3
	Change efficacy	3.96 ± 0.9	3.6 – 4.3
	Organisational readiness for change (ORC_{RMC})	4.01 ± 0.9	3.7 – 4.3
	Individual readiness for change (IRC_{RMC})	4.23 ± 0.6	4.1 – 4.4
Predictors	Awareness of mistreatment during childbirth in their facilities	3.90 ± 0.5	3.7 – 4.1
	Women's rights during childbirth	3.85 ± 0.5	3.8 - 4.0
	Change valence	4.46 ± 0.8	4.3 – 4.6
	Informational assessments	3.30 ± 0.7	3.1 - 3.4
	Availability of resources to implement RMC in their facilities	2.70 ± 0.6	2.5 – 2.9
	Core self-evaluation	4.34 ± 0.5	4.3 – 4.4
	Job satisfaction	3.70 ± 0.6	3.6 – 3.8

The mean scores for all the study scales are shown in Table 5.3. The health providers were well aware of the mistreatment of women during childbirth in their health facilities across the 12

items with a high mean score of 3.9±0.5 out of a maximum of 5. However, the mean score of 3.9±0.5 out of 5 also indicates high acceptance of the rights they believe women should always be granted during childbirth.

5.3.3. Individual and organisational readiness for change to RMC practice

In assessing organisational readiness for change to RMC, the health providers scored high on their commitment to the change and their change efficacy, which is their perceived ability to implement the change (Table 5.3). These two constructs were strongly positively correlated (rho: 0.830, p<0.001). Combined, this gave a high mean organisational readiness for change (ORC_{RMC}) score of 4.01±0.9, which is 75.3% of the maximum obtainable mean score of 5. The health providers had even higher individual readiness to change (IRC_{RMC}), with a mean score of 4.23±0.6, 80.8% of the maximum. Organisational readiness was only moderately but significantly correlated with individual readiness for change to RMC (rho: 0.407, p<0.001).

5.3.4. Change valence and informational assessments

The health providers scored high on how much they value the change to RMC, with a mean of 4.46±0.8 out of 5 (Table 5.3). They, however, did score lower in their informational assessments (3.30±0.7), which describes their perceptions of the adequacy of the available resources to implement the change to RMC practice in their facilities. The providers' mean score for the availability of the WHO-recommended resources to implement RMC was even lower (2.70±0.6), 42.5% of the maximum. There was a mild but significant positive relationship between their perceived availability and adequacy of the resources needed to implement RMC in their facilities, (rho: 0.263, p=0.0001).

Notwithstanding these perceived deficiencies, the health providers indicated relatively high levels of job satisfaction and core self-evaluation- that is, they had high self-esteem, locus of control, emotional stability and generalised self-efficacy (Table 5.3).

5.3.5. Factors associated with individual readiness for change (IRC_{RMC}) and organisational readiness for change (ORC_{RMC}) to RMC practice

Table 5.4 shows the bivariate and multiple regression analysis for IRC_{RMC}, while Table 5.5 shows the analysis for ORC_{RMC}. The health providers' change valence and informational assessments were significantly associated with individual readiness for change in the multiple regression analysis, increasing IRC_{RMC} scores by 0.45 and 0.07 respectively. Doctors and nurses had significantly higher IRC_{RMC} than health assistants, in the bivariate analysis but this was no longer significant after adjusting for other covariates.

Table 5.4: Factors associated with health providers' IRC$_{RMC}$

Covariates	Simple linear regression			Multiple linear regression		
	Crude Coeff.	95%CI	p-value	Adjusted Coeff.	95%CI	p-value
Health providers' age	-0.003	-0.01 - 0.007	0.497			
Sex						
Female	Ref	-	-	Ref	-	-
Male	-0.21	-0.02 – 0.44	0.065	-0.14	-0.84 – 1.13	0.743
Study Local Government Area						
Ibadan North	Ref	-	-			
Ibadan North East	0.02	-0.54 – 0.58	0.946			
Ibadan North West	-0.22	-0.47 – 0.03	0.078			
Ibadan South East	-0.45	-052 – 0.37	**<0.001**			
Ibadan South West	-0.09	-0.32 – 0.14	0.383			
Health facility in LGA						
Facility 1	0.19	0.10 – 0.19	<0.001	0.35	-0.01 – 0.70	0.053
Facility 2	Ref	-	-	Ref	-	-
Facility 3	-0.53	-0.53- -0.53	<0.001	-0.06	-0.39 – 0.27	0.675
Facility 4	0.29	0.29 – 0.29-	<0.001	0.07	-0.05 – 0.18	0.218
Facility 5	-0.37	0.37 - -0.37	<0.001	-0.23	-0.51 – 0.04	0.087
Facility 6	-0.06	-0.06 - -0.06	<0.001	0.04	-0.07 – 0.14	0.423
Facility 7	0.12	0.12 – 0.12	<0.001	0.22	-0.13 - 0.54	0.175
Facility 8	-0.10	-0.10 – -0.10	<0.001	0.0002	-0.09 – 0.09	0.970
Facility 9	-0.42	-0.42 - -0.42	<0.001	0.03	-0.30 – 0.35	0.844
Providers' type of health facility						
Primary health facility	Ref	-	-			
Secondary health facility	0.23	0.56 – 0.09	0.135			
Professional cadre						
Doctor	0.43	0.04 – 0.83	**0.036**	-0.13	-0.46 – 0.19	0.360
Nurse	0.37	0.05 – 0.70	**0.030**	Ref	-	-
CHEW/ CHO	0.08	-0.06 – 0.21	0.233	-0.19	-0.63 – 0.24	0.329
Health Assistant/ Aide	Ref	-	-	-0.16	-0.50 – 0.18	0.296
Monthly Income (in USD/ 1000)	-2.36	-0.06 – 5.28	0.097	0.05	-0.03 - 0.13	0.187
Years of professional experience	0.01	0.004 – 0.03	0.106	0.004	-0.02 – 0.03	0.644
Years of experience in the health facility	0.004	-0.02 – 0.031	0.727			
Awareness of the mistreatment of women	0.01	-0.04 – 0.05	0.712			
Perceived women's rights during childbirth	0.04	-0.05 – 0.11	0.357			
Ever heard of RMC (n=170)						
Yes	-0.02	-0.33 – 0.30	0.883			
No	Ref	-	-			
Perception of RMC being implementable						
Agreed	0.10	-0.34 – 0.53	0.620			
Indifferent	Ref	-	-			
Disagreed	0.06	-0.46 – 0.58	0.794			
Change valence (value for RMC practice)	0.45	0.19– 0.71	**0.005**	0.40	0.11 – 0.70	**0.015**
RMC Informational assessment	0.07	0.15 - 0.42	**0.001**	0.07	0.008 – 0.13	**0.032**
Provider perceptions on available resources	0.03	-0.02 – 0.09	0.182			
Provider job satisfaction	0.010	-0.03 – 0.22	0.105	0.004	-0.13 – 0.14	0.953
Provider core self-evaluation	0.25	0.01 – 0.50	0.055	0.09	-0.22– 0.39	0.513
*Male # Doctor				0.15	-1.01 – 1.31	0.765
Constant				1.76	1.37 – 2..14	**<0.001**

n=212; R^2= 0.4363; p<0.001

Note: Ref: means the reference category; 95%CI: 95% Confidence Interval; Predictors with p-value ≤0.2 from the simple linear regression analysis were included in the multiple regression model; The Mean-variance inflation factor vif for the multiple regression model is =2.33, significant p-values in bold. Male # Doctor- Interaction between gender and profession

Table 5.5: Factors associated with health providers' ORC$_{RMC}$

Covariates	Simple linear regression			Multiple regression		
	Crude Coeff.	95%CI	p-value	Adjusted Coeff.	95%CI	p-value
Health providers' age	-0.01	-0.02 – 0.02	0.916			
Sex						
Female	Ref	-	-	Ref	-	-
Male	-0.21	-0.09 – 0.50	0.146	0.15	-0.11 – 0.41	0.213
Study Local Government Area						
Ibadan North	Ref	-	-			
Ibadan North East	0.34	-0.26 – 0.94	0.226			
Ibadan North West	-0.22	-0.42 – 0.02	**0.034**			
Ibadan South East	-0.46	-0.59 – 0.33	**<0.001**			
Ibadan South West	-0.27	-1.21 – 0.66	0.510			
Health facility in LGA						
Facility 1	0.43	0.43 – 0.43	**<0.001**	0.38	0.30 – 0.46	**<0.001**
Facility 2	Ref	-	-	-	-	-
Facility 3	-0.23	-0.23 - -0.23	**<0.001**	0.24	0.12 – 0.35	**0.002**
Facility 4	0.65	0.65 – 0.65	**<0.001**	0.16	-0.03 – 0.35	0.087
Facility 5	-0.09	-0.09 - -0.09	**<0.001**	-0.29	-0.40 - -0.19	**<0.001**
Facility 6	-0.24	-0.24 - -0.24	**<0.001**	-0.11	-0.16 - -0.07	**0.001**
Facility 7	0.63	0.63 – 0.63	**<0.001**	0.56	0.54 – 0.57	**<0.001**
Facility 8	-0.54	-0.54 - -0.54	**<0.001**	-0.41	-0.47- -0.36	**<0.001**
Facility 9	-0.41	-0.41 - -0.41	**<0.001**	0.11	0.02 – 0.20	**0.024**
Providers' type of health facility						
Primary health facility	Ref	-	-			
Secondary health facility	0.09	-0.68– 0.50	0.717			
Professional cadre						
Doctor	0.31	-0.50 – 1.12	0.391			
Nurse	-0.07	-0.88 – 0.75	0.857			
CHEW/ CHO	0.09	-0.38 – 0.56	0.667			
Health Assistant/ Aide	Ref	-	-			
Income (in USD/ 1000)	0.26	-0..05- 0.56	0.083	0.08	0.02– 0.15	**0.021**
Years of professional experience /10 years	0.05	0.02 – 0.3	**0.034**	0.08	0.01 – 0.2	**0.024**
Years of experience in health facility	-0.004	-0.03 – 0.02	0.678			
Awareness of mistreatment of women	0.02	-0.06 – 0.09	0.650			
Perceived women's rights during childbirth	0.02	-0.12 – 0.16	0.767			
Ever heard of RMC (n=170)						
Yes	0.10	-0.27 – 0.46	0.553			
No	Ref	-	-			
Perceptions of RMC being implementable						
Agreed	0.60	-0.02 – 1.23	0.056	0.19	-0.08– 0.45	0.148
Indifferent	Ref	-	-	Ref	-	-
Disagreed	-0.09	-0.76 – 0.58	0.765	-0.12	-0.60 – 0.36	0.570
Change valence (value for RMC practice)	0.74	0.47 – 1.01	**<0.001**	0.47	0.21 – 0.74	**0.004**
RMC Informational assessment	0.72	0.40 – 1.05	**0.001**	0.43	0.22 – 0.63	**0.002**
Provider perceptions on available resources	-0.002	-0.25 – 0.25	0.984			
Provider job satisfaction	0.23	-0.08 – 0.55	0.125	0.05	-0.10 – 0.20	0.477
Provider core self-evaluation	0.15	-0.38 – 0.68	0.521			
Constant				0.06	-1.28 – 1.41	0.915

n=212; R^2= 0.6016; p<0.001

Note: Ref: means the reference category; CI: 95% Confidence Interval; Predictors with a p-value ≤0.2 from the bivariate analysis (simple linear regression) were included in the multiple regression model; The Mean-variance inflation factor vif for the multiple regression model is =1.55, Significant p-values in bold.

IRC_{RMC} varied significantly between health providers from different health facilities in the bivariate analysis but this was no longer the case in the multiple regression analysis. None of the known predictors of individual readiness for change (providers' job satisfaction and core self-evaluation), nor the newly proposed ones (perceived rights of women, years of experience, income), was significantly associated with IRC_{RMC}.

Change valence and informational assessments were also significantly associated with organisational readiness for change (ORC_{RMC}) (Table 5.5). A unit increase in the health providers' change valence and informational assessments increased their perceived ORC_{RMC} by 0.47 and 0.43 units respectively, after adjusting for other covariates. Also, each additional 10 years of work experience significantly increased ORC_{RMC} by 0.08 and each $1000 increase in providers' monthly income increased their perceived ORC_{RMC} by 0.08. There were significant varied associations (positively or negatively) between the health providers' facility of practice and their ORC_{RMC} in relation to the reference facility. The only exception was for Facility 4, a secondary health facility in one of the LGAs.

5.4. Discussion

This is the first study to explore individual and organisational readiness for change to RMC practice, and associated predictors. The health providers had a high level of awareness of the mistreatment of women in their health facilities, but also a high general acceptance of women's rights during childbirth (Figure 5.2). However, there were some RMC rights, such as being allowed a birth companion, that few providers regarded as essential, and these were then seldom practised (Figure 5.2). Nonetheless, the health providers scored high in their perceived IRC_{RMC} and ORC_{RMC}. IRC_{RMC} and ORC_{RMC} were only moderately correlated in this analysis. Higher change valence and informational assessment of the adequacy of resources increased not only organisational readiness for change, as has been found previously,[19,22] but also IRC_{RMC}. Job satisfaction and the providers' core self-evaluation, which have been shown to influence IRC_{RMC}[8,24], had no statistically significant effect in this study. Of the newly proposed predictors, the provider's years of work experience, their monthly income (individual characteristics) and their health facility of practice (a workplace characteristic) significantly influenced ORC_{RMC}.

This study has provided an understanding of the state of readiness for change to RMC practice, eliminating it as a possible implementation problem for RMC practice in the study setting. It has also been established that IRC_{RMC} and ORC_{RMC} have a positive influence on each other. This study has further confirmed the critical role of change valence and informational assessments in increasing both organisational and individual readiness for change.

The study findings however failed to establish a significant relationship between the providers' readiness for a change to RMC and their perceptions of women's rights during childbirth. Respectful maternity care is premised on the fundamental human rights of women to receive dignified care[25]. It would have been expected that provider perceptions of women's rights would be positively associated with their readiness for change. The relationship was in the correct direction but not statistically significant. The provider's low perceptions of resource availability to implement RMC did also not significantly reduce their IRC_{RMC} and ORC_{RMC}.

This study had some limitations. It was a relatively small study and its geographical extent was limited to one Metro in Nigeria which may not be representative of facilities and providers in other regions of Nigeria. I also did not examine readiness for change to RMC in tertiary health facilities. This was because there was only one tertiary health facility serving populations across the five LGAs studied. Social desirability bias may have influenced some of the providers' responses to the availability of resources and their perception of women's rights during childbirth. To mitigate this, the data collectors stressed the academic purpose of the research to the providers when obtaining informed consent. Limited awareness of RMC, as found in this study, may affect an accurate assessment of readiness for change. I attempted to address this by educating the providers on RMC concepts before assessing their readiness for change to RMC practice.

Health providers cannot truly be ready to implement RMC if they do not support certain women's rights during childbirth. This would result in persistent mistreatment and may prevent a positive change to RMC practice. The most common forms of mistreatment to women during childbirth in the study health facilities were being denied birth companions, not being allowed to decide on a birth position, and being denied mobility in labour. All three forms of mistreatment were also reported by Tanzanian women in a qualitative study of the perspectives of mothers and fathers on mistreatment during childbirth[26]. Ethiopian women who delivered at health centres were allowed to take light foods and choose their birth positions more than those who delivered at hospitals[27] Several other studies have reported these forms of mistreatment experienced by women during childbirth[28–31]. According to the WHO[32,33], having a birth companion during labour provides emotional support, reduces labour pain and strengthens the woman's capability to deliver. The WHO has also recommended that women are supported to deliver in their preferred birth position because alternative birth positions, such as standing to deliver, are safe and may result in shorter labour from better foetal alignment[30,32]. It has also been reported that mobility during the first stage of labour is safe[30]. Denying women autonomy,

or not respecting women's choices during childbirth without a justifiable medical reason, constitutes mistreatment that negatively affects their overall childbirth experience[34].

The health providers perceived that women should always have the right to full information about their care and to receive their care in privacy. Unfortunately, many may not practice it for several reasons, including unconscious behaviour, an abusive work culture, and perceived excessive workload amongst others[35]. About 33.0% of maternity care providers in Western Kenya attested that they do not often give explanations before conducting procedures on women during childbirth, and 73.0% do not wait to obtain consent before conducting these examinations[35]. This is similar to the inconsistent support for women's right to autonomy found among Australian midwives and doctors[36]. They confirmed their support for women's autonomy, but override women's decisions sometimes on safety reasons, claiming full accountability for every pregnancy outcome. Women should be included when safety decisions need to be made during childbirth. When this is not done, women may conclude it is an abuse of their rights. Tanzanian women related their abusive maternity care experiences as a deviation from their basic human rights[37]. Hence, advocating for women's rights among health providers should be a key component of RMC-promoting interventions.

Nonetheless, the health providers scored high in their perceived IRC_{RMC} and ORC_{RMC}. Few studies report the overall organisational readiness for implementing change (ORIC) in health programmes as mean scores using the ORIC tool. Many either report the mean change commitment and change efficacy as individual scores[15] or as total scores[38]. The ORC_{RMC} score in my study was higher than the average of the change commitment and change efficacy scores found when the nurse-reported ORC for policy change in acute care hospitals in Switzerland was assessed[15]. There was no comparable study of individual readiness for change using the same instrument applied in the health industry. A scoping review to explore the nature and extent of literature published on individual readiness for change in the health sector and identify appropriate measurement scales used yielded no study found in health[39]. A study on the factors associated with individual readiness for change in a healthcare setting determined the readiness for change as a modelled estimate of employees' resistance to change[39].

IRC_{RMC} and ORC_{RMC} in my study were significantly positively correlated. Thus, a positive increase in IRC_{RMC} by strengthening its facilitating factors should also reflect in increased ORC_{RMC}. This is similar to the postulations by Weiner in his theory where he stated that "*Organisational readiness is likely to be highest when organisational members not only want to implement an organisational change but also feel confident that they can do so*" (page 3)[6].

Weiner theorised that organisational readiness was most strongly influenced by change valence and informational assessments[6]. Change valence, how much the health providers value the change to RMC practice, positively influenced their IRC_{RMC} and ORC_{RMC} significantly in my study. Change valence also positively and significantly influenced organisational readiness for change amongst employees of a private hospital changing to a tertiary hospital[40]. It also strongly correlated with individual readiness for change in the automobile industry[41]. There has been limited assessment of individual readiness for change in health-related industries.

Informational assessment is the perceived adequacy of the available resources such as the equipment, expertise, skills, and time needed to implement the change. Informational assessments also significantly influenced both IRC_{RMC} and ORC_{RMC} in this analysis. Informational assessment of their perceived resource adequacy was found to be positively and significantly correlated with their perceived resource availability in this study. This suggests that if providers' perception of resource availability is high, it should translate to high perceived adequacy of these resources, and thus increase their readiness for a change to RMC practice. However, the providers had a low perception of the availability of recommended resources for RMC implementation in my study setting (Figure 5.3). This may have explained their fairly low perceived resource adequacy (Table 5.3).

Thus, additional resource requirements are critical drivers of RMC implementation[6]. For example, only 9% of the health providers agreed that facilities to support birth companions were available. This would include a private space achievable with the use of curtains (Figure 5.3). In an observational study of childbirths across four countries, Nigeria had the lowest proportion of women (6.9%) in which curtains were used to ensure privacy. This is a challenge that may prevent Nigerian women from receiving RMC as there is limited funding to the Nigerian health system to provide this essential RMC resource[42]. However, 63% of my respondents reported the availability of curtains and partitions for privacy. There is a need to identify cost-effective strategies to address these system challenges. Why such is not perceived as facilities available to allow for birth companions may need to be explored. Though, having curtains on the windows and a door to the labour room that is always shut were construed as ensuring privacy in an unpublished qualitative study amongst health providers.

ORC_{RMC} was found to be significantly higher among health providers with longer years of work experience. They are a population to target in RMC-promoting interventions. The nurses' years of work experience also positively influenced their change commitment, one of the measures of organisational readiness, in Switzerland's acute care hospitals[15]. The providers' workplace

setting, as indicated by their health facility of practice significantly influenced their perceived $ORC_{RMC.}$ This was positive for most of the primary health care facilities across the LGAs and was significantly negative for the two secondary health facilities studied. Interestingly, both the primary and secondary health facilities in the Ibadan North-west LGA were significantly associated with a decreased $ORC_{RMC.}$ According to the literature, the workplace contextual fit is critical to providers' readiness for change to RMC as it informs the adaptability of the local context to the globally defined RMC practice, the quality of the implementation, and whether expected RMC implementation outcomes will be achieved[43–45].

Weiner[6] had theorised that the organisational culture and climate, flexibility of policies and procedures, past experiences with implementing change, and trust in the manager's leadership style, amongst others, are all contextual factors that could influence organisational and individual readiness for change. There is a need to further explore which contextual factors within the health providers' health facilities are the most critical barriers to a successful implementation of RMC practice during childbirth.

5.5. Conclusions

The three most common forms of mistreatment during childbirth noted by health providers corresponded with the low recognition of these as rights that women should always receive. My study confirmed the relevance of the organisational and individual readiness for change constructs to the RMC literature and should prompt more studies on this topic. It is noteworthy that the health providers in my study perceived themselves and their organisations to be ready for a change to RMC practice. It would be important to verify in future research if readiness for change significantly facilitated the implementation of RMC interventions. The main influencing factors of both IRC_{RMC} and ORC_{RMC} scores in my study were a high valuation of the change (change valence) and the perceived adequacy of resources necessary to implement the change. Longer serving providers may be a readier population to target during RMC implementation either as champions or to lead a change to RMC practice. Workplace contexts could significantly influence ORC_{RMC} and should be explored before the implementation of RMC interventions.

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Supplement 1

What is Respectful Maternity Care?

Respectful Maternity Care (RMC) is a human rights approach to childbirth care practice. It is a new strategy for caring for women in labour which we are yet to commence implementing in this health facility. We are interested in knowing how health facilities offering childbirth
services, their managers and individual workers are READY to integrate respectful maternity care into their routine childbirth services.

What is Respectful Maternity care?
Simply, it means the following

1. The preferences of the client must be respected, and she must be involved in the decision making regarding her health.
2. She must be allowed a companion during birth as recommended by the WHO
3. She must be free to move about during labour if she so wishes even in the second stage before the urge to deliver and not restricted to one position.
4. If classified as a low risk pregnant woman, she should be allowed oral fluids or food while in labour as evidence has shown no negative outcomes following this.
5. Her privacy must be ensured by providing one private cubicle or space per woman in labour and information about her should not be shared openly.
6. If she prefers to deliver her child squatting, the health care provider must be willing to support her in the decision.
7. Equitable services must be delivered to her regardless of her personal characteristics.
8. When she calls for help during labour, she must not be denied nor neglected.
9. If she is unable to pay her bills, a consensus must be reached with her on how to pay rather than detaining her illegally for the inability to pay.
10. Overall, she must receive the utmost respectful and dignified care, that she deserves as her fundamental human rights.

Supplement 2

1. **Principal Component Analsysis Results for the scale assessing Health Provider's perception of women's rights during childbirth.**

Test	Measure	Statistics
Kaiser-Meyer-Olkin (KMO)	Sampling adequacy	[a]0.620
Bartlett's	Sphericity	$\chi^2 = 229.126$
		df = 78
		p < 0.001*

Total Variance explained

Component	Eigenvalues	% of variance	Cumulative %
1	2.326	17.89	17.89
2	1.448	11.14	29.04

* Statistically significant [a] Sample is adequate (No of observations -203)

Principal component eignevectors for 4 of 13 components

Variable	Comp1	Comp2	Comp3	Comp4	Comp5
right_Know~r	0.3444	-0.0563	0.0809	0.4687	0.1214
right_priv~y	0.2609	-0.5047	0.0694	0.1062	0.1655
right_info~n	0.1528	-0.1522	0.1208	0.0868	0.6739
right_refu~t	0.1797	0.3353	-0.2941	0.3634	0.0657
right_rese~t	0.2260	0.4095	-0.3549	0.1507	0.2613
right_acce~s	0.2397	-0.2237	-0.3648	-0.3109	0.1185
right_cult~e	0.3100	-0.3255	0.0846	0.2425	-0.4273
right_nola~r	0.0559	0.2120	0.7022	-0.0018	0.2357
right_comp~p	0.3543	0.0971	0.3081	-0.0594	-0.2283
right_mobi~r	0.3228	-0.0195	-0.0627	-0.3274	0.1690
right_noba~n	0.1915	0.4536	0.1623	-0.2516	-0.0634
right_pain~f	0.4288	0.1441	-0.0478	0.0854	-0.3068
right_birt~n	0.3157	-0.0396	-0.0281	-0.5196	0.0064

Correlation matrix showing the total, mean scores and pca predicted scores (final rights) for health provider's perception and frequency of women's rights during childbirth.

	Total scores _perceived women's rights	Mean scores _perceived women's rights	No of items agreed to_ _perceived women's rights	Pca scores _perceived women's rights
Total scores _	1.000			
Mean scores	1.000	1.000		
No of items agreed	0.9157	0.9157	1.000	
Pca scores	0.9919	0.9919	0.9073	1.000

2. Principal Component Analsysis Results for the scale assessing Health Provider's awareness of the frequency of mistreatment f o women during childbith at their own health facilities

Test	Measure	Statistics
Kaiser-Meyer-Olkin (KMO)	Sampling adequacy	[a]0.720
Bartlett's	Sphericity	$\chi^2 = 357.784$
		df = 66
		p < 0.001*

Total Variance explained

Component	Eigenvalues	% of variance	Cumulative %
1	2.783	23.19	23.19
2	1.440	12.00	35.19

* Statistically significant [a] Sample is adequate (No of observations -211)

Principal component eignevectors for 4 of 12 components

Variable	Comp1	Comp2	Comp3	Comp4
physical_a~e	0.1505	-0.1880	0.5230	0.3352
verbal_abuse	0.3260	-0.3530	0.3263	0.1119
lack_of_in~n	0.4237	-0.0759	-0.2696	0.2439
no_informe~t	0.2234	0.1038	-0.4436	0.4205
lack_of_pr~y	0.3758	0.2156	0.0596	-0.2068
lack_confi~y	0.4621	0.0288	-0.1338	-0.1383
discrimina~n	0.4057	-0.1312	-0.1291	-0.0910
no_birth_c~n	0.1262	0.3171	0.2598	0.2618
no_movt_in~r	0.0401	0.4763	0.3472	-0.1348
no_choice_~n	0.1061	0.5535	0.1156	0.3253
separation~y	0.1021	-0.3402	0.3182	0.0749
abandonmen~e	0.2883	0.0975	0.0988	-0.6087

Correlation matrix showing the total scores, mean scores and pca predicted scores (final mistreatment) for health provider's awareness of the frequency of women's mistreatment during childbirth at their facilities

	Total scores _perceived women's rights	Mean scores _perceived women's rights	No of items agreed to_ _perceived women's rights	Pca scores _perceived women's rights
Total scores _	1.000			
Mean scores	1.000	1.000		
No of items agreed	-0.7437	-0.7437	1.000	
Pca scores	0.8658	0.8658	-0.4638	1.000

3. Principal component analysis results for the scale assessing health provider's perception of resource availability for the implementation of RMC as recommended by the World Health Organisation

Test	Measure	Statistics
Kaiser-Meyer-Olkin (KMO)	Sampling adequacy	[a]0.640
Bartlett's	Sphericity	$\chi^2 = 557.535$
		df = 153
		p < 0.001*

Total Variance explained

Component	Eigenvalues	% of variance	Cumulative %
1	2.968	16.49	16.49
2	2.242	12.46	28.95

* Statistically significant [a] Sample is adequate (No of observations -173)

Principal component eignevectors for 6 of 18 components

Variable	Comp1	Comp2	Comp3	Comp4	Comp5	Comp6
adequate_s~f	0.1937	-0.3240	0.2060	-0.0295	0.1330	-0.1381
mgt_sensit~d	0.1834	0.1923	-0.4623	-0.0580	0.1970	-0.0811
regular_rm~g	0.3397	-0.0619	-0.3633	-0.2583	-0.1123	-0.0819
written_gu~s	0.3728	-0.0247	0.0683	-0.3796	-0.1623	0.0967
informed_c~t	0.0625	0.5407	0.1832	-0.1032	0.0221	0.0626
rmc_educat~s	0.2679	0.0166	0.3492	-0.3203	-0.1146	0.1170
rooming_in	-0.0196	0.2111	-0.0005	0.0803	-0.0010	0.6030
clean_priv~e	0.2048	0.2019	-0.1084	0.3604	-0.2740	0.0965
clean_bath~s	0.2307	0.1783	0.0003	0.3818	-0.3967	0.0724
safe_water~e	0.0780	0.1868	0.1777	0.2380	0.0806	-0.6417
curtains_a~s	0.3270	0.1311	0.1233	0.1952	-0.1454	-0.2312
adequate_b~s	0.2094	-0.1672	0.2842	0.2932	0.4128	0.1370
space_woma~s	0.1107	-0.3020	0.3363	-0.0534	-0.3750	-0.0117
adequate_l~t	0.1908	-0.3234	-0.0153	0.3417	0.2592	0.2372
power_supp~r	0.3325	-0.0968	-0.0659	0.0334	-0.0543	0.1038
rmc_practi~w	0.2486	-0.2531	-0.4220	0.0271	0.0132	-0.0762
suggestion~x	0.2576	0.2220	0.1264	-0.2739	0.4053	-0.0240
redress_co~e	0.2430	0.2129	0.0257	0.1119	0.2920	0.0707

Correlation matrix showing the total scores, mean scores and principal component analysis predicted scores (final res) predicted scores for health provider's perception on the availability of resources needed to implement respectful maternity care as recommended by the World Health Organisation

	Total scores _resource availability	Mean scores _ resource availability	No of items agreed to_ _ resource availability	Pca scores _ resource availability
Total scores _	1.000			
Mean scores	1.000	1.000		
No of items agreed	0.9206	0.9206	1.000	
Pca scores	0.9576	0.9576	0.8657	1.000

CHAPTER SIX: THEORY-INFORMED STRATEGIES TO IMPROVE READINESS FOR CHANGE TO A RESPECTFUL MATERNITY CARE PRACTICE IN IBADAN, SOUTH-WEST, NIGERIA

Journal information and publication status for paper 4

Intended Journal	SSM-Qualitative Research in Health
Manuscript ID	
Manuscript type	Research article
Authors	Oluwaseun Taiwo Esan; Salome Maswime; Duane Blaauw
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Publication status	Yet to be Submitted
Keywords	Strategies, interventions, readiness for change, respectful maternity care, implementation, theoretical domains framework, behavioural change, behavioural change wheel, COM-B model, public health facilities,

Abstract

Background: Respectful maternity care (RMC) is the desired standard practice that every woman should receive during childbirth because it improves women's positive experiences and may increase health facility utilisation for delivery. Higher health provider readiness for change to RMC practice could ensure they drive change in settings yet to implement RMC. Many RMC-promoting interventions or strategies have been implemented without first improving health providers' readiness for change or targeting the barriers that limit their readiness. This study is the first to identify theory-informed behavioural change strategies that could improve health providers' readiness for change to RMC practice.

Methods: A qualitative study was done in Ibadan Metropolis, Oyo state, Nigeria. Focus group discussions were conducted to identify barriers limiting readiness for change to RMC practice amongst homologous groups of 35 health providers of the 36 selected from 4 professional categories in pairs across nine health facilities (5 primary and 4 secondary) from the five local government areas within the Metropolis. Seventeen in-depth interviews were also conducted with stakeholders in the state's health system to identify theory-informed strategies for addressing the identified barriers. The barriers amenable to behavioural change were mapped to the 14 domains in the Theoretical Domains Framework and the Behavioural Change Wheel. All the data collected were audio-taped and transcribed verbatim. Framework analysis with a priori themes was used for the data analysis.

Results: Provider, leadership, health systems and patient-related barriers to organisational readiness for change to RMC were identified by the health providers. Participants proposed that a combination of strategies will be required. All nine strategy categories in the Behavioural Change Wheel were applicable for the barriers, but training (self-motivating) and environmental restructuring (enhances capacity) were the most popular. Fifty-five techniques to achieve these strategies were identified by the respondents. Of these, mentoring, job aids, effective communication skills, and procurement of work-related equipment and commodities, with regularly paid remunerations were applicable to more than one derived strategy. The leaders' (ward, unit, facility heads and program managers) role in effecting the strategy techniques was emphasised.

Conclusion: A self-motivated health provider, with enhanced capabilities, who is mentored, communicates effectively, supported with job aids and needed commodities and equipment to work, and remunerations paid regularly could be more ready to embrace positive changes in the organisation, such as a change to RMC practice.

6.1. Background

Respectful maternity care (RMC) is a human rights approach to care[1,2] that ensures a positive childbirth experience[3–5]. RMC has been declared the desired standard for all women[6,7], but many women are yet to experience it, especially in low and middle-income countries (LMICs) which have the highest burden of disrespectful care[8]. Provision of RMC requires a change in the behaviour of particularly the critical frontline health providers who are needed to deliver RMC practice across the health system[9]. This assertion was made by the White Ribbon Alliance, an organisation at the fore of promoting the uptake of RMC implementation globally[9]. Several RMC-promoting interventions had been conducted[10–14], but few of these have engaged with behavioural change theories[15,16]. Only six of the known 158 published literature on interventions in maternity care were explicitly theory-informed[16]. Theory-informed interventions or strategies would promote the uptake of evidence-based maternity care[16]. None has also considered the need to improve organisational and individual readiness for change to RMC practice. Organisational and individual readiness for change (RfC) are known precursors for successful implementation of change in practice[17], such as to RMC. However, there may be barriers to providers' RfC to RMC practice.

A high health provider's RfC to a practice helps the stakeholders own and drive the change process[17]. It also improves the likelihood of effective and sustainable implementation of the interventions[18]. Thus, barriers limiting providers' RfC to RMC need to be identified and addressed[19]. These barriers may require behavioural change strategies and techniques or other forms of health systems response such as structural change. The barriers needing behavioural change could be targeted in theory-informed strategies that would enable health providers' readiness for the change[20]. To the best of my knowledge, this is the first study to systematically engage evidence-based principles and theories to identify strategies that could improve readiness for change (RfC) to RMC practice in LMICs.

In this paper, we have used the Theoretical Domains Framework (TDF)[20,21,22], mapped to the Behavioural Change Wheel (BCW)[23,40] to identify theory-informed strategies and techniques that could address the barriers of RfC to RMC practice. The TDF groups factors influencing behaviours into domains. The 14 TDF domains are knowledge, skills, social roles, capabilities, optimism, consequences, reinforcements, intention, goals, memory, environmental resources, social influences, emotion and behavioural regulation[24]. These TDF domains help to identify factors influencing the behaviours that need to change, termed barriers[20].

The BCW has the COM-B model (capability, opportunity and motivation interacting for a behavioural change) at its hub, the nine potential intervention/strategy functions in the middle layer, and seven policy categories enabling the interventions as the outer circle[22,23]. (See Figure 6.1 for the BCW). The BCW has been recently modified to include a yellow layer consisting of the TDF domains[25]. The COM-B model helps determine what needs to change in the provider for the behavioural change to occur. These include "C" for enhanced physiological and psychological capacity, "O" for access to change enabling opportunities external to the providers and "M" for automatic and reflexive motivation. Automatic motivation means the provider's impulses, desires and inhibitions are controlled and positive. While reflective motivation means that the providers engage in deep and thoughtful analysis and decision-making processes. The nine potential strategy functions in the BCW are implementable strategies that would ensure the change in the selected COM-B model component[22].

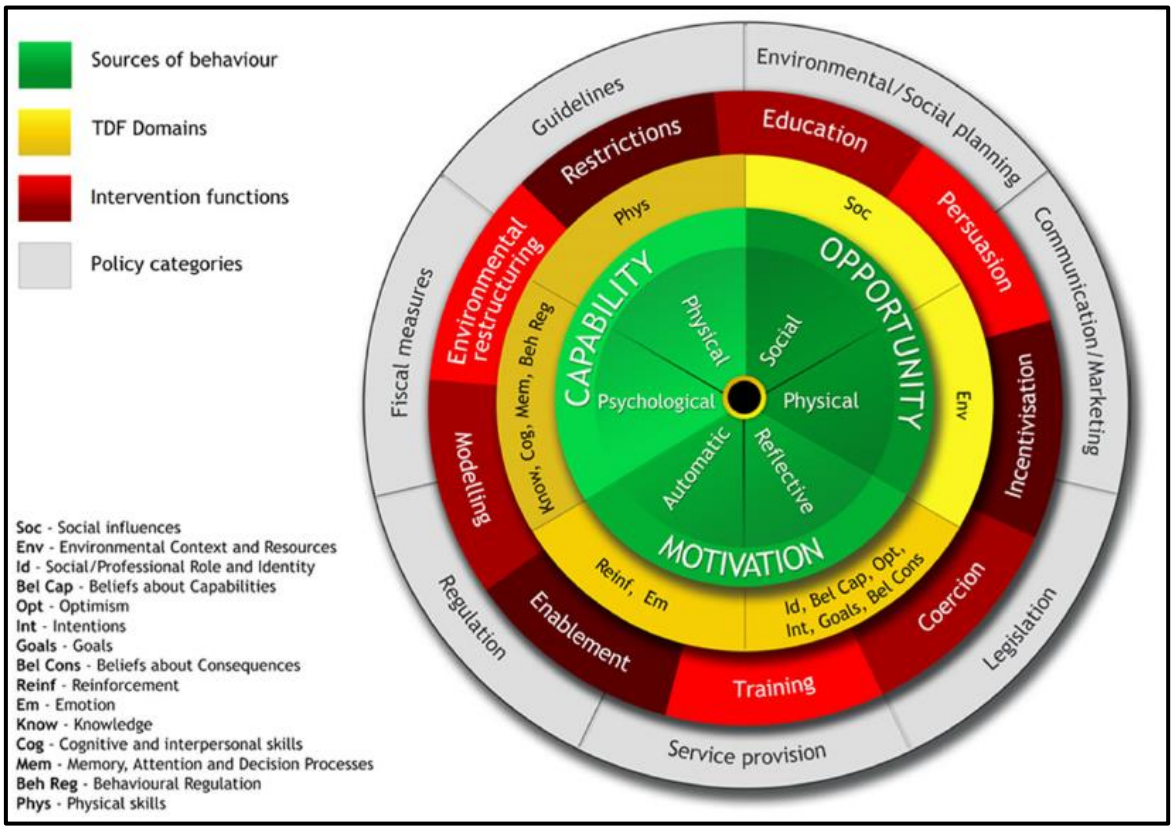


Figure 6.1: The Theoretical Domains Framework and Behavioural Change Wheel

Behavioural change is not easy[24,26]. When behavioural change strategies or interventions are based on intuition, they may not be effective, and the scientific rationale behind the change process may remain obscure even if such interventions were effective[24,27]. However, when interventions targeted at behavioural change are based on evidence-informed principles and

implementation science theory, they are more effective, especially if the theories are applied appropriately[24,27]. Before implementing RMC-promoting interventions, the RfC to RMC, and its barriers must have been determined. If barriers of RfC to RMC practice are found, then the theory-informed strategies identified in this study will be needed to improve their RfC to RMC practice. They could also be incorporated within the RMC-promoting interventions. Thus, the TDF domains and BCW support the uptake of evidence-based RMC-promoting interventions[20]. In this article, we present the theory-informed strategies and their applicability to the respondents' workplace setting.

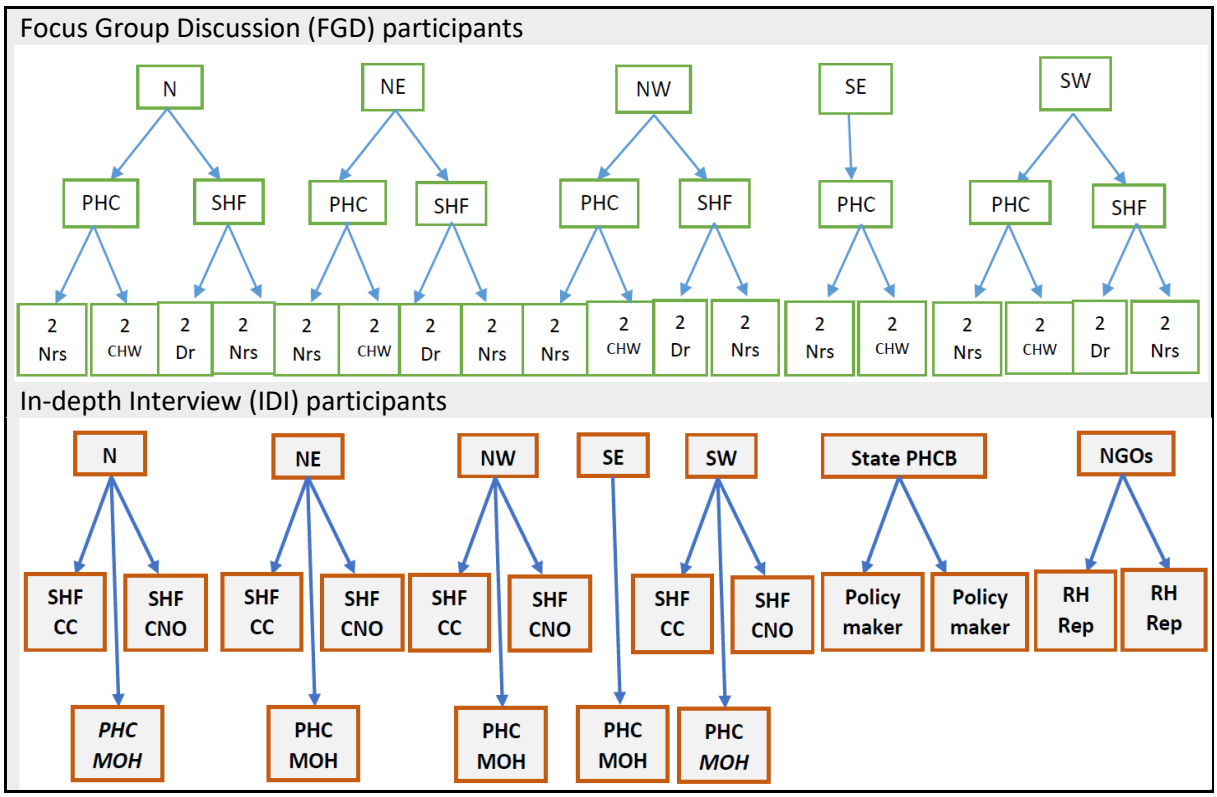
6.2. Methods

This was a qualitative study that entailed conducting four focus group discussions (FGDs) and 17 in-depth interviews (IDIs). The respondents were health care providers and relevant decision-makers in the public primary and secondary levels of health care delivery across the five local government areas (LGAs) in Ibadan Metropolis, Nigeria. These are Ibadan North (N), North-East (NE), North-West (NW), South-East (SE) and South-West (SW). Ibadan Metropolis is the 3rd largest city in Nigeria and the 7th in Africa with an estimated population of 3,756,445 in 2022.

The FGDs were conducted with homologous groups of maternal health care providers which includes doctors (Dr), nurses (Nrs) and community health workers (CHWs) practising in the state's/ province's primary or secondary health facilities (SHF). The CHWs consisted of the Community Health Officers (CHOs), Community Health Extension Workers (CHEWs), and Health Auxiliaries. The CHWs practice only at the primary health care (PHC) facilities. Figure 6.1 shows how the health providers were recruited for the FGDs. The nine selected health facilities (PHCs and SHFs) were those in which earlier phases of the research project had been conducted. One PHC and SHF each were selected from four of the five LGAs in Ibadan Metropolis (N, NE, NW, and SW), while the SE LGA contributed only a PHC, as there is no SHF in the LGA. The 36 respondents were selected by their facility heads. The eligibility criterion was a minimum of two years' work experience in the facilities.

For the 17 in-depth interviews, the Chief Consultant (CC), and Chief Nursing Officer (CNO) from the earlier selected secondary health facilities (SHF) for the FGDs were recruited. So also, the Medical Officer of Health (MOH) (also called the Director of Primary Health Care (DPHC) if not a medical doctor with postgraduate training in public health) who oversees the primary health care facilities in each LGA. In addition, two policymakers on maternal and child health (MCH) at the state Primary Health Care Board and one reproductive health (RH) program

representative from two non-governmental organisations supporting the state in MCH were interviewed (Refer to Figure 6.2 for the recruitment process for the respondents).



N-North, NE-North-east, NW-North-west, SE-South-east, SW-South-west, PHCB-Primary Health Care Board, NGOs-Non-Governmental Organisations, SHF- Secondary health facility, PHC-Primary health care, CC- Chief Consultant, CNO- Chief Nursing Officer, MOH- Medical Officer of Health, RH Rep- Reproductive Health representative.

Figure 6.2: Pictorial representation of recruitment of health providers for the FGs and IDIs

Ethical approval for the study was obtained from the Human Research and Ethics committees of the Wits School of Public Health (M190658), Institute of Public Health, OAU, Ile-Ife, Nigeria (IPHOAU/12/1243) and Oyo State Ethics Review committee (AD/13/479/1386).

The FGDs with health providers were aimed at identifying barriers to health providers' readiness for change to RMC practice in Ibadan Metropolis, Nigeria. The FGD guide was not theory-informed. The FGDs were audio-recorded and transcribed verbatim. From the transcribed FGD data, the perceived barriers were extracted and categorised into 4 broad categories: provider-related, leadership-related, health systems-related and patient-related (See the categorised barriers in Suppl. 6.1). These barriers were then presented to the stakeholders in the IDIs to identify potential strategies in addressing them. These stakeholders are decision makers who oversee the activities of health providers at the PHCs or SHFs or both.

The approach taken in the IDIs is summarised in Table 6.1. We prioritised the provider- and leadership-related barriers as those amenable to behavioural change and within the respondents'

circle of influence. These were then mapped to the 14 domains of the TDF by the respondents after we had explained the TDF to them. The respondents could map each barrier to multiple TDF domains if they wanted to. The mapped TDF domains by the interviewees were then used by the PhD candidate to derive the components in the COM-B model and the specific strategies or intervention functions (See Figure 6.1) to be implemented to address the barriers needing behaviour change. Finally, the respondents were then asked about the techniques or activities needed to apply these derived strategies in addressing the identified barriers within their health system's context. In summary, the strategies would ensure the change in the mapped COM-B model components which influences the determining factors of behavioural change specific to the identified barriers.

Table 6.1: Process of deriving potential strategies from the Theoretical Domains Framework

<table>
<tr><th>14 Theoretical Domains Framework (TDF)</th><th>6 Behavioural Change Wheel (COM-B) Model</th><th>9 Potential Strategies</th><th>Definition of the strategies</th></tr>
<tr><td>Knowledge</td><td rowspan="5">Capability- Psychological</td><td>Modelling</td><td>Providing an example for people to aspire or to follow</td></tr>
<tr><td>Cognitive skills</td><td rowspan="2">Environmental restructuring</td><td rowspan="2">Changing the physical or social context of work</td></tr>
<tr><td>Memory</td></tr>
<tr><td>Behavioural regulation</td><td rowspan="2">Restrictions</td><td rowspan="2">Using rules to reduce the opportunity to engage in a behaviour</td></tr>
<tr><td rowspan="2">Physical Skills</td><td rowspan="2">Capability- Physical</td></tr>
<tr><td>Education</td><td>Increasing knowledge</td></tr>
<tr><td>Social Influences</td><td>Opportunity- Social</td><td>Persuasion</td><td>Using communication to induce positive behaviour</td></tr>
<tr><td>Environmental context</td><td>Opportunity- Physical</td><td>Incentivisation</td><td>Creating an expectation of reward</td></tr>
<tr><td>Social-professional role & identity</td><td rowspan="6">Motivation- Reflective</td><td>Coercion</td><td>Creating an expectation of cost or punishment</td></tr>
<tr><td>Beliefs about capabilities</td><td rowspan="6">Training</td><td rowspan="6">Impacting skills</td></tr>
<tr><td>Optimism</td></tr>
<tr><td>Beliefs on consequences</td></tr>
<tr><td>Intention</td></tr>
<tr><td>Goals</td></tr>
<tr><td>Reinforcement</td><td rowspan="2">Motivation- Automatic</td><td rowspan="2">Enablement</td><td rowspan="2">Increasing means or reducing barriers</td></tr>
<tr><td>Emotion</td></tr>
</table>

The data from the IDIs were transcribed verbatim. Using a framework analysis, deductive coding was done guided by the TDF, the COM-B model and the strategy categories. Afterwards, inductive coding to identify the applicability of the strategies to the barriers was done. Regarding the trustworthiness of the research process, the credibility of the data was

assured by triangulating the FGD and IDI data on the perception of the barriers to providers' RfC to RMC and the applicability of the strategies. The IDIs were conducted in two sessions for 50% of the participants because of the inability to conclude the IDI in the first session. Member checks (respondent validation) were done at the start of the second IDI session to verify the data obtained and the researchers' interpretation from the first session.

Through purposive sampling of key stakeholders across the operational, tactical and strategic levels of management in the Oyo state Ministry of Health, transferability of the findings to the providers in the study setting can be assured. Detailed information on the research process has been provided that could ensure the dependability of the process for other researchers. To ensure confirmability, two independent researchers assigned fine codes to 20% of the broadly coded strategies. Their inter-coder agreement (ICA) was 95.7%.

6.3. Results

The socio-demographic profile of the respondents is presented in Table 6.2. Their mean age was 52.9 ± 5.2, and 58.8% were female. Six of them (35.3%) had a postgraduate degree. The respondents had an average of 26 years of work experience and 7 years in their current position. The majority of them described themselves as being at the middle level of management. The policymakers were the two who reported being at the strategic management levels.

Table 6.2: In-depth interview respondents' socio-demographic profile

Variables	Frequency (n=17)	Percentage
Mean Age (range) in years	52.9 ± 5.2 (43 – 60)	
Sex		
Male	7	41.2
Female	10	58.8
Highest level of education		
Nursing/ midwifery school	4	23.5
BSc. Nursing	2	11.8
Medical School	4	23.5
Masters' degree	2	11.8
PhD degree	1	5.9
Postgraduate medical fellowship	3	17.6
Grade level in Public service		
≤15	8	57.1
≥16	6	42.9
Not applicable	2	11.8
Location of practice		
Ibadan North	3	17.6
Ibadan North-East	3	17.6
Ibadan North-West	3	17.6
Ibadan South-East	1	6.0
Ibadan South-West	3	17.6
State Ministry/ PHCMB	4	23.6
Facility type		
Primary	7	41.2
Secondary	8	47.0
Non-governmental organisation (NGO)	2	11.8
Position		
Medical Officer of Health/ Director of PHC	5	29.4
Chief Consultant, SHF	4	23.5
Chief Matron, SHF	4	23.5
Policymaker at state level	2	11.8
Supporting NGO Rep	2	11.8
Mean years of experience (range)	26.0 ±8.1 (5 – 38)	
Mean years in position (range)	7.3 ±5.9 (2 – 21)	
Management level		
Lower / Operational	4	23.5
Middle / Tactical	11	64,7
Top / Strategic	2	11.8

Eleven (64.7%) of the interviewees reported that they had been trained on RMC, and 8 of these (72.7%) had also trained others on RMC

6.3.1. Strategies derived to address identified barriers of RfC to RMC

Table 6.3 lists the prioritised 20 provider- and leadership-related barriers identified by health providers in the FGDs down the left side of the table in no particular order of importance.

Table 6.3: Mapped potential strategies to identified barriers prone to behavioural change

	Barriers prone to behavioural change strategies	Training (n=15)	Education (n=15)	Restriction (n=15)	Persuasion (n=15)	Modelling (n=15)	Incentivisation (n=15)	Env. Restructure (n=15)	Enablement (n=15)	Coercion (n=15)
	Provider-related	**n (%)**	**n (%)**	**n (%)**	**n (%)**	**n (%)**	**n (%)**	**n (%)**	**n (%)**	**n (%)**
1	Die-hard old provider habits	9 (60)	9 (60)	7 (47)	4 (27)	10 (67)	3 (20)	10 (67)	3 (20)	8 (53)
2	Abusive stressful background	10 (67)	5 (33))	3 (20)	7 (47)	5 (33)	3 (20)	10 (67)	5 (33)	7 (47)
3	Pressure of work overload/ stress	11 (73)	2 (13)	2 (13)	6 (40)	5 (33)	4 (27)	6 (40)	11 (73)	9 (60)
4	Low provider knowledge on RMC	4 (27)	11 (65)	11 (73)	1 (7)	12 (80)	0 (0)	13 (76)	3 (20)	1 (7)
5	Poor motivation- remuneration, loans	9 (53)	2 (13)	1 (7)	5 (33)	1 (7)	4 (27)	1 (7)	9 (60)	5 (33)
6	Poor interpersonal skills (e.g. EI*)	9 (60)	9 (60)	10 (67)	5 (33)	6 (40)	2 (13)	10 (67)	4 (27)	6 (40)
7	Personal attributes (lacks courtesy)	10 (67)	7 (47)	4 (27)	6 (40)	7 (47)	4 (27)	7 (47)	11 (73)	5 (33)
8	Non-challant attitude to work	11 (73)	2 (13)	1 (7)	6 (40)	6 (40)	6 (40)	6 (40)	7 (47)	13 (76)
9	Inadequate staff a justification for mistreatment	11 (73)	1 (7)	1 (7)	7 (47)	5 (33)	6 (40)	10 (67)	6 (40)	12 (80)
10	Inter-professional rivalry	11 (73)	8 (53)	2 (13)	5 (33)	5 (33)	0 (0)	10 (67)	4 (27)	8 (47)
11	Lack training on delivering women with alternative birth position	9 (60)	11 (73)	9 (60)	3 (20)	8 (53)	1 (7)	11 (73)	2 (13)	7 (47)
12	Inadequate training for all professional cadres on RMC	10 (67)	12 (80)	11 (73)	2 (13)	10 (67)	1 (7)	11 (73)	8 (53)	5 (29)
13	Fear of low back pain for delivering women squatting	10 (67)	8 (53)	7 (47)	2 (13)	6 (40)	1 (7)	10 (67)	5 (33)	8 (53)
14	Providers give empathy but patients want sympathy conflict	9 (60)	6 (40)	3 (20)	4 (27)	4 (27)	2 (13)	7 (47)	3 (20)	8 (53)
15	Perceive patients demanding their rights as stubborn	7 (47)	7 (47)	3 (20)	2 (13)	8 (53)	0 (0)	8 (53)	4 (27)	6 (40)
16	Episiotomy cannot wait for informed consent (Safety vs RMC)	8 (53)	2 (13)	1 (7)	2 (13)	8 (53)	0 (0)	10 (67)	3 (20)	6 (40)
	Leadership Related Barriers									
17	Leadership not knowledgeable on RMC, not committed to change	11 (73)	5 (33)	6 (40)	1 (7)	11 (73)	1 (7)	11 (73)	4 (27)	10 (67)
18	Considering using rewards and punishment to promote RMC*	12 (71)				2 (13)		2 (13)	12 (80)	5 (33)
19	Poor leadership in assigning corrections and rewards	10 (67)	4 (27)	3 (20)	7 (47)	3 (20)	5 (33)	6 (40)	5 (33)	10 (67)
20	Power tussle & victimisation of providers promoting RMC	10 (67)	6 (40)	2 (13)	5 (33)	7 (47)	2 (13)	8 (47)	1 (7)	11 (73)

Table 6.3 also shows the derived strategies from mapping the TDF to the barriers to these prioritised barriers by the interviewees. For more than 50% of the respondents, guided by their mapped TDF, training and environmental restructuring strategies were derived for the highest number of barriers, 18 and 12 (out of 20) respectively. Training would motivate the providers and environmental restructuring would enhance their physical and psychological capabilities (Figure 6.1). Coercion (6 of 20), education (5 of 20), enablement, modelling and restriction (with 4 of 20) were identified infrequently as potential strategies for addressing the identified RMC obstacles (Table 6.3). Persuasion and incentivisation that are linked to the opportunity component of the COM-B Model were not selected by more than 50% of providers as being relevant to any of the barriers. The next sessions were strategy-specific and not barrier specific because a strategy could be applied to more than one barrier.

6.3.2. Strategy techniques that improve health provider capabilities as defined in the COM-B model towards addressing prioritised barriers of RfC to RMC practice.

6.3.2.1. Environmental restructuring

This was the second most popular strategy selected for 11 out of 20 barriers of RfC to RMC and it would enhance the psychological and physical capabilities of the health provider according to the COM-B model. Environmental restructuring was mapped most frequently by >70% of the respondents to barriers with serial numbers 4,11, 12 and 17 in Table 6.3 all addressing providers' or leaders' knowledge and training on RMC.

As regards the strategy techniques needed to apply environmental restructuring, the stakeholders stressed the importance of a conducive work environment to improve the interpersonal relationships between healthcare providers and clients. They referred to both the social and physical environments for this strategy.

> *"Environmental restructuring that's erm… creating a conducive working environment that would bring out the best from the providers…"*
> *(IDI 5; Chief Consultant)*

Mentoring was suggested as a way to improve the social environment of the workplace. This could be achieved by pairing trained and untrained health providers on the same schedules. An abusive junior colleague can be paired with a respectful senior which should hopefully impact a positive influence on the junior.

"Evil communication corrupts good manners but…. You see that there are some people on their own they are good but when they are paired with somebody, they are very bad. So sometimes when we are posting people you have to look at the people you are pairing together…" (IDI 7, MOH/DPHC)

The environment could be modified by moving difficult staff, through redeployments or reshuffling positions.

"One can shift roles. For example, somebody that is meant to be in labour ward but because of her attitude/ behaviours, one can move to the place where she would have less contact with clients". (IDI 5; Chief Consultant)

Improving the organisational climate to one where providers feel cared for was another form of social environmental restructuring recommended by participants.

"Yes, where you can actually show that you care about that worker, is not just about them doing their work 100% but realising that they're also human beings. They may have needs, …challenges, so that's the exact ***atmosphere****. Do leaders actually care about us?" (IDI 4; MOH/DPHC)*

To achieve this, one of the stakeholders gave this suggestion below

"So maybe from time to time, they may be 'kind of' meeting, not necessarily to look at work but just to kind of socialise, to attend to people, to listen, and that will mean the leader should also know that for people to actually give their best they must be in a good place emotionally". (IDI 4; MOH/DPHC)

For the physical environment, the stakeholders recommended the use of job aids such as posters bearing behavioural change communication (BCC) or instructions placed in strategic positions in the health facility discouraging abusive practices. They called for the procurement of necessary resources, commodities and consumables like curtains and screens for privacy. The need to provide ergometrically fitted infrastructure and resources in the labour room to the health provider to support the delivery of a woman in the squatting position.

The importance of ensuring basic infrastructure, such as water, light and ventilation, at all health facilities is stated below.

"The environment is very important. Look at it when there is light, work is always easier and when its sunny we dare not sit down there most especially when there's no light". (IDI 4; MOH/DPHC)

To achieve physical environmental restructuring, many said it is the responsibility of the government. However, an RMC focal person was said to be necessary to improve the social environment.

"For example if you say somebody is a malaria focal person, so you must have respective maternity care focal person sort of, you get. So that person …sees to the

social environment and promote the delivery of that service so that when the health providers are straying, that person reminds them of what the code, the conduct, the protocols are". (IDI 16; NGO Rep)

6.3.2.2. Restriction

Restriction was not as popular as derived from the respondents' mapped TDF to barriers. Restriction was the most preferred strategy to address barriers with serial numbers 4 and 12 on Table 6.3 which speaks to inadequate knowledge of health providers on RMC. According to one of the respondents, restriction is about ensuring health providers are:

"doing what you are permitted to do and not going beyond your limits" (IDI 2,.Chief consultant)

In applying restriction, rules and regulations must be put in place. These include time books (a daily record of the number of hours worked by health providers by documenting their check-in and check-out time from the facility), and movement books (a daily register of details on health providers' movement when they exit the facility during working hours). Standing orders and standing operation procedures (SOPs) (guiding instructions on RMC practice) were all restriction tools mentioned.

The use of internal controls such as the Service Compact for Nigerians (SERVICOM) to promote quality service delivery and ensure patient satisfaction at the secondary and primary levels of care was recommended. The SERVICOM is an agency of the Federal Government of Nigeria, implemented at the tertiary levels of care.

"This SERVICOM thing, it has to do with the way you attend to the patients. Those days you can shout on patients, but now they tell you, you don't shout. If you are caught with the don'ts involved, you will have to come up and explain yourself for something that we used to do in those days anyhow nobody will ask you" Should SERVICOM be introduced into the Primary health care? "Yes, Introduce it" (IDI 7; MOH/DPHC)

The respondents also mentioned the use of mystery clients, client exit interviews, posters and charts as restriction tools even though these are known tools used in monitoring, accountability checks and evaluation.

The respondents advised using a combination of these restriction activities. Educating patients fully on their rights would also serve to restrict health providers.

"What I am saying is you combine two things together eh… eh…interpersonal lecture series for the client, then exit client questionnaire or mystery client could be a way to check people" (IDI 15, Policymaker)

6.3.2.3. Modelling

Low knowledge of providers and leaders on RMC were the barriers that had >70% of the respondents selecting TDF domains that generated modelling as the preferred strategy to address them. The respondents described models as enablers, an example for positive change, who inspire others to do what they need to do. They are health providers trained in RMC and practising what they have been taught. They referred to models as mentors. One of them suggested that rather than investing much in training, one could engage models so that their colleagues learn directly from them.

> *Through modelling, you know, bring people, show them how you can do it. The training we had were practical trainings. We had **role-playing** during the training (IDI 17, NGO Rep).*

> *"That (modelling) can still be linked with training. If like a mentor. Like somebody giving the training. And you see that this person practices what he or she preaches. So, that will enhance the **mentoring.** So, that person can actually stand in as a trainer, a mentor" (IDI 5; Chief consultant)*

Modelling was also suggested as a way of introducing RMC into health facilities. Modelling was proposed as an exchange programme where trained health providers from RMC-certified health facilities are posted to non-RMC practising health facilities for a short period, and vice versa, to lead the change. Either way, the models must be committed to the change.

> *For example, in facilities where you have people that are doing very well, and they provide quality RMC and you have a facility that feels that they need more trainings, instead of doing like a training, you can pick that person to go and model it there for them. You can do like an exchange. Take this person to a certain facility for a certain period.*

> *"So, modelling cannot work except people understand the change" (IDI 13; Chief Nursing Officer)*

They said the RMC models should be charged with raising new RMC champions. Criteria to define who is an RMC champion could be developed. Client exit interviews could help identify deserving health providers as RMC champions. However, providers' poor means of identification by not wearing name tags or appropriate uniforms would challenge this. RMC models could be given t-shirts, crests or lapels for better identification. Other names suggested for certifying RMC practising health providers include RMC ambassadors, awardees, and influencers.

> *"….and you should not necessarily be the only one in your local government, you want to get more. ….. So at the end of the day, we want to increase the number of people who are RMC champions in the facility". (IDI 14; Policymaker)*

One suggested having RMC community champions who liaise between the women in the community and the health providers. They are to observe or be informed about, the care women received at the facility, and provide feedback to the facility heads for improvement. They however acknowledged that dedicated funds will be needed to actualise these.

> *"O [It's] possible. It depends on availability of funds. It is those partners [funders] with stamina [financial strength] that do such things". (IDI 14; Policymaker)*

6.3.3. Strategy techniques that improve health provider opportunities as defined in the COM-B model towards addressing prioritised barriers of RfC to RMC practice.

6.3.3.1. Persuasion

Persuasion was not a popularly derived technique for the barriers. Its' highest proportion of providers (47%) selected it to address barriers 2, 9 and 19 in Table 6.3. These speak to provider abusive behaviours. Also, poor judgements by providers and facility managers concerning RMC practice. This strategy is premised mainly on the act of communication. The stakeholders highlighted the need to be trained in the skills of persuasion as not all providers or facility managers have the skill to make people do what they would naturally not want to do. Persuasion should be targeted at building health providers' self-esteem and self-confidence in practising RMC. The persuasive message should include the merits of why RMC is being introduced. Every opportunity should be used to persuade. It should be incorporated into training, supervisory visits, and daily review meetings at the facilities. Whoever must persuade, however, must be knowledgeable in RMC, be committed to the change, and have personal experiences to share. It is expected that persuasion would create more awareness of RMC.

> *"For persuasion, the act of communication is very… So, it's important, definitely during every training opportunity, the importance of communication must be emphasised, how to communicate, what to communicate and how not to communicate also its important". (IDI 16; NGO Rep)*

The use of counsellors and counselling teams for persuasion was also mentioned by some. The counselling teams should represent the interest of all the professional cadres. Social media platforms could also be used as persuasive platforms.

> *"We can use social media as a platform to remind people through Whatsapp groups. We can also use Instagram and other social media to communicate with health workers across board. They trained us sometimes ago on Instagram, how to use it to communicate". (IDI 14; Policymaker)*

Another means of achieving persuasion as recommended by the stakeholders is making changes to the environment of the facilities. These include the use of posters on prohibited provider habits to patients, women's rights during childbirth and the RMC Charter being shown in strategic places across the facilities.

6.3.3.2. Incentivisation

This was not a popular strategy across the barriers. Forty percent was the highest proportion of providers who selected TDF domains mapped to barriers with serial numbers 8 and 9 which generated incentivisation. These are the provider's non-challant attitude and poor justification for mistreatment. According to the stakeholders, instituting incentives makes people comply and serves as an encouragement for good behaviour. Incentives could be in cash or kind, although the majority described incentives in kind rather than in cash because cash awards were believed to be meagre, easily spent and forgotten.

The most important incentive is the provider's statutory earnings which include their salaries and allowances, according to the stakeholders. Other possible incentives include the giving of awards such as for the most respectful employee of the month/ year/quarter. It could also be the giving of stipends, gifts such as plaques, or RMC-customised bracelets. Training opportunities were commonly mentioned mainly for the associated benefits such as hotel accommodation and paid daily allowances. Many of these are already being done by the government but could be targeted to RMC.

> *"You give annual award, remuneration, stipends, trainings, send for training, expose to further training, it's a form of incentive, letter of recommendation and commendation" (IDI 15; Policymaker)*

> *"We have so many seminars that they do send nurses to. They do pick among us. Like me, I have been to a seminar three times using a week, and we were lodged in a hotel" (IDI 3; Chief Nursing Officer)*

However, the not-so-common forms of incentives mentioned include the giving of appointments and double promotion described as "promotion out of turn".

> *"When you see somebody, and the person is your colleague. You entered service at the same year, and the person is being promoted without waiting for the next turn. That will challenge everybody o. At least, civil servants. Everybody will run after him" (IDI 7; MOH/DPHC)*

Allowing health providers to further their education if they have performed well was another form of incentive but being discouraged by the state government because of its abuse.

"They can go to school…to read more…of course, most of them they are in school …we achieve motivation and they will have more knowledge"
(IDI 10; MOH/DPHC)

"If the training is going to be fully paid by the people doing it, so they won't mind, the government for now are not willing to pay for your trainings."
(IDI 12; Chief Consultant)

One respondent felt that paying attention to meeting health providers' emotional needs could be a form of incentive, though measuring that may be challenging. The only suggested incentive for health facilities was an RMC logo that could state "women are respected here".

"Yes, it's a form of logo. 'RMC certified centre', and then the head of the facility too may be given an award, that may not be in monetary form, may just be a form of plaque". (IDI 11; MOH/DPHC)

The challenges of identifying deserving health providers for incentivisation were the same as discussed under the modelling strategy. One of the stakeholders said the use of name tags may not be embraced by health providers with tendencies to mistreat women during childbirth. One suggested that determining who deserves incentivisation should be done discreetly by the facility head with the health providers unaware of being watched.

Some of them that knows she is wicked won't wear it [name tags], if she wears it when you're there, the time you won't be present she won't wear it. These state people went to one area in the night, then they met the CHEW on duty tying wrapper. Tell me, if she will wear name tag on wrapper. When you are an adhoc or not, is that the reason why you will not wear your uniform?"
(IDI 7; MOH/DPHC)

"So you will never know what they do except the guards are down [not conscious of being watched]" (IDI 4; MOH/DPHC)

. However, interviewees did note that the challenge with incentivisation is the availability of resources to support and sustain such strategies. One respondent argued that incentive schemes required clear communication about how much is available and for how long.

"Sometimes that is also the problem with incentivisation, they start something without communicating the fact that it has a timeline and that beyond this timeline, this thing is not going to be sustainable", (IDI 16; NGO Rep)

Who will also be responsible for providing the incentives was explored. They suggested the government in the majority of cases, including the heads of the wards and facilities. One suggested that incentives should be made very competitive to achieve better results.

"So that way, once there is competition, people can strive to be the best". (IDI 4; MOH/DPHC)

6.3.4. Strategy techniques that improve health provider motivation as defined in the COM-B model towards addressing prioritised barriers of RfC to RMC practice.

6.3.4.1. Education and Training:

Training was the most popular of the strategies applicable to almost all the barriers. It enhances motivation while education creates social opportunities, however, the respondents used them interchangeably as many felt either is a subset of the other. However, one was able to differentiate the two.

"So, for the education, its training and retraining" (IDI 5, Chief consultant)

Education is still part of training now? (IDI 2, Chief consultant)

Training is targeted on particular skills. Training has to do with skill. Education could be general but training has to do with a specific skill. Education it's a general exercise. (IDI 7, MOH/DPHC)

To train health providers about RMC, they suggested the organisation of seminars and workshops, mentoring, and peer review processes at regular review meetings. The re-orientation of health workers on their job roles, professional boundaries and ethics were also mentioned. The importance of monitoring training and orientation outcomes is stated below:

"The workers should be orientated often and often on RMC. There should be proper training, there should be presentations practically. . And they should be monitored properly to ensure adherence" (IDI 14; Policymaker)

As regards the training modalities, they suggested an "adult mixture" methodology which consists of hands-on, practical sessions with demonstrations. They recommended the use of audio-visuals with pictures and videos for training, especially at the LGAs. Didactic lectures were termed ineffective and a waste of time. The reason for this is stated below.

"…Because the kind of people you are talking about, they are elderly ones, they can't go through rigorous reading. But if you do less reading for them, more of practicum, it becomes more useful for them". (IDI 15; Policymaker)

Concerning the training content, the respondents suggested that it include topics such as how to deliver women in alternative birth positions, interpersonal skills, communication skills, emotional intelligence, life skills and stress coping mechanisms besides the overall RMC concept. They suggested that the pre-service curriculums of all cadres of health workers should include RMC, communication skills and psychology with topics such as emotional intelligence. The training should be need-based and designed to target identified gaps in practice.

"Some people …are having self- esteem issues, they're having psychological issues, so they cannot do better for the patient. …So somebody has to realise that there is a problem in the way some of us were trained, and in the psychological aspect of our training. So that needs to be looked into". (IDI 4; MOH/DPHC)

"People should be trained on communication skills during undergraduate". (IDI 8; Chief Consultant)

Probing further on communication skills, the stakeholders felt that health workers communicate poorly and that getting communication right would help RMC. One stated that what is currently being practised is not communication but "*telling" or "giving instructions*" to the women.

"And you know most of the time our health workers don't really communicate, especially those in the public system, …They only tell them, they don't communicate. "Oya" [Let's, go and buy this, go and do this" (IDI 16; NGO Rep)

"… They are supposed to inform their patients about their right and privileges and they have the right to ask questions and you explain patiently to them, if they have further questions ... you explain again". (IDI 4; MOH/DPHC)

Training involving the entire facility that would include all clinical and non-clinical staff was proposed. This was termed necessary because abusive non-clinical staff could also drive patients away, even at the facility gate. Training the right kind of people, for example, the facility manager who should drive the implementation was raised. They attributed faulty methodologies not well suited to the audience as responsible for the ineffectiveness of some training.

As regards the monitoring and evaluation of the training conducted, lack of accountability was suggested as a reason why training was ineffective. To ensure accountability, they suggested that a peer review or monitoring process be integrated into the training. They also called for the constitution of mentoring teams, RMC monitoring teams, and more effective supportive supervision teams. Accountability and result frameworks for the expected services to be provided following the training were a few monitoring tools suggested. According to the respondents:

"Yes, yes because it is one thing to just impact knowledge but it is another thing to want the people that are recipient of that knowledge to become accountable". (IDI 16; NGO Rep)

Some interviewees said that health workers should be viewed like customer service representatives in corporate organisations where service providers are trained in relating with

the customer. Health providers should also be trained in such a way and cultivate the culture of everyone training one another on RMC.

Some training programs are perceived as not genuine nor relevant with topics not based on their training needs. Also, the disposition of the training facilitators gives away the genuineness of the training programs. Such training packages are often not taken seriously.

> *" ..you see when you organise a training and you get there to see people are not genuine. You can know when they are playing and when they are serious kind of thing. What you are teaching them they won't take it serious. They will attend quite alright but as soon as they are leaving, they are leaving your whatever with you and they are going, and if you ask them what was taught, they will give you the manual to check for yourself. The training has to be relevant not just bring anything. So that's the problem we have in training" (IDI 7; MOH/DPHC)*

6.3.4.2. Enablement

Enablement was derived most frequently to address the pressure of work overload on providers, providers lacking courtesy and leaders using rewards and punishment to promote RMC practice (Refer to Table 6.3). According to the stakeholders, enablement could be addressed by removing the work overload, either by employing more adjunct staff, or more task shifting where some responsibilities can be ceded or shared with other professional cadres. The second most popular option was the giving of incentives which also include paying their emoluments, statutory earnings and allowances. Two of the stakeholders reported they have been enabling themselves, by procuring the sphygmomanometer used for their patients from their purses. These were necessary to provide effective and efficient care domain of RMC. One, because these were not provided for at their LGA, and another because she needed more modern equipment like a digital sphygmomanometer to ease her work burden.

> *"Enough skilled providers should be on ground to offer the service so that we won't be having stories that touch. Enough skilled personnel should be available, so that one person would not be attending to too many people and this would hinder the individual from giving the best of services". (IDI 4; MOH/DPHC)*

> *"you can't tell somebody to promote RMC when the person has not been trained on RMC, when all the commodities and equipment to implement it is not available when there are no incentives, you know, statutory incentives are not even paid as at when due" (IDI 1; NGO Rep)*

Some stakeholders' suggested that it would be enabling to encourage health providers to engage in academic programmes. They called for more qualitative supportive supervision saying this is not being done adequately because of inadequate funding support. One of the respondents

said that the providers should be regularly asked why they are not performing and what they need to perform, and then provide what they need to perform.

6.3.4.3. Coercion

Coercion was most frequently derived to address providers' non-challant attitude to work, their justification for mistreatment and facility managers who victimise trained providers promoting RMC practice (See Table 6.3). According to the stakeholders, adequate knowledge of RMC and the means needed to practice it, must have been ensured before implementing coercive strategies. While one attributed the failure of the health system to the lack of coercive mechanisms, another felt coercion is never effective. This is because of corruption in the system. Another reason for the ineffectiveness of coercion is that some providers never change irrespective of the punitive measures meted out. Many would prefer giving mild coercion such as warnings and cautions to reprimand defaulting health providers. Nonetheless, one insisted that for coercion mechanisms to be effective, the rules must be codified and institutionalised (integrated into the protocols of the health facility).

> *"Codified means that it is in a document, it needs to be documented and accented to maybe by the highest authority within the health sector, usually maybe the commissioner and its institutionalised because it becomes an instrument for engaging the workers" (IDI 16; NGO Rep)*

The giving of queries was a popular and strong means of administering coercion, especially after 2 to 3 warnings. This will be deposited in the provider's file. It could lead to worse experiences like a demotion or downgrading in salaries. Leaders could be removed from office or reported to higher authorities if undesirable behaviour persists after being warned.

> *"A leader can be reported to a higher authority…Every leader has another leader (IDI 1; MOH/DPHC)*

> *"The question is why, and that is the indiscipline. If you know that you are going to be asked you know for everything you do, you are going to be called to question for everything you do, you will be held liable for everything you do, then you are going to adjust". (IDI 1; MOH/DPHC)*

6.3.5. Summary of strategies and strategy techniques

Overall, the respondents identified 55 strategy techniques by which the derived strategies can be achieved. Five of these were identified for more than one strategy. The providers also suggested combining strategies. Some of the strategies mentioned were generic and not specific to RMC, but applicable for improving the quality of health services. Table 6.4 presents a summary of the strategy techniques mentioned for each strategy at a glance.

Table 6.4: Summary of identified strategies and strategy techniques to address barriers of RfC to RMC practice

	Strategies	Strategy Techniques for provider behavioural change	
1	Environmental Restructuring	Conducive work environment	**Job aids (posters on RMC)**
		Mentoring	**Commodities and equipment**
		Reshufflements	Ergometrics in the labour room
		Socialisation meetings	Provide infrastructure
2	Restriction	Rules and regulations	Mystery clients
		Time book	Client exit interviews
		Movement book	Internal controls (SERVICOM)
		Standard operating procedures	**Posters reading- E.g. "Don't shout"**
3	Modelling	**Mentoring**	Staff Exchange programs
		Facility RMC champion	Community RMC champion
4	Persuasion	**Improve communication skills**	Counselling teams
		Improve persuasion skills	Social media platforms
			Job aids (Posters)
5	Incentivisation	**Regular salaries and wages**	Give appointments (political)
		Awards- best staff of the year	Promotion 'out of turn'
		Stipends- for practising RMC	Career Advancement
		Gifts- plaques, RMC bracelet	Training opportunities
		Meet emotional needs	Make incentives competitive
		For facility- RMC logo and certification	
6 & 7	Education and Training	Seminars and workshops	Revise pre-service curriculums
		Mentoring	Need-based training
		Regular peer review meetings	Accountability mechanisms
		Orientation and re-orientation	Customer service-like relationships
		Training with Audio-visuals and	RMC Mentoring teams
		Practical demonstrations	RMC monitoring teams
		Train on communication skills	Introduce psychology- EI
8	Enablement	Engage adjunct staff	**Procure commodities and equipment**
		Task shifting	Train on RMC
		Pay salaries and allowances	Adequate number of health providers
9	Coercion	Codify coercion	Demotion
		Institutionalise coercions	Degrading with salary reduction
		Give queries	Removal from office

Note: BCC-Behavioural change communication; EI- Emotional intelligence; RMC- Respectful maternity care; e.g- For example. Words in bold- Strategy techniques applicable to more than one derived strategy

6.4. Discussion

This study aimed to assist RMC implementers and programme managers identify strategies that would address barriers limiting health providers' RfC to RMC practice. I derived all nine strategy functions in the Behavioural Change Wheel to address the identified barriers of RfC to RMC practice in this study. This was informed by the TDF domains mapped to the barriers of RfC to RMC by the respondents. Of the nine strategies, environmental restructuring to build health worker capabilities, and training/education to improve their self-motivation were the

respondents' most preferred strategies. While persuasion and incentivisation, both addressing opportunity in the COM-B model were not as preferred in addressing the barriers. I also identified 55 strategy techniques directly from the IDI respondents as the methods by which the derived strategies can be applied. A few strategy techniques spanned more than one derived strategy. These included mentoring, job aids, communication, commodities and equipment and paid remuneration. The respondents suggested a combination of strategies to effectively address the barriers. They emphasised the need for facility and community RMC champions and a committed leader to lead the change and oversee the implementation of these strategy techniques. However, some of the strategy techniques are not specific to RfC to RMC, but applicable to the delivery of quality health services. The details of how these techniques will be applied were also not explored in this research.

6.4.1. Making training effective as a motivational strategy

Training is a motivational tool[28,29] which is key to achieving organisational goals through its human resources[28]. The expected immediate output of training is capacity building[30]. However, according to the Behavioural Change Wheel, the end result of training is motivation[23]. For example, training significantly increased motivation amongst health workers in the Narok County of Kenya[29]. Motivation refers to the habits, emotional responses, and analytical thinking that direct behaviour[23]. These are the self-motivational intrinsic factors that influence provider decisions[31] and inspire them to do much more than their call of duty[32]. Regarding RMC practice, they could be motivated to be more respectful to women during childbirth despite the contextual limitations such as high work overload or limited resources[33].

Human resource training incurs huge costs and requires significant investment. Unfortunately, training workshops are sometimes not taken seriously with poor provider participation[34]. According to the respondents, health providers would not take an RMC training programme seriously if they doubt its sincerity of purpose and relevance. Training could be made more effective by determining RMC training needs using a bottom-up approach, and this should guide training package decisions[35]. Well-prepared subject experts should be used as training facilitators. This was supported by a recent study where managerial trainees ranked the resource person as the most important factor for a training programme's success[36]. Also, accountability mechanisms for trained health providers using result and accountability frameworks[37] should be used to monitor and ensure their training outcomes are achieved.

The respondents' suggestions for training curriculums to be reviewed regularly correlates with similar opinions in the literature[38,39]. The quality of the training curriculum directly impacts the

proficiency of the providers trained[40,41]. The stakeholders recommended that communication skills and psychology should be an integral part of health provider training curriculums. This was corroborated by the reported need for teaching communication skills to medical students in America[42] and nursing students in Sweden[43]. Most Nigerian medical schools' curriculums were adapted from the British with a call made to revise the curriculums in 2021[39].

6.4.2. The cost-effectiveness of an enhanced workplace environment

The workplace environment is critical to addressing provider-related barriers of RfC to RMC practice. From the findings, the mechanisms by which the strategy techniques identified for physical and social environmental restructuring of the workplace will lead to enhanced provider capabilities can be explained as 'making it easy to learn, retain and practice what is leant'. A friendly work climate with the necessary amenities would make work a worthwhile experience. Regarding RMC practice, more respectful, skilled and competent health providers working in a comfortable and enhanced health facility environment should increase health facility delivery and eventually lead to improved maternal and neonatal health outcomes.

One possible challenge with creating a conducive work environment is the high cost[44]. However, there is less cost in influencing the social work environment positively. Improving the physical environment may be more cost-effective in the long run as it is expected to yield high health worker productivity[45]. Empirical research will be needed to determine how cost-effective is the cost of restructuring the physical environment or not compared to a measured outcome such as the provider's organisational and individual readiness for change to RMC practice, or barrier-specific behavioural change or health service delivery outcome.

6.4.3. Effectiveness of identified dual and multi-purpose behavioural change strategy techniques for addressing barriers of RfC to RMC

The existing evidence in the literature was explored for the identified strategy techniques in this study applicable to >1 derived strategy for addressing RfC to RMC. A systematic review has described peer mentoring as an effective approach to behavioural change in meeting personal health goals[46]. A qualitative inquiry of mentoring interventions amongst nurses also found it effective[47]. A systematic review of 28 papers assessing communication-related behavioural change techniques found behavioural counselling as one of the effective communication techniques that influenced nurses' and physicians' capability to communicate and influence their patients' lifestyle-behaviour[48]. However, another systematic review of communication interventions for maternity care providers and the effect on women's experience of care, with 2 eligible papers reviewed, showed low-quality evidence with some effect in one and no effect

in the other. Behavioural change techniques were not reported in the papers. The authors called for urgent research to characterise the communication priorities of women in labour and explore how organisations, implement, and sustain effective communication-related strategies.

A Cochrane review of four different forms of payment for remuneration mechanisms showed its significant effect on the clinical activity of primary care dentists though the quality of evidence was low for the two papers included in the review[49]. A 3-hour intervention entailed training antenatal care nurses on the use of a job-aid designed to assist in counselling women on birth preparedness and complication readiness[50]. The findings showed a wide increase between the baseline and end-line results of women's perceptions of being told the danger signs in pregnancy and a favourable caring behaviour of the nurses[50].

6.4.4. Gaining more with few- combining RMC strategies

The respondents recommended the combination of the strategies and strategy techniques. For example, training alone may be insufficient in promoting the uptake of RMC by providers without addressing other health system factors[51]. Combining the various strategies should strengthen the expected outcomes at a minimal cost. A scoping review of 135 articles advised the combination of strategies as one could make up for the limitations in another[45]. The derived strategies with similar strategy techniques could form a basis for the combination of strategies. Mentoring was common to environmental restructuring, modelling and training. For a barrier of RfC to RMC that has all three strategies derived as possible solutions for it by a high proportion of the respondents, these three strategies can be combined. An example of such a barrier is the provider's old or die-hard habits and inadequate training of providers on RMC (Table 6.3). Other strategy techniques within these strategies could also be combined. Future research may be needed to determine the most effective and cost-effective combination of strategies and strategy techniques for addressing barriers of RfC to RMC practice.

6.4.5. Leadership- critical to driving RfC to RMC uptake

Overall, the participants stressed the key role of leadership in successful RMC implementation. Leadership at various levels will be needed. According to IntraHealth International, RMC is everybody's business[52]. Individual health providers should take leadership and be agents of change in the labour wards, maternity care units and facilities. They can achieve this by being role models for their peers. The respondents suggested the use of RMC champions at the health facility or the LGA. They said they should be mandated to recruit more RMC champions. The RMC champion is to motivate other providers to practice RMC during childbirth. Similar programs engaging champions have been implemented in the past and found effective[53]. The

respondents also proposed the need for an RMC focal person. This is a technical person with a job description to supervise and monitor the implementation of RMC in health facilities. Ensure that all the derived strategies are in place, track outputs, identify barriers early and take necessary actions. The RMC focal person could operate at the LGA and state levels of care. Leadership, within the complex interaction with governance and finance, were reported as some of the health systems' constraints in RMC implementation among maternal care providers in Ethiopian public hospitals[54]. Leaders responsible for driving RMC must be accountable, lead by example and be committed to championing the change.

6.5. Conclusion

Training and environmental restructuring were the most frequently occurring of the nine derived strategies to address the prioritised behavioural change-related barriers of RfC to RMC practice. This strongly suggests that when the providers are self-motivated and given an enabling environment, their readiness to embrace positive changes in the organisation will be enhanced regardless of external incentives. There are evidence-based effective strategy techniques to achieve the derived strategies, which may apply to more than one derived strategy. Thus facilitating a combination of strategies and the techniques for achieving them as advised by the respondents. This would maximise the cost of implementing these strategies and techniques to achieve much more with few. However, the most cost-effective combination of strategies with the maximum effect on health providers' RfC to RMC, or other behavioural and maternal health service delivery outcomes should be determined. Overall, a leader supported by an army of RMC champions and RMC focal persons, all committed to the change to RMC practice will be needed to implement the strategy and strategy techniques and improve provider readiness for change to RMC practice.

6.6. Strengths and Limitations of the Study

This study triangulated data from the FGD and the IDI. We used an evidence-based systematic process to identify strategies for improving RfC to RMC practice. We used theoretical evidence to identify strategies that could address barriers to RfC to RMC. Findings from this study should guide future planned RMC-promoting interventions.

There were also some limitations to the study. The mapping of the TDFs to the barriers was a very tasking process for many of the stakeholders with already very busy work schedules. To ensure the quality of work done, the researchers had to schedule two visits to patiently explain the TDF and BCW to them. This could have led to some fatigue in the data collection process.

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Supplement 1: Perceived barriers of readiness for change to respectful maternity care by FGD participants (health providers)

S/no	Provider related barriers	Leadership related barriers	Health systems related barriers	Patient related barriers
1	Old provider habits die hard/ people's mindset	Leadership not vast in the knowledge of RMC and not committed to a change to it – a challenge in taking lead for RMC change	Lack of enabling environment (screens, staffs, equipment space, structural design of the facility, insecurity, no electricity)	Low level of awareness of patients on RMC
2	A provider's abusive training/ stressful background	Considering using rewards and punishment to promote RMC	Facility's physical appearance and neglect of patients in labour	Patients not knowing their rights (enlightened patients)
3	Pressure of work overload/ stress/ High patient to provider ratio	Poor leadership in assigning correction and rewards appropriately	Irregular or non-review of provider activities/ performance	Poor birth preparedness plans by patients (eg. Leruless one)
4	Low level of awareness & knowledge of providers on RMC	Power tussle & victimisation of providers promoting RMC	Non-functional feedback systems	People absconding with hospital bills Vs No Illegal detention
5	Poor motivation of providers (poor remuneration, staff loans, etc)		Barriers with poor process of introducing RMC to facilities	Uncooperative behaviour of patients (religious activities- Purdah)
6	Poor interpersonal skills by providers (communication skills e.g verbal & non-verbal, emotional intelligence, transfer aggression)		Lack of Standard Operating Protocols on RMC	Harmful cultural practices (Hantu, ounde, ewedu)
7	Provider's Personal attributes- (eg. lacks courtesy & morals easily angered, family problems, not empathetic, egoistic, shouts		Promoting quality versus RMC together- any challenge with this?	
8	Inadequate staff is a justification for mistreatment of women		The rigour in practicing new ideas (RMC)	
9	Non-chalant attitude of health workers to work		Awareness of competitors as a driver for RMC?	
10	Inter-professional rivalry/Strained provider-provider relationships		Applicability of global research to local context	
11	Lack of training on how to deliver a woman squatting (convenience of HWs for such delivery)		Level of health facility (if 1º, 2º or 3º) a limitation to provider's readiness to change to practicing RMC?	
12	Getting all cadres of health workers trained and retrained on RMC with re-enforcements of trainings		Rigid organisational culture	
13	Fear of low back pain & convenience of provider if client opts for alternative birth positions		Bridging the gap between maternity care services offered in the private and public health facilities	
14	Conflict between patients' expectation & what the provider's should do- empathy versus sympathy			
15	Perceiving patients' demanding their rights as being stubborn			
16	Episiotomy cannot wait for informed consent (Safety Vs RMC)			

CHAPTER SEVEN: INTEGRATED DISCUSSION, RECOMMENDATIONS AND CONCLUSION

7.1. Overview of Research Findings and Implications

For this study, I set out to determine the current status of respectful maternity care (RMC) practice during childbirth in Ibadan Metropolis, Nigeria. If found deficient, determine the state of the health providers' readiness for change to RMC practice, and identify how their state of readiness for change can be improved if not optimal. To address these concerns, I conducted a mixed method sequential exploratory research design in three phases in nine health care facilities across the five LGAs of Ibadan Metropolis, Oyo State, Nigeria. First, pregnant women's perceptions of respectful maternity care (RMC) during childbirth were explored and compared with the global standards of RMC, as represented by the 12 RMC domains characterised by Shakibazaddeh *et al*[1]. I then evaluated current RMC practice in the study facilities using two different methodologies - observation of women during delivery and then interviewing them postpartum. After this, I evaluated the readiness of the study health providers and their organisations to practice RMC and explored the factors associated with increased readiness for change. Finally, focus group discussion with health care providers helped determine the main barriers to readiness for change to RMC practice, and then local stakeholder interviews were used to identify appropriate behavioural change strategies to address those barriers in the study setting. This was done using a systematic, evidence-based, and theoretically-informed process. In this chapter, I have triangulated the findings from the different methods of data collection and identified what is common across them, and what these contribute to improving readiness for change to RMC practice.

This study has provided some novel findings on health providers' readiness for change to RMC practice and the strategies needed to address existing barriers of readiness for change to RMC. A summary of the findings and their implications, by study objective, are presented in Table 7.1. Overall, the proportion of women observed to have received RMC during childbirth was low, but the women themselves reported higher experiences of RMC when interviewed postpartum. The discrepancy in the findings between women's self-reported RMC and what was observed independently during childbirth reflects the women's perceptions and expectations of RMC and their normalisation of mistreatment. The RMC received by women is also influenced by health providers' perceptions of women's rights during childbirth, their knowledge of RMC, and the available resources to provide RMC. However, readiness for

change to RMC practice and the valuation of the change were high, suggesting that RMC implementation should not be problematic in this setting. Also, this research has provided strategies and strategy techniques with which to address the identified barriers of readiness for change to RMC practice. I attest to the adequacy of the frameworks used and that the conduct of the research did not deviate from the theoretical underpinning that guided the research design.

Table 7.1: Summary of research findings and implications

S/No	Objective	Chapter	Key Findings	Implications
1	To explore the perceptions of pregnant women about RMC during childbirth in Ibadan.	3	• Women's definitions of RMC aligned well with seven of the defined 12 RMC domains. • For two of the seven domains, the women had also normalised abuse for certain categories of women. • It deviated for four of the RMC domains • One domain not mentioned (physical environment) • Women's definitions of RMC may vary based on cultural and social differences	• Challenges the applicability of global standards to local settings • Questions who should define RMC • Challenges RMC evaluations and comparability • Impacts on women's ability to demand for RMC • Women normalised-loss of autonomy, privacy • Nonetheless, every woman's rights should be preserved during childbirth.
2	To determine the proportion of women experiencing respectful maternity care (RMC) during childbirth in Ibadan.	4	• No woman received 100% of observed RMC list • Wide disparities in observed and reported RMC • Least observed RMC sub-category received was informed consent (loss of autonomy) and privacy • Observed RMC and reported RMC measures were correlated but methods not in agreement • Women's employment status and delivery site characteristics influenced the level of RMC received	• No agreed cut-off challenges dichotomising women into those who received RMC and those who did not • Questions defining RMC as an all or none concept • Loss of autonomy and privacy were the least sub-categories received • Self-reported RMC received from interviews cannot be a proxy for observational studies • Challenges methods for measuring RMC received
3	To evaluate the organisational and individual readiness for change to RMC and explore associated factors in Ibadan	5	• Provider's perceived women's rights related to the mistreatment women received during birth • High provider ORC_{RMC} and IRC_{RMC} • ORC_{RMC} and IRC_{RMC} were positively correlated • Value for change and adequacy of resources for the change significantly influenced RfC to RMC • Increasing provider income and years of experience positively influenced ORC_{RMC} • ORC_{RMC} varied across different health facilities	• Improving providers' perception of women's rights may reduce mistreatment during birth. • RfC to RMC not likely an implementation problem • RMC values must be emphasised in implementation • Availability and adequacy of resources essential for RMC implementation • Longer serving providers could be RMC Champions • Workplace contexts could significantly influence RMC implementation, and must be explored
4	To identify potential strategies to improve the readiness for a change to RMC practice in Ibadan.	6	• Training and environmental restructuring were preferred strategies to address barriers of RfC to RMC • Useful techniques include mentoring, job aids, communication, enhanced physical environment	• Training motivates and environmental restructuring would enhance capability to practice RMC • Individual workplace contexts and barriers must be overcome for successful RMC implementation

7.2. Integrated Discussion

7.2.1. Women's expectations of RMC and health providers' perception of women's rights are related to what women would receive during childbirth.

The qualitative study amongst pregnant women matched the women's perceptions and expectations of respectful maternity care with current global definitions- the 12 domains of RMC. The pregnant women's perceptions resonated well with the equitable care domain as being necessary for RMC received during childbirth. Their perceptions however deviated for four of the RMC domains namely informed consent; continuous birth companion; privacy and confidentiality; and respect for women's choices about mobility, food intake and birth position. The majority of the pregnant women had felt these four RMC domains were not essential to receiving a respectful childbirth experience (Chapter 3). In the RMC evaluations, the equitable care sub-category had the highest proportion of women who were observed, and who also reported, receiving it (Chapter 4). While the four domains deemed not mandatory for RMC by pregnant women had very low proportions of women who eventually received them.

Several studies in the literature have also shown that the majority of women do not receive these four RMC domains when observed during childbirth. In an observational study of childbirth across four countries, Nigeria inclusive[2], 75% of the women observed received non-consented episiotomy procedures, 78% had no birth companion, and 94% had no option to choose their preferred birth position[2]. Only 3% of women studied across four government hospitals in Tanzania reported they were allowed mobility during labour compared with 15% who reported the same when they chose to deliver at home[3]. Consistently, the women they studied were made to deliver in the supine position, though the majority of the women were not also aware of alternative positions[3]. These findings were similar for these domains in other literature[4,5] and suggest that women commonly do not receive these RMC domains during childbirth.

However, we cannot decipher if the observed RMC received in those studies varied with the studied women's perspectives, pre or post-observation. This is because many of these observational studies did not report women's perceptions or expectations of RMC within the same study design, except for the study conducted across four countries that also conducted a community postpartum study[2]. The women's perceptions in the community survey supported those of the observational study, however, the proportions reported for the women's self-report of their childbirth experience were much lower compared to the observed. In my study, both

the observation and interview of women postpartum were included. I also explored women's perceptions of RMC and related the three study designs and their findings.

The health providers did not believe that women should always have the right to a birth companion and to choose alternative birth positions (Chapter 5). These are also two of the four domains that pregnant women did not deem necessary for RMC during childbirth. Therefore, it is not surprising that these were the most common forms of mistreatment reported by the providers (Chapter 5), and that less than 5% of women were observed to have received them during childbirth (Chapter 4). These deficiencies in RMC practice are unlikely to change unless healthcare providers support the change or pregnant women demand them. Further analytical research is needed to link maternal care providers' perceptions of RMC and women's rights to their practice during childbirth with the providers as the unit of observation. This is to prove that their perceptions would strongly influence their practice in the labour room.

The health providers' perceptions of women's rights did not significantly influence their individual readiness for change to RMC practice (Chapter 5). Their poor perceptions of some of these women's rights may have explained this. Maternal care providers in Queensland, Australia were reported to have a poor understanding of the rights of women and their foetus[6]. Canadian women's autonomy in decision-making was found to be significantly altered by the type of care provider and women's ability for self-determination[7]. An increase in the proportion of providers who support more of these rights during childbirth may yield a more significant association.

However, despite the perception of health providers studied in Kenya on the importance of women's rights to effective communication and autonomy, 33% and 73% of them reported that they do not always explain the purpose of examinations and procedures to the women, nor obtain the women's consent for the procedures respectively[8]. They stated several factors that could be responsible for this which include but are not limited to inadequate provider knowledge and skills, unconscious behaviour, forgetfulness, and women's inability to demand their rights[8]. All these factors mentioned are related to the 14 domains of TDF as published in the literature and also presented in this study. The authors of the Kenyan study called for interventions to address the factors that negatively influence provider interactions with their clients[8]. In addition, I advise that the theory-informed interventions and strategies such as were identified in this research (Chapter 6) be considered in addressing the barriers identified, as well as to improve the providers' readiness for a change to give women their rights to autonomy and effective communication. I also call for experimental studies that would measure the

effectiveness of such interventions on health providers' sustained perception of women's rights and maternal outcomes.

Pregnant women also need to know about and demand their rights during childbirth[8]. The majority of seventeen Tanzanian women studied using a mixed-method approach were aware that their rights were being violated during childbirth, they could describe what were their basic rights and suggested solutions to forestall this[9]. Women may have poor perceptions and low expectations of RMC during childbirth because they are ignorant of RMC, and of their rights during childbirth[10]. In addition, power imbalances between the health providers and the women[11], or misplaced trust in the health providers' decisions, actions and inactions[12] during childbirth, may explain why women would not expect or demand all of the dimensions of RMC during childbirth. These low expectations and normalisation of mistreatment could also explain the significant gap between self-reported RMC compared with observed RMC received (Chapter 4).

7.2.2. The normalisation of abuse may explain the disparity between the observed and reported RMC scores for the domains women had mixed perceptions

The pregnant women interviewed had mixed perceptions for two domains- being free from harm and mistreatment, and preserving women's dignity. They did mostly agree with these two RMC domains. However, some believed that uncooperative women and teenage mothers could be beaten or hit and that there should be a mixture of harshness and love to discourage women from being indulged during childbirth. Also, they agreed with the policy whereby women who could not pay their delivery bills should be detained at the health facilities until they pay, empathising with the providers rather than the women. All these suggest some normalisation of abuse in the study context and would lead to under-reporting of these practices. Self-reported RMC scores were significantly higher than the scores by independent observers (Chapter 4). Many have called for women's active involvement in defining the "who" and the "what" of RMC received[9,13,14]. However, the normalisation of abuse by women in certain settings may challenge the universality of the RMC definitions.

The disparity between observed and reported RMC could also challenge the methods used to measure RMC. This disparity has been noted in studies that compared the two methodologies, with observed RMC many times lower than the reported[2]. These findings strengthen the call for observational studies in assessing RMC received. Standardised tools and methods of

measurement may positively impact the evaluation of RMC and its comparability across settings. However, the standardised tools should not be complex nor lengthy, but rather easy to use. It should be tested across multi-cultural settings and be easily adaptable for use. It should have a well-defined criterion to measure who has received RMC. There should be broad stakeholder and subject expert engagement in its development. These could increase the acceptability and use of the tools.

7.2.3. The importance of context in readiness for change to RMC and its implementation

The important role of context in RMC implementation is repeated across the different study components. Pregnant women themselves stated the difficulties with providing privacy in public facilities. They perceived privacy as a luxury only available at a higher cost in private health facilities (Chapter 3). The level of RMC delivered (Chapter 4) and organisational readiness for change to RMC (Chapter 5) showed statistically significant variations across the different health facilities studied.

Some of the contextual factors explored include the availability and adequacy of resources. These resources include adequately trained health providers in RMC, RMC training guidelines, educational materials, equipment and commodities. The health providers (91.4%) reported that facilities to support birth companions were not available (Chapter 5). The process of introducing RMC into health facilities, the leadership and health systems-related barriers identified by the health providers (Chapter 6) also all relate to the role of context in RMC implementation. Health providers' perceived adequacy of resources significantly influenced their readiness for a change to RMC (Chapter 5). This shows that for a successful RMC implementation process, the individual facility contexts must be investigated, local resource deficits should be rectified, and implementation strategies appropriately individualised.

Variability in the level of organisational and individual readiness for change to RMC practice across health facilities could result in undue inequitable access to RMC across settings as unveiled in a commentary on this[15]. A high organisational and individual readiness for a change to RMC will be needed across the levels of health care to address these contextual factors across the different levels of care as presented in Chapter 4 of this thesis. Committed and effective leadership across the levels of health care delivery will be needed to lead the change to RMC. These are necessary to successfully implement the identified strategies and thus overcome these health systems' constraints. (See Chapter 5).

7.2.4. The relevance of the identified strategies to improving provider readiness for change

Training and environmental restructuring were the two most preferred derived strategies that would address the provider- and leadership-related barriers of readiness for change. Training would address the reported low awareness and knowledge of providers on RMC and thus lead to self-motivation for RMC practice. Environmental restructuring would contribute to solving the contextual challenges through the use of job aids, mentoring and physical infrastructure improvements, and address the unavailability of key resources required for RMC implementation. The job aids could be used to reinforce women's rights and the RMC domains in the facility.

Other strategies were also mentioned by the stakeholders that would improve individual and organisational readiness for change to RMC practice. These include enablement, coercion, modelling and restriction. The various strategy techniques to achieve these have also been discussed in Chapter 6. The health facilities that were readier for a change to RMC (Chapter 5) could be targeted, and if truly practising RMC, these could be certified as model RMC facilities as advised in Chapter 6. These RMC practising health facilities could mentor health providers from non-RMC certified facilities or those facilities negatively associated with readiness for change to RMC practice. Longer serving providers and those with higher incomes (Chapter 5) could be trained to become RMC champions (Chapter 6).

A study investigated the health systems constraints to promoting RMC across three public Southern Ethiopian hospitals[16]. They identified both "hardware" factors interacting in a complex system. The hardware included infrastructural challenges, while the software included the providers' mindset, awareness of RMC and motivation[16]. Interestingly, these findings can be addressed with the theory-informed strategies and strategy techniques identified in this study. The physical environmental restructuring identified in this study could address the infrastructural constraints, while training/education would create awareness, help the providers address negative mindsets and also motivate them.

7.3. Conclusions

1. Women in the study setting were observed to experience mistreatment during childbirth and low levels of RMC. However, the evaluation of RMC depends significantly on the method used. Observational studies find much lower levels of RMC than women report themselves at interview post-partum.
2. Some mistreatment and abuse have been normalised by both pregnant women and healthcare providers. Pregnant women do not know their rights and the expected standard of care they should receive. Health providers do not support all of the rights in the RMC charter and described in the12 RMC domains. They do not always have the resources required to provide RMC.
3. Nevertheless, we found high individual and organisational readiness for change to RMC practice in the study facilities, with a high value for the change.
4. The provider- and leadership-related barriers to readiness for change to RMC are amenable to behavioural change strategies. The nine potential strategy categories in the Behavioural Change Wheel were all thought to be applicable in addressing these barriers, although training and environmental restructuring were most preferred by stakeholders.
5. The need for committed leaders to drive a change to RMC practice was also emphasised The Stakeholders advised that the combination of different strategies and techniques would be more effective. Mentoring, engaging in effective communication skills, the use of job aids, procurement of needed commodities and in-depth interviews and regular payment of the providers' salaries and allowances were strategy techniques that spanned across the derived strategies. Combining the strategies that these techniques are applicable to could be cost-effective in addressing their related barriers as mapped out by the respondents.
6. Individual facility contexts were found to be an important determinant of both the level of RMC and readiness for change. This suggests the need for more individualised and targeted RMC interventions.
7. Overall, strategies that should improve health providers' readiness for change to RMC have been identified in this study. Improving health providers' readiness for change to RMC would indirectly improve their perceptions of women's rights and reduce women's mistreatment during childbirth.

8. This study has also shown the critical role of context on possible implementation outcomes when RMC practice during childbirth is being implemented. This was seen in the facility effects influencing observed RMC received and organisational readiness for change to RMC practice. The feasibility of some of the RMC domains in some facilities was also expressed by some of the pregnant women and health providers interviewed qualitatively in this study. We did not explore the contextual factors in detail in this study and recommend this in future studies.

7.4. Recommendations

7.4.1. Policy recommendations from the research

1. I recommend the introduction of RMC certification courses for maternity care providers. These could be prerequisites for employment and promotion. This would address the low level of awareness of RMC as found in the study.
2. Relevant stakeholders in the state Ministry of Health should commit to cost-effective means to improve the physical workplace environment. This contributes to enhancing health providers' readiness and capacity to practice RMC. Even though the women did not perceive the physical environment as necessary for a respectful childbirth care, the health providers identified it as critical to readiness for change to an RMC practice.
3. Health providers need to be reminded of the need for consent for all procedures. Consent for episiotomy and other procedures could be obtained early during childbirth, and documented in the women's files. This study had shown the very low practice of obtaining women's consent before conducting procedures on them.
4. The Service Compact for Nigerians (SERVICOM), and the internal auditing agency active in tertiary health facilities, should be expanded into the primary and secondary facilities to enhance accountability. One of the stakeholders interviewed suggested this.
5. The wearing of appropriate uniforms and name tags by all professional cadres, irrespective of their shifts, should be enforced. This will improve the identification of respectful and disrespectful health providers, and would be necessary for the proper administration of any RMC incentives. One of the stakeholders had referred

to the non-wearing of appropriate uniforms as tags by health providers as a limitation to RfC to RMC.

6. Regular payment of health workers' salaries and all emoluments is an important contributor to provider job satisfaction in the workplace. This was applicable to enablement, and incentives as stated by the respondents and should not be delayed.
7. The pre-service training curriculums for all professional cadres should include person-centred care such as RMC, communication skills and topics in psychology (including emotional intelligence and other interpersonal skills).
8. The position of an RMC focal person needs to be created for Ibadan State. This may be added to the existing roles of relevant persons in the state Primary Health Care Board and the State Ministry of Health. They will be tasked with the responsibility of identifying RMC champions, monitoring the availability and adequacy of needed resources to implement RMC, and tracking defined indicators of readiness for change to RMC practice and effective RMC implementation. They would also be responsible for advocacy towards increasing awareness, knowledge and readiness for change to RMC practice.

7.4.2. Programmatic recommendations from the research

1. I recommend the development and dissemination of Nigerian-focused RMC training guides, job aids, posters, and standard operating procedures for RMC. These were reported as currently unavailable resources for RMC implementation.
2. The Nigerian customised RMC Charter as well as job aids on RMC and women's rights should be placed in labour rooms, antenatal clinics, maternity wards and other strategic locations within the facility, to remind health providers about what is expected of them, and encourage pregnant women to demand their rights during childbirth. These were not available at the health facilities during the conduct of the study. Placing these in antenatal clinics would inform the women of their rights and what they should expect to receive during childbirth. This could improve their ability to demand respectful childbirth care.
3. Scale up the training of health providers on the use of social media platforms as strategy techniques to achieve the derived persuasion strategy. Social media platforms can also be used to showcase respectful health providers and certified RMC facilities as forms of RMC incentives. These could be leveraged on existing mHealth (mobileHealth) programs.

4. Respectful maternity care mentoring and counselling teams should be put in place. Counselling can be provided to health providers with personal challenges on how to compartmentalise their emotions so it doesn't negatively affect their jobs. However, the cost-effectiveness of having RMC practice dedicated counselling teams would need to be considered.
5. Put in place an effective feedback mechanism to aid the identification of RMC champions and facilities for RMC certification.
6. Initiate provider exchange programmes for introducing RMC into health facilities by posting identified RMC Champions from RMC-certified facilities to non-RMC practising health facilities.
7. Introduce RMC and women's rights education programs to all pregnant women at antenatal clinics. Women in the reproductive age groups could also be targeted so that un-booked women and teenagers can be reached as well. The contents of the educational materials and tools should include what health providers should be expected to do, at each stage of labour. The items on the MCHIP RMC checklist and RMC scale should be consulted in developing the materials.
9. Cheaper and affordable means of ensuring availability and adequacy of resources needed for RMC implementation should be put in place. These could include the use of curtains and drapes rather than structural partitioning to ensure privacy.
10. Social marketing and advocacy tools should be used to emphasise the value of RMC to all relevant stakeholders including the community, pregnant women, health providers, decision-makers, and funding partners. Evidence has shown that a higher value for the change would increase readiness for a change to its practice.
11. A monitoring and evaluation plan should be developed with indicators to track health facility performance as regards RMC implementation and practice.

7.4.3. Recommendations for future research

1. Additional research is required from a range of contexts to explore how, and to what extent, social and cultural norms influence women's interpretations of RMC.
2. Quantitative research to measure women's perceptions of RMC on a larger scale across settings is also needed.
3. I recommend comparing self-reported RMC from postpartum interviews conducted within the health facility and at women's homes.

4. Larger studies comparing observed and reported RMC measures in different settings are required to confirm the discrepancies identified in this study.
5. Randomised controlled trials or quasi-experimental evaluation studies are needed to identify and test the best combination of strategies to improve health provider readiness for change to RMC practice
6. More rigorous research is required on the impact of improved RMC on subsequent health-seeking behaviour and birthing decisions of pregnant women.
7. Further quantitative and qualitative research exploring contextual factors such as organisational culture, work climates, organisational structures and other contextual factors as predictors of organisational readiness should is recommended.
8. I recommend a randomised control trial or an experimental evaluation study to evaluate the effect of having RMC mentors or champions on site and off site for a set time at health facilities on improved RMC experienced by women during childbirth using standardised tools before and after the intervention.

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APPENDICES

Appendix 1.0: Result of Similarity Index

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Appendix 1.1: Theoretical Domains Framework

S/No	Theoretical Domain	Definition and Construct
1	Knowledge (An awareness of the existence of something)	Knowledge (including knowledge of condition/scientific rationale)
		Procedural knowledge
		Knowledge of task environment
2	Skills (An ability or proficiency acquired through practice)	Skills
		Skills development
		Competence
		Competence Ability
		Interpersonal skills Practice Skill
		Skill assessment
3	Social/professional role and identity (A coherent set of behaviors and displayed personal qualities of an individual in a social or work setting)	Professional identity
		Professional role
		Social identity
		Identity
		Professional boundaries
		Professional confidence
		Group identity
		Leadership
		Organisational commitment
4	Beliefs about capabilities (Acceptance of the truth, reality or validity about an ability, talent or facility that a person can put to constructive use)	Self-confidence
		Perceived competence
		Self-efficacy
		Perceived behavioural control
		Beliefs
		Self-esteem
		Empowerment
		Professional confidence
5	Optimism (The confidence that things will happen for the best or that desired goals will be attained)	Optimism
		Pessimism
		Unrealistic optimism
		Identity
6	Beliefs about Consequences (Acceptance of the truth, reality, or validity about outcomes of a behavior in a given situation) 7.	Beliefs
		Outcome expectancies
		Characteristics of outcome expectancies
		Anticipated regret
		Consequents
7	Reinforcement (Increasing the probability of a response by arranging a dependent relationship, or contingency, between the response and a given stimulus)	Rewards (proximal/distal, valued/not valued,
		Incentives
		Punishment
		Consequents
		Reinforcement
		Contingencies
		Sanctions
8	Intentions (A conscious decision to perform a behaviour or a resolve to act in a certain way)	Stability of intentions
		Stages of change model
		Trans theoretical model and stages of change
9	Goals (Mental representations of outcomes or end states that an individual want to achieve)	Goals (distal/proximal)
		Goal priority
		Goal/target setting
		Goals (autonomous/controlled)
		Action planning
		Implementation intention
10	Memory, attention and decision processes (The ability to retain information, focus selectively on aspects of the environment and choose between two or more alternatives)	Memory
		Attention
		Attention control
		Decision making
		Cognitive overload/tiredness

Appendix 1.1: Theoretical Domains Framework cont.

S/No	Theoretical Domain	Definition and Construct
11	Environmental context and resources (Any circumstance of a person's situation or environment that discourages or encourages the development of skills and abilities, independence, social competence and adaptive behavior)	Environmental stressors
		Resources/material resources
		Organisational culture/climate
		Salient events/critical incidents
		Person × environment interaction
		Barriers and facilitators
12	Social influences (Those interpersonal processes that can cause individuals to change their thoughts, feelings, or behaviours	Social pressure
		Social norms
		Group conformity
		Social comparisons
		Group norms
		Social support
		Power
		Intergroup conflict
		Alienation Group identity Modelling
13	Emotion (A complex reaction pattern, involving experiential, behavioral, and physiological elements, by which the individual attempts to deal with a personally significant matter or event)	Fear
		Anxiety
		Affect
		Stress
		Depression
		Positive/negative affect
		Burn-out
14	Behavioral regulation (Anything aimed at managing or changing objectively observed or measured actions)	Self-monitoring
		Breaking habit
		Action planning

Appendix 1.2: Respectful Maternity Care Charter

Appendix 1.2a: The Respectful Maternity Care Charter by the White Ribbon Alliance



Appendix 1.2b: The Nigerian adapted Respectful Maternity Care Charter



Appendix 2.1: Monthly Delivery Rates in Functional Health Facilities in Ibadan, Nigeria

S/no	List of Health Facilities	Dec/17	Jan/18	Feb/18	Mar/18	Apr/18	May/18	Jun/18	Jul/18	Aug/18	Sep/18	Oct/18	Nov/18	Total	Average/month
	Ibadan North-East LGA														
1	Akeke PHC	0	1	0	1	0	0	0	0	1	7	6	3	19	2
2	Alafara PHC	9	4	9	16	12	15	8	16	8	4	15	17	133	11
3	Ayekale PHC	8	7	5	0	7	7	2	10	8	10	10	7	81	7
4	Oke-Adu PHC	9	7	10	15	9	17	13	17	20	7	0	0	124	10
A	Aremo Hosp.	0	13	7	12	18	2	11	12	8	9	10	0	102	9
	Ibadan North LGA														
5	Agbowo PHC	9	15	24	24	20	15	14	10	12	14	14	15	186	16
6	Barika PHC	9	0	0	3	2	5	5	3	0	4	4	3	38	3
7	Basorun PHC	12	9	7	9	9	5	12	7	8	10	11	9	108	9
8	Bodija PHC	13	6	11	6	15	6	10	11	2	12	12	12	116	10
9	Idi-Ogungun PHC	6	1	2	2	3	3	2	2	0	1	5	0	27	2
10	Mokola PHC	0	1	2	6	4	0	5	3	4	0	0	0	25	2
11	Sango PHC	9	18	8	20	11	20	9	17	17	12	15	18	174	15
B	Adeoyo Hosp.	188	0	175	203	0	86	155	156	153	155	187	0	1458	122
	Ibadan North- West LGA														
12	Ayeye PHC	7	4	6	9	10	3	15	14	4	6	10	7	95	8
13	Eleyele PHC	16	16	16	16	16	16	16	16	16	8	4	4	160	13
14	Koseunti PHC	5	5	4	2	6	5	2	4	6	5	6	0	50	4
15	Oniyanrin PHC	17	13	24	14	21	22	32	37	12	16	22	24	254	21
16	Ori-Eru PHC	7	10	5	13	9	7	9	7	6	5	5	7	90	8
17	Unity Medical PHC	18	31	29	25	33	31	29	30	32	24	30	31	343	29
C	Jericho Nursing Home	25	0	19	43	35	10	25	23	19	15	25	20	259	22
	Ibadan South East LGA														
18	Agbongbon PHC	30	36	19	39	49	50	24	36	22	34	29	34	402	34
19	Boluwaji PHC	13	28	17	18	23	14	12	11	13	14	15	15	193	16
20	Molete PHC	3	2	1	0	2	0	1	4	2	1	2	0	18	2
21	Odinjo PHC	22	32	16	22	33	25	9	22	26	19	25	23	274	23
22	Oranmiyan PHC	36	49	22	32	53	38	34	31	26	39	50	45	455	38
23	Orita-Aperin PHC	1	2	2	0	4	2	2	0	3	2	4	1	23	2
	Ibadan South West LGA														
24	Adifase PHC	3	5	6	10	11	9	6	9	4	9	11	8	91	8
25	Awodife PHC	5	3	6	4	5	11	2	25	13	19	10	7	110	9
26	Foko PHC	5	8	7	9	8	5	5	5	5	4	2	3	66	6
D	MCH Centre, Apata	0	36	28	33	23	6	20	21	29	26	38	45	305	25
E	Ring Road State Hosp.	5	41	51	0	51	19	38	47	35	27	73	0	387	32
F	Jericho Specialist Hosp.	67	0	67	0	101	43	49	73	48	76	109	0	633	53

Note: The Primary health facilities are numbered in Arabic numerals while the secondary health facilities are represented by letters of the alphabet. Source: Oyo State Health Management Information System, Dec. 2017 to Nov. 2018)

Appendix 2.2: Distribution of Health Providers in Health Facilities, Ibadan, Nigeria

S/No	Health Facilities	Doctor	Nurse/ Midwives	Community Health Officers	Community Health Extension Worker	Total workers
	Ibadan North-East LGA					
1	Akeke PHC	0	0	3	1	4
2	Alafara PHC	0	0	1	1	2
3	Ayekale PHC	0	1	0	3	4
4	Oke-Adu PHC	0	1	0	4	5
A	Aremo Hosp.	5	23	0	1	29
	Ibadan North LGA					
5	Agbowo PHC	0	6	1	4	11
6	Barika PHC	0	4	0	4	8
7	Basorun PHC	0	6	4	2	12
8	Bodija PHC	0	4	2	4	10
9	Idi-Ogungun PHC	0	8	0	6	14
10	Mokola PHC					
11	Sango PHC	0	4	1	7	12
B	Adeoyo Hosp.	28	166		4	198
	Ibadan North-West LGA					
12	Ayeye PHC	0	1	1	4	6
13	Eleyele PHC	1	3	2	3	9
14	Koseunti PHC	0	0	1	5	6
15	Oniyanrin PHC	0	1	2	6	9
16	Ori-Eru PHC	0	0	1	6	7
17	Unity Medical PHC	5	2	0	2	9
C	Jericho Nursing Home	5	39	0	0	44
	Ibadan South East LGA					
18	Agbongbon PHC	1	4	3	2	10
19	Boluwaji PHC	1	4	2	5	12
20	Molete PHC	1	0	3	4	8
21	Odinjo PHC	0	2	4	4	10
22	Oranmiyan PHC	0	4	3	5	12
23	Orita-Aperin PHC	1	0	1	2	4
	Ibadan South West LGA					
24	Adifase PHC					
25	Awodife PHC	0	0	1	2	3
26	Foko PHC					
D	MCH Centre, Apata	2	2	0	0	4
E	Ring Road State Hosp.	23	122	0	2	147
F	Jericho Specialist Hosp.	21	60	0	0	81

Note: The Primary health facilities are numbered in Arabic numerals while the secondary health facilities are represented by letters of the alphabets. Source: Oyo State Health Management Information System, Dec. 2017 to Nov. 2018)

Appendix 2.3: Focus group discussion guide for pregnant women interview

Good day and welcome. Thanks for taking the time to join our discussion on the readiness for respectful maternity care practice. My name is Seun Esan, and I will serve as the moderator for today's focus group discussion. Assisting me are my research assistants. The purpose of today's discussion is to get information from you on your opinions on what you expect should be a respectful maternity care, what you define as a disrespectful maternity care, what are the factors responsible for it, your opinion on the rights of women during childbirth and what should be done to ensure every woman receives respectful maternity care during childbirth.

You were invited because you are a pregnant woman who registered in this health facility or a post-partum woman who recently delivered either in this health facility or another within this state. There are no right or wrong answers to the questions. Feel free to have and say your opinion even if it is different from others. You are free to agree, disagree or give example to what anyone else says. You only need to indicate by raising up your hand. You also don't have to respond all the time to everything anyone says. We will like to hear from each one of you. If you are too quiet, I may call on you to speak. We have a few refreshments for you. We will also like to record the sessions on a digital voice recorder because of recollecting the conversations. We assure you that no names will be reflected in the report. Let's begin by having each person in the room tell us their name and the county in which they work. And if anyone decides not to continue with the interview, you are free to stop at any time. Any questions? Let us take this song together (serves as an ice breaker)

Questions:

1. What do you understand by the word respect for women?
2. What other words can be used to describe respect, either in Yoruba or English?
3. How can somebody show respect? (Bawo ni a se le fi 'respect' han)?

Respectful maternity care

4. How should health care providers show 'respect' to a woman who comes to the hospital/ maternity centres to deliver?
5. From what you have heard or seen, which one of respect or disrespect do health providers often show to women who come to deliver in hospitals/ maternity centres? Give reasons and share personal experience.

6. When you come to the health facility to deliver your baby, what are the things the health providers can do to you that will make you feel very well respected?
7. When you come to the health facility to deliver your baby, what are the things the health providers can do to you that will make you feel very disrespected or mistreated?
8. If they show you instead more of disrespect, what kind of decisions can such lead you to make?
9. Women that you know who had been shown much disrespect when they came to hospitals to deliver, what decisions had such led them to make, please give practical examples.
10. Why do some health providers show disrespect to women who come to deliver in hospitals or maternity centres?
11. In your opinion, do women who come to deliver in health facilities have rights that they can demand for? What are these rights?
12. Should a woman that has come to deliver demand that a health provider should speak to her with respect and politeness, or gently?
13. Should a woman who has come to deliver demand that the health provider introduce themselves before doing anything for them?
14. Should a woman who has come to deliver ask that the health provider inform her of anything that they want to do to her before they do it?
15. Should a woman who has come to deliver insist on having a companion of their choice during birth?
16. Should a woman who has come to deliver request for water or oral food if hungry during birth?
17. Should a woman who has come to deliver insist on having a private space of their own (not shared with any other woman) during birth?
18. Can a woman who has come to deliver choose to walk about and not lie down in one position during birth?

19. Should a woman who has come to deliver demand for attention if she thinks she is being neglected during birth?

20. Should a woman who has come to deliver demand that they be given equal kind of treatment as given to any other woman during birth?

21. Should a woman who has come to deliver choose the position she prefers to deliver that is most convenient or comfortable for her (eg. Squatting) as it is known that it cannot harm the child?

22. Should a woman who has come to deliver but has no money to pay yet be detained in the hospital with her child till she can afford to pay?

23. In your own opinion, do women have any rights at all to demand for when they come to deliver?

24. What should be done to the health care provider that has shown disrespect to women who has come to the health facility to deliver?

25. How can the government and the managers of the hospital ensure that every woman receives respect when they come to deliver in government owned hospitals or maternity centre?

Appendix 2.4: Observational Study Instrument (Facility)

Health Facility Background Information for RMC

Background Information on Health Facility (*Complete one of this per facility*)	
Facility Record ID	_____
Is this facility designated urban or rural?	☐ Urban ☐Rural
What type of facility is this?	☐ Primary Health Care Facility ☐ Secondary Health Facility
What is the average monthly number of births/ deliveries at this facility? (**from delivery records**)	_____
How many beds are available for women in the labour room of this facility?	_____
How many beds are available for childbirth / delivery in this facility?	_____
How many beds are available in the postnatal unit in this facility? (write number)	_____
What is the condition of the beds? (Mark one response)	☐ All are functional ☐ Some are not functional ☐ None is fully functional
Observe women sharing beds in any of the labor, delivery, or postnatal units?	☐ Yes ☐ No
Observe women waiting, resting, or sleeping on the floor in any of the labor or postnatal areas?	☐ Yes ☐ No
Who provides linens for patients? (from observation)	☐ Health Facility ☐ Family ☐ Both family and facility ☐ No-one
Does this facility have electricity?	☐ Yes ☐ No
If yes, is it stable for more than half of the day?	☐ Yes ☐ No
Does the health facility have any of the following within it, a bore-hole/ sanitary well/ running tap water?	☐ Yes ☐ No

Appendix 2.5: Background information on the health facilities

Description of Health Facilities

In Table 3.0, the findings describe the state of the study health facilities at the time of conducting this research. There were 5 (55.6%) primary and 4 (44.4%) secondary health facilities (SHFs) and the results are presented by type of health facility. The number of health providers by professional cadre and overall were more at the secondary than the primary health care (PHC) facilities. Caesarean sections were conducted only at the SHFs. The vaginal deliveries conducted at the SHFs were thrice the number at the PHC facilities. There were twice the total number of beds at the SHFs than at the PHC facilities. However, the PHC facilities and the SHFs had similar ratio of beds used for maternity care to the total number of beds in the facilities. All the beds used for maternity care at both facility types were in good condition. All the SHFs and majority 4 80.0%) of the PHC facilities had a source of water and electricity. At 4(80.0%) of the PHC facilities, the women had access to 1 toilet for use, while it was the inverse for the SHFs with 3(75.0%) of them providing access to 2 toilets for women's use.

Characteristics and practices of study facilities in providing maternity care services

	Primary Health Facility (n=5)	Secondary Health Facility (n=4)
Discrete variables	Mean ± SD	Mean ± SD
Maternity service providers		
Mean No of Doctors	0.6 ± 0.5	9 ± 7.5
Mean No of Nurse/midwives	2 ± 0.7	22.3 ± 13.5
Mean No of CHO/ CHEW	5.4 ± 3.7	0.0 ± 0.0
Mean No of Health Assistant	5.6 ± 2.4	0.0 ± 0.0
Overall Mean of Total health providers	13.6 ± 4.7	31.3 ± 21.0
Average monthly deliveries per facility in 1immediate 12 months preceding visit to the facility (n-295)		
Agbowo	16	
Adeoyo		123
Alafara	12	
Aremo		14
Oniyanrin	21	
Jericho		21
Adifase	6	
Ringroad		49
Agbongbon	33	
Mean No of vaginal deliveries/ year	209.6 ± 121.6	622.5 ± 594.5
Mean No of vaginal deliveries/month	17.5 ± 10.1	51.9 ± 49.5
Mean No of Caesarean sections/ year	0.0 ± 0.0	165.3 ± 202.6
Available Beds for maternity services		
Beds in first stage room	3.0 ± 2.5	7.5 ± 2.6
Beds in 2nd stage room	1.4 ± 0.5	2.8 ± 2.2
Beds in immediate post-natal	1.6 ± 3.6	5.0 ± 4.2
Total number of beds	6.0 ± 3.2	15.3 ± 5.6
Beds being used for maternity service	5.8 ± 3.0	13.8 ± 6.4
Condition of the beds (assessed by research assistants)		
Beds in good condition	5.8 ± 3.0	14.3 ± 5.0
Beds in bad condition	0.2 ± 0.4	1.0 ± 2.0
Categorical variables	**Freq. (%)**	**Freq. (%)**
Facility have electricity		
Yes	4 (80.0)	4 (100.0)
No	1 (20.0)	0 (0.0)
Facility has a source of water		
Yes	4 (80.0)	4 (100.0)
No	1 (20.0)	0 (0.0)
Functional toilets for women's use		
1 toilet	4 (80.0)	1 (25.0)
2 toilets	1 (20.0)	3 (75.0)

Note: CHO- Community Health Officers, CHEW- Community Health Extension Worker

Appendix 2.6: Respectful maternity care received observational checklist (Clients)

Background Information for Woman Observed during childbirth		
Record ID	_____	
Clients' Initials	_____	
Date and Time at admission in the labour room	____/____/___ (DD/MM/YY); ____/___(Hr :Min) am/pm	
Age of this pregnancy at presentation (in weeks)	_____	
Cervical dilatation at presentation (asked from nurses)	_____	
Status of fetal heart sound on arrival in labour room	☐ Heard ☐ Not heard	
Observational Checklist of Childbirth Process (Repeatable Instrument)		
	☐ Doctor ☐ Nurse/ Midwife ☐ CHO ☐ CHEW	
Women's right to information and information consent (*Provide comments where necessary*)		
Introduces self to woman and her companion	☐ Yes ☐ No	Comments:
Encourages companion to remain with woman for as long as possible	☐ Yes ☐ No	Comments:
Encourages woman and her companions to ask questions	☐ Yes ☐ No	Comments:
Responds to questions with promptness, politeness and truthfulness	☐ Yes ☐ No	Comments:
Explains what is being done and what to expect throughout labor and birth	☐ Yes ☐ No	Comments:
Gives periodic updates on status and progress of Labour	☐ Yes ☐ No	Comments:
Allows the woman to move about during labour	☐ Yes ☐ No	Comments:
Allows woman to assume position of choice during Birth	☐ Yes ☐ No	Comments:
Obtains consent or permission prior to doing all procedure for/ on woman	☐ Yes ☐ No	Comments:
Woman protected from physical harm and ill treatment		
Never uses physical force and abrasive behaviour with woman, including slapping or hitting or made attempt to	☐ Yes ☐ No	Comments:
Never physically restrained woman	☐ Yes ☐ No	Comments:
Touches or demonstrates caring in a culturally appropriate way	☐ Yes ☐ No	Comments:

Never separates woman from her baby except when medically necessary	☐ Yes	☐ No	Comments:
Does not deny food or fluid to woman in labour unless medically necessitated	☐ Yes	☐ No	Comments:
Provides comfort or pain relief as necessary	☐ Yes	☐ No	Comments:
Confidentiality and Privacy is protected			
Observer confirms that patient's file is stored or kept in locked cabinet with minimal access or not displayed carelessly	☐ Yes	☐ No	Comments:
Uses curtains or other visual barriers to protect woman during all examinations	☐ Yes	☐ No	Comments:
Uses drapes or coverings appropriate to protect woman's privacy	☐ Yes	☐ No	Comments:
Never discussed woman's personal and medical details openly for non-health providers to hear	☐ Yes	☐ No	Comments:
Woman is treated with dignity and respect			
Speaks politely to woman and / or her companions	☐ Yes	☐ No	Comments:
Allows woman and her companion to observe their cultural or religious practices as much as possible	☐ Yes	☐ No	Comments:
Never makes insults, intimidation, threats, nor coerces woman and her companions	☐ Yes	☐ No	Comments:
Receives equitable care free from discrimination			
Speaks to the woman in a language and at a language level that she understands	☐ Yes	☐ No	Comments:
Does not show disrespect to the woman based on any specific personal attribute of the woman	☐ Yes	☐ No	Comments:
Woman never left without care			
Encourages woman to call if needed	☐ Yes	☐ No	Comments:
Comes quickly when woman calls	☐ Yes	☐ No	Comments:
Never leaves woman unattended to	☐ Yes	☐ No	Comments:
Never detained or confined against her will			
The facility does not have a policy to detain women who do not pay	☐ Yes	☐ No	Comments:

Appendix 2.7: Questionnaire- Interview with postpartum women

Socio-demographic profile	
Record ID	_____
Date, month and year of birth	_____ (DD/MM/YY)
Had formal education?	☐ No formal education ☐ Formal education
Highest Completed Level of Education	☐ Primary ☐ Secondary ☐ Post-secondary ☐ Post-tertiary
Ethnicity	☐ Yoruba ☐ Ibo ☐ Hausa ☐ Others
If Others, Please specify	_____
Obstetric Profile	
Number of pregnancies ever had	_____
Number of deliveries ever had	_____
Number of children alive	_____
Ever delivered in health facility?	☐ Yes ☐ No
No of times ever delivered in this health facility?	_____
Where was your last place of delivery?	☐ This health facility ☐ Another public health facility ☐ A private health facility ☐ A religious center (church, mosque) ☐ With a Traditional Birth Attendant ☐ At home ☐ On the way to the health facility
How many years ago was your last delivery? (If this is your first delivery, write 0 year)	_____
What was the outcome of the last pregnancy?	☐Live birth ☐Still-birth ☐Died few days after
Are you very familiar with the health providers' in this health facility? (*Like knowing them one on one*)	☐ Yes ☐ No
If yes, On which basis are you familiar with them?	☐ Family relations ☐ Religious group member ☐ Friend / peer ☐ Business relations ☐ Neighbour ☐ Others
Select all the types of health workers that attended to you during your childbirth process	☐ Doctor at PHC Facility ☐ CHO ☐ Nurse/midwife ☐ CHEW
These responses describe care received from	☐ Doctor at this health facility ☐ Nurse or midwife in this health facility ☐ CHO in this health facility ☐ CHEW in this health facility ☐ All the health workers in this health facility

15-item RMC Scale	Strongly Disagree= SA, Disagree=D, Neutral= N Agree= A, Strongly Agree= SA				
Type of Care Received During Childbirth	SD	D	N	A	SA
Healthcare workers approached me in a kind manner (very nice and ready to help)	☐	☐	☐	☐	☐
Healthcare workers were friendly (pleasant) in their treatment	☐	☐	☐	☐	☐
Healthcare workers sounded encouraging on topics about pain and its relief	☐	☐	☐	☐	☐
Healthcare workers were concerned and empathic.	☐	☐	☐	☐	☐
Healthcare workers respected me as an individual	☐	☐	☐	☐	☐
Healthcare workers communicated to me in a language within my understanding	☐	☐	☐	☐	☐
Healthcare workers addressed me by name	☐	☐	☐	☐	☐
Healthcare workers responded to my needs in a professionally expected manner	☐	☐	☐	☐	☐
Healthcare workers hit me during delivery*	☐	☐	☐	☐	☐
Healthcare workers yelled at me because I did not do what they me to do*	☐	☐	☐	☐	☐
I was not given prompt service and I waited for a long time.*	☐	☐	☐	☐	☐
I was free to practice my cultural and religious traditions in the facility	☐	☐	☐	☐	☐
Problems in the health facility often delay their attending to their patients*	☐	☐	☐	☐	☐
Some healthcare workers mistreated treat me because of some of my personal characteristics. (E.g, my age,financial status).*	☐	☐	☐	☐	☐
Some healthcare workers offended me and my companions due to my personal characteristics (for example, my age, my financial status).*	☐	☐	☐	☐	☐
Maternal and Neonatal Outcomes for this childbirth Process					
Maternal outcome of this childbirth you just had was	☐Uncomplicated delivery		☐Complicated delivery		
If complicated, which of these complications occurred (*Select as many that may apply*)	☐ Prolonged labour ☐ Excessive bleeding ☐ Tear of the womb ☐ Baby not breathing well ☐ Tear of the neck of the womb ☐ High blood pressure/ convulsion)				
What in your opinion was responsible for the complications you had?	_____				
Fetal outcomes of this childbirth process	☐ Live birth		☐ Still birth		
Let us assume you get pregnant again, will you intend to deliver in this health facility?	☐ Yes		☐ No		
Would you recommend anyone to deliver in this health facility?	☐ Yes		☐ No		

* Means responses will be scored in reverse order

Appendix 2.8: Questionnaire- Interview with health care providers

Section A: Socio-demographic profile of health provider	
RMC Record ID (For example: Adeoyo/ HW/001)	
Which Local Government Area (LGA) is this facility situated	☐ Ibadan North ☐Ibadan South West ☐ Ibadan North West ☐ Ibadan South East ☐ Ibadan North East
Level of Public Health Facility	☐ Primary ☐ Secondary
Facility ID No	☐ 01 ☐ 02 ☐ 03 ☐ 04 ☐ 05 ☐ 06 ☐ 07 ☐ 08 ☐ 09 ☐ 10
Date of Birth	_____
Today's date	_____
Age of the respondent	
Levels of education completed	☐ Secondary education ☐ Medical School ☐ School of Health Technology ☐ Master's program ☐ PhD program ☐ Nursing ☐ Fellowship of a medical postgraduate college ☐ Midwifery school
	Others, please Specify_____
Professional type	☐ Specialist Consultant ☐ Nurse
	☐ Resident Doctor ☐ Nurse/Midwife
	☐ Medical Officer ☐ CHO
	☐ House Officer ☐ CHEW
	☐ Health Assistant/ Nurse Auxiliary/ Nurse Aide
Your total income in a month (from all sources) may fall within which of these ranges	(a) < ₦30,000 (83.3USD) ☐ (b)₦30, 000 - ₦50,000 (138.9 USD) ☐ (c) ₦51,000 - ₦70,000 (194.4 USD) ☐ (d) ₦71, 000 - ₦90,000 (250 USD) ☐ (e) ₦91,000 - ₦110,000 (305.5 USD) ☐ (f). More than ₦110,000 (>305.5 USD) ☐
Specifically, these total Income from (all sources) per month will be about	_____ in Naira
Year you completed pre-service training (graduated from school) for your current profession	_____
Years of professional experience after pre-service training (Calculated variable)	_____
Year you started working in this facility as one of the following (nurse/midwife//CHO/CHEW)	_____
Years of experience working in this facility as one of the following (nurse/midwife/doctor/CHO/CHEW) cal	_____
Have you ever been promoted in your current job?	Yes No
In which year were you last promoted in your current job?	_____
No of years ago you were last promoted (calculated	_____

Has any of the following ever been done to women who have come to deliver in this hospital in the past 1 year to the best of your knowledge? Kindly select the most appropriate response					
Section B: Mistreatments to women during childbirth	Always	Very frequently	Occasional	Rare	Never
1. Physical abuse (slapping or hitting, pinching, beating or attempts made to)	☐	☐	☐	☐	☐
2. Verbal abuse (Insult)	☐	☐	☐	☐	☐
3. Lack of information about the care provided/ Lack of informed consent	☐	☐	☐	☐	☐
4. Lack of privacy (not screening during examinations)	☐	☐	☐	☐	☐
5. Lack of confidentiality (discussing patients' details openly or patients' files kept discriminately)	☐	☐	☐	☐	☐
6. Discrimination based on ethnicity, race, religion or economic / financial status	☐	☐	☐	☐	☐
7. Birth companion not allowed to be present	☐	☐	☐	☐	☐
8. Denying freedom of movement during labour	☐	☐	☐	☐	☐
9. Denying choice of position for birth	☐	☐	☐	☐	☐
10. Unnecessary separation of mother and new-born after the birth	☐	☐	☐	☐	☐
11.Leaving the woman alone or unattended/ delaying attending to the woman after being called/ sent for	☐	☐	☐	☐	☐
12. Other types of similar actions done to women during childbirth in this health facility, please, specify	_____				
13. How long are women kept on admission at the facility after an uncomplicated delivery on the average before discharge home?	☐ Less than 6 hours ☐ 6 - 12 hours ☐ More than 12 hours to a maximum of 24 hours ☐ More than 24 hours ☐ Don't know				

Which of these do you think women should have a Right to during childbirth and in what frequency? Please, select the best option					
Section C: Perceived rights to women	Always	Very frequently	Occasionally	Rarely	Never
1. Right to information about the professional identity and qualifications of those involved with her care	☐	☐	☐	☐	☐
2. Right to communicate with caregivers and receive all care in privacy	☐	☐	☐	☐	☐
3. Right to full and clear information about benefits, risks and costs of the procedures, drugs, tests and treatments offered to her	☐	☐	☐	☐	☐
4. Right to accept or refuse procedures, drugs, tests and treatments, and to have her choices honoured	☐	☐	☐	☐	☐
5. Right to be informed if her caregivers wish to enrol her or her infant in a research study	☐	☐	☐	☐	☐
6. Right to unrestricted access to all available records about her pregnancy, labor, birth, postpartum	☐	☐	☐	☐	☐
7. Right to receive maternity care that is appropriate to her cultural and religious background, and to receive information in a language in which she can communicate	☐	☐	☐	☐	☐
8. Right to have a family member **of her choice** present during all aspects of her childbirth care (having a birth companion)	☐	☐	☐	☐	☐
9. Right to freedom of movement during labour, not hindered by tubes, wires or other apparatus	☐	☐	☐	☐	☐
10. Right to virtually uninterrupted contact with her newborn from the moment of birth, as long as she and her baby are healthy and do not need care that requires separation	☐	☐	☐	☐	☐

Readiness Assessment for a Change to a Respectful Maternity Care Practice

Respectful Maternity Care (RMC) is a human rights approach to childbirth care practice. It was introduced about 10 years ago. It promotes the fundamental human rights of women during childbirth. The National Council on Health had adopted it as the standard for childbirth care in Nigeria in 2013. However, abusive care has been more rampant. We are interested in knowing how health facilities offering childbirth services, their managers and individual workers are READY to integrate respectful maternity care into their routine childbirth services. RMC consists of these 12 domains done to women during childbirth as shown below

The Twelve Domains of Respectful Maternity Care			
1	Being free from harm and mistreatment	7	Providing equitable maternal care
2	Maintaining privacy and confidentiality	8	Engaging with effective communication
3	Preserving women's dignity	9	Provision of efficient and effective care
4	Provision of information and get informed	10	Availability of competent and motivated
5	Ensuring continuous access to family	11	Continuity of care
6	Enhancing quality of physical environment and resources	12	Respecting women's choices that strengthens their capabilities to give birth

These meant that the preferences of the client must be respected, and she must be involved in the decision making regarding her health. She must be allowed a companion during birth as recommended by the WHO and be free to move about during labour if she so wishes, not restricted to one position. If classified as a low risk pregnant woman, she should be allowed oral fluids or food while in labour as evidence has shown no negative outcomes following this. Her privacy must be ensured by providing one private cubicle or space per woman in labour and information about her should not be shared openly. If she prefers to deliver her child squatting, the health care provider must be willing to support her in the decision. Equitable services must be delivered to her regardless of her personal characteristics. When she calls for help during labour, she must not be denied nor neglected. If she is unable to pay her bills, a consensus must be reached with her on how to pay rather than detaining her illegally for inability to pay. Overall, she must receive the utmost respectful and dignified care, that she deserves as her fundamental human rights.

Please select one option for each of these sentences below that best describes how much you think your health facility management and staff are READY to integrate respectful maternity care (RMC) practice into the routine childbirth/ delivery care services in this facility (Please, tick one of these 5 options: Strongly Disagree=D, Somewhat Disagree= SWD, Neither Agree nor Disagree =NA/D, Somewhat Agree= SWA, Strongly Agree= A)

Section D: Organisational and Individual readiness for change					
Organisational Readiness for a change to RMC Practice	SD	SWD	NA/D	SWA	SA
Respectful Maternity Care can be implemented in this health facility	☐	☐	☐	☐	☐
1. Health workers in this health facility feel confident that the facility's management can get people invested in implementing a change to RMC practice.	☐	☐	☐	☐	☐
2. Health workers in this health facility are committed to implementing a change to RMC practice	☐	☐	☐	☐	☐
3. Health workers in this health facility feel confident that they can keep track of progress in implementing a change to RMC practice.	☐	☐	☐	☐	☐
4. Health workers in this health facility will do whatever it takes to implement this change to RMC practice	☐	☐	☐	☐	☐
5. Health workers in this health facility feel confident that the facility managers will support them to adjust to a change to RMC practice.	☐	☐	☐	☐	☐
6. Health workers in this health facility will want to (will not mind to) implement a change to RMC practice.	☐	☐	☐	☐	☐
7. Health workers in this health facility feel confident that they can keep pushing to implement a change to RMC practice.	☐	☐	☐	☐	☐
8. Health workers in this health facility feel confident that they can handle the challenges that might arise in implementing a change to RMC practice.	☐	☐	☐	☐	☐
9. Health workers in this health facility are strongly determined to implement a change to RMC practice	☐	☐	☐	☐	☐
10. Health workers in this health facility are confident that they can organise the work tasks so that implementation goes smoothly to RMC practice.	☐	☐	☐	☐	☐
11. Health workers in this health facility are motivated to implement a change to RMC practice.	☐	☐	☐	☐	☐
12. Health workers in this health facility feel confident that they can manage the politics of implementing a change to RMC practice.	☐	☐	☐	☐	☐
The options below are assessing your own personal readiness for your health facility to integrate respectful maternity care practices into your routine childbirth care. Select one option each					
Individual Readiness for a change to RMC Practice	SD	SWD	NA/D	SWA	SA
1. When changes such as change to RMC practice occur in our health facility, I believe that I am ready to cope with them.	☐	☐	☐	☐	☐
2. I usually try to convince people in my health facility to accept the change such as a change to RMC practice.	☐	☐	☐	☐	☐
3. When changes occur in my health facility, I tend to complain about them rather than deal with them*	☐	☐	☐	☐	☐
4. I believe that I am more ready to accept a change to RMC practice than my colleagues.	☐	☐	☐	☐	☐
5. I don't worry about changes in my health facility because I believe that there is always a way to cope with them	☐	☐	☐	☐	☐
6. When changes such as a change to RMC practice occur in my health facility, I always have the intention to support such.	☐	☐	☐	☐	☐

Please select the most appropriate option for each of these statements below regarding a change to integrate respectful maternity care (RMC) practice into the routine childbirth/ delivery care services in this facility.					
Section E: Perceived Change Valence	SD	SWD	NA/D	SWA	SA
1. Health workers in this health facility feel this change to a respectful maternity care is in line with our values	☐	☐	☐	☐	☐
2. Health workers in this health facility feel we need to implement a change to RMC practice	☐	☐	☐	☐	☐
3. Health workers in this health facility believe a change to RMC practice will benefit our community	☐	☐	☐	☐	☐
4. Health workers in this health facility believe a change to RMC practice will make things better	☐	☐	☐	☐	☐
5. Health workers in this health facility believe a change to RMC practice is a good idea	☐	☐	☐	☐	☐
6. Health workers in this health facility value a change to a RMC practice	☐	☐	☐	☐	☐
Section F: Informational Assessments					
The people who work here, we……	SD	SWD	NA/D	SWA	SA
1. People who work here believe we have the equipment we need to implement a change to a respectful maternity care practice.	☐	☐	☐	☐	☐
2. We believe we have the expertise we need to implement a change to a respectful maternity care practice.	☐	☐	☐	☐	☐
3. We believe we have the time we need to implement a change to a respectful maternity care practice..	☐	☐	☐	☐	☐
4. We believe we have the skills we need to implement a change to a respectful maternity care practice.	☐	☐	☐	☐	☐
5. We believe we have the resources we need to implement a change to a respectful maternity care practice.	☐	☐	☐	☐	☐
6. We know how much time it will take to implement a change to a respectful maternity care practice.	☐	☐	☐	☐	☐
7. We know what resources we will need to implement a change to a respectful maternity care practice	☐	☐	☐	☐	☐
8. We know what each of us has to do to implement a change to a respectful maternity care practice	☐	☐	☐	☐	☐

Concerning the availability of the resources needed to integrate a respectful maternity care practice into the routine childbirth care in this facility, please select the best option					
Section G: Availability of resources	SD	SWD	NA/D	SWA	SA
1. We have adequate number of competent, trained, and adequately paid skilled birth attendants working in teams that are able to provide dignified and continuous care to all women.	☐	☐	☐	☐	☐
2. The Management of our health facility are well sensitised to the provision of a respectful maternity care practice.	☐	☐	☐	☐	☐
3. Regular practical, in-service training on the provision of respectful maternity care is being done for the staff in this health facility	☐	☐	☐	☐	☐
4. There are written, up-to-date standards that outline clear goals, operational plans and monitoring mechanisms for the provision of a respectful maternity care during childbirth in this health facility	☐	☐	☐	☐	☐
5. There are health education materials on respectful maternity care in pictures and the languages of the communities served in this health facility	☐	☐	☐	☐	☐
6. Rooming-in (Nursing baby by the mother's side) is practiced in this facility to allow women and their babies to remain together	☐	☐	☐	☐	☐
7. There are clean, appropriately illuminated, well ventilated labour, and childbirth areas	☐	☐	☐	☐	☐
8. There are clean and accessible bathrooms for use by women in labour	☐	☐	☐	☐	☐
9. There is safe drinking water, and a hand washing station, with soap and water (preferably running water) or alcohol-based hand rubs	☐	☐	☐	☐	☐
10. There are curtains, screens, partitions and sufficient bed capacity (needed number of beds for childbirth in this facility)	☐	☐	☐	☐	☐
11. Facilities for companions of women in labour, including a private space that can allow for the woman and her companion are available	☐	☐	☐	☐	☐
12. Staff meetings are held regularly to review our childbirth practices if respectful (RMC practices) or not in this health facility	☐	☐	☐	☐	☐
13. There is a suggestion box for service users (clients/ patients) and providers to submit complaints to the management	☐	☐	☐	☐	☐
14. There are established accountability mechanisms for redress in the event of mistreatment or violations (eg. disciplinary committee to handle report of mistreatment of women or providers) in this health facility	☐	☐	☐	☐	☐
15. There are established informed consent procedures	☐	☐	☐	☐	☐

These last set of questions help us to self-evaluate ourselves as a person and may elicit the factors that are associated with our readiness for a change to a respectful maternity care					
Health care providers' Core Self-Evaluation Personality Traits- Kindly select the most appropriate option to each of the sentences below as it describes you as a person					
Section H: Providers' Core Self-evaluation	SD	SWD	NA/D	SWA	SA
1. I am confident I'll get the success I deserve in life.	☐	☐	☐	☐	☐
2. Sometimes I feel miserable*	☐	☐	☐	☐	☐
3. When I try, I generally succeed	☐	☐	☐	☐	☐
4.Sometimes when I fail, I feel worthless*	☐	☐	☐	☐	☐
5. I complete tasks successfully	☐	☐	☐	☐	☐
6. Sometimes, I do not feel in control of my work*	☐	☐	☐	☐	☐
7. Overall, I am satisfied with myself	☐	☐	☐	☐	☐
8. I am filled with doubts about my competence*	☐	☐	☐	☐	☐
9. I determine / choose what will happen in my life	☐	☐	☐	☐	☐
10. do not feel in control of my success in my career*	☐	☐	☐	☐	☐
11. I am capable of coping with most of my problems	☐	☐	☐	☐	☐
12. There are times when things look pretty bleak and hopeless to me*	☐	☐	☐	☐	☐
Health care providers' Job satisfaction- Regarding the extent to which you are satisfied with your job, kindly select the most appropriate option for the sentences below					
Section I: Providers' perceived job satisfaction	SD	SWD	NA/D	SWA	SA
1. My salary is fair compared to other staff in other southwest states with the same level of responsibility	☐	☐	☐	☐	☐
2. My benefits are fair compared to other staff at my level	☐	☐	☐	☐	☐
3. My job description is clear to me, accurate and up to date	☐	☐	☐	☐	☐
4. My supervisor and I have agreed on the priorities of my job	☐	☐	☐	☐	☐
5. I get clear feedback from my supervisors about how well I am performing on my job	☐	☐	☐	☐	☐
6. My annual performance appraisal is based on the priorities in my work-plan (my actual performance)	☐	☐	☐	☐	☐
7. My supervisor seeks my input when faced with a challenge or problem	☐	☐	☐	☐	☐
8. The organisation (the management of this facility) acknowledges and value my work	☐	☐	☐	☐	☐
9. The organisation provides me with the essential coaching and training to do my job.	☐	☐	☐	☐	☐
10. The organisation works (as much as possible) to provide me with opportunities for career growth.	☐	☐	☐	☐	☐

Responses will be coded in reverse order

Appendix 2.9: Focus Group Discussion Guide with health care providers

Good day and welcome. Thanks for taking the time to join our discussion on the readiness for respectful maternity care practice. My name is Seun Esan, and I will serve as the moderator for today's focus group discussion. Assisting me are my research assistants. The purpose of today's discussion is to get information from you on your opinions about respectful maternity care and the factors that may limit or facilitate health providers from integrating it into your current routine childbirth practices. We will also be interested in things we call contextual factors. These are those factors about your health facility that may explain why health care providers behave the way they do.

You were invited because you are a maternity care provider in the health facilities we studied and you must have had more than 1 year of experience in this work and in this health facility. There are no right or wrong answers to the questions. Feel free to have and say your opinion even if it is different from others. You are free to agree, disagree or give example to what anyone else say. You only need to indicate by raising up your hand. You also don't have to respond all the time to everything anyone says. We will like to hear from each one of you. If you are too quiet, I may call on you to speak. We have a few refreshments for you. We will also like to record the sessions on a digital voice recorder because of recollecting the conversations. We assure you that no names will be reflected in the report. Let's begin by having each person in the room tell us their name and the county in which they work. And if anyone decides not to continue with the interview, you are free to stop at any time. Any questions? Let us take this song together (serves as an ice breaker)

Questions:

1. How in your opinion is the possibility of practicing respectful maternity care in our health facilities in Oyo state? (Moderator will describe the contents of RMC with respondents)

2. What are the things that must be in place in this health facility for us to be able to practice RMC?

3. What are the challenges to practicing RMC in our facilities?

4. How do the following contribute to the readiness to practice RMC by the health facility (Education on the desired change, staff adequacy, improving the physical environment)?

5. How do the following contribute to the health providers themselves being ready for a RMC practice?
6. The provider to provider relationship?
7. The staff to patient relationship
8. The provider to family of the client relationship
9. What do you understand by fundamental human rights?
10. Do women have rights at all? What are those rights? To what extent should human rights be allowed in a health facility.
11. How do these rights relate to women during childbirth?
12. Which of these rights must women enjoy compulsorily during childbirth in your type of health facility?
13. Would you as a health provider tolerate woman during childbirth demanding for any of these rights, and why?
14. Are there any further comments or questions to address?
15. If none, thank you for the time and God bless.

Appendix 2.10: In-depth interview guide with stakeholders

Good day and thank you for being willing to speak with me about Respectful Maternity Care Practice and the possibility of it being integrated into the routine childbirth care in your health facility/ Health facilities in Ibadan, Oyo state.

I will like to start by asking you, in your own words, could you please describe your roles in the delivery of maternal and child health services, particularly childbirth services in this health facility/ in Oyo state?

Probing questions – Kindly describe your regular day at work.

1. If you were to apportion the time you spend at work across administrative, clinical care and teaching, what percentages would you give to each?
2. What do you know about or think is Respectful Maternity Care?
3. Probing questions: Have you ever heard of it? If yes, where and when?
4. Have you ever been at a training or a meeting to discuss it? If yes, where and when?
5. In your own words, will you describe to me what is meant by respectful maternity care?
6. In your own opinion, do you think respectful maternity care is being practiced in your health facility / in Oyo state and if yes, to what extent?

Narratives: We have done some studies to look at how is respectful maternity care being practiced in this health facility and in Ibadan Municipal Area. We conducted the study between June and September, this year. We observed women in labour and how they were being cared for, we also interviewed these women and the health care providers in the health facilities we visited, both at primary and secondary level. We have made a summary of our findings and have brought it to you first as a feedback, knowing your role in the delivery of maternal care services in this hospital/ in Oyo state. We will also need your help to look deeper into what we found and together learn from them and chart a way forward.

We also have some papers to explain in a very simple way what is meant by respectful maternity care and what the Nigerian and some non-governmental organisations have done as regard it in Nigeria.

Our research findings showed that factors a, b and c were facilitators r barriers to the implementation of respectful maternity care practice in Ibadan health facilities.

7. In your own opinion, what do you think about these findings in terms of correctness.
8. Are there other factors that we might have missed that you think could be a facilitator or barrier to RMC implementation in your health facility/ in Oyo state?
9. What in your own opinion could be responsible for these facilitators and barriers that we found?
10. Which of these behaviours need to change and in what ranking order? Which do you think should change first? And why?
11. Can you describe clearly what is being done before and what should change and not be done again for us to practice this respectful maternity care in your health facility/ in Oyo state?

Narrative: researchers have also done some work and came up with something called Theoretical Domains Framework. In it they say that most behaviours that need to change can be found or related to one or more of the domains they described (about 14 of them) I will show him/ her the constructs and give some time to study it.

12. Which of these 14 domains is closely related to the behaviour we descried no that needs to change/ the factor we found in the study that neds to change?
13. If we want to address this domain among health providers, what methods, or activities or actions should we do or take? do you think this action will work?
14. What are the things that may not make this action to yield good results in the way things are done in this health facility?

Table 1: Facilitators or Barriers to improving organisation and individual providers' readiness to change to RMC practice During Childbirth in Oyo state

	Perspectives on the facilitators and barriers to improving health providers' readiness to change to RMC practice in Oyo state	Barrier/ Facilitator/ None	Where it fits within the 14 Domains of the TDF	Where it fits in the Behavioural Change Wheel	What Strategies will be needed	What Policy Interventions will be needed
A	**PROVIDER RELATED FACTORS**					
1	Old provider habits die hard/ people's mind set					
2	A provider's abusive training/ stressful background					
3	Pressure of work overload/ stress/ High patient to provider ratio					
4	Low level of awareness & knowledge of providers on RMC					
5	Poor motivation of providers (poor remuneration, staff loans)					
6	Poor inter-personal skills by providers (communication skills e.g verbal & non-verbal, emotional intelligence, transfer aggression)					
7	Provider's Personal attributes- (eg. lacks courtesy & morals easily angered, family problems, not empathetic, egoistic, shouts					
8	Non-chalant attitude of health workers to work					
9	Inadequate staff is a justification for mistreatment of women					
10	Inter-professional rivalry/Strained provider-provider relationships					
11	Lack of training on how to deliver a woman squatting (convenience of HWs for such delivery)					
12	Getting all cadres of health workers trained and retrained on RMC with re-enforcements of trainings					
13	Fear of low back pain & convenience of provider if client opts for alternative birth positions					
14	Conflict between patients' expectation & what the provider's should do- empathy versus sympathy					
15	Perceiving patients' demanding their rights as being stubborn					
16	Episiotomy cannot wait for informed consent (Safety Vs RMC)					
B	**LEADERSHIP RELATED ISSUES**					
1	Leadership not vast in the knowledge of RMC and not committed to a change to it – a challenge in taking lead for RMC change					
2	Considering using rewards and punishment to promote RMC					
3	Poor leadership in assigning correction and rewards appropriately					
4	Power tussle & victimisation of providers promoting RMC					

C	**HEALTH SYSTEM RELATED FACTORS**					
1	Lack of enabling environment (screens, staffs, equipment space, structural design of the facility, insecurity, no electricity)					
2	Facility's physical appearance and neglect of patients in labour					
3	Irregular or non-review of provider activities/ performance					
4	Non-functional feedback systems					
5	Barriers with poor process of introducing RMC to facilities					
6	Lack of Standard Operating Protocols on RMC					
7	Promoting quality versus RMC together- any challenge with this?					
8	The rigour in practicing new ideas such as RMC					
9	Awareness of competitors as a driver for RMC?					
10	Applicability of global research to local context					
11	Level of health facility (if 1º, 2º or 3º) a limitation to provider's readiness to change to practicing RMC?					
12	Rigid organisational culture					
13	Bridging the gap between maternity care services offered in the private and public health facilities					
D	**PATIENT'S RELATED FACTORS**					
1	Low level of awareness of patients on RMC					
2	Patients not knowing their rights (enlightened patients)					
3	Poor birth preparedness plans by patients (eg. Leruless patients)					
4	People absconding with hospital bills Vs No Illegal detention					
5	Uncooperative behaviour of patients (religious activities-Purdah)					
6	Harmful cultural practices (Hantu, ounde, ewedu)					
E	**OTHER FACTORS NOT EARLIER MENTIONED**					
	From the Observational Checklist					
	From the Post-partum Interview					
	From the Health Provider Interview					

Appendix 2.11: Ethical clearance from the University of the Witwatersrand, Johannesburg

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

R14/49 Dr Oluwaseun Esan

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)

CLEARANCE CERTIFICATE NO. M190658

NAME: (Principal Investigator)	Dr Oluwaseun Esan
DEPARTMENT:	Centre for Health Policy School of Public Health Ibadan Municipal Area, Oyo State - Nigeria
PROJECT TITLE:	Improving Readiness for Change to Respectful Maternity Care Practice in Public Health Facilities, Ibadan, Nigeria
DATE CONSIDERED:	28/06/2019
DECISION:	Approved unconditionally
CONDITIONS:	
SUPERVISOR:	Dr D. Blaauw and Dr T.S. Maswime
APPROVED BY:	Dr CB Penny, Chairperson, HREC (Medical)
DATE OF APPROVAL:	02/10/2019

This clearance certificate is valid for 5 years from date of approval. Extension may be applied for.

DECLARATION OF INVESTIGATORS

To be completed in duplicate and **ONE COPY** returned to the Research Office Secretary on the Third Floor, Faculty of Health Sciences, Phillip Tobias Building, 29 Princess of Wales Terrace, Parktown, 2193, University of the Witwatersrand. I/we fully understand the conditions under which I am/we are authorized to carry out the above-mentioned research and I/we undertake to ensure compliance with these conditions. Should any departure be contemplated, from the research protocol as approved, I/we undertake to resubmit the application to the Committee. **I agree to submit a yearly progress report**. The date for annual re-certification will be one year after the date of convened meeting where the study was initially reviewed. In this case, the study was initially reviewed in **June** and will therefore be due in the month of **June** each year. Unreported changes to the application may invalidate the clearance given by the HREC (Medical).

Principal Investigator Signature Date

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES

Appendix 2.12: Ethical clearance from the Institute of Public Health, Obafemi Awolowo University, Ile-Ife, Nigeria

HEALTH RESEARCH ETHIC COMMITTEE (HREC)
INSTITUTE OF PUBLIC HEALTH
OBAFEMI AWOLOWO UNIVERSITY, ILE-IFE, NIGERIA.

Our Ref: HREC NO: IPHOAU/12/1243

Your Ref:_____

Date: April 24th, 2019

Notice of Full Approval after Full Committee Review

READINESS FOR CHANGE TO RESPECTFUL MATERNITY CARE PRACTICE IN PUBLIC HEALTH FACILITIES, IBADAN, NIGERIA

Health Research Ethics Committee assigned number: IPH/OAU/12/1243

Applicant's Name: ESAN OLUWASEUN TAIWO

Applicant's Address: Dept. of Community Health, O.A.U., Ile-Ife.

Date of receipt of valid application: 12th February, 2019

Date of meeting when final determination of research was made: 25th March, 2019

This is to inform you that the research described in the submitted protocol (HREC No: IPH/OAU/12/1243), the consent forms and other participant information materials have been reviewed and *given full approval by the Health Research Ethics Committee.* This approval dates from March 25th, 2019 to March 24th, 2020. If there is delay in starting the research, please inform the HREC so that the dates of approval can be adjusted accordingly. Note that no participant accrual or activity related to this research may be conducted outside of these dates. *All informed consent forms used in this study must carry the HREC assigned number and duration of HREC approval of the study.* In multiyear research, endeavor to submit your annual report to the HREC early in order to obtain renewal of your approval to avoid disruption of your research.

The National Code for Health Research Ethics requires you to comply with all institutional guidelines, rules and regulations and with the tenets of the Code including ensuring that all adverse events are reported promptly to the HREC. No changes are permitted in the research without prior approval by the HREC except in circumstances outlined in the Code. The HREC reserves the right to conduct compliance visit to your research site without previous notification.

Chairman, HREC

Web-site: www.iphoau.org // E-mail: iph@oauife.edu.ng, iphhoauife@gmail.com

Appendix 2.13: Ethical clearance from the Oyo State Ministry of Health

TELEGRAMS..... TELEPHONE.....

OYO STATE: THE PACESETTER

MINISTRY OF HEALTH

DEPARTMENT OF PLANNING, RESEARCH & STATISTICS DIVISION

PRIVATE MAIL BAG NO. 5027, OYO STATE OF NIGERIA

Your Ref. No. .....

All communications should be addressed to the Honorable Commissioner quoting

Our Ref. No. AD 13/479/1386

31 July, 2019

The Principal Investigator,
Department of Community Health,
Obafemi Awolowo University,
Ile-Ife,
Osun State, Nigeria.

Attention: Esan Oluwaseun

ETHICS APPROVAL FOR THE IMPLEMENTATION
OF YOUR RESEARCH PROPOSAL IN OYO STATE

This is to acknowledge that your Research Proposal titled: "Improving Readiness for Change to Respectful Maternity Care Practice in Public Health Facilities, Ibadan, Nigeria." has been reviewed by the Oyo State Ethics Review Committee.

2. The committee has noted your compliance. In the light of this, I am pleased to convey to you the full approval by the committee for the implementation of the Research Proposal in Oyo State, Nigeria.

3. Please note that the National Code for Health Research Ethics requires you to comply with all institutional guidelines, rules and regulations, in line with this, the Committee will monitor closely and follow up the implementation of the research study. However, the Ministry of Health would like to have a copy of the results and conclusions of findings as this will help in policy making in the health sector.

4. Wishing you all the best.

OYO STATE RESEARCH ETHICAL REVIEW COMMITTEE

Dr. Abbas Gbolahan
Director, Planning, Research & Statistics
Secretary, Oyo State Research Ethics Review Committee

Appendix 2.14: Informed Consent form for pregnant women focus group discussion participants

INSTITUTE OF PUBLIC HEALTH, OBAFEMI AWOLOWO UNIVERSITY, ILE IFE

INFORMED CONSENT DOCUMENT FOR PREGNANT WOMEN

Study Title: Improving Readiness for Change to Respectful Maternity Care Practice During Childbirth in Public Health Facilities, Ibadan, Nigeria

Principal Investigator: Dr. Esan, Oluwaseun T.

HREC No.: IPHOAU/12/1243

PI Version Date:

This study is aimed at exploring the type of childbirth experiences women receive when they deliver at public primary and secondary health facilities in Oyo state, Nigeria. The study also hopes to determine the state of readiness of health care providers and their health institutions to integrate respectful maternity care into their routine childbirth services that is, if they are not already practicing respectful maternity care. We will also go further to identify strategies that can help shift their state of readiness towards practicing respectful maternity care if their state of readiness is found to be low.

As a client, you are being asked to participate because you are pregnant and you have registered at this health facility and we hope you will come back to deliver at the facility. If you give your consent to join the study as a pregnant woman. We will give you this informed consent form to sign. There are two copies. One will be given to you and one with us. We will like to know your opinion on what is respect for women during childbirth, how can this be demonstrated, what has been your experience and what are your expectations. The interview can be done in Yoruba. We can get an interpreter for you if you don't understand Yoruba. The interview will last for about 40 minutes. There are no risks to you for participating in this study. The information you give us will not be used against you, nor your baby, nor the health providers. It will only help to improve our health system. There are no direct monetary benefits to you for participating in this study. However, the information you provide will help improve the quality of childbirth services for you and any other person who intends to deliver in the public health facilities. This may help reduce the number of people who choose to deliver at home and at other unsafe places and increase the number that deliver safely in the hospitals.

We will give you a token amount to add to your transportation here and small refreshment too, for your time spent. The interview with the providers will be done in a private space within the health facility to provide some degree of privacy. There will be no negative implications for leaving the study at any point in time. Your health information will only be shared with other members of the research team and the data will be analysed, not a personal information about you. There are no conflicts of interest in this study. The result of this study will not lead to a financial gain to the principal investigator or her team. There are no intervention that can lead to the respondents experiencing an adverse effect from his study. Call the principal investigator, Dr Esan at <<08037250980>> if you have questions, complaints, or get sick or injured as a result of being in this study.

Call or contact the Obafemi Awolowo University Institute of Public Health HREC Office if you have questions about your rights as a study participant. Contact the HREC if you feel you have not been treated fairly or if you have other concerns. The HREC contact information is:

Address: Health Research and Ethics Committee, Institute of Public Health, Obafemi Awolowo University, PMB 045, OAU Post Office, Postal Code 220005, Ile Ife, Telephone:+2348088428726; E-mail :iph@oauife.edu.ng; iphoauife@gmail.com

What does your signature (or thumbprint/mark) on this consent form mean?

Your signature (**or thumbprint/mark)** on this form means:

- You have been informed about the study's purpose, procedures, possible benefits and risks.
- You have been given the chance to ask questions before you sign.
- You have voluntarily agreed to be in this study.

Add any of the following lines that are required; delete any that do not apply.

_____ _____ _____

Print name of Adult Participant Signature of Adult Participant Date

Give one copy to the participant and keep one copy in study records

Appendix 2.15: Informed Consent form for pregnant women for the observation and postpartum interview

Study Title: Improving Readiness for Change to Respectful Maternity Care Practice During Childbirth in Public Health Facilities, Ibadan, Nigeria

Principal Investigator: Dr. Esan, Oluwaseun T.

HREC No.: IPHOAU/12/1243

This study is aimed at capturing women's childbirth experiences when they come to deliver at public primary and secondary health facilities in Oyo state. It entails observing the woman, her state of preparedness, her coping strategies, and how this informs her cooperation with providers. It is known that women's childbirth experiences may inform their future decisions on health facility births. Hence, this study. My research assistants who are also nurses will observe you when you come to deliver at the health facility and other research assistants will interview you after you have delivered safely. You are being asked to participate because you are pregnant and you have registered at this health facility. We hope you will come back to deliver at the facility.

If you give your consent to join the study as a pregnant woman. We will give you this informed consent form to sign. There are no risks to you for participating in this study. The information you give will not be used against you, nor your baby, nor the health providers. It will only help to improve our health system. There are no direct monetary benefits to you for participating in this study. However, the information you provide will help improve the quality of childbirth services for you and any other person who intends to deliver in the public health facilities. We will give you a token gift for your baby. There will be no negative implications for leaving the study at any point in time. Personal information about you will not be shared with anybody not involved in the research. Please, Call the principal investigator, Dr Esan at 08037250980 if you have questions, complaints, or get sick or injured as a result of being in this study or the ethical office that granted the permission for this research on +2348088428726. Kindly sign this consent form believing that you have been fully informed about the study. Thank you

_____ _____ _____

Print name of Adult Participant Signature of Adult Participant Date

Health Facility Patient is registered at: ----------

Appendix 2.16: Consent form for the health care providers' interviews (FGD)

INFORMED CONSENT DOCUMENT FOR HEALTH PROVIDERS

Study Title: Improving Readiness for Change to Respectful Maternity Care Practice During Childbirth in Public Health Facilities, Ibadan, Nigeria

Principal Investigator: Dr. Esan, Oluwaseun T.

HREC No.: IPHOAU/12/1243

This study is aimed at exploring the factors that influence health providers' readiness for change to respectful maternity care practice. As a health provider, you are being asked to participate because we believe you play a key role in the delivery of childbirth services and will play a key role if and when respectful maternity care is to be implemented in this health facility.

If you give your consent to participate as a health care provider by signing the informed consent form, I will be asking you a series of questions in a focus group discussion along with other colleagues in a similar profession as yours. The discussion will be recorded for the purpose of recall and storage. The data gathered will be analysed and published to inform evidence base policies changes. I cannot guarantee confidentiality of your responses in a FGD as it is involves other participants.

There are no risks to you for participating in this study. The information you give will not be used against you as a health provider in this facility as it will be taken anonymously. It will only help to improve our health system. There are no direct monetary benefits to you for participating in this study. The token amount given is to support your transportation cost to the interview. However, the information you provide will help improve the quality of childbirth services in public health facilities. There will be no negative implications for leaving the study at any point in time. Please, Call the principal investigator, Dr Esan at 08037250980 if you have questions, complaints, or the ethical office that granted the permission for this esearch on +2348088428726. Kindly sign this consent form believing that you have

Name of Health facility ----------

KINDLY APPEND YOUR CONSENT TO PARTICIPATE IN THE ABOVE STUDY HERE

_____ _____ _____

Signature of Respondent Phone number (for tracking to complete interview) Date

Name of Health facility ----------_____

_____ _____

Signature of Respondent Phone number (for tracking to complete interview) Date

Name of Health facility ----------_____

_____ _____

Signature of Respondent Phone number (for tracking to complete interview) Date

Name of Health facility ----------

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Signature of Respondent Phone number (for tracking to complete interview) Date

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Signature of Respondent Phone number (for tracking to complete interview) Date

Name of Health facility ----------

_____ _____ _____

Signature of Respondent Phone number (for tracking to complete interview) Date

Name of Health facility ----------

_____ _____ _____

Signature of Respondent Phone number (for tracking to complete interview) Date

Appendix 2.17: Consent form for the health care providers' interviews (IDI)

INFORMED CONSENT DOCUMENT FOR STAKEHOLDERS

Study Title: Improving Readiness for Change to Respectful Maternity Care Practice During Childbirth in Public Health Facilities, Ibadan, Nigeria

Principal Investigator: Dr. Esan, Oluwaseun T.

HREC No.: IPHOAU/12/1243

The purpose of the research today is to identify the key strategies needed to address the target behaviors derived from the elicited facilitators and barriers to improving health providers' readiness to change to a respectful maternity care (RMC) practice during childbirth. This means that RMC is integrated into the routine childbirth care services.

As a health provider, you are being asked to participate because we believe you play a key role in the delivery of childbirth services and will play a key role if and when respectful maternity care is to be implemented in this health facility and/ or in Oyo State.

If you give your consent to participate as a respondent, by signing the informed consent form, I will be asking you a series of questions in an In-depth Interview (IDI) using an IDI Guide. The discussion will be recorded for the purpose of recall and storage. The data gathered will be analysed and published to inform evidence base policies changes. I assure you of confidentiality of your responses.

There are no risks to you for participating in this study. The information you give will not be used against you as a stakeholder in the system as it will be taken anonymously. It will only help to improve our health system. There are no direct monetary benefits to you for participating in this study. However, you will be given some refreshments. We believe if you participate, the information you provide will help improve the quality of childbirth services in public health facilities. There will be no negative implications for leaving the study at any point in time. Please, if you have complaints, call the ethical office that granted the permission for this research on +2348088428726. Kindly sign this consent form believing that you have been fully informed about the study. Thank you.

_____ _____ _____

Signature of Respondent Phone number (for tracking to complete interview) Date

Position ----------

Appendix 3.0: Galley proof of the published manuscript

Research article

SRHM SEXUAL AND REPRODUCTIVE HEALTH MATTERS
MORE THAN A JOURNAL

A qualitative inquiry into pregnant women's perceptions of respectful maternity care during childbirth in Ibadan Metropolis, Nigeria

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Coll:
QA:
CE: SS

Abstract: *Women's perceptions of respectful maternity care (RMC) are critical to its definition and measurement globally. We evaluated these in relation to globally defined RMC norms. We conducted a descriptive study involving eight focus group discussions with 50 pregnant women attending antenatal clinic at one primary and one secondary health facility each in the North-west and South-west local government areas of Ibadan Metropolis, Nigeria. One focus group each with primigravidae and multiparas were held per facility between 21 and 25 October 2019. Shakibazadeh et al's 12 domains of RMC served as the thematic framework for data analysis. The women's perceptions of RMC resonated well with seven of its domains, emphasising provider-client inter-personal relationships, preserving their dignity, effective communication, and non-abandonment of care, but with mixed perceptions for two domains. However, their perceptions deviated for four domains, namely maintaining privacy and confidentiality; ensuring continuous access to family support such as birth companions; obtaining informed consent; and respecting women's choices about mobility during labour, food and fluid intake, and birth position. The physical environment was not mentioned as contributing to an experience of RMC. Whilst the perceptions of the Nigerian women studied about RMC were similar to those accepted internationally, there were significant deviations which may be related to cultural differences and societal disparities. Different interpretations of RMC may influence women's demand for such care in different settings and challenge strategies for promoting a universal standard of care.* DOI: 10.1080/26410397.2022.2056977

Keywords: respectful maternity care, perceptions, pregnant women, qualitative study, low-resource settings, deviations, similarities, global norms, respect, women centred-care

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Introduction

Childbirth has been described as an intense psychological experience in a woman's lifetime that leaves her with vivid memories which may be positive or negative.[1] Women have described a positive childbirth experience as having control of their birth process and having trustful and supportive relationships during birth.[2,3] Being treated disrespectfully or over-medicalisation of the birth process may result in negative experiences.[4] Negative childbirth experiences may affect a woman's health and wellbeing long after childbirth, influencing the bonding period post-delivery and her future reproductive health decisions. Complications such as post-traumatic stress disorder have also been reported.[5,6]

Respectful maternity care (RMC) received during childbirth can enhance a woman's positive experience. In addition to ensuring the clinical requirements of a safe childbirth process, the

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delivery of RMC helps to meet a woman's psychological and emotional childbirth needs. It is a rights-based approach to maternal care.[7] Emphasis has been placed on RMC as a global priority in the last decade because it contributes to the overall quality of childbirth care experienced, and may be the missing link in ensuring continuous health facility delivery.[8] Unfortunately, the basic rights underlying the global RMC norms may not be universally accepted. Local expectations of RMC may be lower, due to cultural differences, low self-perception, and structural power imbalances,[9] factors which could negatively affect women's demand for RMC as currently defined.

There has been no agreed global definition of RMC because it is not simply the absence of mistreatment,[10] and women's voices should contribute to defining it.[11] The World Health Organization defines RMC as "care organised for and provided to all women in a manner that maintains their dignity, privacy and confidentiality, ensures freedom from harm and mistreatment, and enables informed choice and continuous support during labour and childbirth".[12] Shakibazadeh et al[13] defined the 12 domains of RMC from a qualitative evidence synthesis of 67 eligible papers from 32 countries, including 6 from sub-Saharan Africa. By exploring women's perceptions of RMC, this study contributes to its global definitions.

The current global norms around RMC should meet women's demands and expectations. They should be continuously reviewed as women's demands and expectations change and as women and girls continue to challenge the normalisation of their mistreatment during childbirth in healthcare settings. It is assumed that women's expectations of birth should be to receive respectful and dignified care that gives a positive birth experience, and that these expectations can be used to define RMC or improve its current definitions. Evaluating the correctness of this assumption is important for the conceptualisation and measurement of RMC, as well as informing the demand for RMC in different settings. If women's expectations deviate negatively from respectful and dignified care, their supposedly positive childbirth experience may not have been optimal, and this also challenges their ability to define a RMC. This represents a challenge for policymakers and programme implementers promoting RMC as the standard of care for all women during childbirth. Understanding the reasoning behind these deviations is also important.

Several studies have explored women's and providers' perceptions of disrespectful and abusive care.[14] Of recent, there has been a shift in the literature to focus on RMC as a broader, more positive concept beyond the absence of mistreatment or disrespect. Women's perceptions and expectations of RMC during childbirth have been less studied, especially women in low-resource settings such as Nigeria. Thus, this study investigated Nigerian pregnant women's perceptions about RMC, and how these relate to the globally defined RMC domains.

Methodology

Study design and setting

This cross-sectional exploratory qualitative study was conducted in Ibadan North-west and South-west local government areas (LGAs) within the Ibadan metropolis, South-western Region, Nigeria. There are six public primary health care (PHC) facilities and one secondary health facility (SHF) offering maternal and child health services in the North-West LGA, while there are three public primary and three secondary health facilities in the South-West LGA. The PHC facilities send referrals to the SHFs. The South-West LGA is one of the LGAs with the largest slums in the Ibadan metropolis,[15] and the main occupation of the people is trading.[16] The North-West LGA is located in the centre of the city and is predominantly urban. The population are artisans and civil servants as well as traders.[17] The character of each LGA is reflected in the socio-demographic characteristics of pregnant women accessing the health facilities within it.

Sampling, study participants, and recruitment

The two LGAs (Ibadan North-West and South-West) were selected purposively (one predominantly urban and one including more slums, though urban). One secondary and one primary health facility were selected in each of these two LGAs, giving a total of four health facilities. There was only one SHF in the North-West LGA; otherwise, both primary and secondary health facilities were selected based on their relatively large volume of clients.

The study participants were pregnant women in their first or second trimester who were registered at these health facilities. They were selected

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by the research assistants with support from the nursing staff who introduced the research assistants and explained the purpose of the research to them. Pregnant women who were not in any form of distress, had completed their antenatal clinic (ANC) routines for the day and were willing to participate were recruited until predetermined quotas for primigravidae and multiparous women, respectively, were reached. Two focus group discussions (FGDs) were conducted per facility, one with six multiparous women (women who have delivered before) and another with six primigravidae (women with their first pregnancy). This gave a total of eight FGDs. Pregnant women who were ill or in any form of discomfort were excluded.

FGD guide

The guide explored the women's perceptions of RMC and how these are commonly demonstrated during childbirth. Probing questions included, "*what do you understand by the word respect, and how should this be demonstrated by health providers when you come to deliver?*" The FGD guide was translated into Yoruba and back-translated to English. The FGDs were conducted in English or Yoruba depending on the preferred language of each group. Five FGD sessions were conducted in Yoruba. The FGD guide was pretested for length, adequacy and comprehensibility among separate groups of multiparous pregnant women and primigravidae recruited at the ANC of a primary health facility in Ile-Ife, a neighbouring town.

Data collection

Respondents' socio-demographic data obtained consisted of their age, level of education, occupation, number of pregnancies and deliveries, and their current gestational age. We asked multiparous women if they had ever delivered in that facility, at home, in a church or mosque, or a Faith-Based Organisation (called Mission Homes).

The FGDs were conducted from 21 to 25 October 2019 in a separate and secluded room away from the nurses and other staff within the facility, during one of their regular antenatal clinic days and after all health education activities had been concluded. The health providers introduced the research team to the women. The principal investigator is a Community Health Physician with expertise in conducting qualitative interviews and a deep understanding of the RMC concept. The FGDs lasted about 50 min on average. The researchers involved in the FGDs were all female, which helped to prevent gender and social desirability bias. Interesting responses were probed. All the FGDs were audio-recorded using a digital voice recorder.

Data management and analysis

The audio-recorded discussions were transcribed verbatim. FGDs conducted in Yoruba were translated into English. Thematic content analysis[18] was done using the NVIVO 11 software. The transcribed FGDs were imported, initially coded using deductive coding guided by the 12 domains of RMC proposed by Shakibazadeh et al[13] as their thematic framework. Afterwards, inductive coding was done for the remaining information not yet coded. Coding was primarily done by the principal investigator, and also by a research assistant whose codes were compared with those of the principal Investigator.

Ethics approval and consent to participate

Ethical approvals were obtained from the Human Research Ethics Committee (HREC) of the University of the Witwatersrand (clearance Number M190658, 2 October 2019), as well as the Oyo State Ministry of Health (Ref. Number AD/13/479/1386, 31 July 2019). Written informed consent for participating and recording of their voices was obtained from each participant. The researchers had no prior relationship with the pregnant women interviewed. They were introduced as researchers; details about their qualifications and positions were not disclosed, to minimise any power imbalance that could coerce the women into participating. There were no inducements given before participation. A stipend of ₦500 (1.4 USD) was given for transportation.

Results

Description of the study participants

Six women participated in six of the groups and seven women in two groups to give a total of 50 women, consisting of 26 primigravidae and 24 multiparous women (Table 1). The majority of the women were of the Yoruba ethnic group, with one Ibo and one Hausa woman. Their ages ranged between 18 and 41 years, the multiparous women being older. Only one (2%) of the women did not have at least a secondary education. There were more artisans and traders among the

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Table 1. Socio-demographic characteristics of FGD participants

Socio-demographic characteristics	Primary Health Facility		Secondary Health Facility	
	Primigravida ($n = 14$) Freq (%)	Multipara ($n = 12$) Freq (%)	Primigravida ($n = 12$) Freq (%)	Multipara ($n = 12$) Freq (%)
Age (in years)				
18–24	9 (64.3)	0 (0.0)	2 (16.7)	0 (0.0)
25–35 years	4 (28.6)	9 (75.0)	10 (83.3)	7 (58.3)
>35 years	1 (7.1)	3 (25.0)	0 (0.0)	5 (41.7)
Age in years (median, IQR)	23.5 (20–29)	31 (29–36)	28 (26–31)	34 (33–37)
Highest level of education				
Primary	1 (7.1)	0 (0.0)	0 (0.0)	0 (0.0)
Secondary	10 (71.4)	9 (75.0)	4 (33.3)	3 (25.0)
Tertiary	3 (21.4)	3 (25.0)	8 (66.7)	9 (75.0)
Marital status				
Single	3 (21.4)	0 (0.0)	0 (0.0)	0 (0.0)
Married	11 (78.6)	12 (100.0)	12 (100.0)	12 (100.0)
Occupation				
Student	0 (0.0)	0 (0.0)	0 (0.0)	1 (8.3)
Artisan (tailor, hairdresser, etc.)	8 (57.1)	4 (33.3)	2 (16.7)	1 (8.3)
Trading/Business	4 (28.6)	4 (33.3)	3 (25.0)	7 (58.3)
Civil servant/Private employee	2 (14.3)	4 (33.3)	7 (58.3)	3 (25.0)

primigravidae interviewed at the PHC facilities but more skilled professionals among those at the SHFs. A higher proportion of the multiparous women at the SHFs had previously delivered at the same facility while three at the PHC facilities had previously delivered at home or a faith-based organisation (Table 2).

Women's perceptions of RMC with similarities and deviations from the current RMC definition

The 12 domains of respectful maternity care (RMC) as defined by Shakibazadeh et al and how they compare with the study participant's perceptions of RMC are highlighted in Table 3.

Across the focus groups, we found that most of the women's perceptions of RMC related to the domains defined as "preserving woman's dignity"; "engaging with effective communication"; and "continuity of care". However, their perceptions deviated from the globally defined RMC norms for health providers, that is: "ensuring continuous family support"; "maintaining privacy and confidentiality"; "getting informed consent"; and "respecting women's choices" on mobility during labour and birth position. The women made no

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Table 2. Obstetric history of multiparous women

Delivery site history	Primary health facilities ($n = 12$)	Secondary health facilities ($n = 12$)
Ever delivered at same facility		
Yes	9 (75.0)	11 (91.7)
No	3 (25.0)	1 (8.3)
Ever delivered at:		
Home	1 (8.3)	0
Church/ Mosque/ TBA	2 (16.7)	0

mention of the "quality of the physical environment and resources" in relation to RMC.

Being free from harm and mistreatment

The women's perception of a respectful childbirth was one devoid of verbal abuse or being hit or slapped. This was common to all the groups. They denounced providers who shout at women in labour or are rude to them. They mentioned their disappointment with the sudden change in behaviour of providers who had been pleasant at the antenatal clinic but became hostile when the women presented in labour. They deemed as unnecessary, providers who tell women, "Was I there when you were conceiving?", thus blaming the woman for getting herself pregnant. They explained that this abuse of women prevents them from making their complaints known to the providers, for fear of being shouted at, and some not coming to the hospital when in labour.

The manner in which some people will be harsh, you will regret ever going to the hospital. (Multipara, PHC)

Professional treatment was categorised under the "being free from harm and mistreatment" domain. The women described this as receiving proper attention and quality care, resulting in a safe delivery for both them and their baby.

I believe they need to give that woman proper attention … when you came to deliver, some people will be shouting when some will be bringing different attitude, so I think the health attendants they don't need to be shouting, "why did you do this!?", they need to give us proper attention. (Multipara, SHF)

For a few, receiving proper attention and quality care is what they are most concerned with. They would not mind if it was delivered to them under abusive conditions: "*I will not mind if they abuse me, since I came to seek their assistance. What can prevent me from returning to the facility to deliver is if they don't take proper care of me and my baby.*" (Multipara, PHC)

However, women in four FGD sessions believed that women in labour would determine the extent of RMC they received, and two of the groups stated further that some women may deserve being beaten during childbirth. The women perceived to deserve being beaten include those who have not cooperated well with the providers in opening their thighs for vaginal examination or the delivery, as well as teenage mothers, who were mentioned because they were likely to be unmarried rather than because they had done anything wrong. These perceptions came more from the FGDs with older, multiparous women. As one said, "*beat someone (laughs) – when one is not a child! But maybe those girls with unwanted pregnancy can be beaten*". (Multipara, SHF)

Another woman remarked, "So, if there are some you cannot allow the baby to die, so if it's slapping you will have to slap the woman, that "oya" you must open your thighs" (Multipara, PHC). When asked if slapping the woman was disrespectful, she replied by saying "It is not disrespect, that process is not disrespect". Such statements signify perceptions that normalise disrespect for some women and deviate from global definitions which stipulate that all women deserve RMC.

Maintaining privacy and confidentiality

Ensuring privacy as an approach to providing RMC was a controversial issue across the focus groups. In six of the groups, most women believed that ensuring privacy by not unduly exposing their body parts during labour was not a necessity, especially in the presence of other women in labour and attending health professionals.

There is nothing like privacy, when you are in labour, the woman will labour to a stage, the nurses will call the doctor to come, as in male doctor, is he not going to do his work and attend to the patient? So that doesn't have any meaning, and even at that

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Table 3. Relating the 12 domains of respectful maternity care to women's perceptions

	Global 12 Domains	Domains' definitions from the literature	Relationship with women's perceptions
1	Being free from harm and mistreatment	Not using loud voice, have a warm and measured manner, give professional treatment	Similar to the norms A few normalised disrespect to women
2	Maintaining privacy and confidentiality	Privacy during examinations and procedures; shield from visitors, other women and men; limit number of attending staff; maintain secrets about their health	Perceptions significantly deviated from the norms. Only a few insisted on ensuring privacy
3	Preserving women's dignity	Positive labour ward atmosphere; make woman feel welcomed, kind attitudes, calm, tactful, warm, smiling, caring, treat woman as an individual with preferences and differences, respect their cultures, values and beliefs.	Women's perceptions on RMC related mainly to ensuring this domain
4	Provision of information and getting informed consent	Provide information ask permissions before procedures, obtain consent	Agreed with provision of information. Obtaining consent was not always seen as necessary
5	Ensuring continuous access to family support	Have birth companions, physical structure should enable companions	Majority didn't see this as necessary
6	Enhancing quality of physical environment and resources	Provide comfortable, clean and calming birth environment; adequate beddings; regular water supply and electricity with medical & non-medical technologies	There were no RMC perceptions relating to this domain
7	Providing equitable maternal care	Availability of services regardless of age, ethnicity, sexuality and religion	Perceptions were similar to the norms
8	Engaging with effective communication	Give verbal praise and encouragement; provide emotional support; talking to & listening to the women; show empathy; practice effective non-verbal communication; provide interpreters	Perceptions were similar to the norms
9	Provision of efficient and effective care	Minimal delays/prompt attention; minimal interventions (episiotomy; vagina examination, urinary catheter)	Perceptions were similar to the norms
10	Availability of competent and motivated staff	Have adequate and proficient staff; competent and supportive supervision.	Perceptions were similar to the norms
11	Continuity of care	Cared for by familiar staff, available on demand with no abandonment	Perceptions were similar to the norms
12	Respecting women's choices that strengthens their capabilities to give birth	Respecting women's decision on birth positions, mobility during labour and fluid intake during labour.	Women's perceptions deviated from the norms for all the issues raised

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time, nobody cares who is watching … (Multipara, SHF)

There was also a health system perspective to ensuring privacy. All the women in one FGD group conducted at a secondary health facility chorused that privacy cannot be achieved at the public hospitals for women. The lack of this was not perceived as lack of RMC, as it was because of unavailability of space. If a woman desired privacy, she should be ready to pay for it: *"if you want private, pay for private suite".* (Primigravida, PHC)

Even though there were only a few arguing for privacy, they maintained their stance on the need to respect them and their body by ensuring privacy during labour. One of the women was content with covering her body with a wrapper if screens were not available, while another would not mind paying exorbitant fees at private hospitals to ensure the privacy of her childbirth process. The women's idea of privacy was having a private room or private space with screens; they did not describe privacy in terms of confidentiality.

Preserving women's dignity

Overall, the women prioritised this RMC domain relating to dignity as the most important way providers should demonstrate respect during childbirth. Their expectations were about health providers' being caring, showing them love, giving them time and attention, being cheerful with them, treating them as humans, and not looking down on them. When probed on how providers can treat a woman in labour as a human being, one woman responded:

This had happened to me before when I went to the clinic for treatment. The way the medical personnel reacted to me, it was like I do not exist. If a patient should arrive, and you, the first treatment is that you smile to the patient, and see her as a human being, she will be relaxed that I am in the right place. (Multipara, PHC)

The women emphasised how they are received into the labour ward, and how this contributes to their respectful childbirth care experience. The manner of greeting, smiling, and welcoming them helps to relax them and they believe it aids their labour process.

This domain also includes the idea that health providers should respect women's cultural beliefs during labour. However, the women in our focus groups never mentioned respect for their cultural beliefs (such as traditional practices to hasten childbirth) and values as part of the demonstration of RMC. This is probably because there are not many cultural differences between the providers and patients in the study setting, so it was taken for granted. However, many did express demands about meeting their spiritual needs. For example, in one of the FGDs, the women wanted their health providers to pray for them during labour as part of demonstrating RMC as shown in these quotes:

… prayers, they should speak blessings (Primigravida, SHF)

… they should be saying by God's grace, you will deliver safely, and the woman should be saying amen … amen … (Primigravida, PHC)

The common practice of detaining women after childbirth when they are unable to pay their childbirth services bill also compromises their dignity. Perceptions relating to this were explored in six FGDs but the women were divided on the issue. Two groups insisted that the woman needs to pay her hospital bills and if she is detained at the facility, it is not disrespect.

It's a type of disrespect [detaining women for not paying their bills], but they [the health providers] have to receive their money too. (Primigravida, PHC)

The other focus groups, however, were sympathetic to the plight of such women, insisting that they should be pardoned or should benefit from a welfare purse that supports women with limited resources for childbirth fees and they should never be detained. We did not probe participants' understanding of national laws relating to detention for non-payment of childbirth fees.

Provision of information and getting informed consent

The majority of women in four of the FGD groups felt that obtaining informed consent was not necessary. They did not see the need to question a provider's judgement on conducting a procedure on them but understood this as part of the provider's job. We did not probe whether this was because they trust providers, or because of established power imbalances between providers and women in labour, or because they do not want to be seen as uncooperative. A few did not see the need for information or consent,

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while most wanted information but thought that obtaining informed consent or permission was not always necessary, as shown in this quote.

It's not like permission in a way, it's not like they need your permission, but they just want you to know that … so that you will cooperate. See I want to go through a procedure and you take your time to explain to me, yes, even if it's going to be painful, but because you've taken your time, and ehm, maybe they approach you and you are calm with me, it will prepare my mind ahead and then I will be able to cooperate with you. That is just my own kind of person. (Primigravida, SHF)

Even for doing an episiotomy, women in two FGD groups felt there was no need for consent:

They should do it now, whatever that is right. (Primigravida, SHF)

Ha! but they will stitch it back. I don't think one needs any permission. (Multipara, SHF)

Ensuring continuous access to family support

The need to have a birth companion was only expressed by a few women in one of the FGDs, and not everyone in the FGD agreed with them. The majority of women across the FGDs did not identify being allowed to have a birth companion during labour as demonstrating RMC. Rather they even queried the role of the companion with comments such as these:

There is no need for someone to stay with me, when all they do is just watch someone … I don't think so oh, is she the one to hold my legs? (Primigravida, PHC)

It's not compulsory for someone to be present in the labour room when it's not the person that will deliver the baby. (Primigravida, SHF)

Some women dismissed health providers' encouragement of having a birth companion as "*spoiling the woman*" and were concerned that this would result in the woman being lazy and no longer cooperating with the health providers. They also felt it could be safer for some spouses not to be near a woman in labour, as the following quote explains:

Apart from yiyo [being spoilt], because some women, we are like the way we talk or the way we behave to our husband at home. A woman was like "I want to see my husband! I want to see my husband!" when the husband came, she just grabbed him and start cursing him during the labour. So because of such experiences, that is why they don't allow. (Primigravida, SHF)

Others who encouraged their spouses to be present in the labour room wanted it to be brief, and their main motivation was for the spouses to appreciate the rigours of childbirth that they had to endure. All these ideas deviate from the global RMC norm of not barring women access to a birth companion of her choice if she so wishes.

Engaging with effective communication

This domain was the second most commonly identified by study participants as part of RMC. The women wanted health providers to listen to them, show them empathy, give them words of encouragement such as, "you can do it", crack jokes with them, and try to make them happy. The women repeatedly expressed the desire that providers show them love. In response to a question on how providers can demonstrate love to a woman in labour, a respondent said:

The way they talk with someone, and are cheerful towards one, saying things like "come over here, let us examine you", and not say things like, "why is your pant like this, why are you like this?" Many do not like them talking to them anyhow. But when they behave well towards her, she also will cooperate, she will be happy that next time, if I want to deliver, I will come back here, so to show love to us is good. (Multipara, PHC)

These requests show the women's need for emotional support from providers during labour. However, some women noted that uncooperative women and primigravidae should be given both love and a bit of harshness:

They need to be harsh, at the same time, they need to show love. The reason why I said they need to be harsh is because most of us, how will I put it? "A maa n ke ara", [like to be indulged] they will say "open your legs" some will be doing the way they like, so they need, at that point, they need to be harsh on us. At the same time, they will still pet us, so, "yes, small harsh, small love", if there is love in their harshness, we will see it. (Multipara, SHF)

Provision of efficient and effective care

The women in the FGDs did not mention any contradictions to the global definitions for this domain. Their emphasis was on being attended to promptly on arrival. They also stated the consequences of not being attended to promptly as reported here:

I once lost a baby and this was very painful. I was coming from church and felt I was having labour pains. I branched at the health facility to tell them I am feeling labour pains. They just looked at me and said, "see the person who is in labour smiling, is it possible that the pregnant woman should just be shouting for no reason?" Well I lost the baby and I have vowed that I will never go back there. There are no charms that they can give to make me go back there. (Multipara, PHC)

Effective pain management during labour was not mentioned by the women as a perceived component of RMC. However, the majority of women in one FGD lamented the pains they experience during vaginal examinations and would prefer that this be reduced to a minimum. One participant even explained this as a reason for women presenting late in labour. They seemed not to know that they can refuse the procedure rather than presenting late in labour to avoid it. The quote below corroborates this.

You see that insertion of fingers during vaginal examination? It is worse than delivering the child. This is because, when someone has delivered the baby, you will now be passing through the pain of the vaginal examinations. Especially with all those nurses in training that are using you to learn their practice (laughs). In your life, you won't consider presenting too early. The best is you have labour pains and the child comes out the moment you get to the hospital. (Multipara, PHC)

Providing equitable maternal care

The women in our study agreed that equitable care is part of RMC. The FGD respondents recounted provider discriminatory behaviours towards teenage mothers. They also reflected that women who were known to providers, such as friends, relatives, or colleagues, would get better treatment than those without such connections. They further reported that some women "buy" preferential treatment by giving larger tips to health providers. Some also commented on the need for equitable care irrespective of women's socio-economic status (for example, those who present in labour without all the required delivery materials): *"It's disrespect, you don't know anybody in the hospital, maybe you don't have money, you are not a kind of person that gives out something to them, the way they will treat you, you won't even like it."* (Multipara, SHF)

Inequitable care based on ethnicity and religion was not prominent among the issues raised.

Continuity of care

The women's perceptions of RMC were often related to this domain, focusing mainly on neglect or abandonment of care. They described the abandonment of care during childbirth by providers as being common, especially by public health facility providers. One woman described it as the most important RMC issue to address:

Hmm negligence of duty, in most general hospitals, negligence of duty is much. They will just abandon, even if someone is at the point of delivery, in some general hospitals, I am a civil servant, but within the same general hospital, you see them, negligence of duty is the most important thing they should work on. (Multipara, SHF)

Availability of competent and motivated staff

The perceptions of the participants on having competent and motivated staff to ensure RMC were not mentioned directly, but could be inferred from some of the discussions. For example, they mentioned the heavy workload of health providers as a reason for their being disrespectful.

Sometimes ehn, work load. Because WHO say one nurse to four patients. But when you see one nurse taking care of twenty patients, and the nurse is a human being with her own problems too and her own family issues too. (Primigravida, SHF)

They also stated the need for well-motivated staff and the government ensuring that salaries get paid and that staff are provided with the equipment needed to do their work. They stressed that a nurse who is paid performs differently to one who has not been paid.

A few believed that more competent staff would attempt vaginal deliveries rather than

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referring the woman for surgical deliveries even when there are indications for it.

What I will ldqike is for example a situation where the woman has been "condemned" to delivery by operation, but we see some nurses with lots of experience of what one is passing through at that moment, and they come and help the woman to deliver by herself. So, such a situation where the nurse can help, one will be happy to come back again. (Multipara, PHC)

Respecting women's choices that strengthen their capabilities to give birth

The FGDs explored participants' perceptions about their intake of fluids or foods, mobility during labour, and choice of birth position. The majority of participants felt that all these decisions should be left to the health provider, and that being denied their own choices or preferences did not constitute disrespect.

Not being allowed to walk around during labour was justified by most women, across the FGDs. They felt women need to conserve energy to push the baby out.

I'm just saying that if you are fit to walk about and the nurses agree with you that you can, you can walk about. But if they say that it is not good for you for now, you just follow their instruction because that is their duty they know better, they know why. (Primigravida, SHF)

As for the choice of birth position, the women felt that this is entirely the prerogative of the health provider. A few mentioned that the presenting part of the baby during delivery may not even allow for such a birth. They stated that anyone who desires an alternative birth position, besides lying on ones back with both knees bent, should rather go to a private hospital to deliver. Only one of the women was familiar with squatting to deliver or other alternative birth positions, and she had booked at both a private and a public hospital to ensure she could choose her position during childbirth. In general, attitudes to alternative birth positions were of disapproval and disbelief: "*They won't accept, I've not seen it happen, you will have to lie down to deliver your baby*". (Multipara, SHF)

Similarly, none of the women thought it was disrespectful to deny access to oral fluid or food during birth. The general response to this domain is captured in this quote:

In my own opinion, the summary of it is cooperate with your health professional because they are the ones taking care of you and the success of your delivery, they are also a part [i.e. have an interest in a successful delivery outcome]. (Primigravida, SHF)

Enhancing quality of physical environment and resources

There was no reference in any of the FGDs that related to this domain as part of RMC. The women were more interested in the actual service delivery than in the infrastructure when discussing respectful care during childbirth.

We further qualitatively analysed their perceptions in relation to their parity and whether they were attending a primary or secondary health facility. More primigravidae than multiparas would prefer that their opinions were respected for the RMC domains regarding ensuring mobility during labour, obtaining informed consent, preserving their dignity, having access to family support and ensuring their privacy. The FGD participants at the primary health care facilities were predominantly concerned with continuity of care, being free from harm and mistreatment, provision of efficient and effective childbirth services and providing effective communication, as they expressed most of the perceptions on these. Those at the secondary health facilities expressed most of the perceptions on ensuring their privacy, providing equitable care, providers obtaining informed consent, and pregnant women's choices being respected as regards mobility during labour and their birth positions.

Discussion

This study explored the perceptions of women in Ibadan Metropolis, South-western Region, Nigeria about respectful maternity care (RMC) and evaluated how these corresponded with the 12 domains of RMC defined by Shakibazadeh et al.[13] The study participants' perceptions about RMC deviated for four of the defined RMC domains, namely: maintaining privacy and confidentiality; ensuring continuous access to family support; obtaining informed consent; and respecting women's choices about mobility during labour, food and fluid intake, and birth position. The women's perceptions resonated well for five of the RMC domains, and there were mixed perceptions for

two domains. The physical environment domain was not mentioned as contributing to RMC.

RMC domains where women's perceptions deviated from globally defined norms

The study participants seemed more concerned with the outcome of their delivery than their privacy or comfort. From their perceptions, having a private cubicle or a private space during childbirth is a luxury, accessible at extra cost by registering at private hospitals, and was not a basic requirement for RMC in public hospitals. Being exposed during labour and not enjoying privacy has become a norm for them. This is unusual, especially as women may not be comfortable if unduly exposed elsewhere, outside the childbirth process. This normalisation of lack of privacy during childbirth has also persisted because the structural design of local health facilities does not allow for individual private space.

This finding differs from those of other studies, such as those from Abuja (Nigeria),[19] Guinea[20] and Mbale in Uganda,[6] where women criticised the violation of their privacy resulting from hospital structural deficiencies. The lack of privacy did contribute to the negative childbirth experience for the respondents in those studies. One possible explanation for the different perceptions of women in this study may be that our FGDs were held with pregnant women whereas the other studies interviewed postnatal women. Pregnant women may be more anxious about the delivery and the wellbeing of their babies, and less concerned about issues such as privacy. Even though the women in our study did not feel that privacy and confidentiality were essential to RMC, these are established ethical and human rights principles[21] that should not be violated even if women do not demand them.

It is also a universally accepted medical ethical principle that health providers should obtain informed consent from women during childbirth, and ensure that women maintain some control over their birth process.[3] It was surprising that the pregnant women in our FGDs seemed content with receiving information only, did not regard giving informed consent as essential, and trusted healthcare workers to make the right decisions for them. Their disinterest in granting informed consent may also be linked to not wanting to be perceived as a difficult or uncooperative patient, as they associated that with negative consequences such as abandonment of care or abuse. These perspectives are evidence of the entrenched power imbalance between health providers and clients, particularly in low-resource settings.[22] In contrast, Swedish women described their childbirth process as respectful when they were fully engaged and participated in the decisions regarding their birth.[2] A study of post-partum women in Nigeria reported that many had not given consent for episiotomy during labour and they judged this as mistreatment.[23]

Having a birth companion has been linked to better pain management, shorter births, lower levels of mistreatment of women during childbirth, more satisfaction during labour, and early breastfeeding initiation.[24,25] The World Health Organization has emphasised that global efforts at reducing maternal morbidity and mortality should not end with increasing health facility delivery. Rather, women's preferences during childbirth, such as having a birth companion of their choice, must be known and supported.[26] Despite these established benefits, our study participants across the groups did not consider allowing birth companions during labour an essential component of RMC, thus deviating from the global definitions. The implication of this is that women may not demand birth companions and stand to lose its associated benefits.

Spousal participation during labour is low in Nigeria, attributable to low education levels, cultural and religious beliefs that see labour as a women's affair.[27] Poor male involvement during the pregnancy[28] may also explain why their presence during labour seemed unnecessary to the women in our study. Study participants who supported having a birth companion opted either for their mother or their spouse for that role. This is similar to the perceptions of women receiving ANC at a tertiary health facility in Ibadan, Nigeria.[28] In addition, the design of many facilities has no provision for private cubicles which prevents birth companions being present in the labour room. If not addressed, these challenges may limit implementation of this RMC domain in low-resource settings.

The study participants seemed largely unconcerned about their lack of delivery choices. Denial of foods and fluid intake was not common in their experience. In contrast, not being able to move around during labour and delivering in the lithotomy position are routinely enforced, but the women were used to these restrictions and accepted them as normal. Not only were they

not aware of the advantages of alternative approaches, such as walking around during the active phase or squatting for delivery, but they viewed these suggestions as strange and even potentially dangerous. We did not probe if delivering using alternative birth positions was culturally acceptable or not, though to the best of our knowledge, there is no evidence to suggest that it is culturally unacceptable. This could be investigated in further research.

RMC domains that resonated well with the women's perceptions but with mixed feelings

The women's perceptions of RMC focused more on the inter-personal skills of healthcare providers than their medical or technical skills. Thus, their interpretation of RMC mainly emphasised the preserving dignity domain, and wanting to be treated as individual human beings. The women also desired more love and spiritual support from their providers, even requesting prayers. It has been found that one of the reasons women often visit traditional birth attendants (TBA) in Africa is because the TBAs pet, pamper and pray for them during labour.[29] This perception on the need for spiritual support for women during childbirth raises other ethical questions, considering that women and health providers alike may have different religious backgrounds and the ethical rights of both must be preserved. Health providers may need to incorporate the concept of "demonstrating love" in the form of compassion and emotional support to women in labour, as recommended in the literature.[30] The use of professional doulas as birth companions in health facilities may also be encouraged as these are known to provide physical, emotional (love), and spiritual support to women during birth.[31]

The mixed perception in this RMC domain is that a few of the women suggested that some form of abuse is acceptable for uncooperative women, supporting the contention that disrespectful and abusive care for women in labour has been normalised.[32] This deviates from what RMC stands for. Moreover, it is similar to the findings among women in Ethiopia who recently delivered and their family members.[33] Women who had described the abuse of women during antenatal care and delivery as normal behaviour by health providers in government-owned facilities in Nigeria also defended the providers by saying those behaviours were unintentional.[34] Normalisation of disrespect by providers and clients alike are critical targets to eradicate through interventions promoting RMC.[35]

RMC domains that resonated well with the women's perceptions without exception

The continuity of care and effective care domains were strongly supported as critical to the participants' perceptions of RMC during childbirth. Not being attended to promptly and being abandoned during labour were linked to serious negative outcomes such as loss of the baby or maternal complications. Such consequences would dominate any other considerations of RMC, and would probably result in women not returning to the same health facility for delivery in future, or even avoiding institutional delivery completely.[36]

The women in our FGDs assumed that staff who were not paid well would not be motivated to provide RMC. In a systematic review of disrespect and abuse of women during childbirth in Nigeria, the de-motivation of health workers was attributed to their being understaffed, overworked, poorly remunerated, and lacking training on improving quality of care.[37] Our FGD participants felt that governments should ensure healthcare workers are paid well and on time to improve their motivation and performance. Ensuring that they are competent at what they do, and being intrinsically motivated to provide RMC, however, was not mentioned as part of the providers' role by the women.

Ensuring equitable provision of maternal care is a global health priority for the attainment of Sustainable Development Goal 3,[38] but our respondents provided examples of how poorer women in Ibadan received less RMC. The health system should ensure RMC for all women, irrespective of their socio-economic status or demographic characteristics. The costs associated with childbirth, even in the public sector, are not inconsiderable, and the out-of-pocket expenses are not affordable for many women, further worsening inequities. In a recent study, only 10% of 524 pregnant women studied in Lagos had health insurance,[39] and 52% of reproductive-aged women in Nigeria had problems accessing health care for themselves, with 46% of these having challenges with getting money for treatment.[40] Hence, there is a need to ensure better financial protection for pregnant women.

The social health insurance programme for vulnerable groups in Nigeria was meant to cater for pregnant women; however, many have described gains from the programme as poor.[41] Some states

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in Nigeria provide free maternity care services but poor communication affects uptake.[41] Other maternity health care financing options may include compulsory or voluntary contributory schemes for women in the reproductive age group. Paid maternity leave is also an essential component of a social protection package given only to women working in formal settings. Women could also receive social grants or state subsidies during pregnancy,[42] in the form of cash or vouchers, to ensure their financial access to essential health care and to cover additional costs associated with caring for themselves and their baby.

RMC domains that were missing from the women's perceptions

The women did not mention the health facility's physical environment, such as having constant electricity, adequate and safe water, or good toilet facilities, as components of RMC. This is contrary to the perceptions of women in Guinea, who listed poor physical conditions contributing to mistreatment.[20] This may be because specific questions on these were not asked. Rather, the women were asked about their perceptions on respect and respectful childbirth care, and these were then related to the RMC domains by Shakibazadeh et al.[13] This implies that the facility's physical environment is not a priority for them. They may also have normalised and accepted the current state of the facilities, either good or bad.

The management of pain during labour is not a separate domain in the Shakibazadeh et al[13] framework, but is an important part of providing effective care in RMC. For example, the World Health Organization has emphasised that proper pain management is crucial for ensuring a positive childbirth experience for women.[12] Pain relief was not mentioned by FGD participants as necessary for the delivery of RMC during childbirth. The reason for this could be that the women saw pain as a natural part of the childbirth process, and not being able to endure pain is interpreted as a sign of weakness. This is similar to the perceptions of some Ghanaian women on labour pains.[43] Probably, the women did not imagine a childbirth without pain, and so did not identify this as part of RMC.

Strengths and limitations of the study

The study was limited in its spread having been confined to one geographical region in Nigeria. A more holistic perspective from women across several educational and ethno-cultural backgrounds may be needed. The awareness of the health providers' presence within the facility may have influenced the respondents' responses. To ameliorate this, the study was conducted in a separate and secluded room away from possible interference from the providers. Studying pre-pregnant women or women post-pregnancy may have yielded different results. We chose to study pregnant women because we assumed they would have reflected more on their expected childbirth experiences compared to pre-pregnant women. Women who have recently delivered should be considered as the study population in future research.

This study suggests a potential inequity in childbirth experiences across different cultural settings as some health providers in some settings strive to attain an RMC practice while others do not.

The findings of this study have implications for the overall quality of care women receive during childbirth, as well as women's ability to define RMC and demand it during institutional deliveries. The findings also imply that the extent of RMC received during childbirth may be dependent on women's interpretations and expectations of RMC.

Measurement of RMC received cannot be compared accurately across different settings until women have the orientation and expectation of the kind of RMC that they should receive during childbirth in accordance with global standards.

Conclusions and recommendations

Respectful maternity care is a fundamental right of women during childbirth that should be universally accessible to all irrespective of their cultural setting. Pregnant women are critical stakeholders in the implementation of RMC and their expectations and perceptions about RMC should inform its definition. However, when women's perceptions do not align with the current globally defined basic RMC standards, this could challenge an effective implementation process. Nigerian women's perceptions of RMC in this study deviated significantly from globally defined norms. Their definitions of RMC may exclude granting of privacy, labour companions, obtaining informed consent, but would include demonstration of love, trusting health providers solely for decisions on their birth position, and mobility during labour.

This suggests that local interpretations of RMC are clearly influenced by cultural practices and societal norms in different settings. Additional research exploring how and to what extent these influence women's interpretations of RMC is required, considering various contexts. Quantitative research to measure women's perceptions of RMC on a larger scale across settings is also needed.

Nevertheless, pregnant women's human rights, represented by the emerging norms of RMC, should always be upheld by health providers. These include the right to dignity, privacy, choice, informed consent, and not being mistreated, even where some women believe that violations of some of these are sometimes acceptable. We should promote a nurturing and caring RMC environment in maternity units as this builds trust between patients and healthcare workers. In many low-resource settings, birthing facilities need to be better designed to protect women's privacy and dignity, and to support RMC. A strengthened health system with well remunerated, competent, and motivated staff is critical to meeting women's expectations of RMC during childbirth. A respected health provider, whose needs have been met by the employers, should be willing to give the best care and respect to their clients. There is also clearly still much that needs to be done in low – and middle-income countries to inform women about their rights, empower them in their relationships with healthcare providers, and educate them about RMC.

Acknowledgements

We appreciate the Consortium for Advanced Research and training in Africa (CARTA) for all the human and material resources made available towards this research and publication. I specifically appreciate CARTA facilitators Dr Stephen Wandera, Dr Kudus Adebayo and Prof. Oladapo Olayemi for their inputs into the data analysis and drafting the manuscript.

Disclosure statement

No potential conflict of interest was reported by the author(s).

Funding

This research was funded by the Consortium for Advanced Research Training in Africa (CARTA) which is jointly led by the African Population and Health Research Centre (APHRC) in Nairobi and the University of the Witwatersrand, South Africa. CARTA is funded by the Carnegie Corporation of New York [Grant No – B8606.R02]; SIDA [Grant No: 54100029]; the DELTAS Africa Initiative [Grant No: 107768/Z/15/Z]. The DELTAS Africa Initiative is an independent funding scheme of the African Academy of Sciences' Alliance for Accelerating Excellence in Science in Africa and supported by the New Partnership for Africa's Development Planning and Coordinating Agency with funding from the Wellcome Trust (UK) and the UK government. The second author is funded by the South African Medical Research Council's [Mid-Career Scientist Award].

Availability of data and materials

The coded transcripts and codebook from the study have been deposited into the Mendeley Data Repository cited as Esan, Oluwaseun (2021), "Similarities and deviations to RMC", Mendeley Data, v1. Available at: http://dx.doi.org/10.17632/sx5mkydrh8.1

Authors' contributions

OTE, DB and TSM all contributed to the design of the study, the development and finalisation of the tools. OTE collected and analysed the data, and also developed the draft manuscript. All the authors contributed to and approved the final manuscript for submission.

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Résumé

Les façons dont les femmes voient les soins de maternité respectueux est essentielle pour définir et mesurer ces soins dans le monde. Nous les avons évalués par rapport à des normes de soins de maternité respectueux définies au niveau mondial. Nous avons mené une étude descriptive comportant huit discussions par groupe d'intérêt avec 50 femmes enceintes fréquentant une consultation prénatale dans un centre de santé primaire et secondaire situés chacun dans les zones de gouvernement local du nord-ouest et du sud-ouest de la métropole d'Ibadan, Nigéria. Chaque centre a organisé un groupe de discussion avec des primipares et un autre avec des multipares. Les 12 domaines de soins de maternité respectueux de Shakibazadeh ont servi de cadre thématique pour l'analyse des données. La manière dont les femmes concevaient des soins de maternité respectueux cadrait bien avec sept de ses domaines: relations interpersonnelles prestataire-cliente, respect de la dignité des femmes, communication opérante, et non-abandon des soins, mais avec des sentiments nuancés dans deux domaines. Néanmoins, les façons de voir des femmes divergeaient pour quatre domaines, à savoir le maintien du respect de la vie privée et de la confidentialité; la garantie d'un accès permanent au soutien familial, avec par exemple l'accompagnement à la naissance; l'obtention d'un consentement éclairé; et le respect du choix des femmes quant à la mobilité pendant le travail, la prise d'aliments et de liquides, et la position lors de l'accouchement. L'environnement physique n'a pas été mentionné comme contribuant à une expérience de soins de maternité respectueux. Si la manière dont les Nigérianes conçoivent des soins de maternité respectueux était similaire aux approches acceptées au niveau international, des écarts importants ont été observés, qui peuvent être liés aux différences culturelles et aux disparités sociétales. Différentes interprétations des soins de maternité respectueux peuvent influencer la demande des femmes dans différents environnements et remettre en question les stratégies de promotion de ces soins comme norme universelle de traitement.

Resumen

Las percepciones de las mujeres sobre la atención respetuosa de la maternidad son fundamentales para su definición y medición a nivel mundial. Evaluamos esas percepciones con relación a las normas de la atención respetuosa de la maternidad definidas mundialmente. Realizamos un estudio descriptivo que consistió en ocho discusiones en grupos focales con 50 mujeres embarazadas que asistieron a una clínica prenatal en una unidad de salud de atención primaria y en otra de atención secundaria, en zonas gubernamentales locales del noroeste y sudeste de la Metrópolis de Ibadan, en Nigeria. En cada unidad de salud, se realizó un grupo focal con primigrávidas y otro con multigrávidas. Los 12 dominios de la atención respetuosa de la maternidad, por Shakibazadeh, sirvieron como marco temático para el análisis de datos. Las percepciones de las mujeres sobre la atención respetuosa de la maternidad resonaron bien con siete de los dominios, haciendo hincapié en las relaciones interpersonales entre prestadores de servicios y usuarias, preservación de su dignidad, comunicación eficaz y no abandono del cuidado, pero con percepciones mixtas para dos dominios. Sin embargo, sus percepciones se desviaron para cuatro dominios: mantener privacidad y confidencialidad; garantizar acceso continuo a apoyo familiar, tal como acompañantes durante el parto; obtener consentimiento informado; y respetar las decisiones de las mujeres sobre movilidad durante el trabajo de parto, ingesta de alimentos y líquidos, y posición de parto. El entorno físico no fue mencionado como contribuyente a la experiencia de atención respetuosa de la maternidad. Aunque las percepciones de las mujeres nigerianas estudiadas sobre la atención respetuosa de la maternidad fueron similares a aquellas aceptadas internacionalmente, hubo desviaciones significativas que podrían estar relacionadas con diferencias culturales y disparidades sociales. Diferentes interpretaciones de la atención respetuosa de la maternidad podrían influir en su demanda por las mujeres en diferentes entornos y cuestionar las estrategias para promoverla como estándar universal de atención.

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Appendix 4.1: Breakdown of average births in previous months, unweighted women observed and the weighted and unweighted women eventually interviewed amongst the women observed by the facility

Facilities	*Average Births in the previous 12-months	Observed women within study period	Postpartum interviewed women within study period	
	Unweighted	Unweighted	Unweighted	Weighted
Facility 1	16 (5.4%)	17 (5.3%)	16 (6.0%)	15 (5.4%)
Facility 2	123 (41.7%)	158 (49.1%)	123 (45.7%)	112 (41.7%)
Facility 3	12 (4.1%)	11 (3.4%)	11 (4.0%)	11 (4.1%)
Facility 4	14 (4.7%)	10 (3.1%)	10 (3.7%)	13 (4.8%)
Facility 5	21 (7.1%)	22 (6.8%)	21 (7.8%)	19 (7.1%)
Facility 6	21 (7.1%)	23 (7.2%)	16 (6.0%)	19 (7.1%)
Facility 7	6 (2.0%)	6 (1.8%)	6 (2.3%)	5 (2.0%)
Facility 8	49 (16.8%)	40 (12.4%)	33 (12.3%)	45 (16.6%)
Facility 9	33 (11.2%)	35 (10.9%)	33 (12.3%)	30 (11.2%)
Total	295 (100.0%)	322 (100.0%)	269 (100.0%)	269 (100.0%)

*** The immediate 12-month average of the births before the commencement of the observations in each study facility**