

UNIVERSITY OF THE  
WITWATERSRAND,  
JOHANNESBURG



**Development of Strategies for Health Care Providers to Sustain  
Respectful Maternity Care to Women in Labour**

**Thesis submitted to the Faculty of Health Sciences, University of the  
Witwatersrand, in fulfilment of the requirement for the degree of Doctor of  
Philosophy**

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**September 2024**

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## DECLARATION

I, **Alice Muhayimana**, declare that this thesis, with ethical clearance number **(M22/02/65)** from HREC (Human Research Ethics Committee), is my own original work. It is being submitted for the Doctor of Philosophy degree at the University of the Witwatersrand, Johannesburg, South Africa. It has not been submitted before for any degree or examination at any other University or institution. All materials adopted from previously published work have been appropriately cited in this thesis.

Signed at Johannesburg, South Africa

On the 9<sup>th</sup> day of September 2024

A handwritten signature in blue ink, appearing to read 'Alice Muhayimana', with a stylized flourish at the end.

Alice Muhayimana

## DEDICATION

**To**

*Almighty God*

*My beloved husband*

*My beloved children*

*My sisters and brothers*

*My late parents*

*This work is dedicated*

## Abstract

**Key words:** *Mother-friendly care, respectful maternity, dignified care, best practices, positive experience, childbirth, intrapartum, quality, midwives, strategies.*

**Background:** Childbirth is a profound human experience that deserves utmost respect. In 2018, the World Health Organization (WHO) highlighted the significance of ensuring a positive and dignified birth experience for every woman. Respectful Maternity Care (RMC) plays a vital role in improving maternal and neonatal outcomes. The absence of RMC constitutes a violation of the rights of women and newborns. Mere avoidance of abuse does not guarantee RMC; women can experience both positive RMC practices and mistreatment during childbirth. Therefore, proactive advocacy for RMC, efforts to reduce mistreatment, and identifying respectful actions within the local context are all crucial components.

Previous studies on RMC in Rwanda primarily focused on negative experiences. However, this study adopted Appreciative Inquiry (AI) to emphasize positive aspects during intrapartum care. AI was chosen for its ability to generate realistic and culturally accepted results, highlighting strengths rather than solely focusing on challenges. The study aimed to assess and explore positive experiences among women and best practices among healthcare providers (HCPs), capturing their perspectives on providing respectful care in Eastern province hospitals of Rwanda. This was conducted to develop strategies for facilitating and sustaining RMC during labour. Facilitating and sustaining RMC in health facilities are particularly effective in reducing intrapartum mistreatment, enhancing positive birth outcomes, and fostering positive childbirth experiences.

**Methods:** This study was conducted in five hospitals in the Eastern province of Rwanda. The author executed the study in four phases with the five stages of AI: Define, Discover, Dream, Design, and Destiny. *In the define* stage, the author clarified the chosen research topic for focus, ensuring that it has a positive core. **Phase 1** utilized a convergent parallel mixed-method approach. The quantitative part involved a cross-sectional study with 610 **women** who recently gave birth, while in-depth interviews (IDIs) were conducted with a subset of women who reported being respected. Data collection occurred after participants were discharged from the hospital and were preparing to exit. This phase corresponds to *the dream* stage of AI. In the quantitative aspect, the researcher utilized a 15-item RMC questionnaire developed by the



White Ribbon Alliance, updated in 2019. Descriptive, chi-square and logistic regression were employed to analyze the quantitative data. A median cut-off was applied to categorize experiences into binary outcomes (low and high RMC scores), followed by stepwise backward elimination logistic regression to identify predictors of high RMC. For qualitative data analysis, thematic analysis was conducted using NVivo 12 to organize the codes and create a codebook.

In **phase 2**, the researcher used **exploratory qualitative** by conducting ten focus group discussions (FGDs) with midwives and nurses, ten in-depth interviews (IDIs) with physicians working in maternity and ten IDIs with maternity unit managers. **HCPs** expressed their perspectives on the RMC they provided and their thoughts on women's reports from the previous phase, corresponding with AI's ***dream and design*** stage. Thematic analysis was used to analyze the data.

In **phase 3**, the strategies were developed based on findings from the previous phases. The researcher **integrated findings** and used the **strategic formulation process** during this phase, aligning with the ***design*** stage of AI.

In **Phase 4**, using an **expert review** approach, the developed strategies were validated for their relevance, feasibility, acceptability, and context-fitting by ten national and international experts/stakeholders in RMC. This phase corresponds to the part of the ***destiny*** stage of AI.

**Findings:** Most women (70.2%) reported receiving RMC higher than the mean. The most acclaimed RMC items included being allowed to take food and fluid during labour (98.5%), non-discriminatory care (96.2%), receipt of necessary services (96.1%), and privacy (91.3%). The chi-square analysis showed an association between reported high RMC and marital status ( $p$ -value = 0.006), occupation ( $p$ -value = 0.001), and mode of delivery ( $p$ -value = 0.001). Caesarean section delivery was associated with high RMC in multivariate logistic regression with a  $p$ -value of 0.001, crude odds ratio of 1.88, and confidence interval (CI) of [1.29–2.74]. The adjusted odds ratio was 2.11 with a CI [1.40–3.17].

Women recounted positive childbirth experiences with compassionate treatment, respect for preferences, and equitable care. They emphasized maintaining RMC through mother-centred approaches, effective communication, and supportive environments, suggesting improvements like provider training and awareness campaigns. HCPs prioritized RMC as integral to women's rights, ensuring privacy, equality, and satisfaction. They advocate enhanced professionalism,

teamwork, and continuous care evaluation, emphasizing proactive hospital engagement, maternal advocacy, staff motivation, and infrastructure improvements for sustained progress.

After integrating the findings, five themes emerged, each corresponding to a specific strategy. During validation, the strategies scored respectively: 1) *To strengthen women-centred care and childbirth-positive experiences* (91.25%), 2) *To preserve and uphold community trust towards maternity services* (91.25%), 3) *To pursuit professional abidance and ethical conduct* (90.6%) 4) *To strengthen supportive leadership towards sustaining and promoting RMC* (90%) 5) *To maintain and promote adequate environment around childbirth facility* (85.6%). The overall score of all strategies was (89.75%).

**Conclusion and recommendations:** The findings of this study carry significant policy implications for advancing RMC practices in Rwanda. Embracing multifaceted strategies to promote positive childbirth experiences can effectively enhance RMC provision for women during maternity care. Given the sensitivity of the topic, utilizing AI to explore RMC yielded valuable insights within resource-limited settings like Rwanda. We strongly recommend the Ministry of Health establish standardized RMC practices in all health facilities across the country. These strategies could be implemented across various levels, engaging policymakers, health leaders, facility managers, communities, and individuals. The promotion and sustainability of RMC in Rwanda could be integrated into the broader health system, and the relevant stakeholders could be actively involved.

## Thesis Material

### **Original papers**

The following are publications and manuscripts derived from this thesis submitted to peer-review journals:

#### **Published papers**

1. Muhayimana A, Kearns I, Darius G, Olive T, Thierry UC. Reported Respectful Maternity Care received during Childbirth at Health Facilities: A Cross-Sectional Survey in Eastern Province, Rwanda. Midwifery. 2024 Jun 1; 133:103996. <https://doi.org/10.1016/j.midw.2024.103996> (***Published to Science Direct, journal of Midwifery, Elsevier***)
2. Muhayimana, A., Kearns, I. Healthcare Providers' Perspectives on Sustaining Respectful Maternity Care Appreciated by Mothers in Five Hospitals of Rwanda. BMC Nurs 23, 442 2024. <https://doi.org/10.1186/s12912-024-02017-5> (***Published to BMC, Nursing Journal***)

#### **Accepted manuscript**

Muhayimana A, Kearns IJ, Ward K, Bazirete O, Blood-Siegfried J. Strategies for Facilitating and Sustaining Respectful Maternity Care in Rwanda: An Expert Review (***Accepted by Panafrikan medical journal (PAMJ), Clinical Medicine Journal***)

#### **Manuscripts Under review**

1. Muhayimana A, Kearns IJ, Gishoma D, Tengera O, Uhawenimana TC. Experiences and Perceptions of Respectful Maternity Care during Childbirth in Health Facilities of Eastern province of Rwanda: An Appreciative Inquiry. (2023). (***Submitted to Plos One Journal***)
2. Muhayimana A, Kearns IJ. "I credit the midwives for saving my child's life": Providers' perceptions on Respectful Maternity Care and Reflections on their Best Practices

Experiences in Rwanda. (2023). *(Submitted to BMC Clinical Services Research Journal)*

### **Policy brief**

Strategies to sustain respectful maternity care in health facilities of Rwanda. *(Submitted for being published on the CARTA website)*

### **Conference presentations related to PhD data**

1. **Muhayimana, Alice, et al.** Respectful Maternity Care received during Childbirth at Health Facilities in Eastern Province of Rwanda: Appreciative Inquiry. May 2023, International day of Midwives (IDM), Kigali, Rwanda
2. **Muhayimana A et al.** Respectful Maternity Care received during Childbirth at Health Facilities in the Eastern Province of Rwanda using Appreciative Inquiry: Mixed method. August 2023. CARTA fellows annual Conference presentations in Joint Advanced Seminar 4, Makerere University, Kampala, Uganda
3. **Muhayimana A et al.** Strategies to Sustain Respectful Maternity Care in Health Facilities of Rwanda. December 2023, during the 9<sup>th</sup> annual conference of Rwanda Society of Obstetricians and Gynecologists, Kigali, Rwanda
4. **Muhayimana A et al.** Strategies to improve and sustain Respectful Maternity and Newborn Care in Health Facilities of Rwanda were presented at the 11<sup>th</sup> Council of International Neonatal Nurses Conference May 06 to 08, 2024, at Aalborg, Danmark.
5. **Muhayimana A et al.** Respectful Maternity Care in Rwandan Health Facility: Prevalence, Insights and Strategies from Women, Healthcare Providers and Experts Through Appreciative Inquiry was presented at the 7 Annual Africa Interdisciplinary Health Conference (AFIHC) August, 21 to 23, 2024 at Johannesburg, South Africa.

6. **Muhayimana A et al.** Respectful Maternity Care in Rwandan Health Facilities: Prevalence, Insights and Strategies from Women, Healthcare Providers and Experts Review Through Appreciative Inquiry; accepted to be presented during 16th biennial scientific conference of East, Central and Southern African College of Nursing and Midwifery (ECSACONM) to be held from 11 to 13 September 2024 in Lesotho Maseru.

### **Other presentations during the PhD**

1. E-Poster presentation, during XXIV FIGO World Congress of Gynecology and Obstetrics, held at Paris Convention Center, France (9-13 October, 2023)
2. E-poster presentation during 2<sup>nd</sup> international conference on SRH organized by CIRHT/University of Michigan held in Kigali (from 5- 7 October 2022)
3. Online Oral presentation on International and Digital Midwifery Workplace Learning Network project in International Confederation of Midwives (ICM) (23 June 2021)

### **PhD grants**

#### **Fellowship**

- Consortium for Advanced Research Training in Africa (CARTA) Fellowship for PhD valued at \$100,000 (2020-2024)

### **Research Grants during PhD journey**

1. Principal Investigator in the project funded by the Center for International Reproductive Health Training CIRHT/University of Michigan. The research is named “Improving Knowledge in SRHR using MOOC among University of Rwanda students” at \$10,000 (2022-2023)
2. Principal Investigator in the project on Respectful Maternity Care in Rwandan health facilities. Additional funds for my PhD research from the UR/Sweden program at \$10,000 (2022-2023)

3. Co-Investigator in the project funded by CIRHT/University of Michigan. The project is about the use of SRH services among adolescents in Rwanda at \$10,000 (2022-2023)
4. Co-Investigator in the research project called Blended teaching and learning methods in nursing and midwifery education: The project was funded by UNFPA at \$ 6,000 (June to December 2020)
5. Co-investigator in the research project about male partners' physical involvement in the labour and delivery influence on the initiation of family planning and post-delivery care among Rwandan couples. The project is funded by King Faisal Hospital \$5,000 (2022-2023)
6. COVID-19 mitigation grant: Additional funds to take care of my children so that I get the time to work on my PhD research proposal. SIDA funded it at \$1,200 (May-November 2021)

## **Publications**

15 publications <https://www.researchgate.net/profile/Alice-Muhayimana/research>

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## **Service and Collaborations**

- Peer review: 1 review in the journal Midwifery, Elsevier, Inc. (New York, US), review date: February 2024 <https://orcid.org/0000-0002-5318-497X> Review identifier(s)  
SOURCE-WORK-ID: 41cf3e80-e416-4272-b5dc-fdf5e780b65c
- Faculty at the University of Rwanda, College of Medicine and Health Sciences, School of Nursing and Midwifery (2010 to date)
- Coordinator of international partnership at the School of Nursing and Midwifery, University of Rwanda (2017-2020) and Co-chair of internal and external partnership (2024-2025)
- Assistant to Coordinator in the post-graduate program at the School of Nursing and Midwifery, University of Rwanda (2017)
- Co-Investigator for the international and digital midwifery workplace learning network project between Artevelde University of Applied Sciences/Ghent, Belgium and the

School of Nursing and Midwifery/UR. The project was funded by VLIR-UOS (2018-2020)

### **Professional membership**

-  Rwanda Association of Midwives
-  Rwanda Neonatal Nurses Association
-  Council of International Neonatal Nurses (COINN)
-  Sigma Theta Tau International Society of Nurses.

## ACKNOWLEDGEMENTS

I extend my heartfelt thanks to Almighty God for His boundless generosity, which has granted me the strength, courage, perseverance, and successful completion of this study. I am deeply grateful to the University of the Witwatersrand for granting me the knowledge and skills to undertake this research. I also want to express my sincere appreciation to the faculty and students of Wits University, particularly those in the Department of Nursing Education, for their unwavering support and guidance during my academic journey.

I wish to express my sincere gratitude to my Supervisor, Dr. Irene Josephine Kearns, for her invaluable and meticulous guidance, unwavering support, encouragement, and accessibility, all of which played a significant role in the success of this research. I have always cherished the encouraging words you wrote to me about the gift you gave when we first met.: "Stay positive, work hard, make it happen." I am deeply grateful for the days and nights you dedicated to helping me to complete my studies on time. Working with you, dear Supervisor has been an immense pleasure, and I am truly grateful for the opportunity to learn and grow under your guidance. I am indebted to you for your infinite wisdom, foresight, and steadfast support throughout my PhD journey. Considering myself fortunate to have been led by you, I am inspired to share all that I have learned with others. Your encouragement to maintain a positive outlook, keep the momentum, keep the focus and persevere has been memorable. Beyond your role as a Supervisor, I appreciated your caring approach, motivation, and mentorship. I am sincerely thankful for your kindness, constant availability, and constant communication, even through WhatsApp, all of which greatly contributed to the success of my journey through this PhD program.

I express my gratitude to the University of Rwanda for providing me with study leave, enabling me to advance my studies and professional growth as an academician. I also appreciate the additional financial support received from the University of Rwanda (UR)/Sweden program. Special thanks go to the Ministry of Health of Rwanda for their collaboration and permission to undertake this study.

A heartfelt acknowledgement goes to the Consortium for Advanced Research Training in Africa (CARTA) for covering my school fees, providing a stipend, and offering crucial training



and seminar opportunities with skilled facilitators. Additionally, sponsored writing retreats provided by CARTA throughout my PhD study were invaluable. Through CARTA, I acquired many skills and connections that will contribute to building my career. I am thankful to the management of the hospitals where I conducted this study for their flexibility in granting permission to conduct this research. I am very grateful to all those involved in this study, including matrons, midwives, nurses, and physicians working in maternity, as well as the women who gave birth at the hospitals where this research was conducted. I recognize the national and international experts and stakeholders in maternal and neonatal health who participated in the validation process of the findings of this study. Their active participation was indispensable for the completion of this study.

I want to express my enduring gratitude to my family for the love and support they have provided me throughout this journey. A special and deepest gratitude to my husband, Emmanuel Mahirane, for his moral support, assistance, interest, and unwavering encouragement throughout every step of this journey, from its beginning to its end, for consistently being there and taking care of the children in my absence. I appreciate the wholehearted support you have given me. My thanks also go to my children, Alvin Xan Hira, Alvine Hira, and Alvia Hira, for their unwavering patience and adaptability during this period of my studies. To my sisters and brothers, I am thankful for your closeness and assistance whenever needed.

I express my appreciation to all my friends and colleagues who provided support throughout this journey. Special thanks go to my friends, the CARTA Cohort 10 fellows, with whom we have shared the research experience over the past four years. I truly value and appreciate the support they have given. I also want to acknowledge and thank my research assistants for their dedication and hard work.

***This research** was supported by the Consortium for Advanced Research Training in Africa (CARTA). CARTA is jointly led by the African Population and Health Research Center and the University of the Witwatersrand and funded by the Carnegie Corporation of New York (Grant No. G-19-57145), Sida (Grant No:54100113), Uppsala Monitoring Center, Norwegian Agency for Development Cooperation (Norad), and by the Wellcome Trust [reference no. 107768/Z/15/Z] and the UK Foreign, Commonwealth & Development Office, with support from the Developing Excellence in Leadership, Training and Science in Africa (DELTAS Africa) programme. The statements made and views expressed are solely the responsibility of the Fellow.*

## Table of contents

|                                                                                  |      |
|----------------------------------------------------------------------------------|------|
| DECLARATION .....                                                                | II   |
| DEDICATION.....                                                                  | III  |
| ABSTRACT.....                                                                    | IV   |
| THESIS MATERIAL .....                                                            | VII  |
| ACKNOWLEDGEMENTS .....                                                           | XII  |
| TABLE OF CONTENTS.....                                                           | XIV  |
| LIST OF FIGURES .....                                                            | XX   |
| LIST OF TABLES.....                                                              | XXI  |
| LIST OF ACRONYMS/ABBREVIATIONS .....                                             | XXII |
| THE STRUCTURE OF THE THESIS .....                                                | 1    |
| SECTION A: INTRODUCTION, LITERATURE REVIEW, AND METHODS.....                     | 1    |
| OPERATIONAL DEFINITIONS.....                                                     | 1    |
| CHAPTER ONE: INTRODUCTION TO THE STUDY.....                                      | 4    |
| 1.1 RESEARCH CONTEXT .....                                                       | 6    |
| 1.1.1 Historical revolution of Respectful maternity care and its key events..... | 6    |
| 1.1.2 The shift to Respectful Maternity Care.....                                | 6    |
| 1.2 RESEARCH PROBLEM STATEMENT .....                                             | 9    |
| 1.3 RESEARCH GAP.....                                                            | 11   |
| 1.4. RESEARCH PURPOSE, OBJECTIVES AND QUESTIONS.....                             | 13   |
| 1.5 SCOPE OF THE STUDY .....                                                     | 13   |
| 1.6 SIGNIFICANCE OF THE STUDY.....                                               | 15   |
| 1.7 THE SUMMARY .....                                                            | 16   |
| CHAPTER TWO: LITERATURE REVIEW .....                                             | 17   |
| 2.1. INTRODUCTION .....                                                          | 17   |
| 2.3. CONCEPTUAL FRAMEWORK.....                                                   | 20   |
| 2.3.1 WHO statement on the positive experience of maternal standard care.....    | 21   |
| 2.4 CRITICAL DISCUSSION ON STUDIES CONDUCTED ON CHILDBIRTH                       |      |
| EXPERIENCES IN RWANDA.....                                                       | 27   |
| 2.4.1 Women’s Childbirth Experiences in Rwanda .....                             | 27   |
| 2.4.2 RMC Perceptions from Health Care providers .....                           | 28   |

|                                                                                                                                                             |    |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----|
| 2.5. NORMALIZATION OF MISTREATMENT DURING CHILDBIRTH, “ICEBERG PHENOMENON” AND ITS IMPLICATIONS .....                                                       | 29 |
| 2.5.1 Three Paradigms around childbirth.....                                                                                                                | 31 |
| 2.5.2 Lack of RMC as a health system issue.....                                                                                                             | 33 |
| 2.6. METHODOLOGICAL CONSIDERATIONS.....                                                                                                                     | 34 |
| 2.6.1 Approaches mostly used in other RMC studies .....                                                                                                     | 34 |
| 2.6.2 The approach used in this current study.....                                                                                                          | 34 |
| 2.6.3 Strategies to sustain and promote RMC.....                                                                                                            | 36 |
| 2.7 HOW THE CURRENT STUDY FILLED THE EXISTING GAP IN RMC .....                                                                                              | 37 |
| 2.8. THE SUMMARY .....                                                                                                                                      | 37 |
| CHAPTER THREE: METHODOLOGY .....                                                                                                                            | 38 |
| 3.1 PHILOSOPHICAL ASSUMPTIONS UNDERPINNING THIS RESEARCH.....                                                                                               | 38 |
| 3.2 STUDY DESIGN AND METHODS.....                                                                                                                           | 41 |
| 3.3 STUDY PROCEDURES AND THE PHASES OF THE STUDY .....                                                                                                      | 41 |
| 3.3.1 Phase one: Exploration and description of experiences and perceptions of RMC among mothers.....                                                       | 43 |
| 3.3.2 Phase two: Exploration of perceptions of RMC among healthcare providers .....                                                                         | 43 |
| 3.3.3 Phase three: Development of strategies .....                                                                                                          | 44 |
| 3.3.4 Phase four: Validation of developed strategies .....                                                                                                  | 44 |
| 3.4 STUDY PARTICIPANTS .....                                                                                                                                | 44 |
| 3.5 STUDY TOOL.....                                                                                                                                         | 45 |
| 3.6 STUDY SETTING.....                                                                                                                                      | 46 |
| 3.6.1 Sample size of quantitative data.....                                                                                                                 | 48 |
| 3.7 DATA COLLECTION .....                                                                                                                                   | 50 |
| 3.8 APPRECIATIVE INQUIRY METHOD .....                                                                                                                       | 51 |
| 3.9 DATA ANALYSIS.....                                                                                                                                      | 56 |
| 3.9.1 Statistical analysis.....                                                                                                                             | 56 |
| 3.9.2 Qualitative analysis.....                                                                                                                             | 56 |
| 3.9.4 Strategy development.....                                                                                                                             | 58 |
| 3.9.5 Validation Procedure.....                                                                                                                             | 60 |
| 3.10 Ethical consideration.....                                                                                                                             | 62 |
| SECTION B. RESULTS/FINDINGS .....                                                                                                                           | 64 |
| CHAPTER FOUR: REPORTED RESPECTFUL MATERNITY CARE RECEIVED DURING CHILDBIRTH AT HEALTH FACILITIES: A CROSS-SECTIONAL SURVEY IN EASTERN PROVINCE, RWANDA..... | 66 |
| 4.1ABSTRACT.....                                                                                                                                            | 66 |
| 4.2 INTRODUCTION .....                                                                                                                                      | 67 |
| 4.3 METHODS .....                                                                                                                                           | 68 |
| 4.3.1 Study design and setting .....                                                                                                                        | 68 |
| 4.3.2 Participants, sampling, and data sources.....                                                                                                         | 69 |

|                                                                                                                                                                                                            |     |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|
| 4.3.3 Sampling and sample size calculation.....                                                                                                                                                            | 70  |
| 4.3.4 Outcome variable .....                                                                                                                                                                               | 71  |
| 4.3.5 Explanatory variables and covariates.....                                                                                                                                                            | 72  |
| 4.3.6 Statistical methods .....                                                                                                                                                                            | 72  |
| 4.4 RESULTS .....                                                                                                                                                                                          | 73  |
| 4.4.1 Socio-demographic and obstetric characteristics .....                                                                                                                                                | 74  |
| 4.4.2 Self-reported RMC items .....                                                                                                                                                                        | 75  |
| 4.4.4. Chi-Square analysis.....                                                                                                                                                                            | 78  |
| 4.4.5 Logistic regression .....                                                                                                                                                                            | 79  |
| 4.5 DISCUSSION .....                                                                                                                                                                                       | 81  |
| CHAPTER FIVE: EXPERIENCES AND PERCEPTIONS OF RESPECTFUL MATERNITY CARE<br>DURING CHILDBIRTH IN HEALTH FACILITIES OF EASTERN PROVINCE OF RWANDA:<br>AN APPRECIATIVE INQUIRY.....                            |     |
| 84                                                                                                                                                                                                         |     |
| 5.1 ABSTRACT.....                                                                                                                                                                                          | 84  |
| 5.2 INTRODUCTION .....                                                                                                                                                                                     | 85  |
| 5.3 METHODS .....                                                                                                                                                                                          | 88  |
| 5.3.1 Study design.....                                                                                                                                                                                    | 88  |
| 5.3.2 Study Setting and Population.....                                                                                                                                                                    | 89  |
| 5.3.3 Sampling and Data Collection .....                                                                                                                                                                   | 89  |
| 5.3.4 Interview guide and Appreciative Inquiry .....                                                                                                                                                       | 90  |
| 5.3.5 DATA ANALYSIS.....                                                                                                                                                                                   | 92  |
| 5.4 RESULTS .....                                                                                                                                                                                          | 94  |
| 5.4.1 Participants' socio-demographic characteristics .....                                                                                                                                                | 94  |
| 5.4.2 Thematic framework.....                                                                                                                                                                              | 95  |
| 5.5 DISCUSSION .....                                                                                                                                                                                       | 105 |
| 5.6 CONCLUSION AND RECOMMENDATIONS.....                                                                                                                                                                    | 107 |
| 5.7 STRENGTHS AND LIMITATIONS .....                                                                                                                                                                        | 108 |
| CHAPTER SIX: “I CREDIT THE MIDWIVES FOR SAVING MY CHILD'S LIFE”: PROVIDERS'<br>PERCEPTIONS ON RESPECTFUL MATERNITY CARE AND REFLECTIONS ON THEIR BEST<br>PRACTICES EXPERIENCES WITH MOTHERS IN RWANDA..... |     |
| 110                                                                                                                                                                                                        |     |
| 6.1 ABSTRACT.....                                                                                                                                                                                          | 110 |
| 6.2 INTRODUCTION .....                                                                                                                                                                                     | 111 |
| 6.3 METHODS .....                                                                                                                                                                                          | 113 |
| 6.3.1 Study Design.....                                                                                                                                                                                    | 113 |
| 6.3.2 Appreciative Inquiry .....                                                                                                                                                                           | 113 |
| 6.3.3 Setting and Population .....                                                                                                                                                                         | 116 |
| 6.3.4 Data Collection .....                                                                                                                                                                                | 116 |
| 6.3.5 Data Analysis.....                                                                                                                                                                                   | 117 |
| 6.4 RESULTS .....                                                                                                                                                                                          | 118 |
| 6.4.1 Socio-demographic characteristics .....                                                                                                                                                              | 118 |
| 6.4.2 Thematic framework.....                                                                                                                                                                              | 119 |

|                                                                                                                                                         |     |
|---------------------------------------------------------------------------------------------------------------------------------------------------------|-----|
| 6.5 DISCUSSION .....                                                                                                                                    | 132 |
| 6.6 CONCLUSION AND RECOMMENDATIONS.....                                                                                                                 | 134 |
| 6.7 STRENGTHS AND LIMITATIONS .....                                                                                                                     | 134 |
| CHAPTER SEVEN: HEALTHCARE PROVIDERS' PERSPECTIVES ON SUSTAINING<br>RESPECTFUL MATERNITY CARE APPRECIATED BY MOTHERS IN FIVE HOSPITALS OF<br>RWANDA..... | 135 |
| 7.1 ABSTRACT.....                                                                                                                                       | 135 |
| 7.2 INTRODUCTION .....                                                                                                                                  | 136 |
| 7.3METHODOLOGY .....                                                                                                                                    | 138 |
| 7.3.1 Research Design.....                                                                                                                              | 138 |
| 7.3.2 Appreciative Inquiry approach.....                                                                                                                | 138 |
| 7.3.3 Setting and Population .....                                                                                                                      | 141 |
| 7.3.4 Data collection .....                                                                                                                             | 141 |
| 7.3.5 Data Analysis .....                                                                                                                               | 143 |
| 7.4 RESULTS .....                                                                                                                                       | 144 |
| CHAPTER EIGHT: DEVELOPMENT OF STRATEGIES TO SUSTAIN RESPECTFUL<br>MATERNITY CARE .....                                                                  | 160 |
| 8.1. INTRODUCTION .....                                                                                                                                 | 160 |
| 8.2. INTEGRATION OF ALL FINDINGS OF THIS STUDY.....                                                                                                     | 160 |
| 8.2.1 Major findings from quantitative and qualitative data.....                                                                                        | 160 |
| 8.3 METHODOLOGY .....                                                                                                                                   | 166 |
| 8.3.1 Strategic formulation process.....                                                                                                                | 167 |
| 8.3.4 Choose the strategies.....                                                                                                                        | 170 |
| 8.4 DEVELOPED STRATEGIES, OBJECTIVES, ACTION PLAN, ACTIVITIES/TASKS .....                                                                               | 171 |
| 8.5. CONCLUSION.....                                                                                                                                    | 179 |
| CHAPTER NINE: VALIDATION OF DEVELOPED RMC STRATEGIES, GENERAL<br>CONCLUSION AND RECOMMENDATIONS OF THE STUDY .....                                      | 180 |
| 9.1 INTRODUCTION .....                                                                                                                                  | 180 |
| 9.2 VALIDATION PROCEDURE .....                                                                                                                          | 180 |
| 9.3 THE TOOL (QUESTIONNAIRE FOR VALIDATION).....                                                                                                        | 182 |
| 9.4. RESULTS/FEEDBACK FROM THE VALIDATION PROCESS.....                                                                                                  | 186 |
| 9.5 FINAL VALIDATED STRATEGIES AND DETAILED ACTION PLAN, ACTIVITIES, AND<br>FOLLOW-UP .....                                                             | 187 |
| 9.6 THE PROPOSED LOGICAL FRAMEWORK FOR RMC STRATEGIES<br>IMPLEMENTATION IN RWANDA.....                                                                  | 201 |
| 9.7 IMPLEMENTATION FRAMEWORKS, THEORIES USED IN RMC INTERVENTIONAL<br>RESEARCH.....                                                                     | 205 |

|                                                                                     |     |
|-------------------------------------------------------------------------------------|-----|
| 9.8 DISCUSSION .....                                                                | 206 |
| 9.9 CONCLUSION AND RECOMMENDATIONS.....                                             | 207 |
| SECTION C .....                                                                     | 209 |
| CHAPTER TEN: INTEGRATED DISCUSSION, GENERAL CONCLUSION AND<br>RECOMMENDATIONS ..... | 209 |
| 10.1 INTRODUCTION TO THE CHAPTER .....                                              | 209 |
| 10.2 INTEGRATED DISCUSSION.....                                                     | 209 |
| 10. 2.1 SUMMARY OF KEY FINDINGS .....                                               | 209 |
| 10.2.2 DISCUSSION .....                                                             | 212 |
| 10.2.2.1 Synthesis of findings vis as vis to the existing literature .....          | 214 |
| 10.2.2.2 Global initiatives to promote RMC.....                                     | 216 |
| 10.2.3 IMPLICATION OF THEORY, FRAMEWORK AND HOLISTIC PARADIGM .....                 | 219 |
| 10.2.4 SCHOLARLY CONTRIBUTION OF PHD AND METHODOLOGICAL INNOVATION<br>.....         | 220 |
| 10.2.5 IMPLICATIONS OF THE RESEARCH.....                                            | 221 |
| 10.2.6 STRENGTHS AND LIMITATIONS OF THE STUDY .....                                 | 222 |
| 10.3 GENERAL CONCLUSION .....                                                       | 222 |
| 10.4 RECOMMENDATIONS .....                                                          | 223 |
| 10.4.1 FUTURE HEALTHCARE RESEARCH.....                                              | 223 |
| 10.4.2 MIDWIFERY AND OBSTETRIC EDUCATION .....                                      | 223 |
| 10.4.3 CLINICAL PRACTICES AND QUALITY ASSURANCE .....                               | 224 |
| 10.4.4 PROFESSIONAL AND ETHICAL FRAMEWORK.....                                      | 224 |
| 10.4.5 POLICYMAKING.....                                                            | 224 |
| 10.4.6 COMMUNITY HUMAN RIGHTS AWARENESS.....                                        | 225 |
| REFERENCES .....                                                                    | 226 |
| TIMELINE.....                                                                       | 248 |
| FUNDING .....                                                                       | 248 |
| APPENDICES .....                                                                    | 250 |
| APPENDIX A. CLIENT EXIT SURVEY TOOL (FOR QUANTITATIVE OBJECTIVE).....               | 250 |
| APPENDIX B: STUDY INFORMATION DOCUMENT (FOR PHASE 1A: QUANTITATIVE)<br>.....        | 252 |
| APPENDIX C: PARTICIPANT CONSENT SHEET .....                                         | 255 |
| APPENDIX D: TRANSLATED RESEARCH QUESTIONNAIRE IN KINYARWANDA.....                   | 256 |

|                                                                                               |     |
|-----------------------------------------------------------------------------------------------|-----|
| APPENDIX E. TRANSLATED PERSONAL INFORMATION SHEET. ....                                       | 259 |
| APPENDIX F: INTERVIEW GUIDE FOR PHASE 1B.....                                                 | 260 |
| APPENDIX G: STUDY INFORMATION DOCUMENT FOR PHASE 1B.....                                      | 261 |
| APPENDIX H: CONSENT FORM FOR AUDIO RECORDING .....                                            | 264 |
| APPENDIX I: INTERVIEW AND FOCUS GROUPS FOR PHASE 2B.....                                      | 265 |
| APPENDIX J: PARTICIPANT INFORMATION SHEET FOR FOCUS GROUP DISCUSSION,<br>PHASE 2B.....        | 266 |
| APPENDIX K: INTERVIEW GUIDE (PHASE 2B) .....                                                  | 267 |
| APPENDIX L: STUDY INFORMATION DOCUMENT FOR IN-DEPTH INTERVIEW (PHASE<br>2B) .....             | 268 |
| APPENDIX M: PERSONAL INFORMATION SHEET FOR EXPERTS/STAKEHOLDER IN<br>RMC FOR VALIDATION ..... | 269 |
| APPENDIX N: LETTER REQUESTING EXPERT IN RMC TO VALIDATE THE STRATEGIES<br>.....               | 270 |
| APPENDIX O: ETHICAL CLEARANCES FROM THE UNIVERSITY OF RWANDA.....                             | 271 |
| APPENDIX P: ETHICAL CLEARANCE FROM HREC OF WITS UNIVERSITY .....                              | 275 |
| APPENDIX Q: APPROVAL FROM POST-GRADUATE ASSESSORS OF WITS UNIVERSITY<br>.....                 | 280 |
| APPENDIX R: APPROVAL FROM NHRC OF MINISTRY OF HEALTH RWANDA .....                             | 281 |
| APPENDIX S: COLLABORATION LETTER FROM RWANDA BIOMEDICAL CENTER....                            | 282 |
| APPENDIX T: APPROVAL LETTERS FROM FIVE STUDY SITES .....                                      | 283 |
| APPENDIX U: INTERVIEW AND FOCUS GROUPS FOR PHASE 2A .....                                     | 290 |
| APPENDIX V: STUDY INFORMATION DOCUMENT FOR HCP (PHASE 2A) .....                               | 291 |
| APPENDIX W: PARTICIPANT INFORMATION SHEET FOCUS GROUP DISCUSSION<br>(PHASE 2A) .....          | 293 |
| APPENDIX Y: CO-AUTHOR AGREEMENT.....                                                          | 295 |
| APPENDIX Z. Originality report .....                                                          | 298 |

## List of figures

|                                                                                                  |     |
|--------------------------------------------------------------------------------------------------|-----|
| <b>Figure 1.1:</b> Universal rights of women and newborns by White Ribbon Alliance in 2019 ..... | 9   |
| <b>Figure 2.1:</b> WHO quality of care framework for maternal and newborn health.....            | 21  |
| <b>Figure 2.2:</b> Research conceptual framework.....                                            | 25  |
| <b>Figure 2.3:</b> 5D-cycle of Appreciative Inquiry.....                                         | 36  |
| <b>Figure 3.1:</b> Phase of study.....                                                           | 42  |
| <b>Figure 3.2:</b> Flow chart description of the participants .....                              | 45  |
| <b>Figure 3.3:</b> Map of Rwanda and study sites.....                                            | 51  |
| <b>Figure 3.4:</b> 5D-cycle of Appreciative Inquiry used in this study .....                     | 45  |
| <b>Figure 4.1:</b> Self-reported RMC items (n = 610) .....                                       | 76  |
| <b>Figure 8.1:</b> Strategies and action plan developed from findings.....                       | 179 |
| <b>Figure 9.1:</b> Proposed Logical framework for RMC strategies implementation in Rwanda.....   | 201 |



## List of tables

|                                                                                                  |     |
|--------------------------------------------------------------------------------------------------|-----|
| <b>Table 2.1:</b> WHO statement on the positive experience of maternal standard care.....        | 23  |
| <b>Table 4.1:</b> Description of socio-demographic and obstetric characteristics (n = 610) ..... | 74  |
| <b>Table 4.2:</b> Care most appreciated by participants (n = 515).....                           | 76  |
| <b>Table 4.3:</b> Chi-Square analysis of categorical variables (n = 610).....                    | 78  |
| <b>Table 4.4:</b> Logistic regression .....                                                      | 80  |
| <b>Table 5.1:</b> Participant sociodemographic data (n =30).....                                 | 94  |
| <b>Table 5.2:</b> Themes and Sub-themes .....                                                    | 95  |
| <b>Table 6.1:</b> Socio-demographic characteristics of participants in IDIs (n =10).....         | 118 |
| <b>Table 6.2:</b> Socio-demographic characteristics of the participants in FGD (n = 55).....     | 119 |
| <b>Table 6.3:</b> Themes and sub-themes .....                                                    | 119 |
| <b>Table 7.1:</b> Socio-demographic data from individual interviews (n =10) .....                | 144 |
| <b>Table 7.2:</b> Demographic data from Focus Groups (n =40) .....                               | 141 |
| <b>Table 8.1:</b> Strategic formulation process.....                                             | 167 |
| <b>Table 9.1:</b> Questionnaire sent to the participants for validation.....                     | 183 |
| <b>Table 9.2:</b> Socio-demographic characteristics of participants in validation (n =10).....   | 186 |
| <b>Table 9.3:</b> Summarized validation findings .....                                           | 187 |
| <b>Table 9.4:</b> Final Strategies, action plan, activities, follow-up .....                     | 187 |

## List of Acronyms/Abbreviations

**AI:** Appreciative Inquiry

**ANC:** Antenatal Care

**AOR:** Adjusted Odds Ratio

**BEmONC:** Basic Emergency Obstetric and Newborn Care

**BMC:** Biomedical Central

**C/s:** Caesarian Section

**CARTA:** Consortium for Advanced Research Training in Africa

**CFIR:** Consolidated Framework for Implementation Research

**CHWs:** Community Health Workers

**CI:** Confidence Interval

**CINAHL:** Cumulative Index to Nursing and Allied Health Literature

**CIRHT:** Center for International Reproductive Health Training University

**CMHS:** College of Medicine and Health Sciences

**COINN:** Council of International Neonatal Nurses

**COM-B:** capability, opportunity and motivation are essential for any behaviour (B) to change

**COVID-19:** CoronaVirus Disease of 2019

**CPD:** continuous professional development

**CTG:** Cardiotocography

**D&A:** Disrespect and Abuse

**DELTAS:** Developing Excellence in Leadership, Training and Science in Africa

**DONA:** Doulas of North America

**Dr:** Doctor

**ESARO:** East and Southern Africa Regional office

**FGD:** Focus Group Discussion

**FIGO:** International Federation of Gynaecology and Obstetrics

**HCP:** Health Care providers

**HEARD:** Health Evaluation and Applied Research Development

**HINARI:** Health Inter-Network Access to Research Initiative

**HREC:** Human Ethical Research Committee

**HREC:** Human Research Ethics Committee

**HRLN:** Human Rights Law Network

**ICEA:** International Childbirth Education Association

**ICI:** International Childbirth Initiative

**ICM:** International confederation of Midwives

**IDIs:** In-depth interview

**IDM:** International day of Midwives

**IMBCO:** International Mother Baby Childbirth Organization

**IPA:** International Pediatrics Association

**IRB:** Institutional Review Board

**LMICs:** Low- and Middle-Income country

**MCSP:** Maternal and Child Survival Program

**MDGs:** Millennium Development Goals

**MHBP:** MoreHappy Birthdays project

**MNCH:** Maternal Newborn and Child

**MOH:** Ministry of Health

**MoM-QC:** Mobile Monitor for Quality of Maternal Care

**MOOC:** Massive Open Online Course

**NB:** Nota Bene

**NCNM:** National Council of Nurses and Midwives

**NGOs:** Non-governmental organizations

**NHRC:** National Health Research Committee

**No.:** Number

**PhD:** Doctorate in Philosophy

**PIS:** Personal Information Sheets

**PP-IUD:** post-partum intra-uterine

**RBC:** Rwanda Biomedical Center

**RCTs:** Randomized controlled trials

**RE-AIM:** Reach, Effectiveness, Adoption, Implementation, and Maintenance

**RMC:** Respectful Maternity Care

**S/n:** Serial number

**SDGs:** Sustainable Development Goals

**SIDA:** Swedish International Development Cooperation Agency

**SMART:** Specific, Measurable, Achievable, Realistic, Time-bound

**SRHR:** Sexual, Reproductive Health and Rights  
**SSA:** Sub-Saharan Africa  
**STATA:** Statistical software for data science  
**UCSF:** University of California, San Francisco  
**UK:** United Kingdom  
**UNFPA:** United Nations Funds for Population Agency  
**UOS:** Universitaire Ontwikkelingssamenwerking (University Development Co-operation)  
**UR:** University of Rwanda  
**USAID:** United States Agency for International Development  
**USD:** United States dollar  
**VCAT:** Value Clarification and Attitude Transformation  
**VLIR:** Vlaamse Interuniversitaire Raad (Flemish Interuniversities Council)  
**WHO:** World Health Organization  
**WRA:** White Ribbon Alliance

## The Structure of the Thesis

This PhD thesis is structured according to the 'divided block' format. This doctoral thesis is organized into three main sections and ten chapters as follows:

### **SECTION A Introduction, Literature Review and Methods**

**Chapter one** provides operational definitions of concepts guiding this work and introduces the research by outlining the background of the research context, which is Respectful Maternity Care (RMC). It covers its historical evolution and key events, the shifts to RMC studies, and the Universal Rights of Women and Newborns (The White Ribbon Alliance Chapter updated in 2019). The introduction further discusses the problem statement of the knowledge gap and defines the scope of the study, the overall aim of the study, the overarching research question, and the research questions, along with its study objectives. The last part of the chapter highlights the significance of this study. This is followed by a brief summary of the chapter and a paragraph on what is to follow in the next chapter.

**Chapter two** provides a comprehensive literature review. The author presents the conceptual framework established by the WHO quality of care framework for maternal and newborn health in 2016. Additionally, the WHO statement on positive experiences of standard maternal care is clearly outlined and derived from the first framework. Subsequently, the conceptual framework of this study is drawn and explained. Critical discussion of the literature review encompasses studies conducted in Rwanda regarding childbirth experiences and perspectives of healthcare providers (HCPs), along with their documentation methods. The normalization of mistreatment towards women during childbirth, the iceberg phenomenon, its implications, and three paradigms around childbirth are reported.

The author explained how these paradigms inherited in history can be the root causes of disrespectful or respectful maternity. Additionally, there is a discussion on how the lack of RMC is a health system issue. Methodological considerations include critical discussions of approaches commonly used in previous RMC studies. The approach employed in this study is Appreciative Inquiry (AI), with detailed explanations of its application in each phase. Various methodologies used as implementation frameworks and theories in RMC intervention research were also discussed. Furthermore, the author delineated the literature on potential strategies to facilitate, sustain, and promote RMC for women in labour. In the end, the author explained

how this research addressed the existing gap and provided a brief summary of the chapter along with an overview of the next chapter.

In **Chapter three**, the author presented the overall components of the methodological approach to this PhD. The methods, the data collection techniques, the measurement of different variable constructs and the over-arching data analysis strategies used to meet each of the study objectives are set out in this chapter.

## **SECTION B. Results/Findings**

Section B comprises the results and findings segment of this dissertation, spanning six chapters (**Chapters Four to Nine**). Chapters Four to Seven contain two published papers and two submitted manuscripts, each presented as a chapter following the journal article format, including background, methods, findings, and discussion. Chapters Eight and Nine focus on the development and validation of RMC strategies. These papers and manuscripts were collaboratively written with the Supervisor. The first and second manuscripts also involved three Rwandan co-authors, who jointly secured a partial University of Rwanda(UR)/Sweden grant for this study and participated in various study activities. Consequently, each paper duly acknowledges the contributions of all individuals involved.

## **SECTION C**

In **Chapter Ten**, titled "Integrative Discussion, General Conclusions, and Recommendations," the author revisits the study's aim, objectives, philosophical foundation, and conceptual framework to underscore research findings and develop strategies. The chapter delves into the scholarly contributions of the work, exploring the implications of the study findings for policy, practice, public health, and research. The study's strengths and limitations are presented, and the conclusions are drawn from the analysis. The chapter provides recommendations for practice and policy, highlighting areas where future research could enhance RMC provision. It is important to note that the list of references is provided at the end of the thesis.

## SECTION A: INTRODUCTION, LITERATURE REVIEW, AND METHODS

The meanings of some concepts included in this thesis are:

### Operational definitions

*Respect:* Respect is a feeling or showing deference, courteousness, politeness, or obedience to someone [50,260]. The word “respect” is the synonym of courteous, polite, obedient, deferential, mannerly, reverent, admiration, awe, humanism, dutiful, and decorous. Respectful is showing respect for someone [50,260]

*Respectful Maternity Care:* Respectful Maternity Care, shortened as (RMC) is the optimal approach for providing care to women during the maternity period. RMC focuses on preserving women's dignity, privacy, and confidentiality while also safeguarding against ill-treatment and abuse [291]. It ensures autonomy by granting women the right to information and informed choice [291]. RMC is a fundamental human right for individuals throughout the reproductive spectrum, particularly during labour and birth [128]. Women seek top-quality services from service providers, not just admiration [260].

*Care:* This is the act of caring, which is a vital attribute and an expression of human nature [212]. This study explores the caring relationship between healthcare providers (HCPs) and service users, focusing on the positive aspect of "respectful maternity care". A nurse theorist, Jean Watson, fundamentally defined the caring theory, emphasizing a positive energy exchange between the patient and the nurse. Inspired by Florence Nightingale's vision, nurses play a crucial role in healing [226]. Watson highlighted the influential role of human caring, emphasizing its reciprocal benefits for both patients and HCPs [274]. Watson's Theory of Caring prioritizes the interpersonal process, highlighting the healing potential for both caregivers and recipients [154]. Health professionals demonstrate caring through positive behaviour, such as attending to and attentively listening to their patients [208]. Assisting patients or people seeking health care, widely known as the fundamental and indispensable trait of nursing, is referred to as care provision [36]. Caring involves adopting a helpful attitude by offering guidance, advice, appreciation, and moral support through encouragement, attentive listening, and counselling [36].

*Labour:* Labour is the process of giving birth [113]. It involves the birth of a baby, along with the placenta and membranes, from the uterus to the external environment and labour, which includes the immediate 2 hours after the birth of the baby [113]. Labour has four stages. The first stage corresponds to dilatation (opening) of the cervix. The second stage starts when the dilation is complete; the woman is pushing and ends when the fetus has been expelled. The third stage begins with the birth of the baby and extends through the cutting of the umbilical cord and delivery of the placenta. Then, the fourth stage corresponds to the first two hours after birth. The information gathered during this research encompasses, in general, the experience of RMC during all four stages of labour [113]. This study uses the terms '*labour*', '*childbirth*', '*labour and childbirth*' interchangeably.

*Strategies:* A strategy is a structured, comprehensive plan, a blueprint, or a set of actions devised to attain a particular objective successfully [170]. A strategy is an approach or series of steps designed to accomplish a specific goal or desired outcome [120,168]. It involves identifying the most efficient approach to achieve the desired outcomes by utilizing the available resources optimally [170]. Strategy requires making informed decisions on the actions to be taken, the methods to be employed, the rationale behind them, the execution location, and the timing of implementation [170]. Each strategy should encompass clear objectives and the necessary steps to achieve them. It is additionally characterized as the practical methods or guiding actions to realize long-term objectives [120,168]. Strategies encompass decisions concerning the goals to pursue, actions to take, and the allocation of resources to achieve these goals [170]. In the context of this study, strategies entail suggested actions designed to sustain existing positive maternity care and promote RMC during the labour and childbirth process in the health facilities of Rwanda.

*Appreciation:* Recognizing the best in individuals or the surrounding world, Appreciative Inquiry leverages the strengths of both individuals and organizations, forming the groundwork for future development [81].

*Inquiry:* Inquiring involves asking questions [81].

*Appreciative Inquiry:* Appreciative Inquiry, shortened as (AI) is commonly known as an "asset-based" or "strengths-based" approach for driving change within systems, emphasizing the generation of positive concepts and perspectives [29]. AI encourages participants to inquire and engage in questioning, fostering mutual learning and establishing a collective vision for



the future. Participating in an AI process requires a curious outlook and an eagerness for exploration [70,3]. AI serves as a potent strategy for instigating change across individual, team, organizational, and societal realms, facilitating the cultivation of a shared vision for the future through strategic innovation [285]. It aids individuals in leadership coaching and personal growth, while teams and organizations leverage it to pinpoint best practices, devise strategic blueprints, instigate cultural transformations, and propel large-scale endeavours [70,3,29]. AI has been deployed to influence global non-profit organizations and spearhead multinational initiatives across diverse sectors [70,3,29,285]. Diverging from conventional models, AI accentuates existing strengths, fostering a positive outlook that enriches relationships, culture, vision, learning, innovation, and collective endeavours [285].

*Disrespect and Abuse:* Shortened as D&A. Disrespect and Abuse during maternity care is a violation by commission or omission of a woman's rights and dignity as a person who seeks maternity care services and as a human being [47]. It is a deviation from national standards and human rights, resulting in low care quality [139,47]. The terms "*mistreatment*", "*obstetrical violence*", and "*dehumanized care*" have been used interchangeably with D&A [139].

## **Chapter one: Introduction to the study**

In the era of striving to achieve the Sustainable Development Goals (SDGs), all countries worldwide, including Rwanda, are aiming to meet all goals and targets by 2030. Various strategies are being employed, including conducting research and using evidence to improve population health. This study focused on one target of SDG number three: to end all preventable deaths of maternal and newborns [121]. In addition, this study focused on one target of SDG number five: to eradicate all types of violence against women and girls [58].

The intrapartum and immediate post-partum period imposes a high risk for the mother and newborn and requires high-quality care [289]. In the last decade, global public health highlighted mistreatment towards women during facility-based childbirth. Studies have demonstrated that 15% to 98% of women who deliver in facilities receive disrespectful care [239,2,152]. The studies show this is a global public health crisis [182,265,93,249,33,156,231]. Research conducted by the World Health Organization (WHO) in four LMICs revealed that over one-third of women giving birth in healthcare facilities experienced mistreatment [302].

Disrespect and Abuse (D&A) of women during childbirth compromises the quality of maternity care the women receive [47,269,191,199]. Research reported that D&A can cause lasting psychological and emotional effects, leading to a reduction in women's confidence and self-esteem [47,191]. Experiencing disrespect may evoke feelings of shame, sadness, and insecurity, fostering distrust and diminishing confidence in healthcare providers. It may also induce a sense of powerlessness and reluctance to seek assistance [98]. Research indicates that women retain memories of their labour and delivery experiences for their entire lives and often share them with others [47,269,178]. Disrespect and Abuse (D&A) during childbirth constitute a violation of fundamental human rights [163]. Such mistreatment fosters apprehension about seeking future maternity services, leading to its decreased utilization. This reduction in service utilization compromises safe motherhood and contributes to higher rates of adverse maternal and neonatal outcomes [90,100,262].

The White Ribbon Alliance (WRA) defines Respectful Maternity Care (RMC) as the right of every woman and infant to receive compassionate, courteous, and dignified treatment devoid of harm and to maintain complete freedom and autonomy. RMC is not an option; it is a basic human right. World Health Organization (WHO) in 2018 stated that RMC extends beyond preventing maternal morbidity and death [291]. WHO emphasizes ensuring women have a

pleasant delivery experience, which entails being treated with utmost respect and dignity [46,243]. Respect is fundamental to Rwandan culture, influencing various traditional social interactions. Integrating this culture of respect into the journey of childbirth is essential to enhance the women's and newborns' rights as well as the wellbeing of the population in general. [258].

In Rwanda and globally, no attention has been given to RMC-appreciated best practices [173]. Previous RMC studies have overlooked the negative experiences of women and negative behaviours from HCPs [2,231,191]. In addition, during the era of the COVID-19 pandemic, the rights of women, newborns and families have been more violated due to the efforts to restrain the virus [23]. This highlights the need for HCPs to be sensitized to RMC.

Research on D&A or RMC should be based on each country's context and socio-economic and cultural differences. In different countries, the women's perception of respect may differ based on culture and context [47,256,253,35]. Given the varied social and cultural norms influencing women's interpretations of RMC, there is no one-size-fits-all approach to ensuring respectful childbirth care. Therefore, strategies to sustain RMC can be tailored to the local context. In this current study, the author used the appreciative inquiry method (AI) that focused on positive experiences for the mothers and HCPs. The goal was to find strategies that can sustain and promote RMC. AI promotes positive thinking and raises and sustains existing best practices rather than struggling to repair harm. AI promotes a culture of maintaining positive traits, working with what is available in the field, and appreciating what is achieved instead of blaming [173,257]. AI method brings suitable solutions for countries with resource constraints in health settings like Rwanda.

This study aimed to assess and explore RMC in health facilities of the Eastern province of Rwanda and to develop strategies for sustaining positive experiences. In the quantitative part, the author utilized the universal rights developed and updated by the White Ribbon Alliance (WRA) in 2019. In addition, in the qualitative part, women and HCPs self-reported positive experiences, perceptions, or the most valued aspects of care during labour and childbirth. Subsequently, the author developed strategies based on the integration of these findings. National and international experts and stakeholders in RMC validated the strategies. The study encompassed four phases: the first phase focused on women's positive experiences and perceptions. The second phase was to explore healthcare providers' perceptions of RMC

provision. The third phase corresponded with the development of the proposed strategies. The final phase validated the strategies by RMC experts and stakeholders.

## 1.1 Research context

In this first chapter, the researcher discussed the operational definitions of concepts used in this study. The historical revolution and the main events of RMC as the research context of the current study were presented. Emphasis was placed on RMC studies from 2018 onward, as this marks the period when the shift towards RMC began. This was followed by the statement of the research problem and the research gaps. The researcher presented the research questions' specific objectives and defined the scope of the study. The significance of the study and a summary of this chapter were provided.

### 1.1.1 Historical revolution of Respectful maternity care and its key events

#### 1.1.2 The shift to Respectful Maternity Care

Childbirth is a profound human experience which deserves respectful care. RMC is the optimal approach for providing care to women during the maternity period. RMC focuses on preserving women's dignity, privacy, and confidentiality while also protecting against ill-treatment and abuse. It ensures autonomy by granting women the right to information and informed choice [291]. These rights highlight the importance of treating every woman and the newborn respectfully and without discrimination. The rights focus on informed choices and consent, freedom from harm and ill-treatment, and the right to quality care, among other things. The RMC concept has evolved since the 1950s [28]. However, in 2010, the first commonly known research on RMC, named "Exploring evidence for disrespect and abuse in facility-based childbirth" [47], was published.

The first findings drew attention to birth abuse in high-income countries. By 1981, Brazil had documented instances of obstetrical violence, prompting movement toward the humanization of childbirth in Latin America by the 1990s [295,80,94,164]. Three years later, in 1993, there was a declaration for the elimination of violence against women [46,93]. Notably, from 1998 to 2002, seminal research was published in some countries of Latin America and South Africa, highlighting mistreatment in birth facilities [96,180,138,111]. The turn of the century witnessed Brazil's first international conference on the humanization of childbirth [221].

In 2007, the Center for Reproductive rights in Africa published several articles that exposed that the African continent was not exempt from maltreatment of women in labour [60]. In 2007,

Venezuela became the first country to formally define obstetric violation in legislation [33]. This was followed by the USAID Traction project in 2010 [47]. A year later, the White Ribbon Alliance (WRA) played a pivotal role by developing a global RMC council which released the RMC charter on the universal rights of childbearing women [282]. The USAID Traction project supported RMC projects in Kenya and Tanzania [271]. By 2014, WHO emphasized eliminating disrespect and abuse during childbirth [290].

In 2015, WHO introduced a framework for quality maternal and newborn care, emphasizing RMC significantly [289]. Subsequent years witnessed further endorsements, with the WHO launching initiatives and setting standards. The year 2017 was marked by significant advancements like the Addis Declaration and the East, Central, and Southern African Health Community's resolution on RMC [3,101]. In 2018, the WHO launched a shift to focus on ensuring a positive childbirth experience, as highlighted by the WHO, and the establishment of the Lancet Global Health Commission [291]. Finally, in 2019, WRA updated the RMC charter, expanding it from seven rights for women to ten universal rights, including newborns. [284].

The RMC Charter reminds healthcare professionals, policymakers, and communities that every woman and newborn has inherent rights. The charter champions advocacy and sets a benchmark for enhancing the quality and experience of maternity care [284]. The charter clarifies that childbirth isn't just a medical event but also a deeply personal and human experience that deserves respect [284].

The absence of overt disrespect or abuse during childbirth does not necessarily imply that RMC practices are in place [139]. For example, just because there is no physical abuse does not guarantee the presence of compassionate and positive care behaviours [139]. RMC and mistreatment during childbirth represent opposite ends of the spectrum. Research shows that women and newborns can experience a blend of both positive RMC practices and negative mistreatment behaviours within this range [12,139]. Therefore, it is essential to advocate for RMC proactively while simultaneously making efforts to diminish mistreatment. Respectful actions must be identified in a local context because the way women cope with pain or behave during labour may vary from nation to nation [131,33,12]. Providing RMC plays a significant role in enhancing the quality and utilization of maternity services [90,99,262].

Advocating for RMC is vital in advancing the Sustainable Development Goals (SDGs). RMC contributes to this target by improving the quality of care provided during childbirth, which

can prevent maternal and neonatal deaths. Studies have shown that RMC can lead to improved patient satisfaction, better clinical outcomes, and a higher likelihood of women seeking skilled care during childbirth [90,99,262], thereby reducing complications and mortality. In addition, RMC contributes to achieving the targets of eliminating preventable maternal and neonatal deaths and putting an end to all forms of violence against women [58]. Unfortunately, instances of negative childbirth experiences are still documented in several countries, and Rwanda is not exempt [231,191]. There is limited evidence about best practices in facilitating and sustaining RMC [144,91]. Examining the best experiences and practices enables the researcher to discover realistic and culturally accepted sustainable solutions within resource-limited settings like Rwanda. `

#### 1.1.2.1 Universal rights of Women's and newborns

The 2019 RMC Charter, published by White Ribbon Alliance, documented 10 Universal fundamental rights of childbearing women and newborns. WRA developed those rights based on accepted instruments on human rights, which became a framework for high-quality maternity care that supports the dignity of women and their newborns in healthcare facilities.





Figure 1.1: Universal rights of women and newborns by White Ribbon Alliance in 2019

Source: [whiteribbonalliance.org/rmcresources](http://whiteribbonalliance.org/rmcresources) [284]

## 1.2 Research problem statement

In the last decade, global public health has focused on mistreatment towards women during facility-based childbirth. Studies that have been conducted report disrespectful care in childbirth in high, middle, and low-income countries [1,230,93,265]. Studies demonstrate that D&A during childbirth is a worldwide problem [265,144,145,46]. Lack of RMC policy contributes to poor quality of care received by women. D&A during childbirth has been recognized to affect the quality of maternity care and negatively impact safe motherhood [47].

D&A experienced during intrapartum care can result in lasting psychological trauma, diminishing women's confidence and self-esteem [47,191]. Such mistreatment leads to various adverse effects, such as feelings of shame, sorrow, and insecurity, distrust towards healthcare providers. Women who have been disrespected may feel powerless and hesitant to seek assistance [191]. Memories of labour and delivery experiences often persist throughout a woman's lifetime, influencing her perceptions and interactions with others [47]. Encountering disrespectful care instils fear of future engagement with maternity services, potentially reducing their utilization and jeopardizing safe motherhood, thereby contributing to adverse maternal and neonatal outcomes [47].

Most studies on D&A experienced by women have been conducted in Africa. A study done in Kenya reported that 20% of women experienced D&A during labour and delivery [2,151]. In Tanzania, community follow-up reported 70% of D&A [151]. In the studies conducted in Africa, women described being slapped by HCPs and were spoken rudely. They were humiliated, scolded, dehumanized, strapped to the delivery bed, pinched, pushed, insulted, shamed, abandoned, and experienced inappropriate and rough touch. Many were yelled at due to lack of compliance with the instructions, some were stigmatized, abandoned and gave birth on the floor, and those who failed to pay were detained inside hospitals [2,230,191]. Similarly, RMC interventional studies have been conducted in some countries, such as Kenya and Tanzania, effectively reducing D&A [269,152].

Studies demonstrated that both women and healthcare providers are affected by D&A [145, 241,255,48]. Many providers, predominantly women, encounter societal prejudice and violence [110,122,100,40,237]. This problem persists in a vicious cycle, as the research argues that midwives who have experienced violations are more likely to perpetrate similar mistreatment towards others over whom they hold authority [255,48,40,110,237].

A global survey of 2,470 midwives across 93 countries revealed instances of disrespect towards midwives at work and in the community [288]. About 36% reported a lack of respect from senior medical staff, highlighting their lower status and subordination within the medical profession, compounded by limited legal and regulatory support [288]. Gender discrimination and harassment were widespread, with 20-30% encountering such issues, reflecting the undervaluation of midwifery and nursing compared to other medical roles [288]. Despite their



dedication to saving lives, midwives endure challenging working conditions, including understaffed facilities and inadequate compensation [110,253]. The WHO reports on Rwanda noted a lack of public awareness about the role of midwives. In contrast, Nigerian midwives highlighted issues of poor remuneration and a lack of career progression [288].

In 2015, Rosen and colleagues published an article on direct observation of RMC based on seven rights of childbearing women [231] as stipulated by the WRA in 2011 [282]. This study was conducted in five countries in Southern and Eastern Africa, including Rwanda [231]. Through meticulous direct observation, this research discerned pervasive infringements of these rights within the Rwandan context. These transgressions encompassed physical maltreatment, an absence of informed consent, refusal to allow chosen birthing positions, and unprofessional conduct by HCPs, characterized by shouting and discourtesy [231].

Mukamurigo and colleagues, in 2017, conducted quantitative and qualitative research in Rwanda, concentrating on the paradigm of negative childbirth experiences. The quantitative exploration involved a sample of 921 women, assessing their recent childbirth experiences within one to thirteen months [193]. Women reported experiencing neglect during labour, exposure to verbal and physical aggression, insufficient provision of information, refusal of preferred birthing positions, and exclusion of male partners during birth [191]. Based on all that research, no attention has been given to RMC-appreciated best practices [173]. RMC studies conducted in Rwanda and other countries overlooked negative experiences from women and negative behaviours from health care providers [2,231,191].

### 1.3 Research gap

In scholarly discourse on Respectful Maternity Care, the primary emphasis has historically been on the adverse experiences of women [230,1,156,172]. Past RMC studies have predominantly overlooked negative maternal experiences and poor healthcare provider behaviours [2,269]. Notably, researchers need to comprehensively explore the potential benefits and transformative power of positive RMC practices. Many efforts in the domain of maternity care have been aiming to redress mistreatment and abuse rather than proactively championing best practices in RMC. Such a gap is evident in the lack of RMC research utilizing an appreciative perspective in Rwanda, with very limited RMC studies employing the AI approach elsewhere. To the author's best knowledge, since 2021 up to the present, there has

been only one publication on RMC utilizing the AI method [173]. Moreover, no study on RMC has been conducted in Rwanda to explore both service recipients and service providers simultaneously, and the strategies to facilitate and sustain RMC have not been studied or documented.

In 2018, WHO launched a shift towards promoting positive childbirth experiences [291]. Yet RMC practices have largely remained under-examined in academic literature [173,291]. RMC is linked to the entire health system, not only the client-provider relationship [269]. The strategies to sustain and promote RMC for women in labour are important to ensure that every woman has a positive childbirth experience, to mitigate intrapartum mistreatment and to improve maternal and neonatal outcomes [291]. In Rwanda, formal research conducted from the updated women's rights perspective, specifically focusing on positive birth experiences, is lacking. Furthermore, no study has examined HCPs' positive perceptions of RMC provision. RMC actions are not well documented in Rwanda. The report from the East and Southern Africa regional office on RMC indicated that although initiatives have been undertaken to improve RMC in Rwanda, there is still a need for better documentation [101].

Rwanda has made advancements in RMC but has not published information regarding the impact, lessons learned, or their experiences [101], and there are no clear strategies to promote RMC. The recent review of RMC interventions reported that adopting multi-faceted strategies can successfully reduce the mistreatment of women during maternity care and improve the RMC provision [144]. These comprehensive strategies address a range of factors, including the attitudes and conduct of healthcare personnel, staff morale, community engagement, and the removal of barriers in healthcare facilities and systems [144,91]. Interventions beyond a sole focus, like staff training, appear more likely to bring about meaningful change [144,90]. The effort to address the RMC issue solely focused on repairing damages [22,152,269]. Strategies to sustain and promote RMC to women in labour are very necessary to ensure that every woman has a positive childbirth experience, to mitigate intrapartum mistreatment and to improve maternal and neonatal outcomes [291]. This current study was contextual research in Rwanda, but the gap that the author filled is applicable globally.

#### 1.4. Research purpose, objectives and questions

The purpose of this study was to explore the perceptions, experiences, and best practices of maternity care among women and health care providers in order to develop, describe and validate strategies to facilitate and sustain RMC in Rwandan health facilities using 5 phases of Appreciative Inquiry: Define, Discover, Dream, Design, Destiny (Delivery).

The background rationale and problem statement gave rise to three main research questions. The author aligned these research questions with the study-specific objectives and phases of the study as follows:

1. What are the experiences and perceptions of women about RMC during recent childbirth in the Eastern Province of Rwanda?

- To determine and describe the experiences of women about RMC during their childbirth in the Eastern province of Rwanda, using a questionnaire (Quantitative approach) **(Phase 1a)**
- To explore and describe the perceptions and experiences of women with regard to RMC during their recent childbirth using Appreciative Inquiry (AI) questions (Qualitative approach) **(Phase 1b) (IDIs)**

2. How do HCPs perceive and ensure RMC during labour and childbirth in the Eastern Province of Rwanda?

- To explore and describe HCPs perspectives on RMC, using AI method **(Phase 2b) (FGD) (IDIs)**
- To explore HCPs views of RMC as reported by the women from Phase 1 **(Phase 2a) (FGD) (IDIs)**

3. What are the strategies to facilitate and sustain RMC in the Eastern Province of Rwanda?

- To develop and describe strategies to facilitate and sustain RMC to women in labour based on the findings from Phase 1, Phase 2a and Phase 2b **(Phase 3)**
- To validate the formulated strategies to facilitate and sustain RMC to women in labour **(Phase 4)**

#### 1.5 Scope of the study

The scope of this current study is limited to exploring the RMC status among women who recently gave birth at selected hospitals in the Eastern province. The study aimed to investigate

the women's and HCPs' experiences and perceptions regarding RMC and strategies for sustaining and improving respectful best practices. Additionally, the study examined how healthcare providers working in maternity services (including midwives, nurses, physicians, and maternity unit managers) perceived RMC. It explored the best moments they experienced while caring for women in labour and childbirth, their thoughts on the feasibility of women's recommendations, and their own recommendations to maintain and promote best practices. Furthermore, insights from women, healthcare providers, stakeholders, and experts in RMC provided additional comments and inputs.

Appreciative Inquiry was used in this study. Appreciative inquiry is recognized as an impactful change method that emphasizes positive ideas, strengths, and functions across individual, team, organizational, and societal dimensions. It encourages a collective vision by promoting strategic innovation [79,132,137]. The author followed the five steps of Appreciative Inquiry;

In this current study's '**Define**' stage, the author defined the research topic and ensured it centred on a positive focus. The research's focus was on identifying "the best RMC moments experienced by women and HCPs working in a maternity section in Eastern Rwanda." [81,70,72].

In the '**Discover**' stage, women shared their individual greatest experiences of RMC during their recent labour and childbirth in health facilities in the Eastern province. HCPs also shared their best RMC practices and moments while working in a maternity section in Eastern Rwanda. Data collection focused on exploring the best experiences of women and HCPs, emphasizing strengths through appreciative interviews and focus groups [81,70,72, 257].

In the '**Dream**' stage: In the Dream phase, participants envisioned a positive future for RMC, building on qualities uncovered in the Discovery phase. Through various imaginative exercises, women and healthcare professionals were asked to picture and recommend ways to sustain and promote optimal RMC practices. Participants were asked to foresee and envision the RMC they wanted for the future. They were requested to provide recommendations to sustain and promote RMC and share their best recent experiences/moments [81,70,72, 257].

In the '**Design**' stage: In the Design phase, the researcher shared with HCPs what women reported in stages one and two. Detailed visions based on what was discovered about women's perceptions enabled HCPs to provide their own plans to address such. Then, the researcher

consolidated findings from prior stages to formulate strategies and action plans. Emphasizing past successes, participants in the study proposed specific measures, procedures, and collaborative efforts to facilitate positive change towards RMC. They crafted concrete intentions and design declarations to guide their actions as healthcare professionals [81,70,72, 257].

In the '**Destiny**' stage, also named '**Delivery**', the researcher engaged stakeholders to validate the formulated strategies and action plans in this study's phase. The researcher proposed a logical framework for RMC in Rwanda's health facilities. Stakeholders participated in evaluating the strategies and offering their insights. It is crucial to note that this phase consisted of both planning and implementation, but the doctoral study was constrained to designing and developing RMC strategies without actual implementation [81,70,72, 257].

### 1.6 Significance of the study

This study benefits healthcare research, midwifery and obstetric education, quality assurance, professional and ethical framework, policymakers and human rights advocacy.

**Domain of healthcare research:** The findings of this study contribute to the global evidence advocating for RMC. Furthermore, by generating pertinent data, this research bridges the evidentiary void surrounding this aspect in Rwanda. Consequently, it establishes a foundational reference point for subsequent studies in this domain.

**Domain of midwifery and obstetric education:** The findings facilitate the development of RMC training for healthcare professionals, ensuring that childbearing women receive treatment marked with utmost respect.

**The domain of quality assurance:** The data derived from this study focus on enhancing the quality of maternity health services, aiming to elevate patient satisfaction and promote safer motherhood.

**Domain professional and ethical framework:** The findings facilitate the development of a module grounded in a professional and ethical framework, ensuring the dignified treatment of childbearing women. Moreover, this research yielded evidence-based practices for healthcare practitioners, enhancing professional accountability and fostering ethical deliberation.

**The domain of policy-making:** The results of this study were disseminated, prompting a more extensive dialogue with key stakeholders, including regulatory bodies, the Ministry of Health, professional associations, women's groups, and international organizations.

***The domain of human rights advocacy:*** The findings of this study raise awareness among maternity service users, healthcare providers, and all relevant stakeholders regarding the universal rights of women of childbearing age and their newborns.

## 1.7 The summary

Chapter one provided an overview of the present study, how RMC has evolved over time in terms of practices, social movements, and research, and the obvious shifts to RMC studies. The author discussed the theory relevant to this study, "Jean Watson's theory of caring". The problem and research gap were presented by critically discussing the scarcity of studies conducted in Rwanda about RMC. The author argued about the need for more studies to be conducted in different corners of the country to increase the visibility of RMC research in Rwanda. The author argued that this study came at an opportune moment to respond to the identified gap. In addition, the author appraises the methodology used, which tends to produce better results than other methodologies used in past studies.

In the following chapter, the author presented the concept. The researcher documented a critical discussion of the literature review of studies conducted in Rwanda about childbirth experiences. Normalization of mistreatment towards women during childbirth, its implication and three paradigms around childbirth were reported. The author discussed how the lack of RMC is a health system issue. Methodological considerations with critical discussions of approaches mostly used in the past RMC studies, the approach used in this study, Appreciative Inquiry, were explained in detail, and the author applied it to each phase of this study. Various methodologies were used as implementation frameworks, theories in RMC intervention research were reported, and RMC strategies from other studies were discussed. In the end, the author explained how this research covered the existing gap and provided a summary of this chapter and the next chapter.

## Chapter two: Literature review

### 2.1. Introduction

In this chapter, the author presented the conceptual framework (WHO, Standards for Improving quality of maternal and newborn care in health facilities) established in 2016 [288]. In addition, the WHO's statement on the positive experience of maternal standard care was clearly displayed, as derived from the first one. Then, the conceptual framework of this particular study was drawn and explained. A critical discussion of the literature review covers studies conducted in Rwanda about childbirth experiences and the perspectives of healthcare providers (HCPs). Normalization of mistreatment towards women during childbirth, the iceberg phenomenon, its implication and three paradigms around childbirth were reported.

The author explained how the paradigms inherited in history can be the root causes of disrespectful or respectful maternity. Methodological considerations with critical discussions of approaches mostly used in the past RMC studies, the approach used in this study is Appreciative Inquiry (AI). The author has discussed how the lack of RMC is a health system issue. The author delineated the literature on possible strategies to facilitate, sustain and promote RMC towards women in labour. Finally, the author explained how this research covered the existing gap and summarised the next chapter.

The researcher consulted different search engines via HINARI, such as PUBMED, CINAHL, Google Scholar, and Cochrane Library, among others. Recent peer-reviewed articles on RMC published in the last five years have been utilized, as this marks the period when the shift towards respectful maternity care began. The author read articles published in the English language. The researcher consulted various resources related to RMC, including the WRA repository, the RMC resources website, and multiple RMC project reports, among others. The literature search was conducted through various electronic databases using research keywords, including the Boolean "and" in order to retrieve articles. The author constructed a literature review matrix encompassing important summarized information from each chosen article to facilitate the reading of retrieved articles. This information included the article's aim, methodology, limitations, and contents based on research concepts. In this study, the concepts were RMC, universal rights of women and newborns, and positive childbirth experience.

This chapter describes the conceptual framework that guided the study and the empirical and theoretical studies related to the research questions. In addition, the 5D cycle (Definition, Discovery, Dream, Design and Destiny) of AI was described, and the author reflected on

quantitative and qualitative studies conducted on the RMC theme. Hence, the researcher provided critical discussions on RMC's current knowledge. The author criticized the methodological details used in previous RMC studies compared to the AI method. The research identified what is known and what is not known from an RMC point of view among women and HCPs, specifically the strategies that aim to sustain RMC, areas of controversy, and areas that need further exploration. The author synthesized and analyzed the primary source materials on women and HCP insights on RMC from broad to narrow. The critical discussion indicated that what this study discovered is missing from the existing RMC literature. In addition, the methodology used in RMC-published papers was criticized, and the way AI method made a difference. Finally, the author argues on the lessons learned from the critical analysis of RMC literature and restates the new knowledge brought by the current study.

## 2.2 Jean Watson's Theory of Caring and its application to the current study

Jean Watson's Theory of Caring is a middle-range theory first utilized in the field of nursing [16]. This theory is relevant to the current study as it revolves around the concept of caring [273], and the study specifically focuses on the care provided by health professionals (such as nurses, midwives, and physicians) to mothers. Consequently, the study investigated how these professionals care for mothers during labour and childbirth. Given that caring constitutes the primary role of nurses and midwives [211,273] and is also significant for physicians, the Theory of Caring was particularly suitable for this study. Watson's Human Caring Theory is a foundational and transformative guide in nursing, emphasizing caring as a moral and ethical core [211,273,64]. The theory's assumptions highlight interconnectedness as central to nursing, considering the importance of caring for preserving human dignity [277]. Trustful interpersonal relationships are crucial in the moral ideal of caring [13,154]. The Human Caring Theory advocates for a unique way of being human, present, attentive, conscious, and intentional, addressing profound life experiences [273,154].

Nursing is fundamentally characterized by the concept of caring [142,49]. Caring, which promotes the integration of mind, body, and spirit, facilitates a positive energy exchange that is mutually fulfilling for both the patient and the provider [273]. Watson was inspired by Florence Nightingale's vision, which emphasized the nurse's role in positioning the patient for self-healing. Nurses are ideally situated as the nurturing essence in the healing process [226]. Through active participation in caring, marked by authentic presence and intentionality, the



nurse can enhance the patient's inherent capacity for healing [273]. Watson highlights that human caring is a pivotal life process influencing health [275]. Nurses can create meaningful, caring moments by authentically connecting with patients and recognizing their individuality [273]. Watson further asserts that caring is a positive and inspirational force, revitalizing life energies and unleashing the potential of healthcare providers [273]. This reciprocal experience of caring safeguards and affirms health providers' humanity, unveiling genuine thoughts, feelings, and attitudes while fostering enduring relationships and human connectedness [275,64]. Caring not only enhances patient outcomes and satisfaction but also enriches the overall well-being of healthcare providers [142,273].

This study adhered to Watson's Human Caring Theory, encouraging healthcare providers to return to their professional roots and values [209]. It positions Watson's theory as the archetype for ideal healthcare providers, endorsing professional identity within a context where humanistic values are often questioned [278,29]. Upholding caring values contributes to positive outcomes for both service users and providers, enhancing professional satisfaction. [218,153]. Watson's theory uniquely considers the cared-for and the caregiver, emphasizing the significance of caring values in finding meaning in best practices [273].

Watson's Human Caring Theory incorporates the caring relationship, which includes love-centred caring and compassion, forming the essence of caring and enhancing the patient's experience during actual caring occasions [13]. This theory fosters a helping-trusting relationship with sensitivity and compassion [275]. Healthcare providers must be present and supportive of expressing positive and negative feelings, using various ways of knowing and creating a healing environment, and assisting the patient with basic needs, aligning the mind [209,148].

Caring for patients creates meaningful interactions, contributing to a mutual search for meaning and wholeness [275]. Caring consciousness, central to Watson's Human Caring Theory, relates to caring-loving consciousness within a single caring moment [273]. Emphasis in this theory, even in this study, is placed on appreciation of the best moment in caring and the interconnectedness between the one caring (nurses, midwives, doctors) and the one being cared for (mothers). This caring-healing-loving-consciousness transcends time and space and is communicated to the one being cared for [273,276]. In accordance with Watson's Theory of Caring, the core principle is that humans should not be treated as mere objects; instead,

emphasis is placed on the interpersonal process between the caregiver and the care recipient [148].

The theory of human caring centres on the importance of human caring and the transpersonal relationship involved in caregiving, emphasizing its healing potential for both the caregiver and the recipient [274]. Furthermore, Watson emphasized the significance of self-care as a prerequisite for effectively caring for others [218,273]. Engaging in self-healing is essential for revitalizing energy reserves and nurturing one's spiritual well-being [236]. This self-care is rejuvenating and has a contagious effect, infusing others with caring energy [236]. It fosters heightened awareness and intuition within the caregiving process. Watson's Caring Science provides a language for authentic human-to-human caring, acting as a transforming force of compassion-in-action, born from knowledge, courage, love, and passion [49,209]. It seeks philosophical congruence and embodies compassion in the search for inner, spirit-filled experiences [118,277].

This study emphasized respect with positive interpersonal caring moments and the positive environment around childbirth [50]. This aligned with Watson's theory, indicating that the nurse's role is to develop and sustain trusting relationships that create a healing environment [20]. Transpersonal human caring moments align with practising loving-kindness and support for others on their healing journey, viewing every person as whole and complete, regardless of health condition [276]. In conclusion, Watson's Human Caring Theory focuses on creating human-spirit oneness during caring occasions, providing a holistic framework for healthcare providers, emphasizing spiritual dimensions, interconnectedness, and transformative caring practices [38].

### 2.3. Conceptual framework

In 2016, the WHO established a comprehensive framework of eight domains to assess and enhance the quality of maternal and newborn care within health systems [289]. The framework, focused on provision and care experience, addresses key areas such as clinical guidelines, standards of care, effective interventions, quality measures, relevant research, and capacity-building. Emphasizing standards of care and quality measures, the WHO aims to provide evidence-based guidance for improving maternal and newborn care by formulating specific standards, quality statements, and measurable improvements across the defined domains. (**Figure 2.1**) [289].

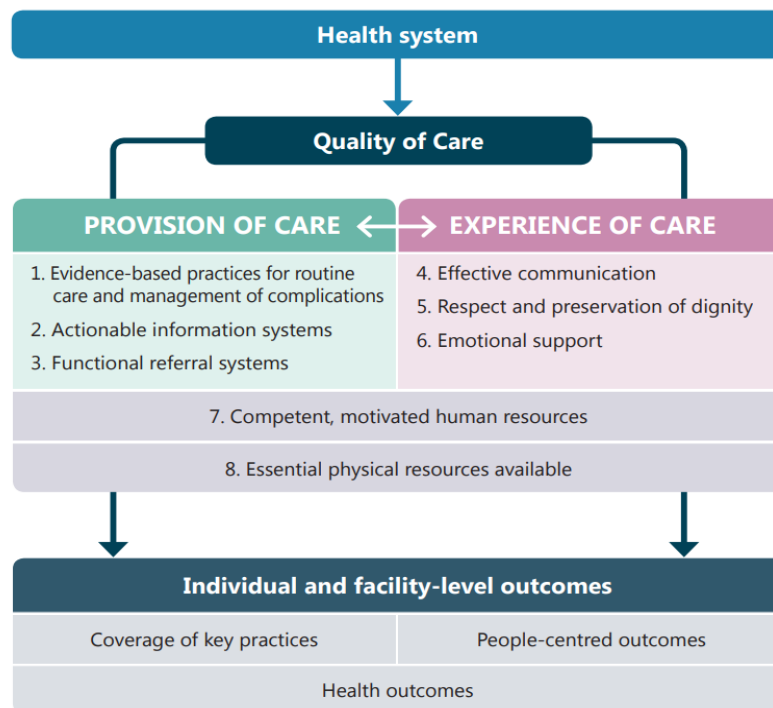


Figure 2.1: WHO quality of care framework for maternal and newborn health

**Source:** WHO, Standards for improving quality of maternal and newborn care in health facilities, Geneva, Switzerland: 2016

### 2.3.1 WHO statement on the positive experience of maternal standard care

Under experience of care, there are three components: effective communication, respect and preservation of dignity, and emotional support. Two additional components are cross-cutting: competent and motivated staff and availability of essential physical resources (**Figure 2.1**) [289].

#### **Effective Communication**

The WHO stated that it is imperative to prioritize and customize effective communication with women and their families, considering their specific requirements and preferences [289]. The WHO advises providing all women and their families with information regarding their healthcare and allowing them to participate actively in meaningful conversations with healthcare professionals. In addition, they should be actively engaged in the decision-making processes concerning their treatment. The provision of coordinated care, characterized by the seamless interchange of information across pertinent healthcare and social service experts, is of utmost importance for women and their families. The objective of this standard is to guarantee the efficacy of communication, which holds significant importance in the

comprehensive care of patients and their families. The establishment of efficient communication channels between healthcare practitioners and patients has the potential to mitigate avoidable anxiety and enhance the overall birth experience for women [289].

### ***Upholding and safeguarding dignity***

The WHO indicated that it is essential to offer care for women and newborns in a way that maintains their dignity and guarantees respect [289]. The purpose of this standard is to guarantee the utmost regard and safeguard the dignity of all women throughout their healthcare stay at the facility. To maintain the women's dignity and consistent adherence to privacy and confidentiality while ensuring the prevention of any instances of mistreatment, such as physical, sexual, or verbal abuse, discrimination, neglect, detention in facilities, oppression and denial of services. Preserving privacy during labour and childbirth is fundamental for both women and newborns, with a commitment to maintaining confidentiality. Women should be provided with well-informed choices regarding the prescribed care and services while HCPs take measures to communicate the rationales for interventions or outcomes effectively [289].

### ***Psychological assistance***

The WHO recommended that every woman and her family should be cared for with compassionate and emotional support to meet their requirements and improve the woman's capacities [289]. The provision of emotional support is an essential component of the caregiving process. A selected birth partner enhances a woman's ability to navigate labour with increased assurance. Each woman should be offered assistance in strengthening her resilience during labour and delivery. Every woman can have a selected companion during labour and childbirth, which guarantees assistance in improving her coping skills.[289].

### ***Skilled and driven personnel***

The WHO reported that the availability of competent and motivated personnel is paramount in ensuring high-quality care and effective management of complications for both women and newborns [289]. Healthcare facilities must provide the presence of competent and well-trained workers, as well as skilled birth attendants, in all labour and delivery areas at all times. These personnel should be adequately staffed to handle the anticipated workload. Efficient leadership and management in the healthcare institution are crucial for offering direction and guaranteeing continuous quality improvement. It is imperative to ensure that every woman and her baby

have uninterrupted access to at least one skilled birth attendant and a team of support workers for normal care and effective management of complications. The required skills and experiences for birth attendants are crucial for effectively addressing the needs of labour, childbirth, and the immediate postnatal period. In addition, every healthcare institution must possess a combination of management and clinical leadership that together undertakes the responsibility of formulating and executing suitable policies. This will cultivate an atmosphere that promotes ongoing quality enhancement among the facility's personnel [289].

### ***The availability of essential physical resources***

Based on the WHO criteria, health institutions must maintain appropriate physical settings. [289]. Health facilities must possess operational, dependable, and secure services that guarantee access to sufficient water, sanitation, energy provisions, waste disposal amenities, medications, supplies, and equipment for routine maternity and newborn care, as well as for the management of problems to adequately address the healthcare requirements of mothers and babies. Labour, birthing, and postnatal care areas should be kept clean, comfortable, and organized logically to allow smooth and uninterrupted care. These sections should be meticulously planned, structured, and upheld to guarantee that each woman and newborn receives personalized care tailored to their specific needs in a secluded environment that promotes uninterrupted care provision [289].

| <b>Experience of Care Standard</b>                                                                                                                           | <b>Quality Statements</b>                                                                                                                                               |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Standard 4:</b><br>Communication with women and their families is effective and responds to their needs and preferences                                   | 4.1 All women and their families receive information about the care and have effective interactions with staff.                                                         |
|                                                                                                                                                              | 4.2: All women and their families experience coordinated care, with clear, accurate information exchange between relevant health and social care professionals.         |
| <b>Standard 5:</b><br>Women and newborns receive care with respect and preservation of their dignity                                                         | 5.1: All women and newborns have privacy around the time of labour and childbirth, and their confidentiality is respected.                                              |
|                                                                                                                                                              | 5.2: No woman or newborn is subjected to mistreatment, such as physical, sexual, or verbal abuse, discrimination, neglect, detainment, extortion or denial of services. |
|                                                                                                                                                              | 5.3: All women have informed choices in the services they [and newborns] receive, and the reasons for interventions or outcomes are clearly explained.                  |
| <b>Standard 6:</b><br>Every woman and her family are provided with emotional support that is sensitive to their needs and strengthens the woman's capability | 6.1: Every woman is offered the option to experience labour and childbirth with the companion of her choice.                                                            |
|                                                                                                                                                              | 6.2: Every woman receives support to strengthen her capability during childbirth.                                                                                       |

*Table 2.1: WHO statement on the positive experience of maternal standard care*

**Source:** World Health Organization. *Standards for improving quality of maternal and newborn care in health facilities*, Geneva, Switzerland: WHO; 2016

This table indicates the standards for care during childbirth. Effective communication means providing information about care, fostering effective interactions, and ensuring coordinated care with accurate information exchange between relevant professionals. Respect and preservation of dignity embrace privacy and confidentiality and empower women to make informed choices. Prevention of mistreatment, discrimination, and denial of services are outlined. Emotional support includes emotional support deemed crucial for the care experience. Women are offered the option to have a chosen birth companion, and support is provided to strengthen their capabilities during childbirth. This standard aims to enhance the emotional well-being of women and their families throughout the childbirth process (**Table 2.1**).

### 2.3.2 The adapted conceptual framework of this current study

The study framework was adapted from previous RMC frameworks. The RMC items in these frameworks are similar and complement each other. Those are the universal rights of women and newborns, updated in 2019 by the White Ribbon Alliance [284] (**Figure 1.1**). Also, the WHO Standards for improving the quality of maternal and newborn care in health facilities were published in 2016 [289]. Moreover, there are twelve domains of RMC developed by Shakibazadeh published in 2018 [243], landscape analysis developed by Bowser and Hills published in 2010, especially the contributors to RMC [47]. The concepts within this study are respectful maternity care, positive childbirth experience, and the rights of women and newborns (**Figure 2.2**).

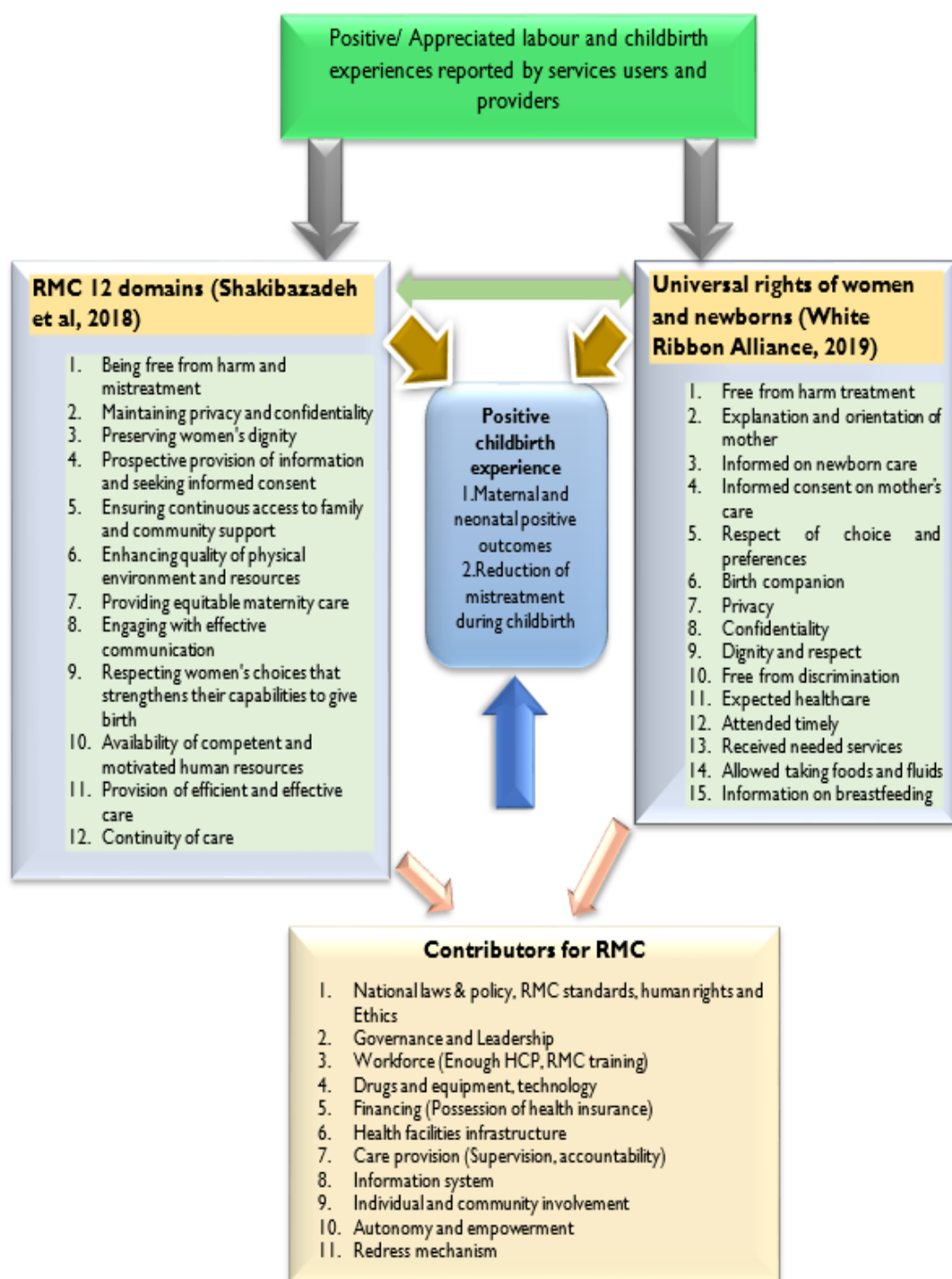


Figure 2.2: Research conceptual framework

*” Development of Strategies for Health Care Providers to Sustain Respectful Maternity Care to Women during Labour and Childbirth in Rwanda ”*

This figure delineates the core concepts of the research: Respectful Maternity Care, Universal Rights of Women and Newborns, and Positive Childbirth. In addition, the figure contains

contributors to RMC and the variables associated with each concept. Arrows signify the interplay between these concepts, culminating in the primary expected outcome: a positive childbirth experience. The White Ribbon Alliance enumerates ten universal rights for women and newborns [284], and in the quantitative part of this study, these rights were further elaborated into 15 specific items. Upholding these rights paved the way for maternal care valued by both women and HCPs. Shakibazadeh and colleagues proposed 12 RMC domains correlating with the rights mentioned above. The research sample comprised service recipients (women) and healthcare professionals (midwives, nurses, physicians). These participants reported their experiences and perceptions of RMC during labour and birth. Within this study's framework, there was a connection between the narrated experiences and the contributors to perpetuate RMC.

The typology created by Shakibazadeh and colleagues in 2018 is a comprehensive framework that covers 12 domains of RMC [243]. This framework was developed through a qualitative synthesis of existing literature. The 12 domains included freedom from harm and mistreatment, maintenance of privacy and confidentiality, preservation of women's dignity, provision of information and obtaining informed consent, ensuring continuous access to family support, enhancing the quality of the physical environment, and strengthening women's capabilities to give birth [243]. Moreover, the RMC domain encompasses providing equitable maternal care, engaging in effective communication, delivering efficient and effective care, ensuring the availability of competent and motivated staff, maintaining continuity of care, and respecting women's choices regarding resources and environment [243]. This typology provided a useful tool for healthcare providers, policymakers and researchers to evaluate and improve the quality of maternity care and promote positive maternal and neonatal outcomes.

Bowser Hills and other researchers identified various contributors to RMC across different levels [47,269,46]. These included establishing national laws and policy standards for RMC, adherence to human rights and ethical principles, and effective governance and leadership. Contributors included qualified numbers of HCPs trained in RMC, sufficient drugs, equipment, and technology, maintaining a functional information system, and securing financing, such as health insurance. It is essential to have well-equipped health facilities with adequate infrastructure, delivering care with accountability and supervision. Individual and community involvement is crucial, with women empowered to demand RMC autonomously and to make



the communities aware of RMC principles. Furthermore, a complaints redress mechanism should be implemented [47,269]. (*Refer to Figure 2.2*).

## 2.4 Critical discussion on studies conducted on childbirth experiences in Rwanda

### 2.4.1 Women's Childbirth Experiences in Rwanda

Prior to 2015 in Rwanda, the issue of disrespect and abuse during childbirth had largely remained unaddressed due to underreporting and the absence of formal reports or research. This pervasive silence is likely due to the perception that pain and suffering during labour and childbirth are routine aspects of the birthing process [47,2]. Bowser and Hills contend that various forms of mistreatment during childbirth are deemed normal, which dissuades women from voicing concerns or reporting incidents [47]. Pioneering researchers in RMC suggest that perceptions of respectful or disrespectful actions should be contextualized locally [50,47], as responses to labour pain or behaviour during childbirth can differ across cultures [34,243]. In Rwandan cultural norms, for instance, labouring women are often dissuaded from vocalizing their pain; societal expectations encourage them to remain calm and quiet.

Limited knowledge exists regarding the context and depth of RMC experienced by women during childbirth in Rwanda, as well as the perceptions of RMC by HCP. A study encompassing five African countries, including Rwanda [231], identified a systematic violation of women's rights, especially their right to be free from harm and mistreatment, most notably by the use of physical abuse. Additional breaches included the denial of information, informed consent, and respect for women's choices, evident in the refusal to allow preferred birth positions. Moreover, violations against the right to dignity and respect were apparent, with reports of women in labour being subjected to shouts and derogatory remarks from HCPs [231].

In 2017, a study was conducted on the experience of childbirth in Rwanda, with one qualitative study supplementing the findings of the quantitative study [191]. The quantitative research was a cross-sectional household survey involving a sample of 921 women [193]. This investigation delved into the relationships between perceived care and childbirth experiences, targeting mothers in Kigali and the Northern province of Rwanda who had given birth between 1 to 13 months prior to the study. Participants who recounted negative childbirth experiences were then enlisted for qualitative interviews to elucidate the meaning of their poor childbirth experiences [191]. These women described that they were slapped, verbally berated,

humiliated, reprimanded, physically assaulted, insulted, abandoned, or subjected to inappropriate and rough handling by healthcare providers. Many reported being shouted at for failing to follow instructions, and some were retained within hospitals due to unsettled bills [191]. A notable limitation of that research is the lack of consideration of the time elapsed between delivery and the conduct of the study. The extended interval, which spanned up to a year between childbirth and the subsequent interview, rendered the study susceptible to recall bias [193]. A distinct contrast between that study and the present research is the focus; while the former concentrated on the negative aspects of childbirth experiences, while this current investigation emphasized the positive dimensions.

In 2018, Ndirima and colleagues published findings on perceptions of maternity services at Mibilizi District Hospital in Rwanda's Western Province [200]. The study involved rural women who had hospital births. The mothers stated that the need for respectful treatment included spaces, privacy, preferences of the gender of the birth attendant and the potential presence of their husbands during the childbirth process. Women from these remote areas made considerable efforts to access healthcare facilities with positive expectations. However, the study demonstrated that staff shortages posed the primary obstacle to RMC provision [200]. In 2018, Mutaganzwa studied maternal satisfaction in Rwandan Health Centers and found that interventions needed to be tailored to the local context. The study further demonstrated that effective communication and confidentiality are correlated with high satisfaction levels [196].

#### 2.4.2 RMC Perceptions from Health Care providers

No formal research has been published specifically addressing the perceptions of HCPs regarding RMC in Rwanda [284]. However, in 2013, the WRA staff interacted with midwifery students, tutors, and practising midwives in Rwanda to understand their perspectives on RMC provision in their settings [284]. The main challenges that hindered the provision of RMC in Rwanda's maternity wards included non-consensual care and inadequate privacy [284]. The shortage of midwives and lack of motivation were contributing factors to mistreatment in various maternity wards across Rwanda [284]. Studies have predominantly centred on mistreatment by midwives, with limited focus on the full spectrum of professionals involved in childbirth care [230,207,1]. Importantly, the care provided to women during labour and childbirth is delivered by a multidisciplinary team encompassing midwives, nurses, gynaecologists, and general practitioners.

## 2.5. Normalization of mistreatment during childbirth, “Iceberg phenomenon” and its implications

In ancient times, suffering during labour was considered a punishment from God for Eve's transgression [74]. Some religious personalities fueled these beliefs in the 4th century. St. Jerome, a Latin father of the Christian church, said: "*Woman is the gate of the devil, the path of wickedness, the sting of the serpent, in a word... a perilous object*" (213). Thomas Aquinas, the 13<sup>th</sup>-century Christian theologian, said that "*woman was created to be man's help mate, but her unique role is in conception . . . since for other purposes men would be better assisted by other men*" [117,14]. The issue became even more complex in Europe in the Middle Ages and early Renaissance when women were left to deliver on their own due to the belief that midwifery was associated with witchcraft [112,314]. Midwives who were caught assisting women in delivery were punished, sometimes by being killed [112]. These beliefs, rooted in gender inequality, infringed upon women's rights and made them feel inferior. Consequently, women were often expected to endure labour pain without assistance [230].

Global society in the past normalized D&A during childbirth. To keep silent on obvious issues is called the "Iceberg Phenomenon" [231]. The feminist movement, the White Ribbon Alliance, and scientific research began to break the silence [167,282]. The silence was broken by uncovering, exploring, and bringing to light the issue of D&A towards pregnant women. Scientists published empirical evidence on D&A, challenged existing beliefs or misconceptions, raised awareness, and engaged with the public and stakeholders [167,282]. They advocated for women's rights, such as the administration of drugs for labour pain and prohibiting unnecessary painful procedures during childbirth. Although advances have been made, problems still exist. For example, some HCPs resort to slapping a woman in labour, believing it will benefit the baby [230,166]. A study by Rominski demonstrated that midwifery students believed they needed to slap women to make them comply with instructions [230]. Similarly, Maung's study reported instances of healthcare providers who justified slapping and shouting at women as a form of encouragement during labour [166].

Gender is another point to consider. Gender inequalities and imbalanced power dynamics within the healthcare system have a detrimental impact on the provision of high-quality treatment and impede women's ability to exercise their rights as both recipients and providers of maternity care [40]. In a patriarchal society, women are considered inferior to men, and this leads to disrespecting women [67,39]. Cohen argued that during labour, women are

disrespected because they are women, and they are made to feel pain [67]. That violence seems to be deemed essential to domesticate women's bodies and restore them to a perceived state of "femininity" [67,242]. Gender inequality has a negative impact on both mothers and practitioners and plays a role in fostering mistreatment and abuse within maternity care [40].

In 1988, the WHO released an animated film titled "Why did Mrs. X die?". Mahmoud Fathalla narrated the tragic story of a pregnant woman's fate [158,307]. Mrs. X represented the many women in low-income countries who die unnecessarily each year [158,307]. In contrast, the cause of her death certificate was attributed to haemorrhage, with her passing linked to a multitude of factors, including poverty, limited education, inadequate prenatal care, scarce hospital resources, lack of family planning, and societal attitudes towards women [307]. Fathalla emphasized that women do not succumb to untreatable diseases but rather due to society's failure to recognize the value of women's lives and address preventable maternal deaths [307]. In connection with this, the study revealed that systemic gender inequality renders women more vulnerable to abuse [255]. Frequently, women encounter poor-quality maternity care, which leads to avoidable complications due to difficulties in accessing information and financial resources [47,308].

Studies reported that HCPs usually mistreat women who look to deviate from traditional feminine stereotypes [153,309]. This results in normalizing the mistreatment of women, both within and outside health facilities [153,47]. HCPs encounter gender discrimination through unfavourable working conditions, lack of respect for their abilities, violence and harassment, a limited voice at work, and restricted training and professionalization opportunities [40]. These challenges undermine their capacity to provide high-quality care [40].

Grilo Diniz (2018) found that addressing gender violence in medical training, particularly the hidden curriculum, requires a long-term effort to change the misogynistic culture in health services [122,267,17]. The definition of misogyny by Diniz was discrimination against women or girls as a type of sexism that keeps women at a lower social status compared to men [267,62]. Genuine change in maternity care involves evolving policies, regulations, and widespread dissemination of information. Dissemination of policies should be closely aligned with comprehensive training for health providers in ethics, gender, and human rights [122]. Maung emphasized the importance of comprehending how gender norms and power dynamics influence the treatment of women during childbirth [166]. Bradley's literature synthesis emphasized the low status of midwives within health system hierarchies [48]. A lack of respect

for midwives marks the culture of healthcare facilities, often viewing them as inferior and ineffective professionals [48].

Research indicates that HCPs are more likely to identify instances of D&A than mothers do, primarily due to differences in recall periods [12]. Providers frequently witness D&A among their colleagues, whereas mothers are susceptible to recall bias [12]. Studies have shown that women often underreport mistreatment [46]. Bowser and Hills noted that some women struggle to differentiate between violating behaviours and standard care practices [47]. In contrast, providers can objectively recount experiences [12]. HCPs are more likely to report instances of D&A than women do because they consistently witness mistreatment among various patients [12]. However, providers may still underreport their involvement in mistreating women [12].

Mutaganzwa studied women's satisfaction during antenatal and maternity care. Women responded that they prefer male birth attendants [196]. Similarly, the study conducted by Bante in Harar hospitals in Eastern Ethiopia found that services provided by male HCPs were linked to higher feelings of RMC by women [33]. Studies reported that mothers perceived male HCPs as more friendly and likely to offer RMC, assumed that males have greater empathy, are more friendly and sensitive, are more knowledgeable than females, and possess physical force to help in case of complications [187,156,33,249]. Conversely, the midwifery profession was considered a feminine profession dominated by women [56]. More males are attracted to join the midwifery profession to promote and empower the profession, as men are considered superior in society and provide higher RMC [249]. Empowering the midwifery profession involves addressing gender stereotypes and promoting a more gender-diverse workforce. This diversity can help normalize and increase acceptance of midwifery in society, leading to better public perception and understanding. As a result, the profession may gain more respect and credibility. On the other hand, some women prefer females because giving birth is reserved only for females and is a feminine experience [200,244].

### 2.5.1 Three Paradigms around childbirth

Three dominant healthcare paradigms significantly influence contemporary childbirth: technocratic, humanistic, and holistic models, as defined by anthropologist Davis-Floyd [87]. These models diverge fundamentally in their conceptualizations of the body and its relationship to the mind, shaping distinct approaches to healthcare [197,218]. The technocratic model

accentuates the separation of mind and body, viewing the body as a machine [87,88]. In contrast, the humanistic model underscores the connection between mind and body, defining the body as an organism [87]. Lastly, the holistic model asserts the unity of body, mind, and spirit, portraying the body as an energy field engaged in continuous interaction with other energy fields [87,197].

The technocratic model, named the bio-medical model, is characterized by specific core values, including the division between the mind and body, the mechanization of the human body, and a lack of consideration for cultural backgrounds [87,197]. Within this framework, a woman's body is viewed as a machine that may occasionally malfunction; childbirth is an event detached from the broader context of life [197,221]. This perspective has significantly influenced the philosophy of contemporary midwifery care [88,85,221,197]. A hierarchical system exists in a technocratic/ paradigm where the physician is perceived as the ultimate authority [88]. Various cues, such as the donning of white coats and the use of technical jargon, serve to reinforce this authoritative status [197]. Consequently, the patient is relieved of a significant degree of responsibility, as the practitioner assumes sole responsibility in their role as the authority figure [197].

The technocratic paradigm is the gradual erosion of humanistic values, a decline in women's natural capacity for childbirth, a rise in the prevalence of cesarean sections, and a tendency among women to unquestioningly adhere to the decisions made by their physicians [197,86,88]. Technocratic is different from the midwifery philosophy that states: "Midwifery is and should be in conflict with the medicalization of childbirth when that medicalization is applied unnecessarily" [316]

The humanistic paradigm, named the bio-psycho-social model, was introduced to midwifery and obstetric care to establish a connection between the mind and the body [85,119]. The emergence of this approach, focusing on providing humane support during labour, started in the 1970s [227,197]. In this perspective, treating physical ailments without considering psychological factors is deemed practically impossible. It advocates for integrating mind and body, replacing the mechanistic approach to childbirth with an organismal one [197]. Key accomplishments of this ideology include a shift away from a paternalistic outlook, the departure from one-sided decision-making by healthcare providers, and the establishment of shared responsibility between the patient and the practitioner.

This holistic perspective, developed in recent years, simultaneously considers the mind, body, environment, and society. This comprehensive outlook posits that health and healing are interdependent on these factors, assigning greater importance to the mind and metaphysics. Additionally, the body is perceived as an energy field capable of connecting with other energy fields [37,169]. Consequently, the outcome of this approach suggests that the midwife provides supportive care, which can generate a vast amount of energy [85]. Moreover, the patient's overall healing hinges on addressing all factors influencing her life. In this context, illnesses are seen as arising from the imbalance of both the mind and body. Comprehensive healing requires consideration of all contextual factors, including the location of the residence [169]. Another fundamental principle of this approach is the unity between practitioner and patient [197]. The healing process is initiated from within, with external factors being addressed subsequently [20]. Care is personalized based on the patient's condition, and practitioners tailor their responses to the unique needs of everyone. For instance, the midwife may recommend a distinct pain management method aligned with the specific labour conditions of the birthing woman [197].

Labour support, rooted in a holistic approach, can potentially generate significant results. The holistic paradigm is appropriate to this current study ‘‘RMC’’ because the holistic approach enhances satisfaction with the birthing experience, increases maternal self-confidence, improves childbirth capabilities, and more successful completion of the birthing process [197]. Contrarily, the technocratic paradigm involves separating the cognitive and physical aspects of human existence, mechanizing the human body, and neglecting the cultural contexts of individuals [86,88].

### 2.5.2 Lack of RMC as a health system issue

The lack of RMC is not only an individual issue but an issue of the health system [269,312]. As reported in the findings from the Heshima project in Kenya, the lack of RMC goes beyond the interaction between women and HCPs; conversely, it is a problem of the health system functionality [269]. Disrespect is beyond bad attitudes of HCPs towards women [269]. Poor quality care in maternity services, like lack of infection control, poor hygiene standards, and resource scarcity, have been linked to disrespectful maternity care [246,151]. The relationship between RMC and the quality of care is evident; for instance, women's privacy can be violated merely when the institution does not have curtains or partitions to provide visual protection from a third party [46,269]. Women are being informed of adverse outcomes without proper



prior psychological preparation because the health institution does not have a sociologist or psychologist [32].

Warren and colleagues reported that RMC can not be addressed at the individual level; it is a matter of the entire health system [269]. Therefore, stakeholders, such as health administrators, political actors, and media, should be involved [269]. To eradicate D&A and implement RMC requires partnerships, alliances, and worldwide coalition efforts. The coalition should foster robust collaboration and advocacy among human rights advocates, civil societies, non-governmental organizations (NGOs), healthcare professionals, leaders, and communities.

## 2.6. Methodological considerations

### 2.6.1 Approaches mostly used in other RMC studies

Appreciative inquiry is a relatively new method, and there have been very few studies on respectful maternity care that have utilized this approach so far. The first RMC study that employed the appreciative inquiry method was published in 2021, and it was conducted on women, families, and healthcare providers [173]. Since that time, additional studies have utilized quantitative, qualitative, and mixed-method approaches to examine RMC [46,48,131,253,239,249]. The non-interventional design has been used in most studies (173,191,193,231). The systematic review, health facility, and community-based cross-sectional studies have been conducted in RMC research areas [40,139,33,145,243]. A limited number of RMC interventional studies have been conducted in some countries [144,91]. Interventions were mostly conducted in Africa [2,151,152,187,231,269]. Some studies used simulated scenarios (such as the PRONTO simulation), which is an innovative, low-tech, realistic simulation team-based training program that is appropriate for resource-limited settings [12,310].

### 2.6.2 The approach used in this current study

#### 2.6.2.1 *Appreciative Inquiry Method*

In this study, the research employed the Appreciative Inquiry (AI) method. The application of AI enhances the power, efficiency, and durability of traditional organizational development interventions [257]. Appreciative Inquiry, often termed a powerful change methodology focusing on positive ideas, operates on individual, team, organizational, and societal levels, fostering a shared vision through strategic innovation [79,132,137]. Participants engage in promoting mutual learning and the identification of a shared future vision. It is a dynamic strategy for leadership coaching, personal development, team practices, organizational



planning, cultural-based solutions, and large-scale initiatives [65,116]. AI differentiates itself from traditional models by emphasizing existing strengths and cultivating a positive approach across various dimensions. [65,116,137,259,248].

The foundational concepts of AI include appreciation, inquiry, and wholeness [132]. Appreciation involves recognizing the best in individuals and the world and leveraging strengths to lay the groundwork for future development. Asking questions facilitates mutual learning and the identification of a shared vision for the future [79,159]. Engaging in an AI process requires a curious mindset and a desire for discovery. The principle of wholeness encourages engagement from all organizational levels and acknowledges that valuable ideas often arise unexpectedly [259,248]. AI also promotes the inclusion of external perspectives, representing a holistic and comprehensive system approach [65,116]. "The Power of Appreciative Inquiry" presents an innovative change strategy that uplifts individuals and enhances organizational performance. According to Cooperrider and colleagues, AI transforms organizations into vibrant, positive environments, fostering creativity and constant innovation. AI is rooted in positive psychology and has been developed and tested over time. [65,116,137].

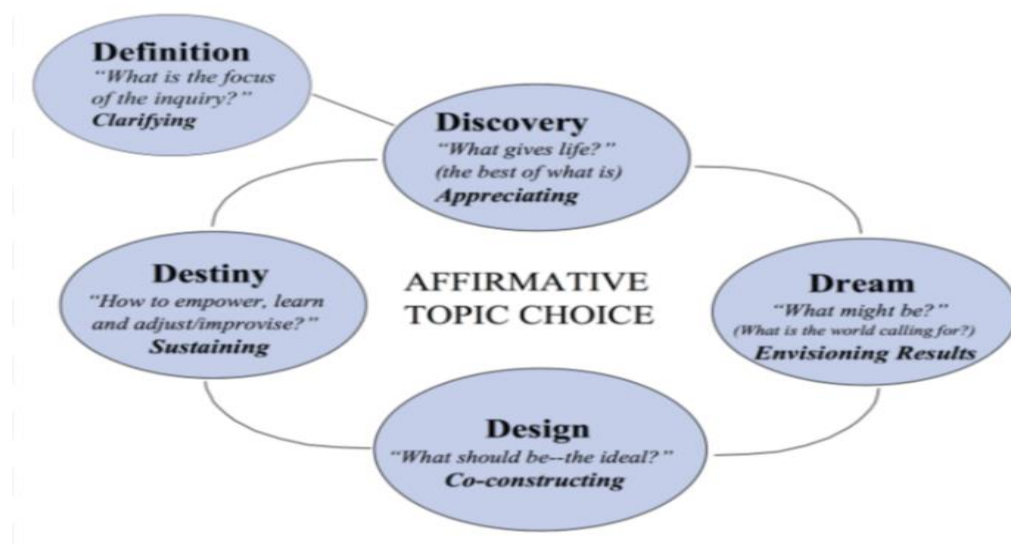


Figure 2.3: 5D-cycle of Appreciative Inquiry

**Source:** Stavros JM, Godwin LN, Cooperrider DL. *Appreciative inquiry: Organization development and the strengths revolution. Practising organization development: Leading transformation and change.* 2015

According to Stavros and colleagues, Appreciative Inquiry embraces a 5D cycle that consists of the **Definition, Discovery, Dream, Design and Destiny phases** [257]. The 5D cycle is the recent version of the 4D cycle that Cooperrider and his colleagues designed in 1995. This 5D cycle allowed the participants to share their best moments of RMC and their future expectations for RMC [65,116,137]. (*See more details in methodology 3.8 Appreciative Inquiry Method*).

#### 2.6.2.2. *Respectful Maternity Care studies using Appreciative Inquiry method*

A study conducted in Tanzania and Malawi utilized AI methods with participants [173]. The study included mothers, HCPs, and family members, who demonstrated an appreciated empathetic interaction between mothers, family members, and HCPs. They also highlighted the importance of a facilitated environment, including cleanliness, adequate infrastructure and equipment, supportive leadership, and positive staff attitudes [173].

#### 2.6.3 Strategies to sustain and promote RMC

Initiatives aimed at facilitating and sustaining RMC have fostered robust partnerships, alliances, and global coalition movements. The researchers recommended that it is essential to establish close collaboration and advocacy efforts involving human rights activists, media, politicians, civil societies, non-governmental organizations (NGOs), healthcare professionals, leaders, and communities [269,152]. Despite these efforts, negative practices persist [32,1].

Despite the significance of RMC, prior research conducted in Rwanda and other locations has predominantly focussed on negative childbirth experiences and the obstacles to providing RMC [156,230,231,191]. As a result, intervention studies have primarily focused on addressing or alleviating these issues rather than sustaining existing positive practices [269,152]. Efforts to tackle maternity mistreatment and abuse have thus primarily been problem-solving in nature. Past experiences with RMC interventions suggest that a single approach is insufficient for reducing mistreatment or enhancing RMC [254]. Therefore, RMC interventions should be tailored to the local context, considering both RMC facilitators and barriers. Recent studies advise against relying solely on provider training methods to promote RMC [254,92]. Instead, they emphasize the importance of involving women in the community and developing interventions that target various aspects beyond healthcare provider training. [254,92]. These interventions can encompass the pre-pregnancy, pregnancy, labour and postpartum periods. Furthermore, there is a call to measure the effectiveness of RMC-promoting interventions using a consensus on global common indicators [254,92].

## 2.7 How the current study filled the existing gap in RMC

Given the current context, it appeared appropriate to conduct this study to offer an evidence-based exploration of strategies by healthcare providers to promote RMC to labouring mothers. This study systematically employed Appreciative Inquiry to address the gap in existing literature, encouraging mothers and healthcare professionals to share their positive experiences. These insights serve as a foundation for advancing and maintaining RMC. Investigating the positive exemplary experiences and practices can identify feasible and culturally appropriate sustainable solutions to facilitate RMC within resource-constrained environments [257,173].

This study highlighted positive aspects and strengths rather than focusing solely on challenges. RMC is indeed a sensitive topic, and using AI to explore it can provide valuable insights within a resource-limited setting like Rwanda. This approach encourages participants to reflect on their best experiences, fostering a more constructive and empowering perspective [285,257]. This current study explored the perspective of mothers and healthcare providers. By exploring mothers' experiences, the mixed method was used to increase the strengths of this research. In addition, HCPs were interviewed twice and asked their views on RMC and what they thought about what mothers had said. AI method emphasized what mothers were happy with or appreciated during labour and childbirth, something they liked during their recent delivery, the best practices of RMC provision they appreciated, and the reason. Mothers were interviewed on their perceptions of best practices and their views on how to construct and sustain RMC best practices.

## 2.8. The summary

This chapter provided the conceptual and critically discussed literature review of studies conducted in Rwanda regarding childbirth experiences. The documentation highlighted the normalization of mistreatment towards women during childbirth, the Iceberg Phenomenon, its implications, and the three paradigms surrounding childbirth. The author discussed how the lack of RMC is a health system issue. Methodological considerations were addressed with a critical discussion of approaches frequently employed in previous RMC studies and the specific approach used in this study. In the following chapter, the author discussed the methodology used in this study.

## Chapter three: Methodology

This chapter provides a detailed and rigorous methodological framework utilized in the PhD research. It aims to justify the study design and overall structure of the PhD and avoids duplication of methods already outlined in published papers and the draft manuscripts. The chapter covers various aspects such as philosophical assumptions, study design and methods, ethical considerations, study procedures, and study phases. It outlines the participants, tools, study setting, sample size calculation for quantitative data, sampling method, data collection methods, the utilization of the Appreciative Inquiry Method, data analysis procedures, including both statistical and qualitative analyses, measures to ensure trustworthiness, mixing procedures, and the steps involved in strategy development and validation. This chapter presents a detailed and comprehensive approach to this PhD thesis research methodology.

### 3.1 Philosophical assumptions underpinning this research

Philosophy encompasses beliefs regarding ontology (the nature of reality), epistemology (what constitutes knowledge and how knowledge claims are justified), axiology (the role of values in research), and methodology (the research process) [78]. Ontology concerns the nature of reality and its characteristics. Methodology is the process of research/ the language of research [78]. In this study, multiple realities are recognized, with the researcher introducing diverse perspectives as themes emerged from the results [78]. Epistemology explores what is considered knowledge, how knowledge claims are verified, and the relationship between the researcher and the research subject [78,124]. In this study, epistemology is a source of knowledge about respectful maternity care, how the researchers understand and interpret the experiences of women receiving maternity care and perceptions of HCPs towards RMC. Epistemologically, the study values subjective insights from participants and aims to reduce the gap between the researcher and the research subjects [78].

The researcher utilized participant quotations as evidence and actively collaborated, participating in fieldwork alongside participants while positioning herself as an "insider." This study relied solely on self-reported responses and quotes from participants. Therefore, the ontological stance of this research was realist and relativist, acknowledging that a discoverable reality exists independently of the researcher yet recognizing that the perception of reality varies among individuals [124,78]. The epistemological assumption for this research is both

positivist and constructivist, acknowledging that knowledge can be objective and subjective at different points [124,78].

The qualitative component of this study adopted the constructivist paradigm, also known as the naturalistic paradigm, as its epistemological stance. Naturalistic inquiry typically unfolds in field or natural settings over an extended period [216,293]. Within the constructivist or naturalistic paradigm, reality is viewed as dynamic and subjective, shaped by the perspectives of individuals involved in the research [216,293]. This paradigm underscores the complexity of human experiences and their influence on reality [216]. In contrast, positivism upholds rigid principles of logic, truth, and predictions. Quantitative researchers believe in a single truth attainable through precise measurement [216]. Objectivity is deemed essential within positivism as it facilitates the discovery of this truth.

In this research, the exploratory design facilitated the researcher in understanding the phenomenon being investigated. Given its descriptive nature, the study described the experiences and perceptions related to RMC among maternity service users and providers. Grove and Burns (2015) state that an exploratory, descriptive design aims to comprehensively portray the phenomenon, capturing the participants' perspectives [124]. The study was conducted in hospitals in the eastern province of Rwanda, where participants shared the same cultural background and spoke the same language (i.e., Kinyarwanda). As per Holloway (2023), the emphasis on context in this study originates from scrutinizing the phenomenon within its immediate environment or setting [130]. As defined by Polit and Beck (2017), purposive sampling entails intentionally selecting participants from particular population groups to augment the study's value [216]. Christensen et al. (2015) elaborate that in purposive sampling, the researcher identifies the traits of the population of interest and chooses individuals who exhibit these characteristics [63].

Axiology concerns the significance of values within research [78]. The researcher acknowledges the inherent presence of values and biases in their role, which has implications for practices [78]. In this study, the researcher openly discussed the values influencing the narrative, incorporating both her own interpretation and that of the participants. The philosophical foundation of this study was pragmatism, a practical philosophy that prioritizes

"what works" through various approaches and values, both subjective and objective knowledge.

Pragmatism in research integrates both quantitative and qualitative methods, prioritizing practicality and real-world relevance [78]. It emphasizes the synergy between these approaches, recognizing that they offer more together than individually. Researchers operating within a pragmatic framework have flexibility in selecting methods that suit their goals and recognize the diversity of research approaches [78]. They perceive reality as what proves effective in a given context, focusing on the "what" and "how" of research to achieve desired outcomes [78].

Pragmatists acknowledge the diverse contextual factors, including social, historical, and political influences, shaping research endeavours [78]. In application, pragmatism advocates utilizing multiple data collection methods to address research inquiries comprehensively. Practical implications are prioritized, focusing on conducting research directly pertinent to the issue at hand [78]. The overarching objective of pragmatism is to identify real-world solutions, recognizing the value of diverse approaches to data collection and analysis across different contexts [78]. Researchers are encouraged to select methods that best align with their specific research questions [78].

This study adopted a convergent parallel mixed-methods approach, which consists of collecting both qualitative and quantitative data simultaneously, analyzing both datasets independently, and then merging the results. This approach allowed the researcher to compare and contrast the findings from both types of data, providing a comprehensive understanding of the research problem. Convergent parallel mixed methods grounded in the philosophical framework of pragmatism [76,185,294]. As Morgan (2014) described, pragmatism is characterized by a philosophical perspective that emphasizes deriving the significance of actions and beliefs from their outcomes. [185]. In conclusion, pragmatism provided a fitting philosophical basis for this research. [185]. The methodological framework of this thesis was shaped by the philosophy of pragmatism, which incorporates mixed-methods approaches [77]. Pragmatism can function as a justification for a formal research design and as a more practical approach to research that centres on the specific problem under investigation and the consequences of the research [77].

In this study, we focused on what works with RMC strategies in the context of Rwanda. As a research paradigm, pragmatism advocates for the utilization of mixed methods, diverse analytical approaches, and a continuous process of abductive reasoning. [2]. The central focus is on the researcher's aim to generate socially valuable knowledge [294]. According to Creswell (2011), pragmatism serves as the primary philosophical perspective underlying convergent parallel mixed-methods research [76]. This is because of its practical orientation, which prioritizes "what works" through diverse approaches and emphasizes the significance of both subjective and objective knowledge [76].

### 3.2 Study design and methods

A research design serves as a blueprint for conducting a study, with its primary purpose being to enhance control over factors that might impede the validity of the study findings [124]. In this study, a mixed-method approach was employed. A mixed-method design is characterized by the inclusion of at least one quantitative method (aimed at gathering numerical data) and one qualitative method (intended for collecting contextual data), with neither method being inherently associated with a specific inquiry paradigm [75]. The rationale for utilizing a mixed-method approach in this study was to understand the research issue (Respectful Maternity Care) and provide additional clarification where needed.

In this study, mixed methods were employed, a methodology increasingly acknowledged as crucial in health research [296,146]. Specifically, the author utilized a convergent parallel mixed-methods approach. The convergent parallel mixed-methods research combines quantitative and qualitative methods in perspectives, data collection, and analysis, emphasizing both approaches equally [296,77]. This methodological approach also embraces a pragmatic standpoint, considering both scientific and interpretive paradigms along with their ontological positions and epistemological assumptions, as outlined by Creswell [76]

### 3.3 Study procedures and the phases of the study

The current research was conducted in four phases using convergent parallel mixed methods to allow the integration of quantitative and qualitative findings (*See Figure 3.1 below for a graphic summary of research activities and methodology*). The fieldwork for data collection spanned from 10 June 2022 to 30 May 2023. The validation process was done over four weeks in October 2023.



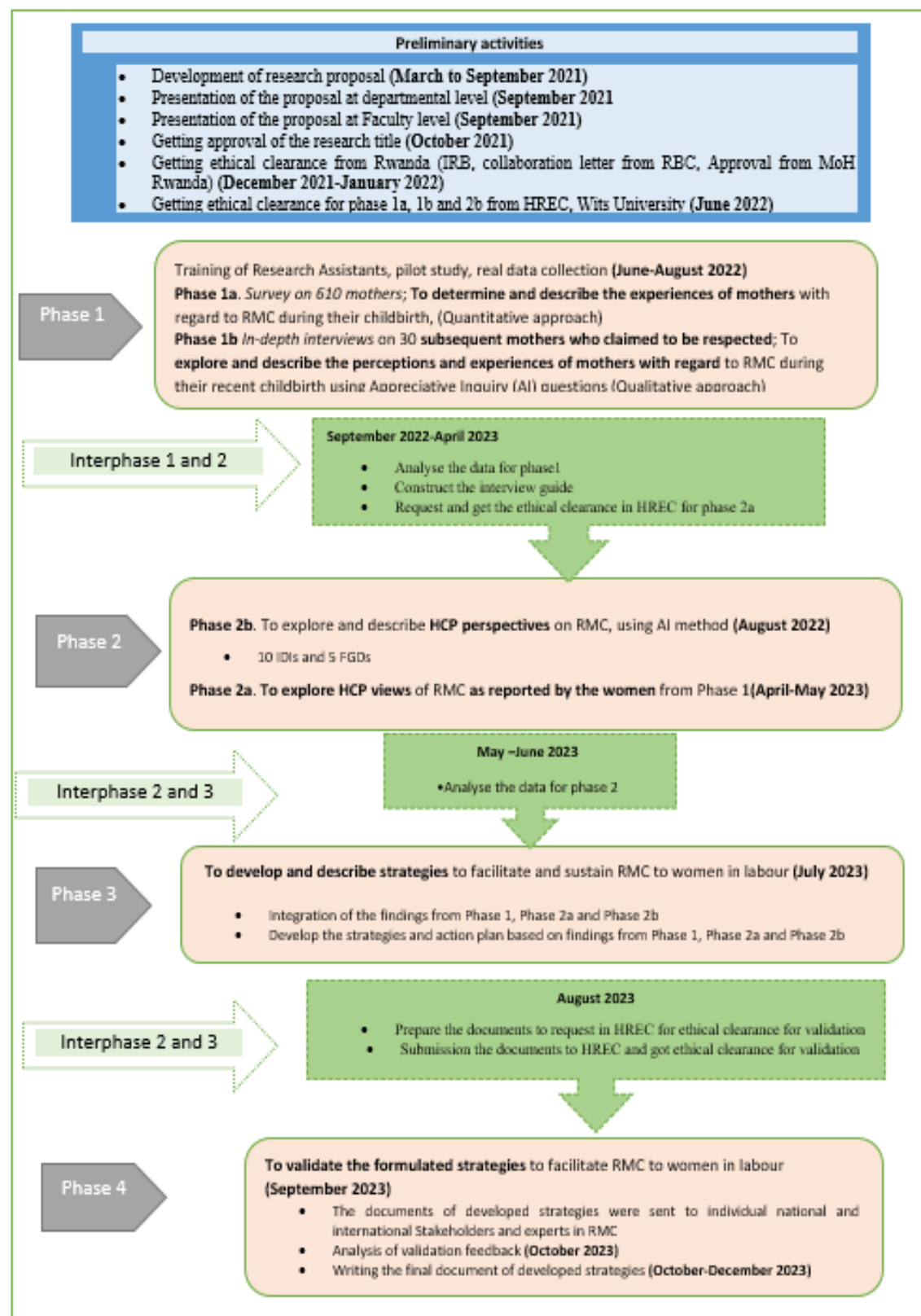


Figure 3.1. Phase of study



### 3.3.1 Phase one: Exploration and description of experiences and perceptions of RMC among mothers

Phase one of the study focused on exploring and describing the experiences and perceptions of RMC among mothers who had recently given birth at hospitals in the Eastern province of Rwanda. The researcher initiated this phase by reaching out to general hospital directors, nursing directors, and research ethics committees at the five selected study sites. Five research assistants underwent training at the outset, followed by a pilot study involving 10% (n=61) of the participants. Those involved in the pilot study were excluded from the final investigation. This phase utilized a concurrent parallel mixed-method design consisting of two sub-phases (1a and 1b). Sub-phase 1a was a quantitative study involving a survey conducted with 610 mothers.

The aim was to assess and delineate the experiences of mothers concerning RMC during their childbirth. This phase employed a cross-sectional study design, utilizing a questionnaire adapted from the universal rights of women and newborns, as revised by the White Ribbon Alliance in 2019 [284]. The questionnaire included inquiries pertaining to the maternity care experiences received at the hospital throughout the entire labour process.

The sub-phase 1b was qualitative, involving in-depth interviews conducted with 30 mothers who reported feeling respected. The aim was to explore and describe the perceptions and experiences of mothers regarding RMC during their recent childbirth, employing the Appreciative Inquiry approach. This phase occurred in June 2022.

### 3.3.2 Phase two: Exploration of perceptions of RMC among healthcare providers

Phase two involved exploring the perceptions of RMC among HCPs, consisting of two sub-phases (2a and 2b). Using the Appreciative Inquiry method, the researcher commenced with sub-phase 2b to examine and describe HCPs' perspectives on RMC. Ten in-depth interviews (IDIs) and five focus group discussions (FGDs) were conducted, involving five maternity unit managers (matrons) and five physicians working in maternity care. Phase 2a aimed to investigate HCPs' views on RMC as reported by women from Phase 1. Upon analyzing the data from Phase 1, the researcher developed an interview guide for Phase 2a, which was submitted to the Human Research Ethics Committee (HREC) at Wits University for approval. Additionally, the researcher sought to renew ethical clearance from the University of Rwanda.

### 3.3.3 Phase three: Development of strategies

Phase three involved developing and describing strategies to facilitate and sustain RMC for women in labour. Following data analysis from phases 1 and 2, the researcher integrated the findings from Phase 1, Phase 2a, and Phase 2b to develop the strategies and action plan. The previous phases resulted in five overarching themes and their corresponding sub-themes aligned with the strategies and action plan. During this stage, each formulated strategy, consisting of an objective and corresponding actions to support RMC, was developed using the strategic formulation process steps.

### 3.3.4 Phase four: Validation of developed strategies

Before the validation phase, the researcher prepared the necessary documents to request ethical clearance from the Health Research Ethics Committee (HREC) for validation. These documents were then submitted to HREC, and ethical clearance for validation was obtained. Additionally, the researcher invited ten national and international experts/stakeholders in RMC to participate in the validation process; we invited 6 national and 4 international people. The documents sent them included an invitation letter, consent form, Personal Information Sheets (PIS), the document of strategies to validate, demographic data, and a self-administered questionnaire. Each participant engaged in the exercise independently over four weeks.

The researcher requested specialists to evaluate individual strategies and action plans using a self-administered questionnaire. Evaluation criteria comprised relevance, feasibility, acceptability, and context. The questionnaire employed a four-point Likert scale, ranging from 1 (lowest grade) to 4 (highest grade) for each item. Furthermore, a designated space for explanatory comments was provided, encouraging participants to offer additional insights and suggestions based on their expertise (n=10). Following the validation feedback, the researcher analyzed the responses and finalized the document outlining the final strategies and detailed, actionable plans proposed during this study and validation process (See **Table 9.4**) that contains final strategies, action plan, and follow-up.

## 3.4 Study participants

The participants included in this study comprised women and healthcare providers. The survey involved 610 women (quantitative) who had recently given birth, either by vaginal birth or caesarean section, at the study sites. The data collection occurred in the hospital when mothers

were discharged and about to exit the hospitals. Additionally, IDIs were conducted with a subset of 30 women from those who reported experiencing respectful care. Interviews and focus group discussions were also conducted with HCPs who had worked in maternity services for at least one year. This involved 10 FGDs with a total of 95 midwives and nurses, 10 IDIs with physicians, and 10 IDIs with maternity unit managers.

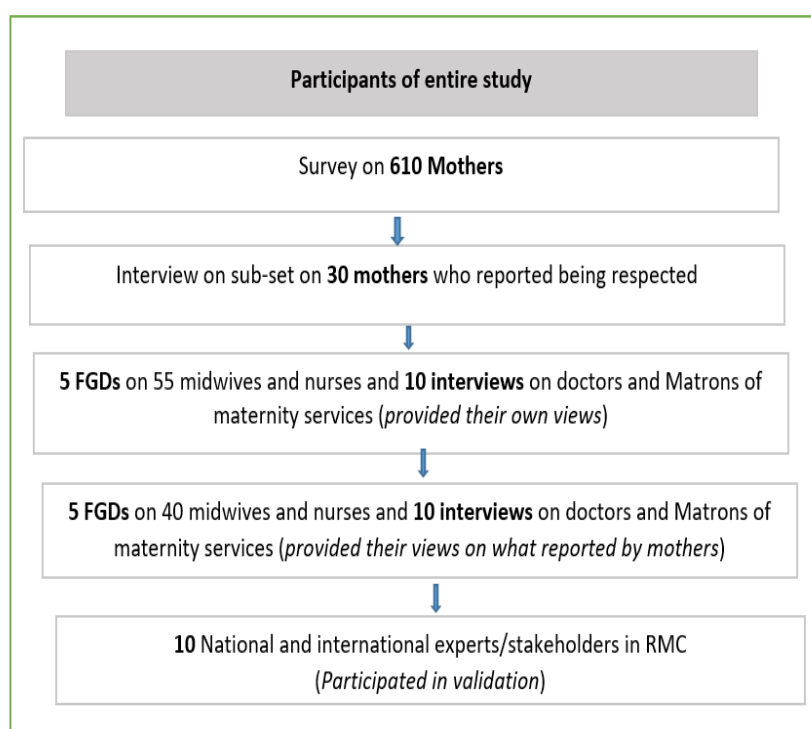


*Figure 3.2 Flow chart description of the participants*

### 3.5 Study tool

The survey tool was adapted from the universal rights of women and newborns, as updated by the White Ribbon Alliance in 2019 (WRA, 2019). These rights were divided into 15 distinct items to ensure clarity. The validity and reliability of the tool was ensured. The validity of a measurement tool in quantitative research refers to how accurately the tool measures what it is intended to measure [124, 215]. This includes construct, content, and face validity [124, 215, 216]. Construct validity relates to the degree to which a test or measure accurately reflects the concept it is supposed to measure [217]. To ensure construct validity in this study, the researcher used an established tool developed by WRA to measure RMC. Content validity examines how comprehensively an instrument covers all relevant aspects of the construct being

measured [124, 215, 216]. It reflects the extent to which a test evaluates all facets of the concept it is designed to measure [216, 217]. In this study, content validity was ensured from the research proposal stage, where the researcher and supervisor defined the key concepts, developed the conceptual framework, and set the quantitative objective. Face validity, which assesses whether a measure appears appropriate and relevant on the surface, was verified by the research supervisor and research assistants [215, 216].

To ensure reliability, a pretest with 10% (n=61) of participants was conducted to assess the internal consistency of the research tool, identifying any ambiguous, unnecessary, or sensitive questions. The reliability test, assessed using Cronbach's alpha, yielded values ranging from 0.65 to 0.74 for each item. The overall test scale for the RMC self-reported questionnaire was 0.72, indicating good and acceptable internal consistency.

The questionnaire was comprised of 11 questions related to socio-demographic and obstetrical characteristics, alongside 15 questions concerning the universal rights of women and newborns in the context of RMC during labour, childbirth, and immediate post-partum obstetrical care. Additionally, the questionnaire included nine open-ended, follow-up questions aimed at respondents who reported having a positive RMC experience. These follow-up inquiries sought to identify the aspects of care that mothers appreciated most (*The complete questionnaire can be found in Appendix A*). The interview guide and focus groups were developed based on the 5D approach of the Appreciative Inquiry method (AI, described below).

### 3.6 Study setting

This study occurred in five public hospitals in the Eastern province of Rwanda. These hospitals manage both normal and complicated births. Employing a simple random sampling technique, the researcher chose five hospitals from ten in the province. The selected hospitals in the province comprised three district hospitals, one provincial hospital, and one referral hospital. The researcher chose this province because it ranked second in birth rate according to the last Demographic and Health Survey [198]

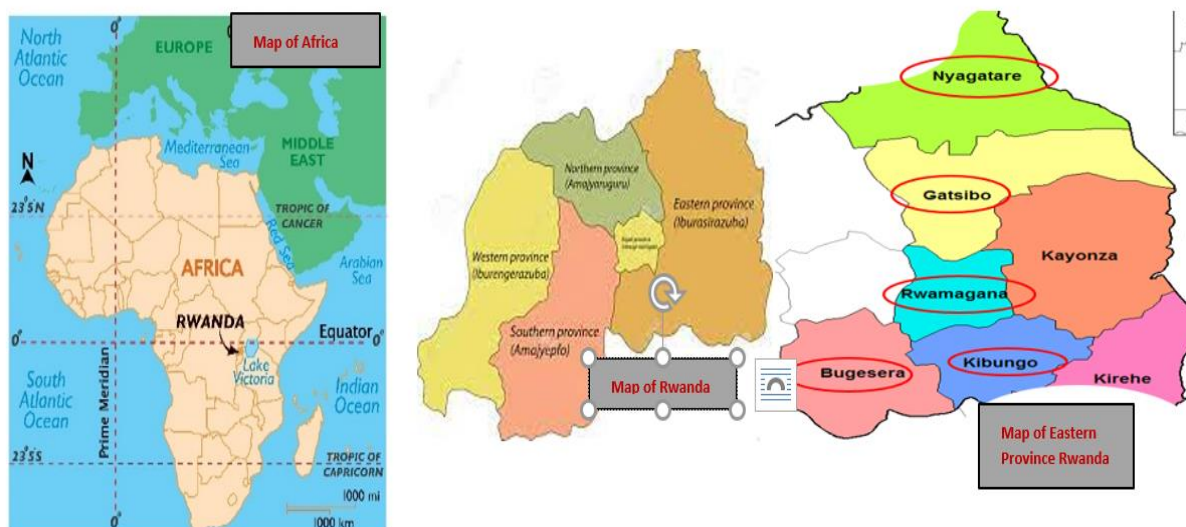


Figure 3.3. Map of Rwanda and study sites

Source: google.com

Rwanda, often called "the land of a thousand hills," is situated in East-central Africa [304]. It spans an area of 26,338 square kilometres and has a population of approximately 14 million [304]. According to data from the National Institute of Statistics of Rwanda (NISR), in 2019, there were 337,004 births annually in the country [198]. The current birth rate is 28.701 births per 1000 people [303]. With a high population density, Rwanda averages around 571 people per square kilometre (1,480 people per square mile) [305], making it one of Africa's most densely populated countries. It shares borders with Burundi to the south, Tanzania to the east, Uganda to the north, and the Democratic Republic of Congo to the west [304]. Rwanda is divided into four provinces plus Kigali city, comprising 30 districts [198]. In Rwanda, there are a total of 55 public hospitals [306]. The Eastern Province is the largest and most populous of Rwanda's provinces. As of the 2022 census, it had a population of 3,563,145 people and covers an area of 9,458 km<sup>2</sup>. The Eastern province, housing ten hospitals [306] across seven districts, was the focus of this research, with five hospitals randomly selected for the study. The districts hosting the study setting hospitals are highlighted in red (*refer to Figure 3.3*). The researcher chose this province because it ranked second in birth rate according to the last Demographic and Health Survey [198], highlighting its significance in Rwanda's maternal healthcare landscape. Additionally, the province has the highest rate of teenage pregnancies, providing a crucial context for examining how respectful maternity care is delivered and perceived.

In the past three decades, Rwanda has been engaged in rebuilding its physical, economic, and social infrastructure following the devastating 1994 Genocide against the Tutsi, which resulted in the loss of over 1 million lives. The genocide had a profound negative impact on the health system, affecting both structural infrastructure and human resources. Many healthcare professionals lost their lives [311]. Since the genocide against the Tutsi, Rwanda has made significant strides in revitalizing the health system, including the expansion of health infrastructure and an increase in the number of qualified healthcare professionals [181].

Rwanda's healthcare system comprises both public and private healthcare sectors. The system features a decentralized public sector complemented by private hospitals and clinics [181,222]. In public health facilities, there are 8 Teaching and National Referral hospitals, which are the highest level of care provided within Rwanda, followed by 4 provincial hospitals, 41 district hospitals, 509 health centers, 1700 health posts and 58,567 community health workers. There are 13 prison clinics, 123 private dispensaries, 149 private clinics, Polyclinic, and 8 private hospitals [137].

In public health facilities, maternity care during labour and delivery begins at health centres, where midwives and nurses handle uncomplicated births [181,222]. In the event of complications, mothers are referred to district hospitals, which cater to normal and complicated deliveries [181]. District hospitals provide services through general practitioners, gynaecologists, midwives, and nurses [181]. Complicated births and significant gynaecological procedures are conducted at provincial and referral hospitals, which serve as the tertiary level of care [222,181]. Notably, the provincial and referral hospitals included in the study do not have associated district hospitals. Mothers either come directly from home or are referred from health centers to access these facilities.

### 3.6.1 Sample size of quantitative data

#### 3.6.1.1 Sampling method

Systematic sampling was employed to select mothers, with every kth case chosen from a list. To establish the sampling interval, the standard distance between the selected elements, the researcher divided the population by the desired sample size [215]. The systematic sampling procedure was as follows: The total estimated population (the total number of mothers who give birth each month at the five hospitals is 1,830) was divided by the sample size of 610.

$$1830:610=3$$

Every 3<sup>rd</sup> woman who was discharged was included in the study.

### ***Inclusion Criteria***

We included mothers admitted to the labour ward at the selected hospitals during the period of study, who were birthed in selected hospitals, and who were ready to be discharged home. We included mothers aged 18 and above, regardless of the birth outcome.

### ***Exclusion Criteria***

The study excluded mothers who were transferred to the hospital (study sites) after giving birth elsewhere.

#### ***3.5.1.2 Sample size calculation***

The author used the estimation of sample size for cross-sectional or descriptive research studies; specifically, this sample size formula is used in case data is on a nominal/ordinal scale and proportion is one of the parameters. Since no clear RMC prevalence was reported in Rwanda, the estimation of RMC prevalence was based on previous extensive research findings regarding the average prevalence of RMC in Kenya and Tanzania [2,151]. Those two studies were the first widest intervention studies conducted on RMC globally. This prevalence was selected because it was derived from a country-wide study in East African countries that first measured RMC prevalence [2,151]. Rwanda is also located in the same region. The reference prevalence of the women who did not experience disrespect and abuse during childbirth was 80%, as reported in a study by Abuya et al. in 2015 [2]. Additionally, the prevalence of women who reported not experiencing any Disrespect and Abuse (D&A) during community follow-up in Tanzania was 30% [151]. The average of the two prevalences was 55%.

Furthermore, a z score of 95% confidence level ( $z_{1-\alpha/2} = 1.96$ ), a relative precision (d) of 5%, a design effect (DE = 1.5), and a non-response rate (10%) were used to calculate the sample size.

$$n = \frac{(z_{1-\alpha/2})^2 (p)(q)}{d^2} \quad [247]$$

$$n = \frac{(1.96)^2 (0.55)(0.45)}{(0.05)^2}$$

$$(n)=380.31$$

**n** = Desired sample size

**$Z_{1-\alpha/2}$**  = Critical value and a standard value for the corresponding level of confidence. At

**95% CI or 5% level of significance (Type-I error)** it is 1.96

**P** = Prevalence based on previous research

**q** = 1-p

**d** = Margin of error or precision

Therefore, based on the formula above, the minimum number required in this study was 380 mothers. The researcher added to this size the 1.5 design effect and a 10% non-response rate; the minimum required sample size becomes  $380 * 1.5 + (380 * 10\%) = 610$ .

### 3.7 Data collection

Data collection was conducted face-to-face. In the first phase, women were recruited at the time of discharge from the hospital. Data collectors asked the women questions and recorded their responses immediately before their discharge from the health facility after childbirth. The Principal Investigator and trained Research Assistants were responsible for data collection. Data collection was delayed until the time of discharge from the hospital to reduce social desirability and recall biases.

Data were collected as early as 12 hours after birth for those who gave birth vaginally and 36 hours for those who gave birth by Caesarean section. The survey took place in a quiet, private unit area with one woman and one data collector. Quantitative data were collected simultaneously with qualitative data, with the mothers in the qualitative phase being a subset of those in the quantitative phase. Mothers who participated in Phase 1b (qualitative) were recruited during the data collection of Phase 1a (quantitative).

In phase 2, data were purposively collected from healthcare providers through face-to-face interviews and focus groups. Participants were provided with an information sheet and signed a consent form before enrolling in the study. In phase 3, the author integrated all findings from phases 1 and 2 and developed strategies to promote RMC in Rwanda. In phase 4, the developed strategies were sent to national and international experts in RMC for validation.

During qualitative data collection, the researcher used the interview guide. As outlined by Babbie [30], probes are often necessary to obtain responses to open-ended questions. The researcher documented field notes promptly after the interviews to capture events and thoughts while they were still fresh in her memory. Aurini, Heath, and Howells (2021) emphasize that maintaining detailed field notes is fundamental for successfully executing a field research



project [25]. Holloway indicates that by recording the interviews, the researcher can preserve the participants' words accurately [130]

### 3.8 Appreciative Inquiry Method

In this study, the research employed Appreciative Inquiry. The application of AI enhances the power, efficiency, and durability of traditional organizational development interventions [257].

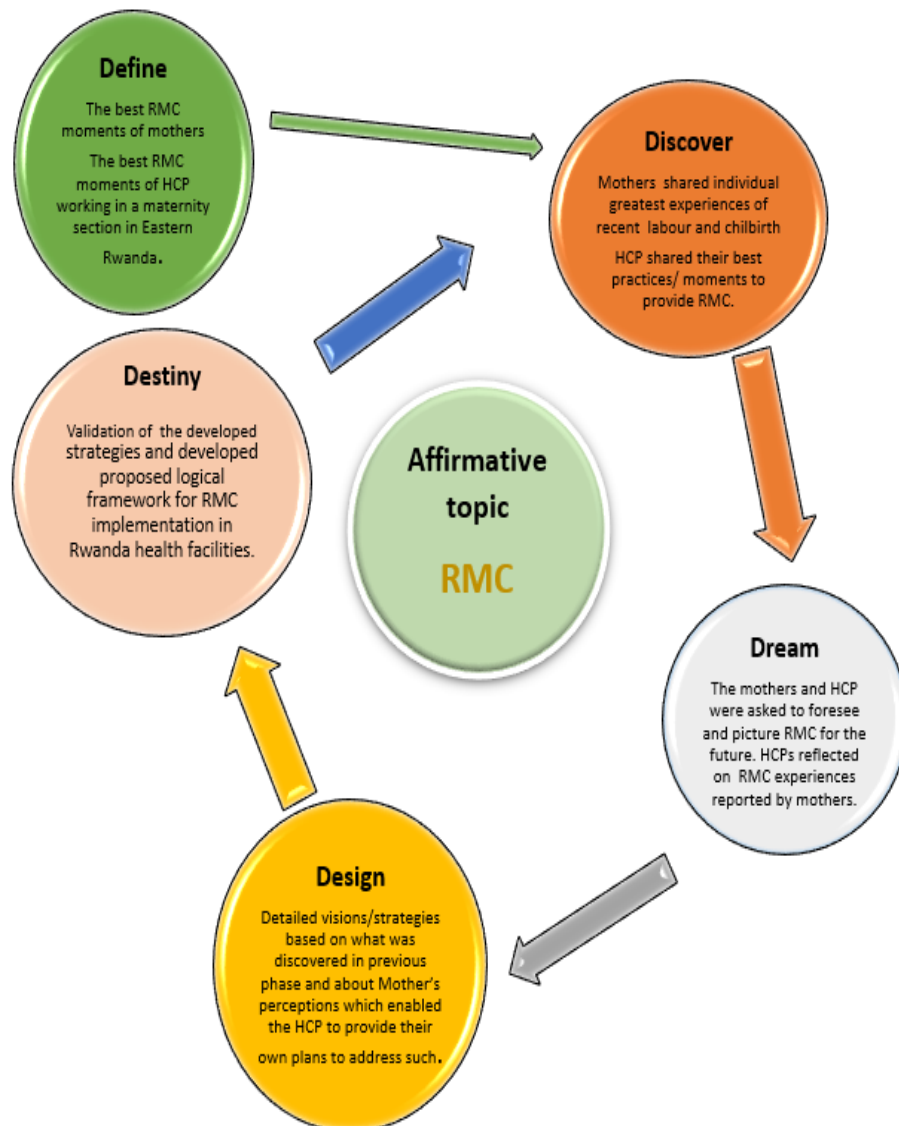


Figure 3.4 5D-cycle of Appreciative Inquiry used in this study

**Source:** Adapted from Stavros JM, Godwin LN, Cooperrider DL. Appreciative inquiry: Organization development and the strengths revolution. Practising organization development: Leading transformation and change. 2015 Oct 19:96-116.

AI embraces a 5D cycle of the **Definition, Discovery, Dream, Design and Destiny phases** [257]. The 5D cycle is the recent version of the 4D cycle that Cooperrider and his colleagues designed in 1995 [257,70,72]. This 5D cycle allowed the participants to share their best moments of RMC and their expectations for RMC. AI significantly shifts sustainable

organization development from traditional deficit-based change to a positive, strengths-based approach [65,116,137]. AI is transforming the field by offering a proven methodology for effectively addressing key change agendas [259,248,81]. It centres on harnessing an organization's 'positive core' strengths to design and redesign systems, fostering a more effective and sustainable future [257,70,72]. AI enables organizations to identify positive core strengths related to the affirmative topic and take concrete steps towards facilitating their goals. AI transcends being merely a 5-D cycle methodology, introducing more profound, meaningful, and sustainable change at the organization's core [257,81,70,72].

**DEFINE:** In this stage, the central inquiry is, “What topic do you want to focus on collectively?”. During this phase, there is often a process of redefining or providing greater clarity to a significant challenge, thereby converting it into opportunities for more in-depth investigation. In addition, the topic should have a positive core in itself [257,81,70,72]. AI emphasizes choosing affirmative topics that genuinely reflect what people want to explore or learn more. In this stage, the study topic is addressed and made more explicit [81,70,72].

Cooperrider and colleagues argue that understanding the positive core is vital in AI interventions. AI emphasizes choosing affirmative topics that genuinely reflect what people want to explore or learn about. These topics focus on the organization's positive moments and envision possibilities for a better future. The affirmative topic choice sets the stage for the 5D Cycle, shaping the inquiry's scope. Initially allowing open-topic choices, AI prioritizes the positive core, which can shape robust growth in human systems. The positive core is integral in all AI phases, underscoring AI's approach of magnifying what gives life to the organization [257,81,70,72]. In the current study, in this phase, the author clarified and defined the chosen topic for focus, ensuring it has a positive core; the research topic was positive: "the best RMC moments of mothers and best practices moments of HCPs working in a maternity section in Eastern Rwanda".

**DISCOVERY:** The Discovery phase emphasizes understanding strengths and potential through appreciative interviews, aiming to uncover the activities associated with success. The discovery phase identifies and appreciates existing positive aspects by exploring what works well. Pose questions centred around "What gives life?" or "the best of what is" to gather positive stories from key stakeholders. During the Discovery phase, the key inquiry posed is, "During your best moments, which endeavours were you actively involved in?" Through storytelling, individuals connect with core values and learn to replicate positive experiences, fostering

personal and organizational growth. Briefly, this phase encompasses conducting interviews between participants, and they share stories concerning their best experiences and moments [257,81,70,72]. AI's unique feature is its positive framing of questions, focusing on peak moments of organizational excellence. Participants deliberately let go of deficit analyses, seeking to isolate and learn from even the most minor wins. Stories of exceptional accomplishments are shared, emphasizing core life-giving factors and valued aspects of the organization's history. A collective appreciation emerges through dialogue, fostering a shared vision and group will. AI creates a supportive context for dialogue, distinguishing itself by maintaining a consistently positive orientation throughout the discovery phase [257,81,70,72].

In this study, women shared their greatest experiences of recent labour and childbirth in the discovery phase, and HCPs shared their best practices/ moments to provide RMC. In this discovery phase, the researcher collected the data from the first, second, and third objectives: to explore and describe mothers' best experiences/moments of RMC during recent childbirth, then to explore and describe HCP's best perspectives, moments and practices on RMC. The discovery phase emphasizes understanding strengths and potential through appreciative interviews, aiming to uncover success-related activities. Women, the unit manager of each maternity service, and the physicians shared their personal stories with the researcher. Then, the midwives and nurses shared their experiences and views with the broader group (Focus group discussion of 10-12 people), which ended up identifying together the vital themes from the stories.

**DREAM:** The Dream phase envisions a positive future, building on qualities discovered in the Discovery phase. It sparks discussions on favourable outcomes with the question, "What will your ideal success look like?". The dream phase envisions the overall vision, results and impacts and fosters innovation by asking questions like "What might be?". This phase involves using the insights from the discovery phase to create a set of aspiration statements, guiding the design of future actions. Participants identify new possibilities for the future. AI grounds future images in the positive past, creating compelling possibilities from extraordinary moments in the organization's history.

The dream phase invites stakeholders to talk and dream about a better organization and world, challenging the status quo to create synergy and excitement. The primary goals are fostering stakeholder dialogue by sharing positive stories and identifying common themes without critique. This phase fosters enthusiasm and collaborative vision, preparing for practical actions

in the Design phase [81,70,72]. AI does not focus on solving problems but emphasizes mutual discovery, guiding participants to envision an organization that embodies their hopes and dreams [257,81,70,72]. AI grounds future images in the positive past. In this study, the Dream phase envisions a positive future, building on qualities discovered in the Discovery phase. Through different varieties of imagining as well as other innovative exercises, the mothers and HCPs were asked to envisage and portray RMC for the future. In this phase, study participants (mothers and HCPs) provided recommendations about sustaining and promoting the best-reported RMC practices.

**DESIGN:** The Design phase emphasises using past successes to formulate action steps towards the vision set in the Dream phase. The design phase generated options for implementation and co-constructed plans by focusing on "What should be the ideal?" This phase aimed to identify concrete actions to support the new possibilities envisioned in the dream phase. This phase involves a two-step approach: brainstorming potential activities aligning with the dream vision and rapid prototyping to visualize these ideas in action. A key question is, "How can we actualize our vision?" After prioritizing brainstormed ideas, the focus shifted to "How will these ideas manifest?" [81,70,72].

Participants collaboratively created and committed to actions that will turn aspiration statements into reality. The design phase articulated the strategic focus, including a vision of sustainability and a compelling statement of strategic intent and how to facilitate it. This phase is crucial for sustaining positive change and realizing the organization's highest potential-grounded examples from the positive past shape future images. Through in-depth dialogues, stakeholders defined the processes to support the new system, ensuring consistency with the inquiry's intended outcome [257,81,70,72].

In this study, the data that emerged from the mothers' interviews was shared with HCPs to investigate their perspectives on the matter. Visions with details grounded on what was discovered among the mother's perceptions enabled the HCPs to provide their own plans to address such. The data from the fourth study objective was collected and analysed. The study objective was to explore HCPs' views of RMC as reported by the women. The maternity unit managers and physicians shared their personal stories with the researcher. Following that, the midwives and nurses shared their experiences and views in a focus group discussion involving 8-12 participants. HCPs reflected on RMC experiences reported by mothers. Then, the researcher integrated all findings from the previous phase and developed the strategies and

action plans. The Design phase emphasizes using past successes to formulate action steps towards the vision set in the Dream phase. In this study, the participants proposed strategies, procedures, and systems. They developed collaborations that, in the end, generated and supported positive change towards RMC amongst them as HCPs. They developed stimulating intentions and designed concrete declarations. Therefore, in this study, the detailed visions/strategies based on what was discovered in the previous phase and about women's perceptions enabled the HCPs to provide their plans to address such.

***DESTINY/DELIVER:*** The Destiny, also named the Delivery phase, focuses on realizing the envisioned outcome using strengths identified in the Discovery phase. It aims to utilize inherent capabilities to achieve the desired future effectively. Evaluations may employ the 5-D technique, with iterative assessments based on system complexity. Collaboration is vital for lasting transformation, fostering appreciative learning and ongoing cycles of success. In this study, the participants narrated both the predictable aspects of the dream phase as well as the inspiring intentions of the design stage. Hence, this phase facilitates reflection and sensitizes the participants towards RMC best practices [73,257,285].

The Destiny phase marks the culmination of discovery, dream, and design, establishing an "appreciative learning culture." It realizes the new future envisioned and fosters a collective sense of purpose. This phase entails continuous learning, adjustment, and improvisation, aligning interactions with shared ideals. Momentum and innovation potential are high. Open-space planning sessions invite stakeholders to discuss contributions to the organizational dream, forming action commitments for ongoing activities. Sustaining momentum involves embedding an "appreciative eye" into all organizational systems. The ongoing destiny phase cyclically returns to discovery, fostering continuous dialogues and learning through systemic appreciative inquiry and potential new affirmative topic choices. In this phase, the author should plan and execute actions guided by the question, "How do you empower, learn, and improvise?" The emphasis is on executing with excellence and facilitating and sustaining positive changes. Participants work together to identify the necessary supports to implement and uphold the changes identified in the design phase, ensuring long-term success [257,81,70,72].

In this study, the researcher invited stakeholders and validated the strategies and action plans developed during this phase. Ultimately, the researcher developed the proposed logical framework for RMC implementation in Rwanda's health facilities. The RMC stakeholders

participated, graded the developed strategies, and provided their inputs. Note that this phase includes both plan and implementation, but this doctoral study was limited to designing and developing the RMC strategies. Therefore, the author did not implement this study's strategies. The researcher plans to undertake it in the future.

### 3.9 Data analysis

#### 3.9.1 Statistical analysis

Data were entered and analyzed using STATA software. The author analyzed data using descriptive and inferential statistics. Socio-demographic data were summarized using descriptive statistics frequencies and percentages. Statistical tests such as Chi-square were used to assess the relationship between categorical independent variables. Bivariate logistic regression and multivariate logistic regression were performed. A  $p\text{-value} < 0.05$  was considered as statistical significance. Adjusted Odds Ratio (AOR) and 95% CI were considered.

#### 3.9.2 Qualitative analysis

In this study, a specialist transcriber transcribed the interviews verbatim in Kinyarwanda. A native speaker of Kinyarwanda translated the transcripts into English, and another translator performed a back-translation. Throughout the transcription and translation process, the author and supervisor meticulously double-checked to verify the accuracy of both the transcription and translation. The author was a native speaker of the Kinyarwanda language and, therefore, understood colloquial nuances. They examined the transcripts and field notes, establishing the codebook based on emerging ideas recorded during the analysis. Polit and Beck (2017) describe data analysis as systematically organizing and synthesizing research data. This study employed thematic analysis [124]. Inductive and deductive analyses were used in this study, allowing themes to emerge from the data without preconceived assumptions or biases. At times, the author also relied on the AI model to analyse the data [77,124].

The data analysis began concurrently with data collection. There was a continuous iterative process between data collection and analysis, with the researcher immersing themselves in the data through repeated listening to audio recordings and reading collected materials to gain a deeper understanding. As emphasized by Christensen in 2015, data analysis should occur in parallel with data collection, focusing on identifying themes, patterns, and meanings [63]. Crucial phrases and statements were extracted from the transcribed data, and a list of meanings was generated through repeated review and reflection on participants' contributions.

Data were analyzed using NVIVO 12. The author and the supervisor of this research independently coded the data. They then compared their coded data to identify any discrepancies or agreements and reached a consensus on the final coding. The double coding process ensured consistent data coding, enhancing the validity of the research findings. Data were presented using themes and supporting quotes.

#### *3.9.2.1 Measures to ensure Trustworthiness*

To ensure the trustworthiness of the findings from this study, the researcher applied the evaluative criteria for rigour in qualitative research analysis. These criteria include credibility, dependability, confirmability and transferability [155]. Korstjens and Moser [116] emphasize that the credibility of a qualitative study hinges on the extent to which the findings align with reality or truth. [150]. The researcher preserved this alignment by maintaining the study's focus on the phenomenon of interest.

Korstjens and Moser [150] emphasize that the credibility of a qualitative study is contingent on the alignment of findings with reality, which helps maintain focus on the phenomenon of interest. Credibility was achieved through purposeful participant selection and open-ended questions in the interview guide, facilitating detailed descriptions of RMC experiences and perceptions. The study employed peer debriefing, member checking for response clarity, and sharing transcripts for accuracy confirmation. Data analysis underwent triangulation to strengthen credibility. Dependability, a qualitative research standard, pertains to the consistency and stability of the research process over time [102,150]. To ensure dependability in this study, the researcher documented decisions made throughout the research process in an audit trail form. The researcher also made efforts to collect data within a specific and relatively short timeframe under consistent conditions and in alignment with the study's purpose.

As highlighted by Korstjens and Moser [150], to achieve confirmability, this study ensured that its findings relied exclusively on participant narratives rather than the researcher's presumptions. An audit trail was employed to establish confirmability, involving the qualitative study's documentation of data collection, analysis, and interpretation processes. Transferability in qualitative research pertains to the relevance of findings in different contexts [102,150]. To enhance transferability, the research team offered an elaborate description of the study's setting, sample, and the phenomenon under investigation. They achieved this through a well-designed interview guide with clear questions, enabling a thorough exploration of the experiences of mothers and healthcare providers regarding RMC in the Eastern province of Rwanda.

### 3.9.3 Mixing procedure

Zhang and Creswell highlight that "mixing" in mixed methods research involves more than just blending quantitative and qualitative data. This study used the "integration" approach as the mixing procedure, involving combining qualitative and quantitative data [296,109]. This approach involves collecting both data types simultaneously (concurrently), analyzing them separately, and then combining the results [296,109]. Integrating qualitative and quantitative methods is increasingly utilized in health services research to facilitate result interpretation and further explore health services issues [296]. In phase 1 of this study, the researcher collected both quantitative and qualitative data on women. These data sets were analyzed separately and then merged. Integrating different methods allows researchers to gain insights that exceed what each method can offer individually. This mixed-method approach is considered pragmatic because it combines quantitative and qualitative data, blending inductive and deductive reasoning through abductive thinking [77]. Abductive analysis is a combination of inductive and deductive approaches. In deductive analysis, researchers often develop a codebook based on a theoretical framework, while in inductive analysis, theories emerge directly from the data.

The researcher employed a convergent parallel/concurrent mixed-methods approach, which entails the simultaneous gathering, analysis, and integration of both quantitative and qualitative data. The main goal of using a concurrent design is to obtain varied complementary data related to the specific objectives of this study and to achieve a comprehensive understanding of the research issue at hand [77]. In this study, researchers gather and evaluate data from two distinct sources, quantitative and qualitative and then merge these datasets to gain a comprehensive understanding [296,109].

### 3.9.4 Strategy development

During phase 3, the researcher developed the strategies, each consisting of an objective and actions regarding the facilitation of RMC using the steps of the strategic formulation process. The author developed the strategies based on mixed phases 1 and 2 findings. The strategy was defined depending on each theme. Strategy formulation is establishing goals and determining the proper plan of action to achieve those goals [129]. Each strategy has aims and actions to achieve the objectives [168].

In this study, strategies are particular actions that guide the facilitation and sustainability of RMC's best practices. The following method was used:



1. Set up the objectives of the strategies
2. Identify the threats, opportunities
3. Choose the strategies
4. Clarify how formulated strategies will be implemented
5. Set up the follow-up mechanism [168,129].

In this phase, the study focused on developing strategies for facilitating RMC based on a strategic formulation process. Strategies consist of specific objectives and corresponding actions. The approach involves the following steps:

*Setting objectives:* Objectives are established using SMART (Specific, Measurable, Achievable, Realistic, Time-bound) criteria to support strategic priorities.

*Identifying threats and opportunities:* Opportunities include political support for maternal and child health, timely access to maternity services through community-based health insurance, well-educated healthcare providers, and established quality improvement processes. Threats encompass traditional herbal practices, confidentiality concerns due to the absence of private rooms, and limitations in accommodating birth companions.

*Choosing strategies:* Strategies are aligned with findings from quantitative and qualitative data. Key areas in RMC requiring strategic attention are patient-provider relationships, the hospital and childbirth environment, continuous professional development, and leadership support.

*Clarify how formulated strategies will be implemented:* Action plans were developed, specifying initiatives, action steps, tasks, responsibilities, and timelines. Resources are allocated based on priorities and needs, and stakeholders are engaged through clear communication. An implementation plan is established, ensuring coordination, collaboration, and effective monitoring.

*Setting up a follow-up mechanism:* Plan the continuous evaluation of the strategy for effectiveness and impact on organizational performance. The plan to progress towards goals and objectives is to be regularly reviewed, and the plan is to be adapted to changing circumstances. Plan to encourage a culture of learning, innovation, and continuous improvement. Plan how the feedback is gathered from stakeholders and employees, key

performance indicators and metrics to be used to monitor and measure progress, and how data-driven insights guide refinements and corrective actions. This phase aims to create and implement strategies to enhance RMC, continuously assess progress, and foster a culture of organizational improvement and learning.

### 3.9.5 Validation Procedure

Phase 4 consists of the validation of the developed strategies. The strategies were sent to individual national and international experts/stakeholders in RMC, and the results were analyzed and compiled for the final strategy document.

Expert review entails seeking guidance from those with extensive expertise, mentorship, teaching, or research experience [105,53,251]. Performing an expert review entails assessing a product, service, or system using the expertise and knowledge of a seasoned professional. *Expert review* is a process that verifies a particular content or product by comparing it to the best practices, standards, and criteria. It also offers significant insights, comments, or recommendations from experienced professionals. This procedure commonly entails consultations, interviews, surveys, or audits and requires meticulous planning and documentation [105,53].

Expert reviews have been utilized to evaluate the content in other studies [133,108]. Expert evaluations involve seeking input from domain experts or specialists and using their knowledge to obtain significant insights into specific elements or aspects from different perspectives and criteria [108]. These reviews evaluate the product's efficacy in meeting user needs, adherence to design principles, compliance with standards, and technical performance.

According to Escobar-Pérez [105], the steps in expert review validation are:

***Determine the aim and goals:*** Provide a clear and concise explanation of the objective of the expert review and specify the particular elements that need to be assessed by the expert. Specify the goals the researcher intends to achieve during the evaluation [105].

***Choose a specialist:*** Find someone with the necessary knowledge and skillset in the specific field. Seek somebody who thoroughly comprehends the subject matter and knows industry best practices [105].

***Give the expert relevant information about the product being reviewed:*** Provide supporting paperwork such as background materials, user manuals, design specifications, or any other

relevant items that can provide a deeper understanding of the context and goals of the review [105].

**Define evaluation criteria:** Specify the criteria or standards the expert will use to evaluate the product. These criteria may include usability, functionality, performance, dependability, accessibility, or other relevant qualities related to the reviewed item [105].

**Perform the evaluation and record the results:** Assign the specialist responsible for conducting a comprehensive assessment of the product or system based on the predetermined criteria. This may entail techniques like product inspections or practical testing. During the review process, it is essential to motivate the expert to write their findings and thoroughly emphasize the positives and drawbacks. They must provide lucid explanations and ideas for enhancing the product, offering specific suggestions or practical measures [105].

**Offer recommendations:** Drawing from the assessment, the expert should propose actionable recommendations to resolve identified deficiencies or concerns. Considering existing limitations and resources, these suggestions should be pragmatic and attainable [105].

Following the expert review, compile a detailed report summarizing the findings and recommendations provided by the expert. Present the information concisely and actionable, ensuring clarity and practicality in the suggestions offered [105].

Note that the researcher did not reach the pre-test.

In the validation process of this study, the researcher engaged the ten experts or/and stakeholders with specialists in RMC drawn from both national and international contexts. The international panel featured faculty members from distinguished institutions like Duke University and the University of Utah. Additionally, the Assistant Director matron from Rahima Moosa mother and child hospital in South Africa, a faculty member and a CARTA graduate from the University of Ile Ife Awolowolo in Nigeria were part of this esteemed group. The national experts encompassed key figures in maternal and child health in Rwanda, including the President of the Rwanda Association of Midwives, the Director of maternal and child health from the Rwandan Ministry of Health, two faculty members from the Midwifery Department at the University of Rwanda, a Director of Nursing from a hospital within the study site, and the community representative.

The researcher provided the experts with a formal request letter, ethical clearances, a Personal Information Sheet (PIS), a socio-demographic data sheet, the strategies to be validated, and an

extensive document outlining the strategies and accompanying guidelines. The validation process was conducted individually over four weeks. The panel of experts assessed each strategy and action plan, considering factors such as relevance, feasibility, acceptability, and context. This assessment was carried out using a self-administered questionnaire with a Likert-type scale featuring four points, ranging from 1 (indicating the lowest grade) to 4 (representing the highest grade) for each item. Additionally, participants were encouraged to provide explanatory remarks, offering insights based on their expertise.

### 3.10 Ethical consideration

All methods were carried out in accordance with relevant guidelines and regulations. The study protocols were approved by the University of Rwanda Institutional Review Board (Approval Notice: No 385/CMHS-IRB/2021, then No 070/CMHS-IRB/2023), the National Health Research Committee (NHRC) of the Ministry of Health (MoH) of Rwanda (Reference: NHRC/2022/PROT/003), and the Human Ethical Research Committee (HREC) from Wits University (Approval Notice: No M220265).

Ethical clearance from the University of Rwanda was obtained twice: the initial clearance was received on December 10, 2021, and it was renewed after one year on January 19, 2023. The ethical clearance from the Health Research Ethics Committee (HREC) was granted in three stages: the author received the first clearance for collecting data for phases 1a&b and phase 2b on June 6, 2021. The second clearance for phase 2a was obtained on April 6, 2023, and the last one, for the final phase involving the validation of developed strategies, was granted on August 22, 2023. Permission was also obtained from the study sites. Informed consent was obtained from all participants involved in the study. None of the participants were minors. Power dynamics were managed by avoiding wearing professional attire, ensuring informed consent, maintaining confidentiality, involving participants as collaborators, and fostering a respectful and inclusive environment during the research process. The researcher and data collectors were from the University of Rwanda and had expertise in the methods. They did not have prior social contact with the participants; the interviewer was working in Kigali while the study was conducted in another province.

### 3.11 Summary

This chapter detailed the methodology used in this study, along with the scientific assumptions. The next is Section B of the dissertation, which serves as the results/findings section, encompassing six chapters (from chapter four to chapter nine). Chapters four to seven consist of published papers or submitted manuscripts in peer-reviewed journals. Chapters eight and nine, which focus on the development and validation process of RMC strategies, are not presented as manuscripts. Each chapter follows a journal article format, covering the background, methods, and findings and concluding with a discussion of the results. The collaborative writing process involved the supervisor as a co-author. In the first manuscripts, three Rwandan co-authors, who secured a SIDA grant and participated in study activities, were also contributors. The acknowledgement in each paper recognized the contributions of all individuals involved.

## SECTION B. RESULTS/FINDINGS

In this section, the author provides an academic overview of the publications and manuscripts from the PhD research aimed at addressing the study objectives. The outcomes section presents the two four manuscripts so far derived from the research: two have been published, and two are under review in peer-reviewed journals. These publications and manuscripts are organized into four chapters, from chapter four to chapter seven. However, the author published another manuscript based on data from chapters eight and nine. In this thesis, however, the data from these chapters are not presented in manuscript form. This research aimed to design effective strategies to facilitate and sustain Respectful Maternity Care in Rwandan health facilities by exploring the experiences, perceptions, and best practices of maternity care among mothers and healthcare providers, using 5 phases of Appreciative Inquiry.

**Muhayimana A**, Kearns I, Darius G, Olive T, Thierry UC. Reported Respectful Maternity Care received during Childbirth at Health Facilities: A Cross-Sectional Survey in Eastern Province, Rwanda. *Midwifery*. 2024 Jun 1; 133:103996. <https://doi.org/10.1016/j.midw.2024.103996> (*Published to Science Direct, Journal of Midwifery, Elsevier*)

This first paper was quantitative and used a cross-sectional survey of 610 women at discharge across five public hospitals, using a 15-item RMC questionnaire developed and updated by the White Ribbon Alliance in 2019. The paper aimed to assess the RMC level experienced by women during childbirth. The findings in paper one highlighted that childbirth by Caesarean section was notably associated with higher RMC. We recommend maintaining high standards of respectful maternity care for all mothers, regardless of delivery mode.

**Muhayimana, A.**, Kearns, I. Healthcare Providers' Perspectives on Sustaining Respectful Maternity Care Appreciated by Mothers in Five Hospitals of Rwanda. *BMC Nurs* 23, 442 2024. <https://doi.org/10.1186/s12912-024-02017-5> (*Published to BMC, Nursing Journal*)

Paper two was qualitative, which explored healthcare providers' perspectives on sustaining RMC actions that mothers previously reported. This study involved 5 focus group discussions (FGDs) with midwives and nurses, alongside interviews with 5 matrons of maternity services and 5 physicians. Four themes emerged from the

findings: women-centred care, professionalism, RMC encounters, and RMC sustenance. The author recommended enhancing women-centred care, promoting professionalism, and building community trust to sustain high RMC standards.

**Alice Muhayimana** Irene Josephine Kearns, Bazirete Oliva, Katie Ward, Jane Blood-Siegfried: Strategies for Facilitating and Sustaining Respectful Maternity Care in Rwanda, An Expert Review. PAMJ Clinical Medicine 2024

This paper reported how the strategies for sustaining RMC in Rwandan health facilities were developed and validated. The study integrated findings from previous phases involving mothers and healthcare providers to formulate five key strategies using an expert review approach. These findings were then validated by ten national and international experts in RMC, who rated them on relevance, feasibility, acceptability, and contextual fit. The top strategies included strengthening women-centred care and community trust, which were prioritized, resulting in a comprehensive action plan to guide RMC implementation.

Minor modifications have been made, such as removing abbreviations, declarations, author affiliations, and numbering of figures and tables, removal of acronyms that have already been introduced and the removal of journal-specific requirements, such as conflict of interest statements. Otherwise, they are presented as published with the permission of co-authors

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## Chapter four: Reported Respectful Maternity Care received during childbirth at health facilities: a cross-sectional survey in Eastern Province, Rwanda

*These are quantitative results from mothers (PHASE 1a) out of Objective 1. To determine and describe the experiences of mothers with regard to RMC during their childbirth in the Eastern province of Rwanda, using a questionnaire (Phase 1a)*

### 4.1 Abstract

**Background:** Respectful maternity care (RMC) fosters positive childbirth experiences and ensures safe motherhood. While past Rwandan studies on childbirth predominantly focused on negative experiences, our research delved into positive experiences. This study aimed to assess the RMC level experienced by women during childbirth in health facilities of the Eastern Province of Rwanda.

**Methodology:** We conducted a cross-sectional survey of 610 mothers at their discharge across five public hospitals. We used a 15-item RMC questionnaire developed by the White Ribbon Alliance, version of 2019. To manage the right-skewed data, we employed a median cut-off, categorizing experiences into binary outcomes (low and high RMC scores). We performed a stepwise backward elimination logistic regression model to identify predictors of high RMC.

**Findings:** The majority (70.2%) reported experiencing RMC. The most acclaimed RMC items (over 90%) included an allowance of food and fluid intake (98.5%), non-discrimination (96.2%), receipt of necessary services (96.1%), and privacy (91.3%). The chi-square analysis showed an association between reported high RMC and marital status ( $p$ -value = 0.006), occupation ( $p$ -value = 0.001), and mode of delivery ( $p$ -value = 0.001). Caesarean section delivery was associated with high RMC in multivariate logistic regression with a  $p$ -value of 0.001; the adjusted odds ratio was 2.11 with a CI [1.40–3.17].

**Conclusion:** The reported RMC items and care that are appreciated at a high level should be sustained. Regardless of the mode of delivery, all mothers should experience consistent care with the utmost respect throughout childbirth and should receive RMC at the maximum level.

**Keywords:** intrapartum, rights, respectful care, quality, positive childbirth.



Adapted from Muhayimana, Alice\*, Irene Josephine Kearns, Darius Gishoma, Olive Tengera, Thierry Claudien Uhawenimana. Reported Respectful Maternity Care received during Childbirth at health facilities: a cross-sectional survey in Eastern Province, Rwanda published in *Science direct, Journal of Midwifery, Elsevier* <https://doi.org/10.1016/j.midw.2024.103996>

## 4.2 Introduction

The World Health Organization (2018) stated that respectful maternity care (RMC) goes beyond preventing maternal morbidity and mortality and highlights that mothers should experience positive childbirth by being treated with full respect and dignity [45,243]. The RMC Charter was first published by the White Ribbon Alliance (WRA) in 2011, and it included seven rights for women of childbearing age. It was updated in 2019 to include the 10 universal rights of women and newborns [284]. These rights were developed based on accepted instruments on human rights, which became a framework for high-quality maternity care that supports the dignity of mothers and newborns in healthcare facilities [284]. RMC improves the quality of maternity services and its use [289,90,100,261], which ultimately leads to achieving the Sustainable Development Goals by diminishing maternal and neonatal mortality and ending violations of women. Respectful actions must be identified in a local context because the way women cope with pain or behave during labour may vary from nation to nation [131,33,12].

In Rwanda, some research has been conducted on disrespectful care experienced by mothers when seeking maternity services. Still, little is known about the extent and context of respectful care experienced by mothers during childbirth, which necessitates more research. Little attention has been given to RMC, which is most appreciated in general [173]. RMC studies conducted in the past in Rwanda looked at the negative experiences of mothers [191,231]. Hence, the current study assessed the status of positive experiences and RMC best practices that mothers appreciated most.

In 2015, Rosen et al. published a study on RMC based on the seven rights of women of childbearing age established by WRA in 2011 and their study used direct observation of labour. It was conducted in five African countries, including Rwanda [231]. This study was conducted in 42 national wide public hospitals in Rwanda and 30 randomly selected health centers despite the seemingly minimal sample size of 193 [231]. They reported a systematic violation of women's rights to be free from harm and ill-treatment, which was characterized by physical abuse. Violations of the right to information, informed consent, and respect for women's

choices and preferences were also observed and manifested through being denied preferred birth positions.

Above 70% of respondents indicated that the provider welcomed them courteously, only 42.6% were encouraged to have a support person, 40.4% were explained procedures upfront, half were briefed on findings, and 42.3% were solicited to ask their questions [231]. The right to be treated with dignity and respect was violated, and women in labour were yelled at and spoken to rudely by HCPs [231]. The observers described an incident where a mother, desiring to give birth in a squatting position during a contraction, was aggressively coerced by doctors [231]. Despite her wishes, they persistently pressured and even hit her, attempting to force her into the conventional birthing position on the bed [231].

Two years later, in 2017, Mukamurigo and colleagues published quantitative and qualitative studies conducted in Rwanda on RMC. These studies were community-based, and the qualitative study complements the quantitative one. The quantitative was cross-sectional household research with a large sample size of 921 women [193,191]. The study investigated associations between perceived care and the childbirth experiences of mothers who delivered between one up to thirteen months prior to the study in Kigali and the Northern province of Rwanda. The findings showed that 3.1% of participants reported having a bad childbirth experience [193]. To understand the meaning of poor childbirth experiences, the authors enrolled mothers who responded that they had a bad childbirth experience in the qualitative study. The mothers revealed that they were abandoned, verbally and physically assaulted, given inadequate information, denied their preferred birth position, and denied male partners as birth companions [191]. To assess the RMC level experienced by women during childbirth in health facilities of the Eastern Province of Rwanda, we assessed the labour experiences reported by mothers from the active phase of labour throughout childbirth and immediate post-partum in health facilities of Eastern Province of Rwanda through RMC tools developed and updated by WRA in 2019. We also invited women to express what aspect of care they appreciated most.

## 4.3 Methods

### 4.3.1 Study design and setting

This study was cross-sectional and used a survey questionnaire. We interviewed 610 mothers across five public hospitals in the Eastern province of Rwanda, where normal or complicated deliveries are handled. We selected five out of 10 hospitals in the province using simple random

sampling. The selected hospitals are three district hospitals, one provincial hospital, and one referral hospital.

#### 4.3.2 Participants, sampling, and data sources

The data were collected in June to August 2022. Five research assistants underwent training to gather data, receiving a comprehensive overview of the research objectives and ethical considerations. The training of the research assistants was harmonized to maximize reliability. Each question was thoroughly discussed and clarified during the training, and the assistants practised with dummy data collection, followed by constructive feedback. The recruitment took place in post-partum wards when the mothers were being discharged from the hospital, and the survey was conducted prior to the exit of hospital premises. Mothers aged 18 years and above who started labour and gave birth via vaginal delivery or Caesarean section were recruited regardless of the birth outcome. Systematic sampling was used to select mothers, and every third woman who was discharged was included in the study.

We conducted the survey on the hospital buildings when mothers were preparing to exit the hospital; we engaged with them in the survey while their family members were making payments and arranging to go home during the discharge process. The earliest time to start data collection from a mother was 12 hours after childbirth by normal delivery and 36 hours after Caesarean section delivery. The participants read the information sheet and signed the consent form before being enrolled in the study. The research assistant facilitated by reading the materials to participants who were unable to read. A structured questionnaire was used to collect the data, and trained research assistants collected the data. The survey was conducted in a discrete private room in the hospital, and the interviewer asked the participants questions and logged the responses.

The survey tool was adopted from the updated ten universal rights of women and newborns developed by the White Ribbon Alliance in 2019 [284]. The rights were divided into 15 items to ensure clarity for each item. The questionnaire was pretested with 10% of the participants to ascertain the internal coherence of the research tool by checking for ambiguous, unnecessary, and sensitive questions. The reliability test Cronbach's alpha for each item ranged between 0.65 and 0.74, and the overall test scale for the RMC self-reported questionnaire was 0.72, which is good and shows acceptable internal consistency. The questionnaire had 11 socio-demographic and obstetrical characteristic questions and 15 questions about the universal rights of women and newborns related to RMC during labour, childbirth, and immediate post-partum

obstetrical care. The questionnaire also included nine open-ended follow-up questions to those who responded *yes* to RMC's positive experience. The follow-up questions were about the aspect of care mothers most appreciated. One of the questions posed was: What showed you exactly that your confidentiality was respected? (State the one you mostly appreciated).

#### 4.3.3 Sampling and sample size calculation

Systematic sampling was used to select the participants. The total estimated number of mothers who delivered at the five hospitals was 1,830 during the study period, which was divided by the sample size [217]. Every third woman being discharged was included in the study. Mothers who were admitted into the labour ward, delivered in the same hospital, and were ready to be discharged were recruited.

The author used the Estimation of Sample Size for Cross-sectional or Descriptive Research Studies; specifically, this sample size formula is used in case data is on a nominal/ordinal scale and proportion is one of the parameters. Since no clear RMC prevalence was reported in Rwanda, the estimation of RMC prevalence was based on previous research findings regarding the average prevalence of RMC in Kenya and Tanzania. The reference prevalence of the women who did not experience disrespect and abuse during childbirth was 80%, as reported in a study by Abuya and colleagues in 2015 [2]. This prevalence was selected because it was derived from a country-wide study in East Africa that measured RMC prevalence, as indicated by Warren in 2017. Additionally, the prevalence of women who reported not experiencing any type of Disrespect and Abuse (D&A) during community follow-up in Tanzania was 30% [151]. Furthermore, the researcher used a z score of 95% confidence level ( $z_{1-\alpha/2} = 1.96$ ), a relative precision (d) of 5%, a design effect (DE = 1.5) and a non-response rate (10%) to calculate the sample size.

$$n = \frac{(z_{1-\alpha/2})^2 (p)(q)}{d^2} \quad [247]$$

$$n = \frac{(1.96)^2 (0.55)(0.45)}{(0.05)^2}$$

$$(n)=380.31$$

n = Desired sample size

$Z_{1-\alpha/2}$  = Critical value and a standard value for the corresponding level of confidence. At 95% CI or 5% level of significance (Type-I error), it is 1.96

P = Prevalence based on previous research

q = 1-p

d = Margin of error or precision

Therefore, based on the formula above, the minimum number required in this study is 380 mothers. We added the 1.5 design effect and a 10% non-response rate to this size, so the minimum required sample size becomes  $380 * 1.5 + (380 * 10\%) = 610$ .

#### 4.3.4 Outcome variable

The outcome variable was a self-reported RMC score measured using the universal rights of women and newborns developed and updated by the WRA in 2019 [284]. It has a maximum score of 15 RMC items with nine follow-up questions about most appreciated care. Each reported item was based on binary responses and was scored 1 for *yes* and 0 for *no*. We did the score summation of the self-reported 15 RMC items. The total RMC score was the sum of responses to the 15 RMC questions, and the total score ranged from 0 to 15, with low scores indicating disrespectful maternity care or some positive experience (low RMC) and high scores indicating a high level of RMC and a positive experience (high RMC).

The mean score was calculated and converted to percentage scores, but we used the median as our cut-off in the current study because the data were not normally distributed and were skewed to the right. This method was previously used in studies conducted respectively in Iran and Nigeria [125,103]. In the literature, there is no clear consensus on the cut-off to define which women received RMC and which did not [103]. In this study, by using a median as our cut-off point, we specified a binary outcome and low RMC and high RMC as categorical variables. We analysed the data from the follow-up questions using frequency and percentages.

The RMC scale was validated in Kenya in a study by Abuya et al. (2015), but it contained only ten items [2]. The scale had not previously been validated in Rwanda. In the current study, the full RMC scale with 15 items was shown to have a good internal consistency of 0.72. The reliability test Cronbach's alpha was measured for each item and was shown to have acceptable internal consistency that ranged between 0.65–0.74 (free from physical abuse = 0.69; orientation = 0.710; consent = 0.73; newborn care = 0.74; choice and preferences = 0.68; birth

companion = 0.72; privacy = 0.71; confidentiality = 0.68; dignity = 0.66; free from discrimination = 0.70; expected health care = 0.65; timely attended = 0.66; needed care = 0.72; allowed eating = 0.73; informed on breastfeeding = 0.73).

#### 4.3.5 Explanatory variables and covariates

Explanatory variables were the mother's socio-demographic and obstetric history data. There were 11 variables: marital status, age, education, religion, occupation, gravida, time of day the mother gave birth, previous living children, gestational age, condition of the baby at delivery, and mode of delivery. We categorized these variables where necessary and summarized them by frequencies and percentages. Among obstetrical history, gestational age was classified into three categories, namely term, preterm, and post-term; marital status was defined as married, cohabitation, and single; mode of delivery was dichotomous (normal delivery and Caesarean section); education level was defined as no formal education, primary education, and secondary and tertiary education; time of day that mother delivered was also dichotomous (night and day); and the condition of the baby at delivery was defined as baby is well/healthy, baby had birth asphyxia, baby was stillbirth, and baby has died.

#### 4.3.6 Statistical methods

Data was entered into Redcap software, and then the data were cleaned and imported into STATA software version 16 for cleaning and analysis. Descriptive and inferential statistics were used.

We evaluated the association between explanatory variables and the reported RMC score in chi-square analysis and performed binary logistic regression. Multicollinearity with pairwise correlation was done to check the correlation between the explanatory variables, and three demographic variables, namely age, gravida, and living children, were highly correlated. Gravida and living children were excluded because they had a variance inflation factor of 6.71. Age had a variance inflation factor of 2.17 and was thus retained for the multivariate logistic regression. After eliminating two highly correlated variables (gravida and living children), we created a multivariate logistic regression model that included all factors, except the correlated variables, to discover the factors associated with the reported RMC score. We used the stepwise backward elimination logistic regression model with the reported RMC score as a binary outcome variable to find predictors of high RMC. We reported the crude and adjusted odds ratios at 95% confidence intervals, and p-values of less than 0.05 were considered significant.

#### 4.4 Results

In total, 610 mothers were interviewed across five hospitals, with 122 mothers being interviewed at each facility. The majority had term babies (87.5%), were Christian (96.4%), had given birth during the night (54.7%), and gave birth to healthy babies (90.4%). The majority of participants were aged between 21 and 30 (53.8%), with a mean age of 27.7. Half of the participants were cohabitating with their partners (50%), and slightly more than half were farming (59.2%). It was 35.9% of the participants' first pregnancy, 48.4% only had primary education, 61.3% birthed vaginally, and 37.8% delivered via Caesarean section. The socio-demographic and obstetrics profiles are further detailed in *Table 4.1*.

#### 4.4.1 Socio-demographic and obstetric characteristics

*Table 4.1 Description of socio-demographic and obstetric characteristics (n = 610)*

| <b>Variables</b>                    | <b>Frequency</b> | <b>Percentage</b> |
|-------------------------------------|------------------|-------------------|
| <b>Gestational age</b>              |                  |                   |
| Term                                | 534              | 87.5              |
| Preterm                             | 32               | 5.3               |
| Post-term                           | 44               | 7.2               |
| <b>Religion</b>                     |                  |                   |
| Christian                           | 588              | 96.4              |
| Muslim                              | 22               | 3.6               |
| <b>Time of the day giving birth</b> |                  |                   |
| During the night                    | 334              | 54.7              |
| During the day                      | 276              | 45.2              |
| <b>Condition of the baby</b>        |                  |                   |
| Baby was healthy                    | 554              | 90.8              |
| Baby had birth asphyxia             | 36               | 5.9               |
| Baby died                           | 20               | 3.3               |
| <b>Age of the mother</b>            |                  |                   |
| 18–20                               | 87               | 14.3              |
| 21–35                               | 446              | 73.1              |
| 36–44                               | 77               | 12.6              |
| <b>Marital status</b>               |                  |                   |
| Married by common law               | 190              | 31.1              |
| Cohabitation                        | 305              | 50                |
| Single mother                       | 115              | 18.9              |
| <b>Occupation of the mother</b>     |                  |                   |
| Homemaker                           | 78               | 12.8              |
| Farming                             | 361              | 59.2              |
| Small business                      | 123              | 20.2              |
| Employee                            | 48               | 7.9               |
| <b>Gravida</b>                      |                  |                   |
| Gravida 1                           | 219              | 35.9              |
| Gravida 2                           | 140              | 22.9              |
| Gravida 3                           | 122              | 20                |
| Gravida 4 and more                  | 129              | 21                |
| <b>Living children</b>              |                  |                   |
| None                                | 248              | 40.7              |
| One child                           | 159              | 26.1              |
| Two children                        | 104              | 17.1              |
| Three children or more              | 99               | 16.3              |
| <b>Education level</b>              |                  |                   |
| No formal education                 | 70               | 11.5              |
| Primary                             | 295              | 48.4              |
| Secondary or tertiary               | 245              | 40.2              |
| <b>Mode of delivery</b>             |                  |                   |
| Vaginal delivery                    | 374              | 61.3              |
| Caesarean section                   | 236              | 38.7              |



#### 4.4.2 Self-reported RMC items

Among the 610 mothers who were interviewed, most received care free from harm and ill-treatment (84.4%) and were provided explanations and orientation (88.4%). The majority reported being given informed consent for their own care (70.6%), experienced respect for their choices and preferences (86.2%), respect for privacy (91.3%), and confidentiality (89.3%). The participants stated that they were treated with dignity (87%), their treatment was free from discrimination (96.2%), they received the healthcare anticipated (82.8%), and they were attended to on time (83%). The highest number (98.5%) reported that they were allowed to take food and fluids during labour and immediately post-partum, and (96.1%) received the needed services. The three RMC indicators that received the lowest percentage were the presence of a birth companion (49.2%), information on newborn care (43.9%) and information on breastfeeding (39.4%). Mothers who reported experiencing all 15 RMC items were only 36 (5.9%). (Figure 4.1).

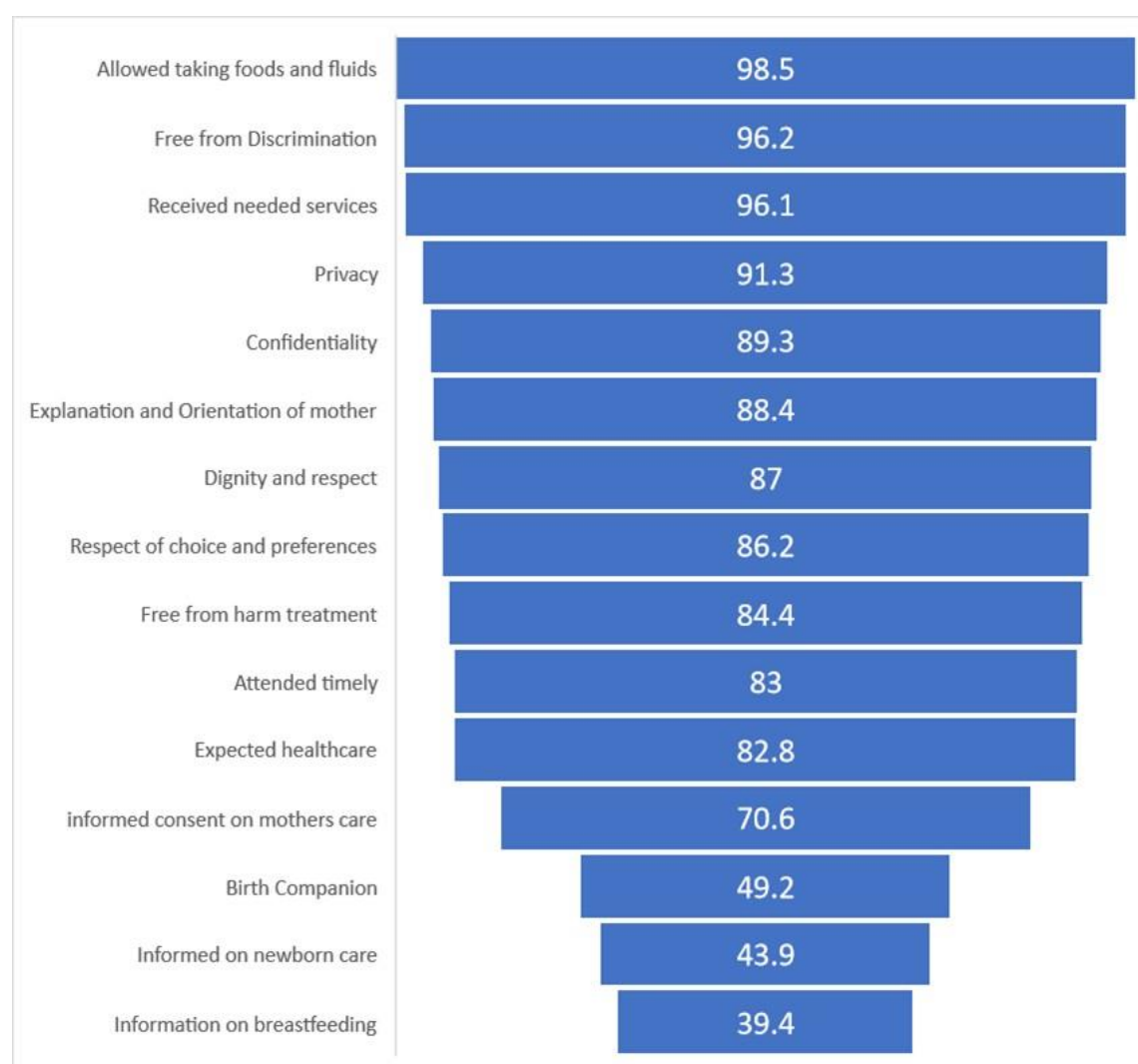


Figure 4.1. Self-reported RMC items (n = 610)

Table 4.2 Care most appreciated by participants (n = 515)

A total of 515 participants responded yes to all/at least one RMC item. The participants were inquired about the kind of care they appreciated most. For instance, we posed the question: “During labour, how have you been treated when experiencing pain or discomfort (State the one you mostly appreciated)? The majority reported appreciating painkillers and anaesthesia given to them (37.3%) and being informed about general examinations and their findings (28.6%). On the question, “What action/procedure was done with your verbal or written permission that you most appreciated?” The participants responded that abdominal palpation and vaginal examination (47.1%) were the procedures most frequently performed with verbal consent and appreciated.

Concerning the choice or preference granted to the participants, the most appreciated was being allowed to take the foods they wanted (36.1%). The privacy the participants most appreciated was being covered during vaginal examinations (98.6%). The dignity and respect that the participants most appreciated was not being humiliated and verbally abused but being spoken to respectfully (76.5%). The highest level of health care that the participants most appreciated was newborns receiving care when needed (55.7%). Equitable healthcare that the mothers most appreciated was receiving fair healthcare like others (97.4%). Table 2 depicts the types of care most appreciated by the participants. These responses were received during the follow-up questions asked only to mothers who responded yes to RMC questions to capture the type of care they most appreciated. There were nine follow-up questions in total (Table 4.2).

| <b>The most appreciated treatment when experiencing pain or discomfort</b> | <b>Frequency</b> | <b>Percentage</b> |
|----------------------------------------------------------------------------|------------------|-------------------|
| Given painkillers/anaesthesia                                              | 192              | 37.3              |
| Just labour went well, no special thing                                    | 124              | 24.1              |
| Psychological support                                                      | 98               | 19.1              |
| Repaired episiotomy/tear with anaesthesia                                  | 97               | 18.8              |
| Back massage                                                               | 4                | 0.8               |
| <b>Information explained to the mother that was most appreciated.</b>      |                  |                   |
| General examination and findings                                           | 154              | 28.6              |
| Orientation on ward environment                                            | 142              | 26.4              |
| Vaginal examination and findings                                           | 102              | 18.9              |
| Meal time/told what to eat and not to eat                                  | 78               | 14.5              |
| Reason for caesarean section                                               | 32               | 5.9               |
| Explained the care given and how to behave during labour                   | 17               | 3.2               |
| Progress of labour                                                         | 7                | 1.3               |
| The sex of the baby                                                        | 5                | 0.9               |

|                                                                                              |     |      |
|----------------------------------------------------------------------------------------------|-----|------|
| When to breastfeed/feed the baby                                                             | 2   | 0.4  |
| <b>Action/procedure most appreciated done with the mother's verbal or written permission</b> |     |      |
| Abdominal palpation and vaginal exam                                                         | 203 | 47.1 |
| Caesarian section                                                                            | 142 | 32.9 |
| Vaginal examination                                                                          | 58  | 13.5 |
| Cutting episiotomy                                                                           | 10  | 2.4  |
| Augmentation of labour and induction of labour                                               | 8   | 1.9  |
| Tubal ligation                                                                               | 8   | 1.9  |
| Hysterectomy                                                                                 | 2   | 0.5  |
| <b>Choice or preference granted to the mother that was most appreciated</b>                  |     |      |
| Allowed to take foods of choice                                                              | 190 | 36.1 |
| Allowed to take the preferred birth position                                                 | 131 | 24.9 |
| Allowed to pray                                                                              | 118 | 22.5 |
| Allowed to take a soft drink                                                                 | 31  | 5.9  |
| Placed in a calm environment                                                                 | 31  | 5.9  |
| Allowed visitors                                                                             | 19  | 3.6  |
| Allowed to listen to music                                                                   | 4   | 0.8  |
| Allowed to wear clothes of choice                                                            | 2   | 0.4  |
| <b>Privacy that the mother most appreciated</b>                                              |     |      |
| Covered during vaginal examination                                                           | 549 | 98.6 |
| There were screens/room walls blocking the views                                             | 8   | 1.4  |
| <b>Confidentiality that the mother most appreciated</b>                                      |     |      |
| My health conditions were not communicated/shown to other clients                            | 531 | 97.4 |
| Other health information was discussed with only the health staff                            | 8   | 1.5  |
| Other health information was discussed when other clients were not listening                 | 6   | 1.1  |
| <b>Dignity and respect that mother most appreciated</b>                                      |     |      |
| Not humiliated                                                                               | 371 | 69.9 |
| Cared with birth compassion                                                                  | 70  | 13.2 |
| Touched in a dignified or respectful manner                                                  | 37  | 6.9  |
| Not verbally abused/Was spoken in a respectful manner                                        | 35  | 6.6  |
| The newborn was touched in a dignified manner                                                | 11  | 2.1  |
| Service was somehow good                                                                     | 4   | 0.7  |
| The newborn was cared for with compassion                                                    | 2   | 0.4  |
| Called by my proper name                                                                     | 1   | 0.2  |
| <b>Equitable healthcare that mothers most appreciated</b>                                    |     |      |
| Received equitable care like others                                                          | 572 | 97.4 |
| Had freedom to make decisions about all care /what happens to my body                        | 8   | 1.4  |
| My newborn was free from discrimination                                                      | 7   | 1.2  |
| <b>The highest level of health care that the mother most appreciated</b>                     |     |      |
| My newborn was attended by a health care provider while needed care                          | 281 | 55.7 |
| I was provided care in a timely manner                                                       | 206 | 40.8 |
| I was provided care in a clean and safe environment                                          | 12  | 2.4  |
| I was attended by a skilled healthcare provider                                              | 6   | 1.2  |

After summing those who responded yes on the 15 RMC items (each reported yes item was scored 1), the mean was 11.8 with a standard deviation of  $\pm 2.4$ , and we converted the mean score to percentage scores (78.9%). We decided to use the median as our cut-off because the data were not normally distributed and were skewed to the right. In addition, there is no clear

consensus in the literature on the cut-off to define the threshold at which women receive RMC. We found a RMC median that was 12 or 80%. Among the 15 RMC items evaluated, 95 (29.8%) mothers reported being provided with 11 of the 15 items (low RMC) and 515 (70.2%) mothers reported experiencing at least 12 and up to 15 (high RMC), with ranges varying from 20 to 100. All mothers experienced at least three RMC items and, at most, 15 RMC items. Using the median as our cut-off point, we specified a binary outcome, namely low RMC and high RMC, as categorical variables.

All explanatory variables and outcome variables of the current study were categorical. We used chi-square, binary, and multivariate logistic regressions in our statistical analysis. Statistically significant scores associated with reported RMC were found for marital status (p-value = 0.006), occupation of the mother (p-value = 0.001), and mode of delivery (p-value = 0.001). In addition, among mothers who received high RMC scores, the majority cohabited with their partners (75.5%), were aged between 36 and 40 (76%), attended only primary school (74.5%), and were primigravida (73.5%). Table 3 displays the outcome of interest in categorical variables (reported RMC score) (low RMC and high RMC). It presents the chi-square results from the association between explanatory variables and the outcome variable of the RMC score.

#### 4.4.4. Chi-Square analysis

*Table 4.3 Chi-Square analysis of categorical variables (n = 610)*

| <b>Table 4.3</b> Chi-Square analysis of categorical variables (n = 610) |                      |                       |                |
|-------------------------------------------------------------------------|----------------------|-----------------------|----------------|
| <b>Characteristics</b>                                                  | <b>Low RMC n (%)</b> | <b>High RMC n (%)</b> | <b>P-value</b> |
| <b>Level of education</b>                                               |                      |                       | 0.644          |
| No formal education                                                     | 18 (26)              | 52(74)                |                |
| Primary                                                                 | 78(29.5)             | 208(74.5)             |                |
| Secondary and tertiary                                                  | 77(31.5)             | 168(68.5)             |                |
| <b>Religion</b>                                                         |                      |                       | 0.789          |
| Christian                                                               | 176(30)              | 412 (70.1)            |                |
| Muslim                                                                  | 6(27.5)              | 16 (73%)              |                |
| <b>Gestational age</b>                                                  |                      |                       | 0.741          |
| Term                                                                    | 162(30.5)            | 372 (69.5)            |                |
| Preterm                                                                 | 9 (28.5)             | 23 (72)               |                |
| Post-term                                                               | 11(25)               | 33 (75)               |                |
| <b>Time of delivery</b>                                                 |                      |                       | 0.676          |
| During night                                                            | 102(30.5)            | 232 (69.5)            |                |
| During day                                                              | 80 (29)              | 196 (71)              |                |
| <b>Condition of the baby</b>                                            |                      |                       | 0.204          |
| Baby was in good condition                                              | 161(29)              | 393(71)               |                |

|                                 |          |           |       |
|---------------------------------|----------|-----------|-------|
| Baby had birth asphyxia         | 14 (39)  | 22 (61)   |       |
| Stillbirth                      | 5(38.5)  | 8 (61.5)  |       |
| Baby was dead immediately       | 2 (66.5) | 1 (33.5)  |       |
| Baby died later after birth     | 0 (0)    | 4 (100)   |       |
| <b>Age of the mother</b>        |          |           | 0.766 |
| 18–20                           | 25(29)   | 62(71)    |       |
| 21–25                           | 50(28.5) | 125(71.5) |       |
| 26–30                           | 52(34)   | 101(66)   |       |
| 31–35                           | 36(30.5) | 82(69.5)  |       |
| 36–40                           | 15(24)   | 48(76)    |       |
| 41–44                           | 4(28.5)  | 10(71.5)  |       |
| <b>Marital status</b>           |          |           | 0.006 |
| Married by common law           | 61(32)   | 129(68)   |       |
| Cohabiting                      | 75(24.5) | 230(75.5) |       |
| Single mothers                  | 46(40)   | 69(60)    |       |
| <b>Occupation of mother</b>     |          |           | 0.001 |
| Homemaker                       | 9(29)    | 22(71)    |       |
| Farming                         | 94(26)   | 267(74)   |       |
| Small sales                     | 36(45.5) | 43(54.5)  |       |
| Employed                        | 9(19)    | 39(81)    |       |
| Not employed                    | 14(30)   | 33(70)    |       |
| Survives on chores              | 20(45.5) | 24(54.5)  |       |
| <b>Gravida</b>                  |          |           | 0.681 |
| Gravida 1                       | 58(26.5) | 161(73.5) |       |
| Gravida 2                       | 44(31.5) | 96(68.5)  |       |
| Gravida 3                       | 39(32)   | 83(68)    |       |
| Gravida 4                       | 17(29)   | 42(71)    |       |
| Gravida 5 and more              | 24(34)   | 46(66)    |       |
| <b>Previous living children</b> |          |           | 0.420 |
| No child                        | 70(28)   | 178(72)   |       |
| One child                       | 46(29)   | 113(71)   |       |
| Two children                    | 36(34.5) | 68(65.5)  |       |
| Three children                  | 26(34)   | 50(66)    |       |
| Four children and more          | 4(17.5)  | 19(82.5)  |       |
| <b>Mode of delivery</b>         |          |           | 0.001 |
| Vaginal delivery                | 130(35)  | 244(65)   |       |
| Caesarean section               | 52(22)   | 184(78)   |       |

#### 4.4.5 Logistic regression

In our binary model, the mode of delivery was associated with a high RMC score. Caesarean section delivery was associated with a high RMC score with a p-value of 0.001 and a crude odds ratio of 1.88 with a confidence interval of [1.29–2.74]. In our multivariate model, the mode of delivery (Caesarean section) was associated with a high RMC score with a p-value of 0.001 and an adjusted odds ratio of 2.11 with a confidence interval of [1.40–3.17]. Table 4 displays the bivariate and multivariate logistic regression results that examined the association between the explanatory variables and the reported high RMC score.

Table 4.4: Logistic regression

|                          | n = 610            | RMC percentage n (%) |            | Crude OR [CI 95%] | p-value | Adjusted OR [CI 95%] | p-value |
|--------------------------|--------------------|----------------------|------------|-------------------|---------|----------------------|---------|
| Variable                 | Category           | Low RMC %            | High RMC % |                   |         |                      |         |
| Gestational age          | Term               | 162(30.5)            | 372(69.5)  | 1                 |         | 1                    |         |
|                          | Preterm            | 9(28.5)              | 23(72)     | 1.11[.50, 2.45]   | 0.791   | 1.26[.51–3.11]       | 0.585   |
|                          | Post-term          | 11(25)               | 33(75)     | 1.30[.64, 2.64]   | 0.459   | 1.55[.70–3.41]       | 0.313   |
| Religion                 | Christian          | 176(30)              | 412(70.1)  | 1                 |         | 1                    |         |
|                          | Muslim             | 6(27.5)              | 16(73)     | 1.13[.43, 2.95]   | 0.789   | 1.33[.48–3.70]       | 0.582   |
| Time of delivery         | During the night   | 102(30.5)            | 232(69.5)  | 1                 |         |                      |         |
|                          | During the day     | 80(29)               | 196(71)    | 1.07[.75, 1.52]   | 0.676   | 1.06[.72–1.54]       | 0.678   |
| Baby condition           | Good condition     | 161(29)              | 393(71)    | 1                 |         | 1                    |         |
|                          | Birth asphyxia     | 14(39)               | 22(61)     | .64[.32, 1.28]    | 0.214   | .55[.25–1.19]        | 0.167   |
|                          | Stillbirth         | 5(38.5)              | 8(61.5)    | .65[.21, 2.03]    | 0.465   | .78[.21–2.84]        | 0.571   |
|                          | Dead               | 2(66.5)              | 1(33.5)    | .20[.01, 2.27]    | 0.197   | .15[.01–2.21]        | 0.163   |
| Age of mother            | 18–20              | 25(29)               | 62(71)     | 1                 |         | 1                    |         |
|                          | 21–25              | 50(28.5)             | 125(71.5)  | 1.00[.57, 1.77]   | 0.978   | 1.01[.53–1.93]       | 0.949   |
|                          | 26–30              | 52(34)               | 101(66)    | .78[.44, 1.38]    | 0.403   | .80[.37–1.71]        | 0.597   |
|                          | 31–35              | 36(30.5)             | 82(69.5)   | .91[.50, 1.68]    | 0.784   | 1.07[.45–2.53]       | 0.880   |
|                          | 36–40              | 15(24)               | 48(76)     | 1.29[.61, 2.71]   | 0.501   | 1.55[.53–4.51]       | 0.296   |
|                          | 41–44              | 4(28.5)              | 10(71.5)   | 1.00[.28, 3.51]   | 0.990   | .86[.18–4.02]        | 0.953   |
| Marital status           | Married            | 61(32)               | 129(68)    | 1                 |         | 1                    |         |
|                          | Cohabitation       | 75(24.5)             | 230(75.5)  | 1.45[.97, 2.16]   | 0.069   | 1.53[.95–2.46]       | 0.097   |
|                          | Single mother      | 46(40)               | 69(60)     | 0.70[.43, 1.14]   | 0.162   | .79[.41–1.49]        | 0.392   |
| Occupation of the mother | Homemaker          | 9(29)                | 22(71)     | 1                 |         | 1                    |         |
|                          | Farming            | 94(26)               | 267(74)    | 1.16[.51, 2.61]   | 0.717   | 1.48[.61–3.57]       | 0.461   |
|                          | Small business     | 36(45.5)             | 43(54.5)   | .48[.20, 1.19]    | 0.116   | .71[.27–1.85]        | 0.454   |
|                          | Employed           | 9(19)                | 39(81)     | 1.77[.61, 5.12]   | 0.290   | 3.01[.95–9.55]       | 0.099   |
|                          | Not employed       | 14(30)               | 33(70)     | .96[.35, 2.61]    | 0.943   | 1.27[.44–3.65]       | 0.681   |
|                          | Survives on chores | 20(45.5)             | 24(54.5)   | .49[.18, 1.30]    | 0.153   | .67[.22–2.02]        | 0.513   |
| Gravida                  | Gravida 1          | 58(26.5)             | 161(73.5)  | 1                 |         |                      |         |
|                          | Gravida 2          | 44(31.5)             | 96(68.5)   | .78[.18, 1.08]    | 0.076   |                      |         |
|                          | Gravida 3          | 39(32)               | 83(68)     | .76[.17, 1.57]    | 0.251   |                      |         |
|                          | Gravida 4 and more | 41(31.8)             | 88(68.2)   | .89[.08, 1.12]    | 0.075   |                      |         |

|                  |                         |          |           |                  |              |                 |              |
|------------------|-------------------------|----------|-----------|------------------|--------------|-----------------|--------------|
| Living children  | No child                | 70(28)   | 178(72)   | 1                |              |                 |              |
|                  | One child               | 46(29)   | 113(71)   | .96[.79, 4.55]   | 0.150        |                 |              |
|                  | Two children            | 36(34.5) | 68(65.5)  | .74[.34, 3.18]   | 0.923        |                 |              |
|                  | Three children and more | 30(30)   | 69(70)    | .75[.44, 6.72]   | 0.431        |                 |              |
|                  |                         |          |           |                  |              |                 |              |
| Education level  | No formal education     | 18(26)   | 52(74)    | 1                |              | 1               |              |
|                  | Primary                 | 78(29.5) | 208(74.5) | 0.82[.45, 1.49]  | 0.531        | .70[.36–1.33]   | 0.344        |
|                  | Secondary and tertiary  | 77(31.5) | 168(38.5) | 0.75[.41, 1.37]  | 0.359        | .67[.32–1.42]   | 0.314        |
| Mode of delivery | Vaginal delivery        | 130(35)  | 244(65)   | 1                |              | 1               |              |
|                  | Caesarian section       | 52(22)   | 184(78)   | 1.88[1.29, 2.74] | <b>0.001</b> | 2.11[1.40–3.17] | <b>0.001</b> |

## 4.5 Discussion

A large proportion (70.2%) of our participants reported being respected during their labour and childbirth. Less than half of the women reported that they were not informed about breastfeeding and newborn care. Healthcare providers in maternity units are often very busy, and given that more than 85% of Rwandan mothers traditionally breastfeed their newborns, these providers tend to assume that the mothers already know how to breastfeed [263]. The majority were not allowed to have a birth companion during labour and childbirth, similar to the findings of a study conducted in Rwanda by Mukamurigo, which reported a very limited number of birth companions being permitted to enter the labour wards and stay with the mother [192]. This may be attributed to inadequate facilities lacking private rooms or partitions to maintain the mother's privacy, the room's narrowed space, and some mothers' preference not to have their husbands present [95].

In the descriptive analysis, the median threshold for RMC in this study was established at 80. Similar to the study conducted in Rwanda by Mukamurigo et al. (2017a), the participants rated good experiences during childbirth between 80% and 100% [193]. In the current study, the mean value was 78.9%, which is similar to the findings of a study conducted in Nigeria where the mean of the self-reported RMC score was 79%; however, they used no clear cut-off standardized tool to define the RMC level [103]. We understand that RMC is a delicate subject that should be counted cautiously because a woman can experience 14 out of 15 items. Still, the missing item may be very traumatic, such as being free from abuse and mistreatment. It is wrong to say that a mother was respected if she endured physical abuse, such as being kicked,

pinched, and beaten during childbirth. Therefore, RMC tool items must be appropriately weighted, and we suggest that RMC is only declared at 100%. However, in the current study, only 36 (5.9%) mothers reported experiencing all 15 RMC items. The lack of a clear RMC cut-off is a critical issue in RMC studies, and we recommend that this be determined in future studies.

In the current study, 70.2% of participants received RMC. In two studies conducted in Ethiopia's urban and rural areas, 82.4% received RMC [149] in Addis Ababa and 39.4% in the South Gondar zone, northwest Ethiopia [107]. The variation in RMC scores and percentages may depend on the location of the study. Wassihun and Zeleke (2018) argue that women from urban areas tend to report more RMC than those from rural areas [272]. This differs from a study conducted in Iran that reported an RMC score of 62.5% [125]. In the current study, most participants were from rural areas, some from district towns.

In chi-square analysis, we found an association between three socio-demographic factors and reported high RMC scores. These factors were marital status, occupation, and mode of delivery. In the current study, after performing bivariate and multivariate logistic regressions, there was no longer any association between high RMC and the two factors: marital status and occupation. Literature reported that marital status and occupation of the mother may influence how she receives and perceives care [131,11]. However, it should be noted that predictors of positive or negative RMC experiences can differ across countries, settings, and cultures [12].

The logistic regression from this study reported that Caesarean sections were associated with reported high RMC. Similar to findings from studies conducted in Ethiopia [107,175], Caesarean section delivery resulted in a two-fold increase in RMC scores. In the current study's hospitals, the protocol for Caesarean sections, either elective or emergency, was very clear and straightforward. Before performing a Caesarean section, a mother must sign a consent form. During the operation, the mother is typically cared for by a team that includes a physician, midwives, nurses, and an anesthesiologist. In addition, the medical pain management protocol is strictly followed before, during, and after the operation, and the mother is closely monitored. The mother may feel more respected during this process than during the normal delivery process. The selected hospitals in the current study do not have medical labour pain management protocol for normal birth.

During vaginal delivery, mothers often experience significant pain from the onset of labour until its conclusion and even in the immediate postpartum period. Epidural anaesthesia and



other painkillers are not routinely administered. During the entire labour process, the mother is typically cared for by one or two health personnel, and the mother may feel uncomfortable with the labour process and monitoring. Furthermore, the duration of labour during birth vs delivery is often longer than for Caesarean sections, and the mother can feel upset and not respected if she was not prepared well before labour. Although our study sites do not yet use pharmacological pain management, such as epidural anaesthesia, for those having vaginal births, many women might not even be aware that such medications exist. The literature argues that women perceive pain as a part of the normal childbirth process, so they do not raise complaints about it [47].

The current study's strengths include the relatively large sample size ( $n=610$ ) and the probability sampling. We addressed an important knowledge gap because the evidence on RMC in Rwanda is limited. This is the first quantitative study that describes the RMC experience in Rwanda using the updated RMC scale. Our findings are the baseline to inform further studies in the field of quality maternity care. This study depicts the RMC status (prevalence) in the Eastern province. It may drive healthcare providers and hospital management to increase the RMC level and sustain the existing best practices to achieve better experiences during labour and improve the outcome of labour. However, this study had some limitations. Since it was conducted on hospital premises, participants, though discharged and ready to go home, may have been prone to response bias due to social desirability. Additionally, we did not use a standardized cut-off to report the level of RMC received by the women, as such a standard does not exist in the literature. We recommend that future studies address this gap by establishing a defined cut-off for reporting RMC levels.

In conclusion, though a large number of mothers reported being respected during their recent labour experience, RMC must still be improved for mothers who gave birth vaginally so that they feel as respected as those who have a Caesarean section. Mothers should be provided with information on breastfeeding before and after delivery. In addition, mothers should be provided with information on caring for their babies. Note that self-reported RMC is always associated with personal perceptions, depends upon context [103], and is multidimensional and dynamic [131]. A standardized cut-off RMC is needed to identify the level of RMC received by mothers, and we suggest the proper weighting of RMC tool items because RMC is a delicate subject.

## Chapter five: Experiences and perceptions of respectful maternity care during childbirth in health facilities of Eastern province of Rwanda: An Appreciative Inquiry.

*This chapter is about the qualitative findings from mothers (phase 1b) from **Objective 2:** To explore and describe the perceptions and experiences of mothers with regard to RMC during their recent childbirth using Appreciative Inquiry.*

### 5.1 Abstract

**Introduction:** The WHO highlighted the importance of respectful and dignified childbirth experiences. Despite this, negative experiences are documented in countries like Rwanda. Identifying best practices can reveal sustainable solutions for resource-limited settings. This study aimed to explore and describe how mothers in the Eastern province of Rwanda perceive and appreciate their childbirth experiences during their recent labour and childbirth.

**Methods:** We employed a qualitative, exploratory, descriptive, and contextual design. The purposive sampling focused on mothers who reported being treated respectfully during labour and childbirth. We selected 30 mothers from five hospitals in the Eastern Province of Rwanda. To collect the data, we conducted in-depth interviews (IDIs) using the first four stages of the 5D cycle of the Appreciative Inquiry (AI) method. We utilized thematic analysis and NVivo 12 to organize the codes and create a codebook.

**Results:** Three main themes with subthemes emerged. Firstly, appreciated care encompassed compassionate care and emotional support, autonomy and self-determination, timely care, privacy and confidentiality, preservation, and an enabling environment. Secondly, perceived respectful care focuses on the meaning of respectful care and the motives for happiness. Thirdly, the participants suggested strategies to increase women's self-control, providers' behaviours, and caring leadership. Participants reported receiving compassionate, empathetic, dignified care and necessary services in a timely manner. Participants were satisfied, and their needs were met. Participants stated that Healthcare providers (HCPs) were kind, polite, and dedicated, often working overtime. Mothers recommended including them in decision-making, maintaining an optimal childbirth environment, and increasing community trust and professionalism. Mothers also recognize their responsibility for birth spacing.

**Conclusion:** The aspects appreciated by the participants should be consistently maintained and promoted. There is a need to build on the progress made in RMC provision to convince the community to increase trust and expectations. Given RMC sensitivity, we suggest conducting further RMC studies utilizing AI.

**Keywords:** *dignified care, humanized care, midwifery, satisfaction, positive experiences, rights*

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Adapted from Muhayimana, Alice\*, Irene Josephine Kearns, Darius Gishoma, Olive Tengera, Thierry Claudien Uhawenimana. Experiences and perceptions of respectful maternity care during childbirth in health facilities of Eastern province of Rwanda: An Appreciative Inquiry. *Under review in Plos One*

## 5.2 Introduction

Respectful Maternity Care (RMC) is the optimal approach for providing care during the maternity period. RMC prioritizes preserving women's dignity, privacy, and confidentiality, preventing ill-treatment and abuse. RMC ensured autonomy, granting women the right to information and informed choice, which is recognized as a fundamental human right [284]. In 2018, the World Health Organization (WHO) emphasized that RMC extends beyond preventing morbidity and death, emphasizing the importance of experiencing a pleasant delivery through utmost respect and dignity [291]. Providing RMC contributes to positive childbirth experiences and reduces maternal and neonatal morbidity and mortality [291,44,243].

Mistreatment towards mothers during childbirth contributes to poor quality of maternity care received by the mothers [47,1,230]. Studies argue that disrespect and abuse (D&A) can impose long-term psychological damage and emotional trauma by decreasing women's confidence and self-esteem [47,152]. Being disrespected may cause shame, sorrow, and insecurity; distrust and loss of confidence in the health care staff; a sense of powerlessness; and reluctance to call for help [193]. Studies have reported that memories of the labour and delivery experiences remain in women's minds for a lifetime and are repeatedly shared with other women [47]. Disrespectful and abusive care contributes to the fear of future utilization of the same maternity services, and reduced utilization of maternity services interferes with safe motherhood, contributing to an

increase in adverse maternal and neonatal outcomes [47]. D&A is a violation of fundamental human rights.

In efforts to reduce maternal and newborn deaths, significant progress has been made in Rwanda through various initiatives. Introducing trained Community Health Workers (CHWs) in 2009 was crucial in promoting maternal and newborn care at the household level [51, 202]. In 2008, the country implemented a national health insurance policy, covering Rwandans with fees based on family income [181]. Presently, 91% of Rwandans have medical health insurance [68], resulting in a significant decrease in post-childbirth hospital detentions due to unpaid bills. The Ministry of Health prioritizes evidence-based practices, including Basic Emergency Obstetric and Newborn Care (BEmONC), skilled birth attendance, and family planning [39]. Critical programs involve CHWs identifying pregnant women [51], the RapidSMS mHealth program facilitating timely transfers [202], and widespread ambulance availability [202]. The goal is to achieve 100% health insurance coverage shortly [202,69]

RMC has been integrated into BEmONC, with healthcare providers receiving RMC training and mentorship through programs such as the Maternal and Child Survival Program [165] and the More Happy Birthdays project [184]. National consultation meetings with RMC stakeholders were conducted in Rwanda to address the mitigation of Disrespect and Abuse [70]. These initiatives have been implemented in recent years in collaboration with the Rwanda Association of Midwives and the Ministry of Health. Despite the progress made in Rwanda concerning RMC, the accomplishments are still less documented [101]

Despite the importance of RMC, previous studies have predominantly focused on negative experiences reported by mothers [230,1,156,172]. Little attention has been given to exploring the power of positive RMC practices. Efforts to address mistreatment and abuse in maternity care have primarily focused on problem-solving. However, there is a lack of studies that examine RMC from a positive perspective [173]. In 2018, there was a shift towards promoting RMC instead of focusing on disrespectful and abusive practices during childbirth. To support this shift, WHO published a document on positive childbirth experiences [291]. From then, studies started to emphasize the significance of compassionate interactions between healthcare providers and women [313,5,6,8]. This included providing timely and relevant care, using courteous language, and effectively exchanging essential information [173,269,144,44].

Teamwork among HCPs and their positive attitude towards mothers, good leadership, and a conducive environment with the necessary equipment and adequate physical setting lead to positive childbirth experiences [152,254,149,33].

AI in RMC is suitable as it focuses on improvement rather than blaming or taking punitive measures, making it less threatening for healthcare providers [173]. This approach appreciates achievements and is posited to foster positive change [55]. AI approach is appropriate to our topic of focus (RMC) since RMC has a positive core. This approach encourages participants to reflect on their best experiences, fostering a more constructive and empowering perspective [285,257]. AI accentuates existing strengths, fostering a positive outlook that enriches relationships, culture, vision, learning, innovation, and collective endeavours [257]. This study systematically employed AI to address the gap in existing literature, encouraging mothers to share their positive experiences, and their insights serve as a foundation for advancing and maintaining RMC. Investigating the positive exemplary experiences and practices can identify feasible and culturally appropriate sustainable, valuable solutions within resource-constrained environments [257,173].

The absence of overt disrespect or abuse during childbirth does not necessarily imply that RMC practices are in place [139]. For example, just because there is no physical abuse does not guarantee the presence of compassionate and positive care behaviours [139]. RMC and mistreatment during childbirth represent opposite ends of the spectrum. Research shows that women and newborns can experience a blend of both positive RMC practices and negative mistreatment behaviours within this range [139]. Advocating for RMC promotion and addressing mistreatment are efforts that need to be simultaneously implemented. Socio-economic and cultural contexts influence women's perceptions of RMC in a given country. In research conducted on mothers, HCPs, and family members in Tanzania and Malawi using AI techniques, participants valued compassionate interactions and a conducive environment, including cleanliness, sufficient infrastructure and equipment, supportive leadership, and positive staff attitudes [173].

In Rwanda, no formal research has been conducted from both a women's rights perspective and a focus on positive birth experiences. Rosen and colleagues examined RMC based on the seven rights of women of childbearing age across five African countries, including Rwanda [231].

The findings highlighted systematic violations of women's rights in childbirth. Another study conducted in Rwanda by Mukamurigo and colleagues explored childbirth experiences and reported on poor childbirth experiences [193]. Mothers were slapped, verbally berated, humiliated, reprimanded, physically assaulted, insulted, abandoned, or subjected to inappropriate and rough handling by healthcare providers [191]. A significant number reported being shouted at for failing to follow instructions, and some were retained within hospitals due to unsettled bills [191,30]. Rather than solely focusing on repairing damages or focusing only on challenges, there is a need to build upon positive experiences. Exploring and describing service users' experiences can maintain the existing appreciated RMC. Exploring and describing the existing appreciated RMC through the eyes and experiences of service users will embrace, establish, and maintain a culture of respect and dignity among healthcare providers towards mothers.

## 5.3 Methods

### 5.3.1 Study design

This study is qualitative, exploratory, descriptive, and contextual in nature. Its purpose is to describe and provide meaning to the world of appreciated RMC experienced by mothers during their recent childbirth within the respective health facilities. The researcher focused on identifying, portraying, exploring, and understanding the positive RMC experiences encountered by mothers during labour, birth, and the immediate postpartum period. The aim was to form a holistic picture of this phenomenon and gain comprehensive insights into the topic.

This study is part of an ongoing doctoral study to design strategies to sustain RMC in Rwanda. The entire doctoral research began with a quantitative survey of mothers, conducted simultaneously with interviews. Alongside data collection from mothers, we also gathered insights from HCPs at the same study sites to understand their perspectives on RMC that had been reported. Utilizing AI methods, we examined and described HCPs' views on RMC. Ultimately, strategies to sustain and promote RMC in Rwanda were developed and validated. This current manuscript only reports the exploratory phase of the qualitative phase that aims to explore the RMC experiences received by mothers. A qualitative approach utilizing the Appreciative Inquiry (AI) method guided the in-depth interviews (IDIs) conducted with

mothers. The aim was to gain a comprehensive understanding and knowledge of the broader perspective of RMC as experienced by mothers [215].

Given that RMC is a sensitive topic, using AI to explore this sensitive subject allowed for focusing on the best experiences, discovering realistic and culturally accepted sustainable solutions, and generating constructive and innovative results within the constraints of limited resources [55]. AI emphasizes the power of positive traits and encourages individuals to consider strengths rather than blame [55,71,173]. The AI approach promotes positive thinking and enhances and sustains existing best practices rather than solely focusing on repairing harm. Exploring people's positive aspects enhances relationships and boosts positive emotions [55].

### 5.3.2 Study Setting and Population

#### 5.3.3 Sampling and Data Collection

**Study Setting and Population:** The study was conducted in hospitals in the Eastern Province of Rwanda. Five of the ten hospitals in this province were randomly selected for the study: three district hospitals, one provincial hospital, and one referral hospital. The participants were women who had gone through labour and given birth, either via vaginal delivery or caesarean section, at the selected sites and were being discharged but still were at hospital premises.

**Sampling and Data Collection:** Purposive sampling was used to select 30 mothers recently delivered at the study sites. One of the inclusion criteria in this study was the mother who self-reported to be respected during labour and childbirth. So, by recruiting them, the researcher wanted to know how they were respected. The Eastern province was selected because it is the second province with the highest birth rate based on the latest report from Rwanda 2019-2020 Demographic and Health Survey [198]. This study was concurrent with the other quantitative study about reported RMC [189], whereby mothers who reported feeling respected in general were invited to participate in this qualitative study. Before the interviews, the researcher purposively recruited a subset of mothers who had reported being generally respected. These mothers volunteered to participate in the study. The researcher provided them with detailed information about the study and the interview process. Participants who agreed to take part signed consent forms, agreeing to participate and to have their interviews recorded.

In-depth individual interviews were conducted with the mothers, taking place 12 hours after childbirth for those who had a normal delivery and 36 hours for those who underwent a caesarean section. The interviews were conducted in quiet and private areas within the hospital. Following the AI approach, the mothers were asked about their experiences and perceptions regarding RMC during labour and childbirth. The field notes were taken and kept by the Principal Investigator. Data collection took place in July 2022. This study utilized semi-structured open-ended questions designed based on the 5D cycle of Appreciative Inquiry, as Cooperrider, Whitney, and Stavros proposed [71]. These questions aimed to elicit responses from the participants (women) regarding their most positive experiences of RMC during labour and childbirth and their future expectations for RMC.

#### 5.3.4 Interview guide and Appreciative Inquiry

The defining stage of Appreciative Inquiry (AI) involves addressing and clarifying the topic of inquiry [71]. In this study, the topic of inquiry focused on exploring the best moments of RMC and the perceptions of mothers who recently delivered in the maternity facilities of Eastern Rwanda. In the discovery stage, participants share their experiences, particularly their best moments [71]. In this study, the mothers were asked to reflect on their experiences and share their best moments of RMC during labour and childbirth in the hospital. The specific question posed to the mothers was: "What is the best RMC experience that you have encountered during your labour and childbirth in the hospital?"

The **defining** stage of Appreciative Inquiry (AI) involves addressing and clarifying the topic of inquiry and ensuring it has a positive core [71]. Cooperrider and colleagues argue that understanding the positive core is vital when using the AI approach, emphasizing choosing affirmative topics that genuinely reflect what people want to explore or learn more about [71]. These topics focus on the positive moments and envision the perceptions of mothers who had recently given birth for a better future. The positive core is integral in all AI phases, highlighting and magnifying what provides the organisation with life [257,81,70]. In this phase of this study, the author defined the topic of inquiry that focused on exploring the best moments of RMC and the perceptions of women who recently gave birth in Eastern Rwanda's maternity facilities.



**The discovery** phase consists of identifying and appreciating existing positive aspects by exploring what works well. The questions asked were centred around "What gives life?" or "The best of what is" to gather positive stories from participants. This phase aims to unveil the strengths and positive elements [71,257, 81]. The discovery phase in AI involves identifying and appreciating the best aspects of experiences [71,257,81]. AI's unique feature is its positive framing of questions, focusing on peak moments of excellence [71,257,81]. The participants share stories of exceptional valued accomplishments, emphasizing core life-giving factors. Throughout the discovery phase, AI creates a supportive context for dialogue by maintaining a consistently positive orientation [71,257,81,70]. In the discovery stage, participants share their experiences, particularly their best moments [71,257].

In this study, mothers were asked to reflect on their experiences and share their best moments of RMC/ their greatest experiences of recent labour and childbirth in the hospital. The specific question posed to the mothers was: *"What is the best RMC experience that you have encountered during your labour and childbirth in the hospital?" "At any point during labour and delivery for this delivery, tell me any other kind of treatment that made you feel good/dignified or respected?"*

*"What care were you happy with or loved the most during labour and childbirth?" "Why did you like that?"* The research team ended up identifying the vital themes from the stories together.

**The dream** phase consists of envisioning the overall vision, results, and impacts and fostering innovation by asking questions like "What might be?" [71,257]. This phase involves using the insights from the discovery phase to create a set of aspiration statements, guiding the design of future actions. Participants identify new possibilities for the future [71,257,81,70]. The dream phase envisions a positive future, building on qualities discovered in the Discovery phase [257,81]. AI grounds future images in the positive past, creating compelling possibilities from extraordinary moments [71,257,81]. The primary goals are fostering participants' dialogue by sharing positive stories and identifying common themes without critique [71,257,81]. AI does not focus on solving problems but emphasizes mutual discovery, guiding participants to envision an organization that embodies their hopes and dreams [71,257,81]. In the dream stage, participants describe their dreams and desires and envision the possibilities of what could be considering their own needs and preferences [71,257]. The mothers and HCPs were asked to

foresee and picture RMC for the future. In this phase, the study participants (mothers and HCPs) recommended sustaining and promoting the best-reported RMC practices.

In this study, the participants were encouraged to share their aspirations for RMC during their labour and birth process in the hospital. They were asked to think broadly and holistically about the future they desired. The specific question posed to the participants was: "*What would be the best RMC for you during your labour and birth process in the hospital? How do you wish it was? What do you think made your care so good?*"

The Design stage generates implementation options and co-constructs plans by focusing on the following: "What should be the ideal?" [71,257]. This phase aims to identify concrete actions to support the new possibilities envisioned in the dream phase [71,257,81]. Participants collaboratively create and commit to actions that will turn aspiration statements into reality [71,257,81]. The design phase articulates the strategic focus, including a vision of sustainability and a compelling statement of strategic intent [71,257,81]. The design stage gathers valuable insights from the participants to inform the development of practical steps and interventions that can enhance RMC within the hospital setting, focusing on recommending and developing strategies to sustain RMC within the hospital setting [71,257].

In this study, the mothers were asked to provide recommendations and suggestions to envision and portray an improved RMC for the future. The specific question posed to the mothers was: "How should RMC be improved to contribute towards creating an RMC hospital environment?" "What can be recommended and developed to ensure the sustainability of RMC in the hospital?"

The **Destiny** or **Delivery** stage involves implementing, evaluating, and maintaining the processes and practices envisioned for achieving the ideal RMC for mothers during their labour and birth process in the hospital [71,257]. Note that we did not reach this last stage.

### 5.3.5 Data analysis

The Principal Investigator conducted the interviews in the local language (Kinyarwanda) and audio-recorded the mothers. Immediately, the research team transcribed the audio recordings verbatim in Kinyarwanda, and then the research assistant translated them into English. This

approach helped expedite the process while ensuring data integrity. Back translation was also performed by another research assistant and the research team as a quality check. The researcher read and reread the transcripts to gain immersion in the data. NVivo 12 was used for open coding and in creating a codebook. Thematic analysis was employed. Supporting quotes were selected to present the findings.

During the analysis process, we used inter-coding to improve the reliability and validity of the data analysis. In this study, the author and co-authors independently coded the same data, compared codes, discussed discrepancies, refined the codebook, and ensured consistent and reliable coding across the dataset. The research team then engaged in multiple readings of the transcripts to become familiarized and immersed in the data. Line-by-line coding was employed to identify initial codes. The research team thoroughly reviewed the initial codes, seeking similarities and differences in participants' viewpoints. Through this process, the researchers grouped related codes and identified categories. The research team carefully reviewed the identified categories, engaging in an iterative process that involved going back and forth between categories and the transcripts to ensure that participants' perceptions and experiences were accurately captured.

The in-depth analysis of the categories identified by the research team allowed for the identification of overarching themes representing broader patterns and concepts within the data.

We applied evaluative criteria for rigour in qualitative research to uphold the quality and trustworthiness of the research findings, enhancing the overall validity and reliability of the study [150,102]. This rigorous analysis enabled the research team to derive meaningful insights and comprehensively present the findings [155]. The study ensured credibility by selecting women who self-reported being respected and employing open-ended interview questions. Sharing transcripts with participants during data collection enhanced credibility. Dependability was ensured through meticulous decision documentation, while data stability was maintained with consistent and timely collection. Confirmability relied solely on mothers' narratives, avoiding researcher bias. The study's transferability was improved through a comprehensive study description using a well-structured interview guide [155].

## 5.4 Results

### 5.4.1 Participants' socio-demographic characteristics

Participants' sociodemographic characteristics included age, gravidity, number of living children, marital status, mode of delivery, and the baby's status. Participants' ages ranged from 18 to 44 years, with a mean age of 26. The majority (60%) were multigravida. The number of living children varied from zero to seven, with most participants (66.6%) having one to two children. Only 16.7% were legally married, while the majority (56.7%) cohabitated with their partners. One-third (33.3%) delivered by caesarean section, and the majority (83.3%) had their babies without complications (**Table 5.1**).

*Table 5.1: Participant sociodemographic data n=30*

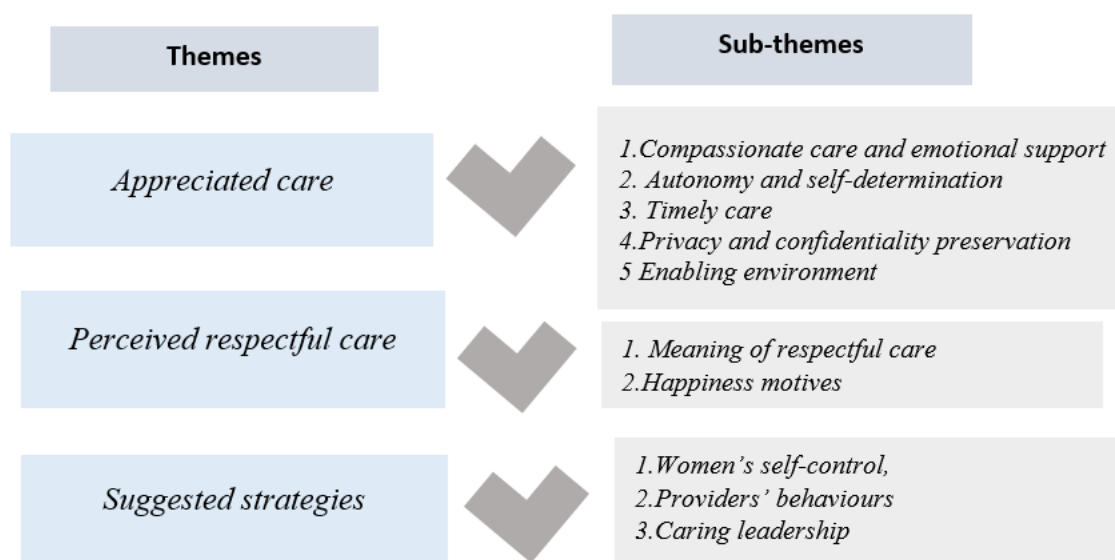
| <b>Variables</b>             | <b>Categories</b>    | <b>Frequency<br/>n=30</b> | <b>Percentage %</b> |
|------------------------------|----------------------|---------------------------|---------------------|
| <b>Age (in years)</b>        | 18-20                | 7                         | 23.3                |
|                              | 21-35                | 20                        | 66.7                |
|                              | 36 and above         | 3                         | 10                  |
| <b>Gravida</b>               | Primigravida         | 12                        | 40                  |
|                              | Multigravida         | 18                        | 60                  |
| <b>Level of the hospital</b> | District             | 9                         | 30                  |
|                              | Provincial           | 12                        | 40                  |
|                              | Referral             | 9                         | 30                  |
| <b>Living children</b>       | No child             | 1                         | 3.4                 |
|                              | 1 child              | 10                        | 33.3                |
|                              | 2 children           | 10                        | 33.3                |
|                              | 3 children and more  | 9                         | 30                  |
| <b>Marital status</b>        | Cohabitated          | 17                        | 56.7                |
|                              | Married              | 5                         | 16.7                |
|                              | Single               | 8                         | 26.6                |
| <b>Mode of delivery</b>      | Vaginal delivery     | 20                        | 66.7                |
|                              | Caesarian section    | 10                        | 33.3                |
| <b>Status of the baby</b>    | Stays in neonatology | 4                         | 13.3                |
|                              | Stays with mother    | 25                        | 83.3                |
|                              | Died                 | 1                         | 3.4                 |

The experiences and perceptions of mothers about RMC related to three main themes and subthemes, namely, 1) *Appreciated care with compassionate care and emotional support, autonomy and self-determination, timely care, privacy and confidentiality preservation, and enabling environment*; 2) *Perceived respectful care with the meaning of respectful care and*

happiness motives 3) Suggested strategies with women's self-control, providers' behaviours and caring leadership (Table 5. 1)

#### 5.4.2 Thematic framework

Table 5.2: Themes and Sub-themes



##### 5.4.2.1 Appreciated care

Participants reported receiving compassionate care, free from mistreatment and violence. They expressed that their choices and preferences were respected throughout their recent childbirth experiences. They also reported receiving dignified and equal care, being attended to in a timely manner, and receiving the necessary services; their privacy and confidentiality were respected, and they received adequate information regarding their health status and care.

##### Compassionate care and emotional support

The participants expressed that they were treated with great empathy and compassion throughout their childbirth experience. They reported receiving anaesthesia before suturing for vaginal tears or episiotomies. Those who gave birth by caesarean section were systematically provided with painkillers after giving birth. Participants who experienced pain during normal delivery were comforted, but they also recognized that pain is a natural part of childbirth and understood that no specific interventions could alleviate it. However, women emphasized that healthcare providers should address all of a mother's concerns during childbirth, even if some pain is unavoidable.

*"I don't know how I can describe that compassion I received here; it's too much. After the operation, they start giving me perfusion and giving me pills to reduce pain.... "It is the first time I gave birth; the first thing that ever causes pain is labour. However, when someone cares about you and ensures you that labour will progress like that or that, you feel energized."* **Participant 12, aged 28 years, gravida 1, C/s delivery**

*"I heard that pain is necessary; you have to suffer and get well... our parents tell us that you have to suffer, but you will be fine...Because there is nothing to reduce the pain, they (HCPs) are saying be patient; you will get better."* **Participant 26, aged 22, gravida 1, normal delivery**

Women appreciated the dignified care they received and consistently expressed happiness and satisfaction with the services. The healthcare providers were patient, speaking to them with comforting words, kindness, and politeness. The women emphasized that they were not harassed in any way; the providers answered their questions respectfully and used gentle, soft expressions. Mothers felt grateful because they felt valued and noticed that the birth attendants stayed close throughout the process. It was particularly meaningful when the attendants praised them for their efforts in pushing the baby out. The mothers described the staff as lovable, kind and have a caring attitude.

*"In healthcare providers, there was a girl who told me "mama, push, be patient, be patient darling, push; the contraction is in, and I felt happy"... the midwife comforted me and told me that" 'all the tears you cried, I want to wipe them away". Now I am satisfied, I don't know how I can say it, but it made me very happy"* **Participant 17, aged 26 years, gravida 2, normal delivery.**

### **Autonomy and Self-determination**

Participants reported feeling freedom during their childbirth experiences. They were not restricted from praying and were allowed to eat and drink; they had the freedom to walk, although within a limited space. The participants reported receiving equal treatment, there was no favouritism, and the hospital assisted those in need, such as providing diapers for the baby. Mothers further stated that their choices and preferences were respected, and they felt supported by the caregivers. Women who came without a transfer letter were also received

with kindness, and the participants were not denied any service and received assistance every time.

*"I told them my choice for family planning, and they immediately did it to me. I told them that I had decided to use the sterilization, and I had to talk to the doctor in charge, and he did it for me."* **Participant 28, aged 40, gravida 8, normal delivery**

Mothers reported that they received guidance on how to behave well during their childbirth. Women reported that they were advised on the precautions to take and practising self-control. They expressed happiness at being shown the placenta and receiving information about family planning and birth spacing. Some mothers were taught breastfeeding techniques and were encouraged to have regular meals to ensure an adequate milk supply. Additionally, some mothers were informed about the progress of their labour and encouraged to stay hydrated by taking fluids.

*"Every time I needed the doctor, he came and told me that you are on this point, you are going to give birth well, relax. When I needed him again, I called him until I gave birth, and she assisted me well, comforting me, telling me to push, and do it quickly without being rude to me but with kindness".* **Participant 21, aged 21 years, gravida 2, vaginal delivery**

Mothers were informed and requested to provide informed consent, especially those who experienced caesarean section.

*"Doctor always requested me "' Would you come for a check-up to see your labour progress? Would you come for an ultrasound to check if the baby is still alive?" and I said yes. They told me that I am going to have surgery, they told me that you have to sign and your companion needs to sign too; once you have signed, you have agreed to the surgery they are going to do for you".* **Participant 13, aged 28, gravida 1, C/s delivery**

However, most participants were not explicitly asked for verbal consent during routine examinations. Mothers reported that they did not feel the need to be asked for permission as they trusted the expertise and abilities of the caregiver. Mothers believed that it was their

responsibility to follow the instructions given by the care provider. Nonetheless, participants expressed satisfaction with the practice of negotiation instead of coercion.

*"When they take you to the examination bed, you are already aware that they are going to examine you.... well, when we are there, there is no need for permission because the doctors do what they were taught, or they were appointed. Whatever they do, you feel it is right..."*  
*"Listen, because of pain, you don't have to argue; you are even thinking the service provider is the one to recover you."* **Participant 18, aged 23 years, gravida 2, vaginal delivery.**

### **Timely care provision**

Most of the mothers expressed happiness and were impressed by the care received. They reported receiving the best services and all the necessary care. The HCP attended to them promptly and assisted them every time, even when working overtime. In some hospitals, they first used available medicines, and mothers reimbursed them later. The entire process was well organized, and mothers who arrived in critical conditions were given hope and excellent care. When the HCPs could not manage a case, they called experts for assistance. One notable example was when a very experienced midwife successfully helped a mother deliver vaginally despite indications for a caesarean section.

*"The doctor gave me the best possible care; he was good-hearted, and I feel very happy. I was so happy with what they did to me that I felt like giving her a car; poor me, I don't have it.... Whenever I wanted the doctor, he came to me no matter what time he left, and he did not complain no matter how much I disturbed him"* **Participant 21, aged 21 years, gravida 2, vaginal delivery.**

### **Privacy/confidentiality preservation**

Privacy was ensured as described by the mothers. They reported that they were not exposed to the public during delivery, and curtains or doors were closed to maintain their privacy. Mothers were allowed to be alone with the HCP, and cleaners were not allowed to enter the room during their stay.



*"I am thankful that these cleaners cleaned after you gave birth; none saw me. In the delivery ward, there are large curtains. Even the doctor who brought the materials took them without letting him in.... When a person wanted something, the service provider went out and opened the curtains to listen to what he needed. However, no one ever saw me"* **Participant 5, aged 27, gravida 2, vaginal delivery.**

To ensure confidentiality, healthcare providers spoke quietly to the mothers. However, mothers reported that they could hear other mothers' health information. Nevertheless, mothers revealed that it did not matter to them, as they shared suffering from labour pain.

*"Even though sometimes, we are many here, I can hear the health information of my colleague's mother and vice versa, but since you are all suffering, it doesn't matter...it would not matter because a colleague's mother can't share my information knowing how she was doing in labour and the way we shared sorrow of labour pain."* **Participant 18, aged 23 years, gravida 2, vaginal delivery.**

### **Enabling environment**

Mothers reported that the birth companions were not allowed to stay with them in the waiting room, particularly in the delivery rooms, due to the structure of maternity rooms. However, most participants believed that birth companions are not helpful during the second stage of labour and that only HCPs are of assistance. Mothers narrated that birth companions are not health professionals and can become scared and discourage the mother. Participants also reported that birth companions are often busy buying medicines or doing other tasks outside. They suggested that they should simply stay outside near the labour room and be available to bring the baby's clothes after birth.

*"The birth companion could not be of help; she wasn't a doctor to examine me; she was only responsible for standing there outside near the door and waiting for them to say that she gave birth and brought the baby's and mother's clothes. I would not want my birth companion to come in! because even now, birth companions can see how you are doing and get scared and say that you are dying, but a healthcare provider, even if you are going to die, keeps telling you to be patient."* **Participant 26, aged 22, gravida 1, normal delivery.**

Some mothers expressed satisfaction with the overall hygiene and cleanliness of the hospital. Cleaned toilets and regularly changed bedsheets made them feel satisfied. HCPs often requested the cleaners to clean rooms multiple times. However, while some mothers were pleased with hygiene, others complained that the cleanliness in the toilets was insufficient.

*"I am also happy that the hospital is clean, you sleep, and they take care of your sheets and change them for you, and the shower and toilet are all clean without any problems. There was no problem, and the cleanliness was satisfying."* **Participant 28, aged 40 years, gravida 8, vaginal delivery.**

#### 5.4.2.2 Perceived respectful care

Participants expressed their understanding of respect during labour and delineated the elements that contributed to their contentment with the services provided.

#### Meaning of respectful care

Most participants understood that RMC encompassed privacy, confidentiality, and freedom of movement during labour. They associated RMC with receiving timely and compassionate care, being spoken to in a soft and compassionate tone, spoken to kindly and politely, comforting her, actively listening, and staying close to her. RMC is seen as attending to the mother promptly, starting with those in critical condition. It involves receiving the mother well, showing patience, and inquiring about her well-being and that of her baby rather than abandoning, harassing, ignoring, or silencing her.

*"The respect is when health service does not expose you in public if you arrive at the hospital, you are cared for, when a service provider comforts you by saying, sorry mom, sorry Darling, with a smiling face, that is good.... When you are in the room, you are in a private place; you are private if there is a door, they put on a curtain or close it, and you feel that you are alone with a healthcare provider, and you feel you are respected."* **Participant 17, aged 26 years, gravida 2, normal delivery**

*"I feel that respecting a mother means being there when she needs you. You should make her feel comfortable and free to express herself. A mother should be allowed to move around during*

*labour because it helps her feel better."* **Participant 21, aged 26 years, gravida 2, normal delivery.**

Mothers perceive professionalism as a crucial factor in providing RMC. They value love, compassion, and a sense of being valued by HCPs as important facilitators of RMC provision.

*"What makes service providers give me good care is the love and compassion healthcare providers have or that they value their duty. Maybe I had met doctors who knew what they wanted to do or who valued their work ".* **Participant 18, aged 23 years, gravida 2, vaginal delivery.**

### **Happiness motives**

Mothers expressed that fulfilling their desires was the most important reason for appreciating and feeling proud of the services they received. Their primary wish and expectation was to have a normal delivery and a healthy baby while maintaining their own health. Additionally, mothers reported negative anticipatory feelings when seeking maternity care. However, HCPs were available round the clock, closely monitoring and encouraging them and instilling hope. Mothers appreciated that HCPs were not preoccupied with phones, treated them respectfully, offered comfort and support, and showed genuine concern for their wellbeing. One mother even expressed happiness at reuniting with a midwife who had assisted her in a previous delivery fifteen years ago. The perceived drivers of RMC, as reported by the mothers, included displaying love and professionalism, having a sense of responsibility, valuing both the work, receiving appropriate training, and appreciating the mother's critical state. The moment of getting their newborn baby was described as a transformative experience, overshadowing the pain of labour.

*"It was truly great. The doctor was telling me to relax and not worry; there was no other reason; service providers told me that I wanted to have a healthy baby because the doctor told me, "I will help you to give birth well. I did not have surgery. The thing that I am happiest about is that I saw a healthy child. For me, the first thing that makes me happy is to see a healthy child."* **Participant 11, aged 28 years, gravida 3, normal delivery.**

Remarkably, one participant who had experienced the loss of her baby due to severe prematurity expressed appreciation for the services received.

*"From when I arrived until I left down there, up to now, healthcare providers took good care of me though my baby passed away. If I were able to reward them, I would do it; I would repay them if I had something. They took care of me".* **Participant 24, aged 20, gravida 1, C/s delivery.**

Very few participants had positive expectations, such as hoping for a quick delivery or expecting to receive an ultrasound examination. Since most of the mothers were referred, some also anticipated a smooth and uncomplicated delivery, and all of these expectations were fulfilled.

*"I saw that my baby was still alive in the womb...They just showed me her and told me she is a girl and ensured me that she is healthy; that makes me happy".* **Participant 13, aged 28 years, gravida 1, C/s delivery.**

Participants generally reported low expectations when seeking maternity healthcare due to the information received from their communities. Mothers expressed concerns upon going to the hospital for childbirth, having heard negative stories from others and anticipating potential insults and physical mistreatment. Some were unaware of the current procedures and expected to receive the same treatment as in previous years. They anticipated being physically abused, insulted, scolded, subjected to fundal pressure, or unnecessarily undergoing a caesarean section. They also expected to be exposed naked in public and spoken to rudely. They came with the fear of dying, being provoked, ignored, and being required to pay before receiving any service. However, participants experienced positive experiences. Some women were excited to give birth in a new large building (on an upper floor).

*"I was thinking that I get here and give birth by insulting me; they don't hit me as I have been told. And the fact that I arrived here, they cared for me, they did not beat me, and then I gave birth immediately, that's again made me happy...Before coming here, I have been told that some are beaten; I thank God they did not beat me. I found it different; I don't know what it is; I've met a kind doctor."* **Participant 16, aged 19 years, gravida 1, vaginal delivery.**

#### 5.4.2.3 Suggested strategies

To sustain RMC, mothers provided recommendations to service users, caregivers, and hospital management. Each level has its own responsibilities to fulfil.

##### **Mother Self-control**

Mothers reported that they have a responsibility to respect HCPs, follow the instructions given, use family planning to space their births and regain confidence. To ensure the lifelong sustainability of RMC, they suggested that their children should attend school and become future HCPs dedicated to providing quality services.

*"Mothers should respect health care providers too; we should have few children. You know, mothers, we always give birth, and you find that it is stressful, and we have to plan for family".* **Participant 30, aged 29 years, gravida 3, vaginal delivery.**

##### **Provider behaviours**

Respondents advised service providers to sustain their courtesy, respect, and love toward the mothers. They should ensure the mothers' comfort and feel responsible in providing maternity care. Providing guidance to the mothers and maintaining the existing culture of timely care, mutual understanding, and respect were emphasized. It was advised that the providers re-evaluate themselves, work diligently, and care for the mother as a human being. Doctors were urged to show respect to subordinates such as cleaners, and cooperation between HCPs and mothers was encouraged.

Mothers requested HCP to prescribe affordable medicine and avoid unnecessary prescriptions of surplus medical supplies. Providers should explain the progress of labour and communicate the results of examinations to the mother. It was suggested that HCP talk to the mother while providing care, explain the labour process and progress, and assist mothers in having a normal delivery as much as possible. It was advised that HCPs prioritize triage and handle emergency cases quickly. Mocking multigravida women and unnecessarily retaining mothers in the hospital were discouraged. Security personnel at the gate were also advised to be briefed on respecting and allowing mothers to enter the hospital.

*"Doctors should take care of patients as if it is their responsibility, not because it is their job, but because it is their responsibility".* **Participant 11, aged 28 years, gravida 3, normal delivery.**

### **Caring leadership**

Mothers recommended that the hospital leadership train, supervise, and innovate ways to motivate the HCPs. Participants emphasized the importance of publicly showing gratitude to the HCPs and ensuring timely payment of salaries. Increasing the number of HCPs and providing sufficient labour monitoring equipment are suggested. Mothers also highlighted the need for continuous training for HCPs, including new graduates and students, and providing mentorship to ensure the delivery of quality care. They recommended that future HCPs be taught to prioritize patient care and love for their patients. Conducting campaigns and workshops on RMC was seen as beneficial. Another important suggestion was to build or renovate hospitals with spacious rooms and an adequate number of beds to avoid mothers and newborns sharing beds. Last, they emphasized the importance of striving to have a good reputation in the community.

*"Doctors in leadership roles would approach their colleagues to express gratitude, perhaps informing them that all the mothers who gave birth during this time are happy. I believe this kind of recognition can motivate them to continue performing well".* **Participant 15, aged 32 years, gravida 3, vaginal delivery.**

Some respondents recommended that the hospital provide food to mothers whenever possible, especially for those who come from a distance and may not have money to buy food from the canteen. Regarding hospital bill payments, it was suggested that priority should be given to providing care to the mother first, with payment arrangements made afterwards. They also recommended that the cost of services should be proportionate to the service received and that prescribed medications should be covered by health insurance. Respondents suggested that the hospital and the mother could enter into a contract allowing for gradual payment to address the issue of mothers being retained in the hospital due to an inability to pay. Participants emphasized the need to improve hygiene and cleanliness in the hospital environment. Some mothers expressed reluctance to use diapers during labour, fearing that they might harm their

babies. Mothers also raised concerns about hospital overcrowding, where two mothers may have to share one bed.

*"Another thing is that they should add hygiene and cleanliness, and they should properly clean so that mothers will not acquire illness."* **Participant 16, aged 28 years, gravida 3, normal delivery.**

## 5.5 Discussion

Our findings indicated that there has been significant progress in RMC in Rwanda over the last few years [191, 231]. The participants expressed excitement about the respectful care received. Mothers described receiving care with compassion, empathy, dignity, equality, and privacy. They also reported being attended to promptly and receiving all necessary services. They mentioned signing consent forms and receiving guidance on how to behave during their stay. Mothers reported that HCPs used comforting words and displayed kindness, politeness, hope, love, and humanism. The professionalism of the HCP was greatly appreciated, as was their sense of responsibility and the value they placed on their work, even going the extra mile by working overtime to save mothers and babies. Overall, participants' desires were met, and they expressed satisfaction. These findings align with global evidence on RMC, highlighting the importance of emotional support, positive attitudes of healthcare providers, and effective communication during labour and childbirth [243,52,173,187,44,52].

Although our participants expressed appreciation for almost every aspect of the care they received, there are areas that we believe require improvement. Expressly, pain management during normal delivery was limited to emotional support. Mothers reported being aware that pain is a necessary part of giving birth. The literature argues about other relaxation techniques and painkiller medications that could be utilized to alleviate labour pain and their effectiveness [191]. It was impressive to discover that most of the mothers attended health facilities with low expectations, but fortunately, they had a positive experience and received more care than they anticipated. Participants suggested explaining maternity services to the community, similar to a study in Kenya that recommended using open maternity days to engage the community in these services [269]. In addition, some mothers emphasized that what is important to them is to have a healthy baby and to stay healthy.

Participants recognized the improvements made in maternity buildings, and mothers expressed excitement about giving birth on the upper floor of a new and beautiful building. However, there were still some inconvenient wards within the facilities. Mothers often labour together in open rooms or rooms separated by curtains, leading to the unintentional breach of confidentiality principles. Interestingly, mothers reported that they are not offended by hearing each other's health information since they are all suffering and going through similar experiences. Studies have revealed that inadequate labouring environments are common in many low-income countries' healthcare settings, and labour wards are open rooms [99,134]. Consequently, the rooms cannot accommodate birth companions [126, 134].

A facilitating environment with the necessary equipment and adequate physical setting leads to positive childbirth experiences [173, 257]. Improving infrastructure may be perceived as challenging to implement and could take time. However, HCPs can work with existing resources, such as using partitions and curtains, to maintain mothers' privacy [173]. Surprisingly, mothers mentioned that birth companions were not necessary during 2nd stage of labour while pushing the baby; they believe that birth companions are not of help at that stage, and the HCP are the only ones needed at that particular moment. However, available pieces of evidence demonstrated that birth companionship improves RMC; birth companions play a crucial role in providing emotional, practical assistance, and advocacy support during childbirth, leading to a more positive birth experience for the women [269,44,5,152].

Mothers believed that there was no need for HCPs to request them to consent to examinations and routine care, and mothers were not disturbed by that because they fully trusted the HCPs' knowledge and skills. However, consented care is necessary [284,291,287]. Participants highlighted interventions such as HCP's training, supervision, and mentorship for new graduates as key factors in sustaining and improving RMC. These findings align with previous interventional studies conducted in the field [269,8,90,176] that have demonstrated the effectiveness of such interventions in RMC promotion.

In Rwandan culture, it is expected to show respect and help the woman in labour. The woman's and in-law's families normally accompany her to the hospital when she goes for delivery. This care is typically provided by her own mother, grandmothers, mothers-in-law, and the in-laws' family, as well as the broader community [190]. When a mother delivers a newborn baby that is alive and healthy, both her family and her husband's family pay a visit to express their congratulations and celebrate the occasion with various gifts, particularly food items, to the



family. In Rwandan culture, this is commonly referred to as "*guhamba umubyeyi*" means ‘‘to reward the mother’’ [190]. In the maternity services at the study sites, birth companions typically stay outside the delivery room or inside the labour room, not in the delivery rooms. It is also worth noting in this study that some women in the study prefer not to have their birth companions stay with them in the delivery room by saying that having birth companions in the delivery room is unnecessary. The reluctance of birth companions to stay with mothers in labour rooms contradicts existing literature. This discrepancy may be due to Rwandan women preferring to maintain their privacy during delivery.

## 5.6 Conclusion and recommendations

The aim of this study was to explore and describe how mothers in the Eastern Province of Rwanda perceive and appreciate their childbirth experiences with RMC. In general, mothers expressed appreciation for the care they received despite initially having low expectations when visiting the hospital. This study emphasizes the importance of maintaining and promoting RMC to provide women with care centered around their needs and to ensure a positive childbirth experience. The findings suggest that healthcare providers should offer timely, compassionate, and emotionally supportive care. This approach should create an environment that maintains privacy and confidentiality, fosters clear and effective communication, and empowers mothers, enhancing their autonomy, satisfaction, and self-determination. This study’s findings also suggest the need to uphold community trust in maternity services. Healthcare providers should always pursue professionalism and adhere to ethical standards. There is also a need for supportive leadership to sustain RMC. Moreover, mothers indicated that they could contribute to receiving RMC by practising birth spacing.

Raising public awareness about the universal rights of women and newborns will increase expectations and trust among mothers seeking maternity care in Rwanda. Mothers' primary desire was to have a healthy baby and maintain their health. While our participants acknowledged infrastructure improvements, they also emphasized the need for further enhancements. Participants suggested strengthening labour support by providing access to labour pain medications, enhancing confidentiality, and improving infrastructure and amenities. This included constructing more spacious rooms separated by walls rather than curtains, where possible. Educating non-healthcare personnel, such as cleaners and security officers, is also essential for respecting and supporting mothers. It is recommended that

communities be informed that healthcare providers' behaviours have improved. There is a need for more studies on RMC using AI approaches, as this method is relatively new in RMC research and since AI is particularly well-suited to the topic with a positive core [173,172].

## 5.7 Strengths and limitations

### *Strengths*

AI is an innovative approach that proved effective in understanding the specifics of what respectful care looks like in Rwandan culture, enabling the gathering of enough information and encouraging mothers to share their appreciated RMC experiences. AI is particularly suitable for RMC because it focuses on the best aspects and is less threatening. AI offered the participants the genuine commitment, energy and motivation to openly discuss their experiences [71,257,81]. AI is engaging, powerful, and inspiring, focuses on the positive aspects of situations [257], and can potentially reveal creative solutions and ideas that may not emerge solely from addressing disrespect and abuse. The recruitment of participants who reported being respected in general allowed for collecting valuable data on their positive experiences. To the best of the author's knowledge, no previous studies on RMC conducted in Rwanda have utilized AI methods.

### *Limitations*

Although Appreciative Inquiry has its benefits, it also has its limitations. Prioritizing positive narratives and experiences during the discovery phase may inadvertently dismiss participants' negative experiences. This may impede essential and meaningful conversations [55,54]. All parties involved must be genuinely committed and willing to concentrate on the positive aspects, even in challenging situations [55,54]. AI can be challenging to transition for people who are used to problem-solving approaches. AI may not be suitable for some circumstances, especially when immediate action is needed, and a problem-solving approach may be more appropriate because AI necessitates persistence, practice, and patience [55,54]

The other limitation was that the study was conducted at the hospital exit time when the mothers were still on the hospital premises; this can lead to desirability bias. To minimize that, the participants were assured of the total confidentiality of their information, and the interviews were conducted in a private room. It is important to note that mothers' experiences of RMC are subjective and can be influenced by socio-cultural factors. In addition, it is impossible to know how representative our participants are of Rwandan women's experiences.

**What is already known on this topic?**

The research conducted in Rwanda in the past, women emphasized the negative experiences of women during labour and childbirth. Women described being slapped by providers and spoken to rudely. Women reported experiences of humiliation, scolding, dehumanization, being tied to the delivery bed, pinched, pushed, insulted, shamed, abandoned, and subjected to inappropriate and rough touching. Many women mentioned being yelled at for not complying with instructions, and some faced stigmatization, abandonment, and even gave birth on the floor. Additionally, those who failed to pay were reportedly detained inside hospitals [191,231]. However, what was not known were the perceptions and experiences of positive experiences of women during labour and childbirth.

**What this study adds**

Rwandan women in our study reported receiving care with compassion, empathy, dignity, equality, and privacy. Mothers noted timely attendance, providing necessary services and guidance on behaviour during their stay. They also reported that HCPs used comforting words and displayed kindness, politeness, hope, love, and humanism. HCPs were greatly appreciated for their sense of responsibility and dedication, even going the extra mile by working overtime to save mothers and babies. Overall, participants' needs were met, and they expressed satisfaction. Participants emphasized the need to be included in the decision-making process, maintaining an optimal environment for facility childbirth, upholding community trust, and supporting healthcare professionals in maintaining professionalism. Mothers acknowledged their responsibility, particularly in terms of birth spacing.

## **Chapter six: “I credit the midwives for saving my child's life”: Providers' perceptions on Respectful Maternity Care and Reflections on their Best Practices Experiences with Mothers in Rwanda.**

*This chapter is about the findings from Health Care Providers (phase 2b) to explore and describe HCP perspectives on RMC using the Appreciative Inquiry (AI) method*

### **6.1 Abstract**

**Keywords:** *Mother-friendly care, appreciative care, midwifery care, maternal health, positive experience, Rwanda*

**Background:** Research in Respectful Maternity Care (RMC) has primarily concentrated on midwives' mistreatment of women, with limited emphasis on exploring best practices. Furthermore, in Rwanda, investigations into RMC have predominantly centred on service users, leaving a significant knowledge gap regarding the perspectives of healthcare professionals providing maternity services to mothers. This study aims to explore and describe healthcare providers' (midwives, nurses, physicians) perspectives on RMC using the Appreciative Inquiry (AI) method.

**Methods:** We conducted 10 in-depth interviews (IDIs) and 5 focus group discussions (FGD) on health care providers (HCPs) who were working in labour wards of 5 hospitals in the Eastern Province of Rwanda. For an interview, we purposely selected 5 unit managers and five physicians. For FGD, we recruited 55 midwives and nurses. Participants were from 3 district hospitals, one provincial hospital, and one referral hospital. Interview and Focus groups were guided by the AI method. The participants were interviewed to gather their insights and experiences regarding the delivery of RMC best practices to the mothers and their opinions on establishing and maintaining best practices for RMC. Nvivo 12 was used to organize codes and to create a codebook. Thematic analysis was used to analyze data.

**Results:** Four themes emerged from interviews and FGDs: 1) Perceived RMC provision, 2) Perceived RMC benefits, 3) RMC enablers, and 4) Sustaining RMC.

Healthcare professionals perceived RMC as a commitment to championing women's rights. This encompasses ensuring privacy, confidentiality, and equality, fostering effective communication, and delivering superior care to guarantee an optimal childbirth experience for

women. Recognized advantages of RMC consisted of mutual satisfaction, increased utilization of maternity services, improved community reputation, enhanced mutual trust and rapport, bolstering family well-being, and a favourable influence on maternal psychological health. Drivers of RMC provision incorporated professional obligations, educational background, religious convictions, and positive feedback. Providers have emphasized the need for their peers to augment their sense of duty, uphold ethical professionalism, foster teamwork, and continuously evaluate care quality and client responses. They also advocated for more proactive hospital engagement, increased advocacy for mothers, staff motivation, continuous professional development opportunities, and improved living conditions for healthcare providers. Other HCPs recognized the more experienced midwives for saving lives. The accreditation endeavours and RMC training furnished by stakeholders signify noteworthy progress.

**Conclusion and recommendation:** The strides in RMC provision, epitomized by the gratitude of mothers, are not the result of individual efforts but collective endeavours. We advise learning from successful RMC actions, maintaining current RMC best practices, and addressing the recommendations provided by healthcare providers. The entire healthcare system in Rwanda, from midwives to nurses to physicians, must unite and strive for RMC improvement. This shared responsibility and collaborative approach are key to ensuring the continued success and advancement of RMC in Rwanda.

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Adapted from Muhayimana, Alice\*, Irene Josephine Kearns. *“I credit the midwives for saving my child's life”*: Providers' Perceptions on Respectful Maternity Care and Reflections on their Best Practices Experiences with Mothers in Rwanda. *Under review at BMC, Research Clinical Services*

## 6.2 Introduction

Respectful Maternity Care (RMC) is a systematized approach to providing care to all women during maternity. RMC emphasizes the preservation of their dignity, privacy, and confidentiality. RMC guarantees autonomy by upholding the rights to information and informed decision-making [254]. The experts argue that the absence of disrespect and abuse during childbirth does not necessarily indicate the presence of RMC. For instance, the absence of physical abuse does not guarantee the presence of positive caregiving behaviours [155, 102]. RMC and mistreatment during childbirth represent opposite ends of a spectrum, and research has shown that women and newborns can encounter a combination of both positive RMC and

negative mistreatment along this spectrum [8,102]. It is crucial to actively promote RMC while simultaneously working to reduce mistreatment. Efforts to achieve RMC play a vital role in advancing the Sustainable Development Goals (SDGs), particularly the goal of ending preventable maternal and neonatal death and eliminating all forms of violence against women [58,121]

Researchers claimed that for research on RMC to yield trustworthy findings aligned with the unique circumstances, it should be rooted in each country's specific context, including socioeconomic and cultural differences [47,215,243]. Research conducted globally and particularly in Africa concerning RMC has predominantly concentrated on the mistreatment by midwives [52,193,149,134,1], with limited consideration given to the experiences of all healthcare cadres involved in childbirth. However, it is worth noting that HCPs caring for women during labour and childbirth are multidisciplinary; they include midwives, nurses, gynaecologists and general practitioner physicians.

There is limited information regarding the viewpoints of healthcare providers (HCPs) working in maternity services in Rwanda when it comes to RMC. Previous studies conducted in Rwanda have exclusively focused on mothers' experiences, leaving a gap in published data regarding the perspectives of healthcare providers on RMC. In addition, published data about how healthcare providers perceive RMC from a positive perspective is scarce. This study employed Appreciative Inquiry (AI) to address this gap. This approach prompted individuals to assess their organization's strengths and propose creative methods for enhancement, emphasizing positive aspects and identifying practical, culturally and contextually accepted solutions [99,198,269].

We anticipate that utilizing AI to identify what brings vitality to a system in its optimal state proves particularly beneficial when addressing sensitive subjects like Respectful Maternity Care [284]. In the realm of RMC, conventional problem-solving approaches for change have frequently been overly critical, potentially fostering blame and hindering open dialogue [187,291]. We systematically utilized AI to encourage HCPs to share their positive experiences. These insights serve as a foundation for further development and the long-term sustainability of RMC. The aim of this study was to explore and describe HCP perspectives on

RMC using the Appreciative Inquiry (AI) method, which focuses on positive perceptions or experiences.

## 6.3 Methods

### 6.3.1 Study Design

This study utilized exploratory qualitative descriptive design with a Focus Group Discussion (FGD) and individual interviews. Appreciative Inquiry (AI) method was used for data collection. This approach incited participants to envision their best practices experiences in respecting mothers during the intrapartum and immediate postpartum periods, promoting a constructive and empowering viewpoint [99, 187]. This research is one of the phases of a doctoral project focusing on gaining insights into healthcare providers, with the overall aim of formulating strategies to maintain RMC in Rwanda [287].

### 6.3.2 Appreciative Inquiry

Appreciative Inquiry (AI) embraces a 5D cycle that consists of the **Definition, Discovery, Dream, Design and Destiny phases**, according to Cooperrider, Whitney & Stavros [99,198]. This 5D cycle allowed the participants to share their best moments of RMC and their expectations for RMC. AI significantly shifts sustainable organization development from traditional deficit-based change to a positive, strengths-based approach. It centres on harnessing an organization's 'positive core' strengths to design and redesign systems, fostering a more effective and sustainable future. AI enables organizations to identify positive core strengths related to the affirmative topic and take concrete steps towards their goals. [269,198] AI does not focus on solving problems but emphasizes mutual discovery, guiding participants to envision an organization that embodies their hopes and dreams [198, 55]. Note that the destiny phase was not reached within the objectives of this study.

Based on the objective of this study, In this study, the HCPs were involved in ***define, discovery, dream and design***

***Define:*** Clarify the affirmative topic, ensuring it has a positive core. During this phase, there is often a process of redefining or providing greater clarity to a significant challenge, thereby converting it into opportunities for more in-depth investigation. In this stage, the study topic is addressed and made more explicit [81,70,72]. The positive core is integral in all AI phases, underscoring AI's approach of magnifying what gives life to the organization [71,257, 55]. In this current study, in this phase, the author defined the study topic; the research topic was

positive: *"The best Respectful Maternity Care moments of HCPs working in a maternity section in Eastern Rwanda"*.

**Discover:** Identify and appreciate existing positive aspects by exploring what works well. Pose questions centred around "What gives life?" or "the best of what is" to gather positive stories from HCPs. The discovery phase in AI involves identifying and appreciating the best aspects of "what is" within an organization. AI's unique feature is its positive framing of questions, focusing on peak moments of organizational excellence. Participants deliberately let go of deficit analyses, seeking to isolate and learn from even the most minor wins. Stories of exceptional accomplishments are shared, emphasizing core life-giving factors and valued aspects of the organization's history. A collective appreciation emerges through dialogue, fostering a shared vision and group determination [71, 257, 55].

In this study, the researcher requested the HCPs share their best practices/ moments in providing RMC, their positive experiences from the community, positive feedback regarding RMC provision, what they appreciated mostly, and what facilitates providing RMC in their work environment. Unit managers (Matrons) and the medical doctor shared their personal stories with the researcher. Then, midwives and nurses shared their experiences and views with the wider group (Focus group discussion of 10-12 people), which identified the vital themes from the stories in the next phase (dream).

Example of questions asked:

*Can you share your positive experiences regarding RMC provision with me?*

*What is the positive feedback? - Do you receive any from the mothers/community/families about the services they receive?*

*What are the best practices being done here to sustain RMC in all care provided to women during labour and childbirth?*

*What have you talked about concerning RMC? What do you appreciate most?*

**Dream:** Envision the overall vision, results and impacts and foster innovation by asking questions like "What might be?" This phase involves using the insights from the discovery phase to create a set of aspiration statements, guiding the design of future actions. Participants identify new possibilities for the future. AI grounds future images in the positive past, creating compelling possibilities from extraordinary moments in the organization's history. The primary



goals are fostering stakeholder dialogue by sharing positive stories and identifying common themes without critique [71, 257, 55]. The Dream phase envisions a positive future, building on qualities discovered in the Discovery phase. It sparks discussions on favourable outcomes with the question, "What will your ideal success look like?" This phase fosters enthusiasm and collaborative vision, preparing for practical actions in the Design phase [81,70,72]. In this study, the dream phase was based on the information obtained from the previous interviews; participants envisioned how the maternity care services could operate at their best. Participants thought widely and holistically about the future they wanted. The participants were asked to envisage and portray RMC for the future through different imagining varieties and other innovative exercises.

Example of questions asked:

*What do you think facilitates you in providing RMC in your work environment?*

*What do you think HCPs can do to ensure RMC during labour?*

**Design:** Generate options for implementation and co-construct plans by focusing on "What should be the ideal?" This phase aims to identify concrete actions to support the new possibilities envisioned in the dream phase. Participants collaboratively create and commit to actions that will turn aspiration statements into reality. The design phase articulates the strategic focus, including a vision of sustainability. This phase is crucial for sustaining positive change and realizing the organization's best potential grounded examples from the positive past shape future images. Through in-depth dialogues, stakeholders define the processes to support the new system for better outcomes [71,257, 55].

Example of questions asked in this study:

*How to co-construct the RMC best practices? Between you and other HCPs and between you and mothers?*

*What can HCPs do to sustain/ incorporate RMC in all care provided to women during labour and childbirth?*

*What can be added to the current practices to engage more in RMC practices?*

*What do you think HCPs can do to ensure RMC during labour?*

**Destiny:** The Destiny phase is marked by planning and execution. The emphasis is on executing excellently and sustaining positive changes [71, 257, 55]. We did not reach this stage.

### 6.3.3 Setting and Population

The research took place in hospitals situated in Rwanda's Eastern province. Five of the ten hospitals in this region were chosen randomly for this investigation. The selection comprised three district hospitals, a provincial hospital, and a referral hospital. The population was HCPs working in 5 hospitals in the Eastern Province of Rwanda. The HCPs include midwives, nurses, general practitioners/ gynaecologists and maternity unit managers (matrons). We purposively recruited HCPs working in the five selected hospitals for at least one year. We conducted 1 FGD and 2 IDIs in each hospital. We conducted ten in-depth interviews (IDIs with five doctors and five managers of maternity units/services). We conducted 5 FGD with 55 midwives and nurses.

### 6.3.4 Data Collection

Interviews and Focus Group Discussions were conducted in person using an AI method. The researcher developed the interview guide and Focus groups for the purpose of this study, and they have not been previously published elsewhere. Before the data collection process commenced, participants were provided with a personal information sheet and signed a consent form agreeing to participate and be recorded voluntarily. Participants were asked about what they do understand by RMC, why it is important to provide RMC given the context and the conditions of their work environment, the benefits of RMC, to share their positive experiences/community positive feedback regarding RMC provision, what HCPs can do to ensure RMC during labour, what they mainly appreciated, what facilitates providing RMC at their work environment, how to co-construct the RMC best practices, how RMC can be sustained.

The interview was conducted in either Kinyarwanda or English, depending on the language better understood by the participant. Probing questions were used to elicit more in-depth information. Demographic information was also gathered using a demographic questionnaire. At the end of each interview, the researcher reminded the participants about the need for a second telephone contact to discuss the study findings and ensure that the study findings accurately reflected their experiences and perceptions. The field notes were taken during the

conversation. New insights from participants were added to the emerging themes as relevant. Data collection took place in August 2022.

#### 6.3.5 Data Analysis

Interviews and Focus Groups were predominantly conducted in Kinyarwanda and were audio-recorded. Following each interview, the audio was promptly transcribed verbatim. Under the guidance of the principal investigator, a research assistant, who was a native speaker of both Kinyarwanda and English and had prior experience in translation, played a crucial role in translating the transcripts into English. Their expertise and linguistic skills streamlined the process and ensured data integrity. For verification, these translations were then back-translated into Kinyarwanda. An inductive thematic analysis approach was adopted, and relevant quotes were used to present the findings. To immerse in the data fully, the researcher repeatedly reviewed the transcripts. The NVivo 12 software facilitated the organization of the transcribed data.

The process of data analysis began with the research team listening to the audio recordings and cross-referencing with transcriptions to ensure the data's integrity and completeness. The team meticulously reviewed the transcripts to become fully acquainted with the content. They employed line-by-line coding to pinpoint initial codes. These initial codes were assessed, and categories were established based on the commonalities and differences in participants' responses. An iterative process ensued: the team continuously reviewed and adjusted the established categories while cross-referencing with the original transcripts, ensuring they encapsulated participants' authentic experiences and viewpoints. This intensive analysis led to the emergence of primary themes.

To validate these themes. A subset of participants from all participating hospitals was selected and consulted for member checking via phone calls. They were provided with the themes and asked to confirm whether these resonated with their experiences. Themes were verbally summarized, and participants confirmed accuracy through discussion, feedback, and clarifications. Member checking is a crucial step in ensuring the validity of the findings. Member checking involves sharing the preliminary findings with participants and seeking their feedback to confirm the accuracy and authenticity of the interpretations [150]. Abductive (a combination of inductive and deductive) thematic analysis was then executed. In deductive

analysis, we did coding based on the Appreciative Inquiry questions framework, while in inductive analysis, codes emerged directly from the data. This process was supplemented with relevant quotes for a comprehensive presentation of the findings [66].

To ensure the trustworthiness of the research findings from this study, the researcher applied the evaluative criteria for rigour in qualitative research. These criteria include Credibility, which refers to the extent to which the findings are believable and can be trusted; Dependability, which relates to the consistency and stability of the findings over time and across different contexts; Confirmability, which concerns the objectivity and neutrality of the findings, ensuring the researcher's biases do not influence them; and Transferability, which refers to the extent to which the findings can be applied to other contexts or settings [155]. These criteria were rigorously applied to enhance the quality and reliability of the research findings.

## 6.4 Results

### 6.4.1 Socio-demographic characteristics

The participants interviewed were between 28 and 47 years old, with a mean age of 34; the majority were male (60%) and had bachelor's degrees (60%). The majority (70%) had experience working in maternity services, ranging from 2 to 10 years (**Table 6.1**).

**Table 6.1: Socio-demographic characteristics of participants in IDIs n=10**

| Variables                           | Categories | Frequency | Percentage (%) |
|-------------------------------------|------------|-----------|----------------|
| Age (in years)                      | 28-37      | 7         | 70             |
|                                     | 38-47      | 3         | 30             |
| Sex                                 | Male       | 6         | 60             |
|                                     | Female     | 4         | 40             |
| Level of education                  | Diploma    | 3         | 30             |
|                                     | Bachelor   | 6         | 60             |
|                                     | Masters    | 1         | 10             |
| Experiences in maternity (in years) | 2-10       | 7         | 70             |
|                                     | 11-20      | 3         | 30             |

**Socio-demographic characteristics of the participants in IDIs**

Table 6.2. Socio-demographic characteristics of the participants in FGD n=55

Slightly half of the participants were between 20 and 30 years old and had 1 year to 5 years of experience working in maternity services. The majority were female (71%) and had diplomas (64%) (**Table 6.2**).

| Variables                           | Categories | Frequency | Percentage (%) |
|-------------------------------------|------------|-----------|----------------|
| Age (in years)                      | 20-30      | 28        | 51             |
|                                     | 31-40      | 22        | 40             |
|                                     | 41-50      | 5         | 9              |
| Sex                                 | Male       | 16        | 29             |
|                                     | Female     | 39        | 71             |
| Level of education                  | Diploma    | 35        | 64             |
|                                     | Bachelor   | 20        | 36             |
| Experiences in maternity (in years) | 1-5        | 28        | 51             |
|                                     | 6-10       | 18        | 33             |
|                                     | 11-15      | 9         | 16             |

**Socio-demographic characteristics of Participants who participated in Focus Groups**

#### 6.4.2 Thematic framework

Four themes and subthemes emerged from interviews and focus group discussions (**Table 6.3**)

Table 6.3: Themes and sub-themes

| Themes                                    | Sub-themes                                                                                                                      |
|-------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------|
| <b>Theme one:</b> Perceived RMC provision | Empathic care<br>Dignified care<br>Equality<br>Privacy and confidentiality<br>Information provision<br>Satisfaction             |
| <b>Theme two:</b> Perceived RMC benefits  | Mutual trust<br>Happiness<br>Positive childbirth outcome<br>Positive relationship                                               |
| <b>Theme three:</b> RMC enablers          | Professionalism<br>Positive reputation                                                                                          |
| <b>Theme four:</b> Sustaining RMC         | Motivating hospital management.<br>Constructing on positive feedback<br>Supporting RMC actions<br>Improving recommended actions |

#### 6.4.2.1 Perceived RMC provision

Caregivers understood that RMC provided care courteously and respected women's rights. HCP described respecting women's rights by showing empathy, providing dignified care, equality care, privacy, confidentiality, calling the mother by her name, listening to her and allowing her to make decisions during treatment. They added that putting a mother in a safe environment makes the mother feel satisfied as well as a service provider.

#### ***Empathic care provision***

Respondents reported that the provision of RMC entails respecting women's rights, demonstrating empathy by putting oneself in the mother's shoes, attempting to educate mothers about their rights, expressing care and affection towards the mother, and delivering the best possible service to her.

*“Empathy would help us to provide Respectful Maternity Care; you wonder what if she was my mother, if she was my sister if she was another friend of mine .... you think that what you are doing to your client, one day if you go for treatment and they can do the same for you if you would be happy. Let us work for the mothers as if you are working for yourself... We should put ourselves in the position of a mother who comes to us, and we give her the best service.” FGD1.*

#### ***Dignified care***

The meaning of RMC lies in communicating with the mother and delivering dignified care through the use of respectful language and greetings and addressing her by her proper name. This is because how healthcare providers care for, speak to, and listen to the mother's wishes can positively impact maternal outcomes.

*"The act of being gentle makes the patient feel more at ease, and thus the first remedy for a patient is a good word; when she gets a good word, the way you cared to the mother, the way you talked, the way you listened to her may help her to get well quickly." FGD 2.*

HCP reported that respecting a mother is calling mother by her proper name

*"Respecting a mother is calling her by her proper name...By using her name, she feels relaxed and feels that you care about her; she feels that you know her and what you are doing for her, and you will take care of her, and she will tell you if she has a problem."* **IDI. Doctor, male, 28years**

### ***Equality***

Healthcare providers described that respecting mothers involves treating every mother equally, regardless of their socioeconomic status.

*"To provide Respectful Maternity Care, we must treat people equally; let's not say that this woman is a rich person, and I care a lot about her, that woman is a poor person, and I don't care about her, we have to care everyone and give them equal care. Respectful maternity care means taking care of every mother regardless of whether she is rich or poor, where she comes from, how she looks like, what the language she speaks, and taking care of her like any other mother."* **FGD4.**

### ***Privacy and confidentiality***

Healthcare providers reported that safeguarding the privacy and confidentiality of mothers represents a fundamental means of demonstrating respect. The provision of privacy instils a sense of security and value in the mother, necessitating its observance by all, including cleaners. Meanwhile, confidentiality can be upheld through the adoption of medical terminology, the utilization of written signage, discreet communication with the mother, and the employment of hushed tones.

*"Respectful maternity care is receiving the mother and keeping the information she has given you confidentially and even receiving her in her private place, even if here, we have curtains and install curtains and examine her in great secrecy.*

*The privacy gives her the feeling that she is in a safe, healthy environment where she feels valued as a patient.* **"IDI. Doctor, male, 28 years**

*"Cleaners also comply with the mothers' privacy because they can not come to clean while you are with the mother or enter without knocking on the door. In handover, we use English to*

*prevent information leakage. Even though there should be someone who understands it, we don't speak loudly; we speak quietly."* **IDI, Matron, female, 47years**

### ***Information provision and autonomy***

The respondents stated that demonstrating respect for a mother involves providing comprehensive information to her, encompassing explanations of her rights and responsibilities. RMC encompasses the notion of providing appropriate care to the mother, aligning with her individual preferences, and transparently communicating all interventions undertaken for both the mother and her newborn. It further emphasizes the importance of allowing the mother to autonomously make decisions rather than deferring to her partner.

*"Partners of mothers should respect healthcare providers even when their preferences conflict with medical recommendations. An example illustrates a situation where a man requested a cesarean section for his wife without medical need. After explaining the situation, he initially saw the providers as inconsiderate, but his wife understood the importance of a vaginal delivery. Fortunately, the mother had a successful vaginal delivery, and the man later apologized. This highlights the importance of balancing respect for preferences with medical expertise to avoid unnecessary procedures"* **IDI, Matron, male, 47years**

HCPs claim to grant mothers the right to choose, ask questions and provide consent. Additionally, mothers are actively involved in the treatment process, which makes them feel empowered.

*"We give the mother the right to choose or to ask questions. She is free to choose the doctor who treats her. She has what to say since she needs to consent to her treatment. The patient is involved in the treatment because she needs to consent for treatment, surgery, and receiving blood; in all of these, she is also involved. It also makes the mother feel empowered".* **IDI. Matron, female, 47 years**

### ***Satisfaction***

Participants perceive satisfaction and internal motivation as outcomes of RMC provided to the clients.



*“Respectful maternity care is to take care of the mother properly, which is suitable for a mother so that you also feel satisfied with how you treat her. Also, we care about the newborn; in what we do, we have to explain to the mother so that she becomes satisfied.”* **IDI. Doctor, male, 29 years.**

*“Wherever I got, I met mothers saying, here is your daughter, here is your son. Everywhere, they notice me, ask for my phone number, and request that I visit them. I heard people saying around here, “This doctor is the best,” and I felt motivated. I felt really motivated, which made me very happy.”* **FGD5**

#### **6.4.2.2 Perceived RMC benefits**

Participants reported that RMC holds significant importance as it fosters a sense of friendship between HCPs and mothers. HCPs have received messages of appreciation from mothers, some expressing a desire for enduring relationships and even offering gifts. Mothers exhibit enthusiasm and return for social visits, further reinforcing the positive impact of RMC. Notably, the provision of RMC serves as a preventive measure against legal complications in case of adverse incidents and results in optimal outcomes, promoting the health of both mother and baby. Furthermore, mothers experience faster recovery, enabling them to promptly return to work, potentially bolstering the country's economy. This approach also serves as a source of motivation for caregivers who take pride in delivering exceptional care. Additionally, it enhances the hospital's reputation within the community, fostering mutual trust and benefit. Consequently, RMC contributes to the overall quality of care and encourages greater utilization of maternity services.

#### **Mutual trust**

*"By respecting mother, she trusts you for the service you have given her; even if it doesn't go well...while she always has confidence in you when she comes back for the second time, she feels, again, she wants to be helped to deliver by you. She feels that she wants to meet again with the doctor she met before because she was given good service...If the respectful maternity care went well, ...mothers would trust us, and we could treat her because she was able to relax and tell us all about her."* **FGD 4**

RMC is beneficial to HCP and mother

*"Providing RMC can boost us and help us do our jobs better. If you provide successful service, you feel peace, you sleep, you feel safe, and you feel calmer. The first thing that makes us happy is to see a mother and child in good health. So respectful maternity care helps both on the client's side and on our side to provide services and make our work easier" FGD 5*

### ***Happiness***

Happiness is experienced by both service users and service providers, which can foster a continued relationship, encouraging service users to seek maternity care at the same facility in the future. This, in turn, contributes to positive outcomes by reducing maternal and neonatal mortality rates. Midwives, gynaecologists, and maternity nurses take pride in ensuring a healthy baby and a healthy mother.

*"Mothers used to tell me, "Doctor... You have really taken care of me, and now I am going back home. May God bless you and keep helping others like this ". If the person thanks you and keeps coming back to your hospital, it means she was happy with the good service you provide to her. When you provide respectful maternity care, because you did it right as it should be, the first thing you get is a good outcome: a healthy baby and a healthy mother." IDI, Doctor, male, 35 years*

### ***Positive childbirth outcome***

Respondents elucidated that RMC plays a pivotal role in influencing the psychological well-being of mothers, facilitating a smoother labour process, fostering maternal openness, and positively impacting the economic aspect of the family. They also highlighted the significance of what they referred to as the "four Ps" for successful labour and delivery: a healthy passage (birth canal), the passenger, the power (uterine contractions), and the psychological state of the mother, which can significantly influence the birthing process. When psychological support is provided, mothers often experience improved progress during labour. Healthcare providers additionally emphasized that providing RMC represents a unique opportunity to gather more comprehensive information about the mother.

*"For mothers, we say the four Ps: In order for the baby to come out, there is a need for a healthy passage. They say the passenger must be healthy, and the power is the uterine*

*contraction, but we say that there is also psychology. In fact, psychology has an impact on the way the child comes out; when it is not supported, often the mother is not progressing well in labour"* **IDI. Doctor, male, 28 years**

### ***Positive relationship***

Participants reported that providing respectful care to women creates long-lasting friendships. HCPs shared several testimonials about motivating the staff and contributing to a good reputation in the community. The reputation of the RMC provision helps prevent legal pursuit in the event of an incident.

*"Providing respectful maternity care helped us to make friends with the mothers; when we give them good service, sometimes it can go beyond the hospital. They thank you, speak well of you in society, or you become very good friends. I helped a mother give birth, and things went well. She told me that I would give you my brother and that you would come to our family."* **FGD1**

*"When the service providers communicate effectively with mothers, even in unexpected complications, the mothers tend to appreciate their efforts. Positive outcomes are more likely when service providers excel in their care, as clients are more likely to acknowledge their efforts and express gratitude. Conversely, clients may escalate their complaints to Rwanda Investment Bureau (RIB), and the repercussions can be severe, potentially leading to legal consequences, including imprisonment for the provider".* **FGD 3**

If the HCP provides RMC, the hospital will have a good reputation in the community. The experience of childbirth remains in a woman's mind, and she likes to share it with colleagues in the community and influence their decision to attend a health facility or not.

*"Mothers do not forget the doctor who helped them to deliver; it does not happen. It is obvious that if our service is good, the people we have provided are ambassadors in the community and end up telling their neighbours to come to get good service."* **FGD4**

#### ***6.4.2.3 RMC enablers***

Among the factors that enable RMC provision, HCPs described several key aspects. These included a sense of responsibility, a commitment to moral professionalism, a vocation-driven

approach, a foundation in deontological ethics acquired during professional training, alignment with the hospital's values and ethos, personal religious beliefs, and feedback and reputation within the community. Moreover, motivation, whether intrinsic or extrinsic, plays a significant role in promoting RMC. This motivation can manifest as a desire for increased compensation, providing meals (such as lunch, breakfast, and snacks), approval from superiors, and appreciation from clients. Nevertheless, one midwife emphasized that receiving accurate information is paramount when deciding to pursue a career in midwifery.

### ***Professionalism***

HCPs asserted that several factors influence the provision of RMC. These include professional duty and responsibility, adherence to moral principles, a sense of calling or vocation, educational background, personal religious beliefs, positive feedback from clients and the community, and active involvement by hospital management.

*"I provide respectful care to the mother because I feel that the most important thing is my responsibility and the client's right. The fact that we have many clients does not mean that we can use it as an excuse to disrespect them, so we try our best to serve many patients; I feel it is part of my duties, [Ahh] it does not bother me."* **IDI. Doctor, male, 28 years**

Participants widely consider the medical profession as both a calling and a vocation. Participants conveyed that their acquisition of professional deontological knowledge during their training, their deliberate choice of midwifery as a career, and their personal values and beliefs collectively contributed to their ability to extend respect to everyone seeking care.

*"Our profession is our calling and vocation. If you have a calling regardless of what you have at work, you feel that you have to help each mother to solve mothers' problems; in this profession, you have to put much dedication into it".* **IDI, Matron, male, 40 years**

### ***Positive reputation***

HCPs are motivated by the good reputation they get from mothers and society.

*"My parents from the village called me and said: "Our son, you are making us proud. We see people you helped to give birth well, they come and thank us for giving birth to you as our son". I say to myself that I am going to continue there and not go back."* **FGD 5**

*"I cared for a mother, and what brought me joy was when they included my name in the names they chose for their baby. Even though their child was a boy, they tried to incorporate my name. The mother came to express her gratitude and said, 'This is your child.' This experience instilled in me a deep sense of respect for the mother and reinforced my commitment to providing the best possible service."* **FGD 4**

### **Motivating hospital management**

HCPs argue that maintaining harmonious relationships with hospital management, receiving approbation from their leaders, appreciation from the clients, receiving on-site meals and snacks for free, and the prospect of salary increase can all motivate the provision of RMC.

*"If a service provider has peace with the management, he can provide service freely; I feel that Respectful maternity care is something that is broader than only doctors; the hospital itself needs to be involved"* **IDI. Doctor, male, 28 years**

*"When you are a hardworking professional, and on your bank account, you receive very little money, you feel bored. If you are bored, something goes wrong with this respectful maternity care. When someone is at work, and she does well, she should be praised... when you say she has done well, it gives her the courage to work, and she feels motivated."* **FGD3**

#### **6.4.2.4 Sustaining RMC**

Healthcare professionals received appreciation through various channels: phone calls, WhatsApp groups, in-person meetings, public feedback, suggestion boxes, and within the community. HCPs argue that mothers testify that midwives are capable and cautious, always double-checking before intervening.

### **Constructing on positive feedback**

HCPs narrated many testimonies from mothers and the broader community expressing appreciation for midwives and their life-saving capabilities. Furthermore, physicians have expressed their appreciation for midwives.

*"On the International Day of Midwives, we received an audio testimonial from a mother thanking us for our service. When she was pregnant, she was told by a doctor that her unborn baby had died in the womb and was recommended termination of pregnancy. A midwife intervened and discovered the baby was alive. The mother said, "The child is now 13, and he is the only child I have. I credit the midwives for saving my child's life." IDI Matron, Female, 47years*

Participants reported that while some mothers arrive with low expectations, healthcare providers establish trust with them. Recently, there has been an influx of positive feedback from the community. Midwives receive significant appreciation from mothers. Doctors have noted that some midwives are highly esteemed and frequently praised by mothers. These mothers often call back to express gratitude or return to show them their babies.

*"There is much positive feedback from the community, but they often appreciate and thank the midwives. Here, there are famous midwives who are very appreciated by mothers." IDI. Doctor, male, 30 years.*

*"We received the feedback from mothers by telephone or talking to you in person. They call and tell me, "You really helped me; the service was given to me, and I am very happy with it" IDI Matron, female, 28 years.*

### ***Supporting attained RMC actions***

HCPs reported significant improvements in RMC compared to the past. Participants who advocate for RMC emphasized the importance of sustaining best practices, including ensuring privacy, clear communication with mothers, effective handovers, teamwork, managing the high influx of clients, prioritizing emergency cases, and obtaining informed consent. They are committed to respecting and valuing mothers, refraining from negative behaviour such as hitting or speaking poorly to them, ensuring confidentiality, supporting breastfeeding, and ensuring the well-being of both the mother and her newborn. HCPs noted that mothers are currently more satisfied due to improved RMC practices, attributable to the hiring of younger professionals, consistent RMC training, effective communication during handovers, continuity of care, trust-building, and collaborative decision-making.

Participants recommended that the government increase the workforce and continue advocacy, emphasizing the need to expand maternity facilities, especially where limited space exists. They recognize the positive shifts in mentality and performance, including the training and awareness of ancillary staff like cleaners, who now know not to enter delivery rooms during births. To maintain a favourable reputation in the community, participants stress the importance of continuous onsite training for all team members, ongoing quality improvement meetings, patient satisfaction surveys, suggestion boxes for user feedback, and prompt handling of client complaints. They also suggest continuing charitable actions, such as providing food to clients. Stakeholders such as non-governmental organizations (NGOs) and the Rwanda Association of Midwives (RAM) play a crucial role in offering RMC training to HCPs.

*"We avoid hitting a mother, saying bad things to the mother, disrespecting mother have been broken, now the mothers and babies are treated well... We are trying to do our best to respect the mothers who come to us. The thing of beating mothers in this place is no longer here; the mother is given information about everything that is done. We have very good feedback from our clients about our excellent service."* **IDI, Doctor, male, 35 years**

*"In this hospital, a lot of effort was made compared to the past; the staff understands it, and they are motivated; we had many Respectful Maternity Care components from the training from the quality improvement meeting. Let's make a plan for improving the few that are left. The accreditation assessment helps us a lot. We want to meet the standard, and we keep reminding each other. In training, we include the whole team of doctors, midwives, and nurses. We do not exclude the doctors because we will all meet that patient."* **IDI. Matron, female, 40 years**

HCPs have emphasized the importance of ensuring continuity of care, with effective communication and teamwork being crucial elements. Effective communication not only facilitates continuity of care but also aids in the dissemination of health information, gathering client feedback, and ensuring informed consent. Collaborative efforts among hospital leaders and the maternity team - including midwives, doctors, nurses - and mothers- are key. Optimal collaboration stems from solid communication. Interpersonal communication between leaders, staff, and service users is paramount; all processes tend to work well when communication flows smoothly. Some HCPs mentioned that words of appreciation from their leaders motivate

them. Midwives are encouraged to utilize media platforms, such as radio or television, to raise awareness among mothers about seeking maternity services promptly and recognizing potential danger signs.

*"Another thing we do is continuity of care. We work together as a team to do the handover. Effective communication is key. When we have a meeting, you find that the hospital management often thanks us in the maternity department because we are providing good service".* **IDI. Doctor, male, 28 years**

### ***Improving recommended actions***

To realize RMC, participants suggest implementing an improvement plan. This plan includes fostering a sense of ownership and responsibility in care provision, emphasizing teamwork, and promoting consistent reminders and collaboration between HCPs and administration. Supporting teamwork among staff is pivotal in saving the lives of mothers and babies and must be grounded in mutual respect. HCPs should advocate for supporting mothers facing financial hardships with hospital bill payments. Furthermore, educating mothers about the risks associated with traditional medicine and recognising danger signs is essential. Regular evaluations of care quality and gathering client feedback are also crucial. Upgrading or renovating infrastructure, including private wards, and ensuring adequate equipment, such as beds, is necessary.

Increasing the workforce will allow HCPs to dedicate more time to patient communication. Midwives require support, such as provided meals, public recognition, regular breaks, improved living conditions, and strategies for self-evaluation and burnout prevention. Participants believe training all HCPs in maternal care on RMC principles will advance its implementation. Hospitals currently display general patient rights and responsibilities on posters, but there is a specific need to raise awareness about the universal rights of women and newborns. Emphasis should also be on RMC-focused onsite training and school upgrading for healthcare professionals.

Respondents were advised to increase their sense of responsibility and ownership by creating women's rights awareness and their responsibility to seek medical care early. Participants claimed they should strengthen the ownership, take RMC seriously, and put more effort into it. Moreover, it is necessary to monitor and evaluate RMC provision.



*"There is a need for external teaching to the community to teach pregnant mothers their rights, teach them the help they should get, and remind them that it is their responsibility to go to the doctor on time. Yes, it is a campaign." FGD2*

*"I want to add that I understand that respectful maternity care should be ours; we should learn it and put effort into it like everything else we put effort into it..." IDI, Doctor, male, 28years*

Service providers explained that teamwork is very important for all providers who help mothers deliver: midwives, nurses, doctors, anaesthesiologists, and even cleaners. Teamwork goes hand in hand with mutual respect since each one plays a specific role, and that relationship enables HCPs to learn from each other.

*"Teamwork is important in all providers who help mothers to deliver midwives, nurses, doctors, anaesthesiologists, even the cleaners. If you need to prepare the theatre, the cleaner will prepare the room quickly, so we need the cleaner to help us pick up mothers or to call the doctors; when you are alone, you tell her/him to call somehow.".... teamwork must go hand in hand with mutual respect, giving each other's opinions because teamwork without mutual respect is not going well." FGD5*

Advocacy efforts emphasize the importance of not detaining mothers who fail to pay their medical bills. There is a need to establish mechanisms to address these social issues effectively. Additionally, participants advocated for community awareness campaigns to discourage the use of traditional herbs. HCPs have encountered numerous cases where mothers consumed traditional herbs. They strongly advise women against using such remedies, as these herbs can lead to adverse maternal and neonatal outcomes.

*"Many mothers we receive and deliver babies with birth asphyxia, most of the people who come with intrauterine fetal death are often people who use traditional medicines. It is obvious, and even if you talk to her carefully, you will be able to see that she has taken traditional medicine. We can go and hold meetings in the villages and teach about the danger of taking traditional herbs." FGD1*

Evaluation by getting the client's feedback is also important. The client satisfaction survey helped to identify the level of respect received by mothers.

*"If we had time to ask patients how they perceived the service received. We would have done it as an improvement plan project and said that we want to know how our clients enjoy the service; then, what we find is a problem, and we would correct it so that mothers can feel respected. IDI, Matron, female, 40 years."*

Participants claimed the need to improve working conditions by increasing the staff, improving the living conditions of midwives and preventing burnout. Some respondents demanded to put effort into claiming and clarifying their rights because though they try to work well, some are being hit or slapped by service users and are not observed. Improvement of living conditions of HCPs was reported as a key to making RMC possible. HCP reported that avoiding burnout (stress) can also contribute to RMC sustenance.

*"The fact that there are few doctors is a well-known problem everywhere for a long time ago. So, when we have enough staff, every midwife or nurse, everyone will be more comfortable. I have something to add: there is stress. We have high work stress or burnout, which can affect the RMC provision." FGD1*

HCPs claim their rights by saying that service users sometimes slap them, and no one cares about that.

*"I just want to add something about the rights of health care providers. Yes. We are working and doing well, but sometimes you find that your rights are not observed... you go and see the client comes and hits you or slaps you; when that person slaps you, you do not continue to care as much as you would.... the rights of the patient were clarified...but now we do not have any rights." FGD 4*

## 6.5 Discussion

Our study focused on the positive experiences of RMC provided to women during childbirth. Healthcare providers reflected on their positive experiences and perceptions of RMC throughout their careers caring for mothers during labour and childbirth. They were keen to

discuss positive RMC testimonials, showing that these experiences deeply resonated with them emotionally. Participants perceive RMC as encompassing all aspects of women-centred care, respecting the rights of women and newborns, such as autonomy, privacy, confidentiality, and equality of care. They believe that the ultimate goal for every healthcare provider attending to a mother during labour is ensuring the health of both the mother and newborn. Our participants perceive RMC similarly to the existing empirical evidence [186, 243, 139, 126].

RMC is a sensitive topic, and deploying Appreciative Inquiry to explore it encouraged participants to reflect on their best experiences, fostering a more constructive and empowering perspective. Mdoe and colleagues argue that AI offers invaluable insights, especially in resource-constrained environments [173]. By harnessing AI, one can glean realistic and culturally relevant findings that spotlight strengths and positive outcomes rather than merely dwelling on challenges and blame [173]. On the contrary, when it comes to reporting on negative experiences, the literature argues that HCPs may underreport their own role in mistreating mothers [46].

In order to sustain RMC, the participants recommended to provide consistent RMC training. This is similar to other recommendations reported that training occurs in the actual work environment and is effective because it provides real-time feedback and practical application [176,134]. However, a recent scoping review [92] highlighted that most RMC interventions in Africa centred on training HCPs in RMC. This approach has been criticized for its limited effectiveness as the acquired knowledge typically diminishes within three to twelve months and creates the need for refresher training. Moreover, the availability of adequate equipment and facility upgrades are crucial for ensuring the privacy, safety, and comfort of service users.

To improve RMC and sustain the existing best practices, the participants suggested actions to ensure the well-being of the staff since they can directly impact the quality of care [152,45]. In addition, our participants suggested community involvement. Other studies that implemented initiatives such as community dialogues and maternity open days reported them to be effective, as they can satisfy the community's curiosity regarding the maternity care package provided at a specific hospital level. [270]. Creating public awareness and advocacy of patients' rights through posters or informational pamphlets can empower mothers to be aware of their rights and demand better care. These interventions yield better results in Kenya and Tanzania [270,152]. It is vital to raise awareness among the population through media platforms about the importance of early antenatal care attendance, recognizing danger signs, and avoiding

potentially detrimental traditional practices, like clandestinely consuming traditional herbs during labour. Participants noted that many women in labour commonly use these remedies, which can adversely affect the health outcomes of both the mother and her newborn [160].

The hospital administration should compassionately address the issue of mothers unable to settle their hospital bills. For example, they could implement a system to facilitate post-discharge follow-ups, allowing families to make payments over time [235], and advise to end the retention of mothers and newborns worldwide in health facilities. The involvement of internal audits by regular checks and quality assessments to ensure that standards are maintained and any anomalies are promptly addressed, for instance, getting the feedback of care received by mothers, is very important. Policy makers' involvement by strengthening and updating the national maternal care policies.

RMC is complex and multi-faceted [24]. Studies reported that RMC provision is beyond the relationship between HCP, the mother and her family [270]; instead, actions should be tailored and function across various levels: individual, facility, community, and national. The recent scoping review argues that the appropriate intervention activities have been contextualized, but there is still a lack of shared consolidated information [92,6]. Interventions to improve RMC should tackle environmental, behavioural, motivational, informational, and structural factors contributing to subpar RMC [98,7].

## 6.6 Conclusion and recommendations

Healthcare professionals take pride in the positive experiences they have facilitated for mothers during labour, childbirth and immediate post-partum care. Achieving and maintaining RMC in Rwanda necessitates a comprehensive strategy encompassing consistent training, infrastructure improvement, active community involvement, and strong RMC policies. Given the dedication shown by Rwanda's healthcare sector and its allies, the nation is making significant strides towards ensuring every mother is treated with the dignity and care she warrants during the pivotal moment of childbirth. We advocate for further studies employing appreciative inquiry and emphasize the need to develop strategies to uphold RMC in Rwanda.

## 6.7 Strengths and Limitations

One of the strengths of this study is that we obtained diverse views from professional staff (midwives, nurses, doctors) who primarily care for women during labour and childbirth. A limitation is that the study relied solely on self-reported information.

## Chapter seven: Healthcare providers' perspectives on sustaining Respectful Maternity Care appreciated by Mothers in five Hospitals of Rwanda.

*This chapter is about qualitative findings from HCPs' views on what was reported by the women (phase 2a) with objective 4: To explore HCPs views of RMC as reported by the women from phase 1*

### 7.1 Abstract

**Keywords:** *positive childbirth, appreciative care, best practices, mother-friendly care, Rwanda*

**Background:** Childbirth reserves respect, as emphasized by the World Health Organization in 2018, and the focus towards the need for positive, dignified delivery experiences has become an integral aspect of Respectful Maternity Care (RMC). It is a known fact that RMC is pivotal for favourable birth outcomes and contributes to the satisfaction of maternity care. The absence of RMC negatively affects women's and newborns' rights. The study aimed to explore healthcare providers' perspectives on sustaining RMC actions that mothers previously reported.

**Methodology:** This study was conducted in five hospitals in the Eastern province of Rwanda, involving 5 focus group discussions (FGDs) with midwives and nurses. For interviews, we purposively selected 5-unit managers and five physicians. Additionally, 40 midwives and nurses were recruited for the FGDs. The research utilized the Dream phase of Appreciative Inquiry (AI) for interviews and Focus Groups. Data collection aimed to gain insights into Healthcare Providers' perceptions of how RMC is provided and how to establish and sustain RMC in Rwandan health facilities. Nvivo 12 was employed for organizing codes and creating a codebook, and thematic analysis was applied.

**Results:** 4 themes emerged and their sub-themes. 1) *Women-centered care* with Compassionate care, Privacy and confidentiality maintenance, Information provision and liberty in decision making, Effective communication, Family involvement, cleanliness, and Equality care. 2) *Professionalism compliance* with Motivated staff, Teamwork, Continuous development, Quality work provision, and Community trust. 3) *RMC encounters* 4) *RMC sustenance*

**Conclusion and recommendations:** The continuous pursuit of high RMC standards in Rwanda involves improving childbirth experiences through utilizing existing resources, ongoing improvement, and sustaining achievements. Key recommended actions in this study

for sustaining RMC encompass promoting women-centred care, enhancing healthcare provider attitudes, ensuring professionalism, building community trust, maintaining conducive health facility environments, and involving leadership.

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Adapted from Muhayimana, Alice\*, Irene Josephine Kearns. Healthcare Providers' perspectives on sustaining Respectful Maternity Care appreciated by mothers in five hospitals in Rwanda. <https://bmcnurs.biomedcentral.com/articles/10.1186/s12912-024-02017-5>  
*Published at BMC Nursing Journal*

## 7.2 Introduction

In the era of striving to achieve the Sustainable Development Goals (SDGs), countries worldwide, including Rwanda, aim to meet all goals and targets by 2030, employing various strategies. This study specifically focuses on one target of SDG number 3: to end all preventable deaths of maternal and newborns [121], and one target of SDG number 5: to eliminate all forms of violence against women and girls [58].

Childbirth, a significant human experience, deserves respect. The intrapartum and immediate postpartum period poses a high risk for both mother and newborn, necessitating high-quality care [90]. White Ribbon Alliance (WRA) defined Respectful maternity care (RMC) as a human right of every woman and her baby to be treated with care, respect and dignity, free from harm, and to maintain absolute liberty and autonomy [291]. Therefore, RMC is not an option but a fundamental human right. World Health Organization (WHO) in 2018 stated that RMC extends beyond the mere prevention of maternal morbidity and death. It emphasizes the need to ensure that women have a pleasant delivery experience, which entails being treated with utmost respect and dignity [45,257]. In 2018, WHO shifted its focus towards ensuring a positive childbirth experience, emphasizing its importance [289].

Mistreatment towards mothers during childbirth contributes to the poor quality of maternity care they receive [47]. Studies argue that Disrespect and Abuse (D&A) can inflict long-term psychological damage and emotional trauma, diminishing women's confidence and self-esteem [191]. Being disrespected may lead to feelings of shame, sorrow, insecurity, distrust in healthcare staff, a sense of powerlessness, and reluctance to seek help [191]. Memories of labour and delivery experiences persist throughout a woman's lifetime and are often shared with others [47,284]. Disrespectful and abusive care instils fear of future utilization of maternity services, reducing their use, which, in turn, hinders safe motherhood and contributes

to increased adverse maternal and neonatal outcomes [47,191]. D&A is a violation of fundamental human rights [291].

Rwanda has made significant strides in maternal and neonatal health, achieving Millennium Development Goals through initiatives like increasing skilled birth attendants, family planning, and Community Health Workers (CHWs) since 2009. CHWs are pivotal in promoting maternal and newborn care at the household level. The introduction of RapidSMS technology in 2010 synchronized health systems, increased ambulance services and improved the transfer of labouring pregnant women to health facilities. Mandatory health insurance coverage since 2008, with 91% coverage, ensures access to healthcare [202].

Rwanda's notable progress in prioritizing women's rights has indeed made significant strides in promoting gender equality, particularly in political representation. The country has surpassed many others regarding the percentage of women in parliamentary positions, showcasing a commitment to empowering women at various levels of society. Ultimately, this commitment to promoting women and gender equality contributes to the overall development and progress of the nation [269]. It sets a positive example for other countries. It highlights the idea that empowering women is not only a matter of rights but also a strategic investment in the social and economic prosperity of the nation.

The absence of overt disrespect or abuse during childbirth does not guarantee the presence of RMC practices; for instance, the absence of physical abuse does not necessarily indicate the existence of compassionate and positive care behaviours [139]. RMC and mistreatment during childbirth represent opposite ends of the spectrum. Research indicates that women and newborns can experience a mix of both positive RMC practices and negative mistreatment behaviours within this range [139].

Providing RMC plays a crucial role in enhancing the quality and utilization of maternity services [289,100,125]. Advocating for RMC is essential for advancing the Sustainable Development Goals (SDGs), particularly in achieving the targets of eliminating preventable maternal and neonatal deaths and ending all forms of violence against women [173]. Although in 2018, WHO launched a shift towards promoting positive childbirth experiences, appreciative RMC practices have remained mainly under-examined in academic literature [58], particularly in Rwanda, where very little is known about the perceptions of healthcare providers (HCPs) towards maternity care mothers received.

Little is known regarding perceptions of HCPs regarding RMC provision in Rwanda. Ndirima published findings on perceptions of maternity services at Mibilizi District Hospital in Rwanda's Western Province. The study involved rural women who had hospital births. The mothers commonly emphasized the need for respectful treatment in spaces which offer ample privacy, preferences regarding the gender of the birth attendant and the potential presence of their husbands during the childbirth process. Women in these remote areas make considerable efforts to access healthcare facilities with positive expectations. However, the staff shortages pose obstacles [200]. Violations against women's dignity and respect were reported by women in labour in the health facilities of Rwanda. Women were slapped, verbally berated, humiliated, reprimanded, physically assaulted, insulted, abandoned, denied having birth companions, and some were subjected to inappropriate and rough handling by healthcare providers. Many reported being shouted at for failing to follow instructions, and some were retained within hospitals due to unsettled bills [191]. In addition, women were being subjected to shouts and derogatory remarks from HCPs [243].

### 7.3 Methodology

#### 7.3.1 Research Design

This study employed an exploratory qualitative descriptive design, incorporating Focus Group Discussions (FGD) and individual interviews as data collection methods. The data collection approach utilized Appreciative Inquiry (AI), encouraging participants to reflect on their most positive experiences and perceptions and fostering a constructive and empowering perspective [258]. This study is a part of a doctoral project aimed at gaining insights into healthcare professional's perceptions of RMC, with the overarching goal of developing strategies to promote RMC in Rwanda. The interview guide was developed for this study and was not published elsewhere.

#### 7.3.2 Appreciative Inquiry approach

Appreciative Inquiry (AI) adopts a 5D cycle comprising the stages of Definition, Discovery, Dream, Design, and Destiny [257]. This approach significantly moves away from traditional deficit-based change to a positive, strengths-oriented strategy [65,116,137]. AI is revolutionizing the field by presenting a proven methodology to address critical change agendas effectively [259,248,81]. Its focus is leveraging an organization's 'positive core' strengths to develop and reshape systems, thus promoting a more efficient and enduring future [257,70,72]. Through AI, organizations can pinpoint positive core strengths related to the



affirmative topic and take tangible steps toward achieving their objectives. Moreover, AI goes beyond being just a 5-D cycle methodology, ushering in deeper, more meaningful, and sustainable change at the organization's heart [257,81,70,72]. In this study, **HCPs** expressed their thoughts on mothers' reports from the previous phase, corresponding with AI's ***dream and design*** stage.

**Dream:** The Dream phase involves envisioning a positive future, building upon the qualities uncovered in the Discovery phase. It stimulates conversations about desirable outcomes, prompting the question, "What would ideal success (for RMC) entail?" Participants explore new possibilities for the future. AI anchors future visions in the positive aspects of the past, drawing inspiration from remarkable moments in the organization's history. The main objectives include fostering dialogue among participants by sharing positive narratives and identifying common themes without criticism. The Dream phase encourages stakeholders to engage in discussions and imagine a better organization and world, stimulating the status quo to generate synergy and enthusiasm [257,81,70,72].

This stage of research entails leveraging the insights gathered from the discovery phase (based on mothers' feedback) to formulate a series of aspiration statements that inform the design of future actions. The Dream phase visualizes a favourable future, drawing upon the qualities uncovered in the preceding Discovery phase, which documented RMC experiences reported by mothers. The author investigated healthcare providers' viewpoints (based on what was reported by mothers) regarding maintaining RMC initiatives through various imaginative exercises and innovative methods. The HCPs were prompted to envision and conceptualize the future of RMC. During interviews and FGDs, the following questions were posed:

*The mother appreciates receiving compassionate care. What do you think can be done to achieve this?*

*The mother values autonomy/independence in the care received. What measures do you think can work to achieve this?*

*The mother values efficient care. What steps can be taken to achieve this? Additionally, how do you propose dignified care and respect be sustained?*

*How would you ensure the maintenance of privacy and confidentiality for women in labour?*

*Mothers prefer giving birth via normal delivery. How can these preferences be honoured?*

*Mothers desire to have a healthy baby. How can this goal be achieved?*

*Mothers prefer to stay in a clean and tidy environment. How can this preference be accommodated?*

*Mothers perceive that RMC is associated with the love of individuals and a passion for the profession. How do you propose these aspects be sustained?*

**Design:** Generate options for implementation and co-create plans by focusing on "What would constitute the ideal?" The Design phase underscores the utilization of past successes to devise actionable steps towards the vision outlined in the Dream phase. Its primary objective is to pinpoint specific actions that align with the novel possibilities envisioned during the dream phase. Participants work collectively to generate and commit to actions that translate aspiration statements into tangible outcomes. The design phase delineates the strategic direction, incorporating a vision of sustainability and a compelling statement of strategic intent. It plays a pivotal role in sustaining positive change and realizing the organization's fullest potential, as exemplars from past successes shape future projections. During extensive dialogues, stakeholders delineate the necessary processes to uphold the new system, ensuring it aligns with the desired outcomes of the inquiry [257,81,70,72].

Examples of questions posed include the following: *The community holds various perspectives, whether positive or negative, regarding the care provided to women during labour and childbirth. How can trust be restored within the community?*

*What interventions or actions by healthcare providers would exemplify RMC?*

The HCPs suggested maintaining and enhancing the most effective RMC practices. In this study, participants suggested strategies, protocols, and systems. They established partnerships that ultimately fostered and bolstered positive changes in RMC among themselves as HCPs. They developed inspiring intentions and precise design statements. Consequently, the detailed visions/strategies derived from the previous phase's findings and mothers' perceptions enabled the HCPs to formulate their plans to address such.

**Destiny:** (We did not progress to this stage). The Destiny phase represents the culmination of discovery, dream, and design, establishing an "appreciative learning culture." It is the implementation stage, bringing the envisioned new future into reality and fostering a collective

sense of purpose. This phase involves ongoing learning, adaptation, and innovation, aligning interactions with shared ideals to ensure long-term success [257,81,70,72].

### 7.3.3 Setting and Population

*Study setting:* The research was conducted at five hospitals in Rwanda's Eastern province. The Eastern province was selected because it is the second province with the highest birth rate based on the latest report from Rwanda 2019-2020 Demographic and Health Survey [198]. We have chosen these hospitals because they handle both normal and complicated delivery.

*Population and the sampling method:* The study involved a sample of 50 HCPs working in maternity services, including medical doctors, midwives, and nurses. We purposefully recruited healthcare professionals (HCPs) from each of the five selected hospitals, ensuring they had worked there for at least one year. The day before data collection commenced, the Principal Investigator reached out to the Nursing Director and maternity unit supervisors (matrons) at each hospital to discuss the data collection plan. On the day of data collection, the researcher invited HCPs to participate in the study. We considered both off-duty and on-duty HCPs eligible for participation. Recognizing the demanding nature of maternity services and staff's busy schedules, we remained flexible with timing for those on duty, conducting interviews during their break times. We explained our study thoroughly to all participants, and those who chose to take part signed a consent form.

Ten in-depth interviews involved five medical practitioners and five maternity unit supervisors (matrons) (**refer to Table 7.1**). Additionally, five Focus Group Discussions were held, with the participation of 40 midwives and nurses working in maternity care (**refer to Table 7.2**). The investigation took place in May 2023. Participants were generally asked about their opinions on the findings reported by mothers in a previous study [188].

### 7.3.4 Data collection

The interview was conducted in either Kinyarwanda or English, depending on the participant's preferred language. The interviewer was a Faculty member from the University of Rwanda. There was no power relationship between the interviewer and interviewees, and they didn't know each other prior to the study; the interviewer was working in Kigali while the study was conducted in another province.

We conducted interviews and FGDs in a private room in the hospital. The participants were assured about the total confidentiality of their information. We assured our participants in IDIs that their names and other identifying information will not be recorded anywhere. Confidentiality was maintained throughout the process of providing information, treating it, and keeping it. In addition, we guarantee that no individual participant will be identified in any report or publication arising out of this study. However, in the FGDs, we kindly asked them to treat the discussions as confidential because of the group nature of a Focus Group.

Demographic details were collected using a demographic questionnaire. We used a semi-structured interview guide with open-ended questions. In-depth information was elicited through probing questions. Participants were informed that mothers value compassionate care, and we asked for their suggestions on providing care free from harm and ill-treatment and ways to demonstrate empathy. The interviewer emphasized that mothers appreciated autonomy and independence and asked the participants how to achieve this. The interviewer asked the participants how they could grant mothers decision-making liberty, allowing mothers to express their choices and preferences and providing them with relevant information. Additionally, participants were informed that mothers value-efficient care, and the interviewer sought their input on achieving this while sustaining dignified care, respect, and maintaining privacy and confidentiality.

Furthermore, HCPs were informed that mothers expressed a desire for a normal delivery, getting a healthy baby, and staying in a clean and tidy environment. The interview inquired about actions that can be taken to uphold these preferences. HCPs were also informed that mothers typically perceive HCPs who provide RMC as those with love for people and passion for the profession; the interviewer asked how these aspects can be sustained. HCPs were then reminded that the community holds varying positive and negative perspectives regarding the care women receive during labour and the birth process. They were asked to propose ways to regain the community's trust and interventions or actions from HCPs that would demonstrate RMC. Furthermore, HCPs were queried about the methods they view as respectful towards a woman in labour, from a healthcare provider's perspective, from hospital management, and within health facilities.

Following the conclusion of each interview, the researcher stressed the significance of subsequent communication via telephone calls to review the study findings and confirm their

precise representation of participants' perceptions. Field notes were documented throughout the discussions, and any fresh insights offered by participants were integrated into the analyzed data. Throughout the discussions, descriptive field notes were documented during the interviews and Focus groups, and any fresh insights offered by participants were integrated into the analyzed data.

### 7.3.5 Data Analysis

After each interview, the experienced transcriber immediately manually transcribed the audio recordings word for word. Guided by the principal investigator, a research assistant translated these transcripts into English, simplifying the process and maintaining data integrity. These translations were then reverse-translated into Kinyarwanda to verify their accuracy. The research employed an inductive thematic analysis approach, utilizing pertinent quotes to convey the findings. To deeply engage with the data, the researcher extensively reviewed the transcripts. The Nvivo 12 software played a pivotal role in organizing the transcribed data.

The research team initiated the process with a meticulous approach, carefully listening to the recorded audio and ensuring the completeness and integrity of the data through cross-referencing with transcriptions. To thoroughly understand the content, the team meticulously examined the transcripts. They utilized line-by-line coding to identify initial codes, which were then evaluated to establish categories based on similarities and differences in participants' responses. This process involved an iterative approach, with the team continually revisiting and refining the categories while cross-referencing with the original transcripts to ensure they accurately captured participants' genuine experiences and perspectives. This rigorous analysis led to the identification of primary themes. Selected participants were consulted to validate these themes through a process known as member checking [123], ensuring that the themes resonated with their perceptions. Subsequently, an inductive thematic analysis was conducted, complemented by relevant quotes to comprehensively present the findings [215].

#### 7.3.5.1 Trustworthiness measure

To ensure the trustworthiness of the research findings in this study, the researcher adhered to the evaluative criteria for rigour in qualitative research. As Lincoln and Guba [155] and Grove and Burns [123] outlined, these criteria encompass credibility, dependability, confirmability, and transferability. Credibility was ensured by deliberately selecting healthcare providers who met eligibility criteria, using open-ended interview questions to elicit detailed responses, and incorporating peer debriefing and member checking during data collection and analysis.

Sharing transcripts for accuracy confirmation further enhanced credibility. Dependability was maintained by meticulously documenting decisions from research initiation to data analysis, creating a comprehensive audit trail. Data stability was also upheld through timely and consistent collection under similar conditions within a specific, relatively short period. Confirmability was maintained by relying solely on participant narratives for analysis, avoiding the imposition of the researcher's assumptions [78,123]. Transferability was enhanced by providing a detailed description of the study's setting, sample, and investigated phenomenon using a well-structured interview guide.

## 7.4 Results

*Table 7.1. Socio-demographic data from individual interviews n=10*

The majority (70%) of participants who took part in the interview were aged between 25 and 35. Among them, 80% were male, and 60% had experience of up to five years or less.

| <i>n=10</i>                    |                   |                  |                    |
|--------------------------------|-------------------|------------------|--------------------|
| <b>Variables</b>               | <b>Categories</b> | <b>Frequency</b> | <b>Percentage%</b> |
| <b>Age</b>                     | 25-30             | 4                | 40                 |
|                                | 31-35             | 3                | 30                 |
|                                | 36 and above      | 3                | 30                 |
| <b>Sex</b>                     | Female            | 2                | 20                 |
|                                | Male              | 8                | 80                 |
| <b>Profession</b>              | Medical doctor    | 5                | 50                 |
|                                | Midwife           | 5                | 50                 |
| <b>Experience in maternity</b> | 1-5 years         | 6                | 60                 |
|                                | 6-10 years        | 4                | 40                 |

*Table 7.2. Demographic data from Focus Groups n=40*

About half of the participants in the FGDs fell within the age range of 31 to 35 (49.5%). The majority of participants were midwives (72.5%), and approximately half of them had accumulated one to five years of experience working in maternity services.

*n=40*

| Variables                      | Categories         | Frequency | Percentage% |
|--------------------------------|--------------------|-----------|-------------|
| <b>Age</b>                     | 25-30              | 11        | 27.5        |
|                                | 31-35              | 19        | 47.5        |
|                                | 36 and above       | 10        | 25          |
| <b>Sex</b>                     | Female             | 30        | 75          |
|                                | Male               | 10        | 25          |
|                                | Midwife            | 29        | 72.5        |
| <b>Experience in maternity</b> | Nurses             | 11        | 27.5        |
|                                | 1-5 years          | 20        | 50          |
|                                | 6-10 years         | 15        | 37.5        |
|                                | 11 years and above | 5         | 12.5        |

During thematic analysis, four themes and sub-themes emerged from the data:

1) ***Women-centered care*** with compassionate care, privacy and confidentiality maintenance, information provision and liberty in decision making, effective communication, family involvement, a clean environment, and equality care. 2) ***Professionalism compliance*** with Motivated staff, Teamwork, Continuous development, Quality work provision, and Community trust. 3) ***RMC encounters*** 4) ***RMC sustenance***

## 1. Women centered-care

### 1.1 Compassionate care

Healthcare providers emphasized the importance of showing compassion to mothers. They stressed the need to put themselves in the client's shoes, treat the mother with empathy, reflect on ethical considerations, ensure her confidentiality, care for her with a good heart, make the mother feel relaxed, and show love and hope. They added that truly compassionate service

would be achieved if a doctor treated every mother like his/her own mother, wife, or sister. HCP reported that performing episiotomy without anaesthesia no longer exists.

*"We need to have a heart of love and patience. There is hard work in maternity, but we should have the heart to love people. So first we should strengthen love in ourselves and then have the gift of patience ... What we should do for the mothers to show them compassion first is to put ourselves in their position because if we put ourselves in their place." FGD1*

HCPs reported that mothers should understand that labour pain is natural and normal. HCPs support labour by reassuring the mothers, providing back massages, encouraging them to ambulate, and ensuring emotional well-being by offering comforting words. Service providers reported having insufficient knowledge about labour painkiller medications.

*"An area where we have little knowledge is pain relief for the mother in labour. Pain management is not appropriately done, but we teach them with the help of the Bible". FGD 5*

### **1.2 Privacy and confidentiality maintenance**

HCPs emphasized the criticality of maintaining privacy and confidentiality in healthcare settings. They noted that while curtains between beds are used to uphold privacy, the use of rooms is recommended as curtains may not always ensure confidentiality. HCPs also highlighted the importance of maintaining confidentiality during key processes such as handovers, labelling laboratory samples, and medical rounds, where they employ medical terms, signs, and identifiers. In our study sites, participants shared that they have transitioned from using printed files to utilizing technology (such as open clinic) for client information storage, with each individual having a unique login password. However, concerns were raised about preventing providers from accessing maternity information from other services. In one study site, plans were underway to construct maternity rooms to enable birth companionship.

*"Mainly, we care about the information we give to the mothers; their information is confidential, and we care about privacy". IDI, matron, female, 34 years*

### **1.3 Information provision and liberty in decision making**



Midwives reported that a mother has the right to request information and receive it, and she also has the right to make choices and express preferences. Participants reported that the rights and responsibilities of the clients are written on the hospital wall. Some information for mother and neonatal care is being provided. Some participants mentioned that during the reception, customer care services welcomed the mothers and allowed them to contact the representative of customer care services at any time during their stay in the hospital. Additionally, before being admitted, mothers are required to sign a consent form. Participants recommended that women's rights should be posted in a visible location for mothers to read.

*"There is a customer care representative of the hospital; her photo and number are available; they call her if they cannot find the matron. If a person has a problem and brings it to customer care, it is solved quickly".* **IDI, matron, female, 33 years**

Participants emphasized that mothers have the right to make their own decisions before receiving care. A mother may not have knowledge about her health; therefore, HCPs should first provide all information to the mother by explaining the pros and cons, allowing her to make a decision, and then sign the consent.

*"The care is central to women, not to us. She is the one who is going into labour; she is the one who is going to bear any procedure that we are going to perform on her, so she has the right to refuse the treatment."* **IDI, doctor, male, 30 years.**

Participants reported that a mother has the right to choose the treatment; for example, she has the right to opt for a caesarean section without medical indication. The decision-making process for a mother's treatment should be done as quickly as possible so that HCPs can take action without unnecessary delays.

#### ***1.4 Effective communication***

A suggestion box is available for clients to share their ideas to promote collaboration and mutual respect among clients, service providers, and hospital management. This feedback is reviewed and thoughtfully considered, empowering clients and ensuring they feel heard. Additionally, some hospitals offer a complaint book for clients to submit grievances, ensuring

that their concerns are considered seriously and appropriate measures are taken in cases of disrespect.

There is a way to handle incidents of disrespect.

*"When there is an incidence of disrespect, we have a quality book; whoever is found to have happened is approached and discussed, and we can register her in the book and resolve an issue with the victim. If this happens for the second time, the case is presented to the higher authorities for punishment:"* **IDI, matron, female, 33 years.**

To handle disrespect issues, HCPs from one hospital reported that they manage it at their level or they refer to mental health services.

*"If a healthcare provider physically or psychologically harms a client, the first is to prevent the spreading of information. In our measures, we have a team leader who must handle the problem and approach the family to find a solution. If it is beyond our control, we can use the mental health service to help us."* **IDI, matron, male, 27 years**

To enhance client-provider communication, providers must explain the labour process to the clients, giving them ample time to ask questions freely. This open dialogue provides clients with the necessary information and makes them feel respected and cared for. Listening to their concerns and providing feedback during this process helps to establish trust, fostering a positive healthcare experience.

*"If you have confidence in explaining to the mother how things are going, and when you explain directly to her, she immediately trusts you".* **IDI. Doctor, male, 37 years**

Participants advised HCPs first to introduce themselves to the mother. Taking time to read the client's file and talking with the client helps avoid harm. Explaining everything to the mother, including information on the baby's care, lab tests, and results, is crucial. Participants emphasized the importance of consented care, stating that service providers should explain everything they do and its significance, ensuring that mothers also understand. Providers should also clarify what is and is not allowed in the hospital, explaining their rights and

responsibilities. They added that sometimes it is challenging to find time to provide all explanations to the mother.

*"First, we respect her rights. Respecting the mother's right is to listen to her and explain what she wants to know."* **FGD1**

### **1.5 Family involvement**

HCPs argue that a mother has the right to involve her family in her care process, and service providers help the mother to achieve that. Midwives used to involve a birth companion to assist in the mother's care. However, the infrastructure hinders the birth companion from staying with the mother during the second stage of labour and is a significant challenge.

*"The mother has the right to involve her family in the treatment when she wants so that the male companion can come if she asks us, but when she does not ask, we have to treat her according to her rights."* **FGD 3**

### **1.6 Cleanliness**

Service providers argue that they encourage mothers to maintain personal hygiene. For infection prevention, HCPs used to request mothers to wear diapers during labour to prevent the spreading of vaginal leakage. However, some mothers with traditional beliefs resist wearing those diapers. Providers ensure the cleanliness of beds and rooms and encourage mothers to maintain personal cleanliness as well. Cleanliness in the service is maintained, and there are cleaners who follow waste management measures specifically for the maternity ward. There is a daily cleaning schedule, as well as total cleaning. They stated that cleanliness should be a cultural norm.

*"It is crucial to keep the hospital clean. To keep it going, everyone in the service is responsible for the mother's hygiene, not just the nurse".* **IDI, Doctor, male, 37 years.**

Participants recommend providing clean water and soap for clients, along with outlining plans for bathing and bedmaking. They also suggest requesting mothers to come with their own hygienic supplies.

### **1.7 Equality care**

Service providers echoed that they provide equal care to all women, accepting them as they are without considering their socio-economic status. However, they reported that educated mothers understand things more simply and quickly than others. Participants questioned why previous findings on quantitative research conducted on mothers reported that mothers who delivered by caesarean section reported being more respected than those with a normal delivery. They pointed out that a team performs a caesarean section, whereas in a normal delivery, the mother is cared for by one or two persons. Thus, a mother may simply be biased, thinking that being cared for by a team is a sign of respect.

*"For mothers who delivered by caesarean section, it is not a procedure that one healthcare provider can perform. There are many anaesthesiologists and obstetricians... there are many. In the operating room, you find 4 to 5 people around you; this leads the mother to think she is really cared for. However, for vaginal delivery, there is only one person. "FGD 2*

In addition, they reported that in a cesarean section, the mother is given pain medication before, during, and after the procedure. In contrast, during vaginal delivery, the mother may struggle to cope with labour pain, leading to feelings of giving up, and sometimes mothers are mistreated in an effort to save the baby.

## **2. Professionalism compliance**

HCPs reported that their profession is a vocation and not like other professions. The love for the profession and respect for the oath are considered very important. Midwives reported that they relate their practices to what they learned in school. Furthermore, they learn from their experiences and avoid repeating past incidents. HCPs reported conducting client interviews and sharing client feedback with the staff. In meetings, the unity manager shares what is appreciated and critiques themselves. Employees know they should provide good services and be safe and calm in difficult situations. There is a culture of prioritization involving triage, starting with emergency cases. The challenge is a large number of clients and an insufficient workforce. There is a culture of listening to the client's complaints and making incident reports if they occur.

*"We have established a culture among the staff that if our clients complain, you should not tell them that I cannot help them, but you should listen to them, help them and give them advice"* **IDI, matron, 34 years.**

### **2.1 Motivated staff**

The matron reported that in order to motivate the team, they have established solidarity and social activities among the maternity team. Midwives organize and attend social events of their colleagues, such as wedding ceremonies and birth events, and even visit colleagues during challenging moments. They added that what keeps them in their career is the feeling that they are saving people, and when mothers are happy, HCPs also become happy (a positive cycle). Participants suggested ways to motivate the staff, such as providing tea or even food to decrease work stress and burnout and rewarding and appreciating the best employees in public.

*"When an employee does something good, you should praise her. Appreciating her is one thing; do not give her money because she is being paid, but showing her that you value what she did; this is also a motivation".* **IDI, matron, 33 years**

### **2.2 Teamwork**

The participants reported that teamwork is key, and everyone in a team should be aware of their limitations and ask for help so that the mothers can achieve better outcomes and happiness. The task allocation schedule exercise is flexible, considering every staff member's issues without compromising the work. They advised if the health personnel don't feel well, it is better to communicate their feelings to their colleagues, and the staff should be attentive to those feelings to prevent any negative mood from affecting the mothers.

*"There are times when a midwife comes with problems. We should know who has a problem so that it can disturb the client's feelings, and we assign her to a place where she will not meet people"* **FGD 4**

### **2.3 Continuous development**

Some midwives have gotten RMC training. One matron requested continuous professional courses at the hospital or at school. The training can be organized by the hospital or the Ministry

of Health. Midwives need the opportunity to receive full scholarships to upgrade their educational level.

*"Here we have midwives who have been around for more than 15 years, and the healthcare system is being updated. Therefore, for mothers to receive quality care, it is essential to increase their knowledge."* **IDI, matron, male, 27 years**

## **2.4 Quality work provision**

Participants reported that accountability is needed to sustain the quality of care. HCPs emphasized their pride in getting a healthy baby and a healthy mother. Planning for pregnancy was highlighted as a key to a successful outcome. Participants appreciated that neonatology rooms are available. Participants stressed the importance of avoiding carelessness, implementing strict labour monitoring, following the partograph, and complying with accreditation guidelines. Hard copies of protocols are available, and HCPs can check online for national guidelines when they encounter challenges. These hospitals are in the process of accreditation to improve the quality of services. Some HCPs reported that they have regular meetings and audits to monitor and evaluate the standards. Employee evaluation has a significant impact on RMC provision. Every staff member receives a bonus based on competence-based performance (PBF), which motivates them to make an effort to work better.

In hospitals, a survey on customer satisfaction is usually conducted, and recommendations based on the feedback are implemented. The project on quality improvement conducts evaluations every month. Protocols from the Ministry of Health are provided to every staff member.

*"When a mother gives birth to a healthy baby, and all of them are healthy, it is our pride as midwives and the pride of the country and the community in general".* **FGD 3**

In the past, some hospital buildings did not have immediate access to macadamized roads. The HCPs appreciate the building of a macadamized road to their hospital.

*"The road to this hospital was damaged, the cars used to get there were going to stack, and you found mothers complaining about it, but now the road is macadamized and enjoyable, and mothers feel respected."* **FGD1**

## **2.5 Community trust**

The participants believe that when they provide friendly service, mothers will repeatedly share their positive experiences within the community, restoring trust.

*"To gain community trust, we need a good outcome. Whenever you treat a woman with empathy, she will be the one to preach to others in the whole village. The one you treat well is the one who is going to change the population's mind".* **IDI, doctor, male, 30 years**

*"We have a program called the patient's voice, as well as visit the community and listen to feedback and recommendations".* **IDI, matron, male, 32 years**

## **3. RMC encounters**

Labour pain medications are not yet available at all study sites. At the national level, labour pain medication protocols are available but only followed in tertiary hospitals in the city. However, doctors in our study sites may not have the necessary skills to administer subdural anaesthesia. In the postpartum period, minor painkillers like paracetamol and tramadol are administered.

*"There are labour pain management protocols that have been developed at the national level, but the nature of the hospital does not allow doctors to give labour painkiller drugs. Still, in our hospitals in Rwanda, we do not have enough doctors to care for the mother who has been given subdural anaesthesia."* **IDI, doctor, male, 35 years**

Participants reported that mothers are taking traditional medications, which can lead to maternal and neonatal adverse outcomes.

*"Although it is not scientifically proven, we do not know what key ingredients are included in traditional medicines. Sometimes you find that mothers are saying they help them, but they can also harm the condition of the baby in the womb."* **IDI, doctor, male, 35 years**

Among reported hindrances to RMC are insufficient labour wards; sometimes, birth companions fear seeing mothers screaming and do not understand it. Most maternity services have insufficient doctors and midwives, overloaded clients, insufficient equipment like one cardiotocography (CTG) machine per 20 clients, and a lack of private rooms. In addition, available rooms are built nearby; one person can hear the other, which hinders confidentiality, privacy, and staying with a birth companion. Insufficient beds where 2 or 3 mothers share one bed have been reported. One matron reported that there is a staffing plan that shows the workload, and they advocate to the Ministry of Health to increase the number of midwives.

Service providers argue that it is mostly difficult to explain to the mothers and meet their level of understanding because many mothers are uneducated. Providers from one hospital reported that obtaining clean water in the hospital is a problem, but the issue has been reported to the hospital management to find a solution. Participants argue that the service can be good, but client satisfaction depends on someone's perceptions and personality.

#### **4. RMC sustenance**

To sustain RMC, participants emphasized that an empathetic approach towards mothers should be a cultural norm. They added that having self-confidence, regular supervision (with the clinical director overseeing technical staff and correcting errors), being reminded of fundamental human rights principles, and avoiding rushing in care provision to avoid being busy on computers. Regular quality improvement meetings and RMC refresher training should reinforce the monitoring system. Workload adjustment, educating mothers on their rights at the hospital entrance. Equipment should be requested on time; collaboration with maintenance services is crucial.

Health education should be conducted during antenatal care and at the community level to discourage the use of traditional medicine. Close monitoring during labour is essential, and increasing the number of workers and implementing shifts is recommended. The participants advocated for receiving motivation, such as salary increases or bonuses, and provided refreshments like tea breaks, which were encouraged. There is a suggestion to increase the



capacity of customer care services to be available 24/7. Participants also recommend organizing study trips to hospitals with high standards.

*"I feel what could be done; there is something called a school trip; I felt that we can learn from another hospital by visiting the model place ... We can learn how their maternity, and how they maintain the privacy of their patients .... We should learn from others to see how they do it, as said in Kinyarwanda's proverb, "A bird that does not fly does not know where the corn is ripe". FGD 4*

The HCPs argue that to enable mothers to have a normal delivery, mothers are encouraged to attend antenatal consultations, perform physical exercises, and attend the hospital early. In addition, participants emphasized that the mother should be called by name.

*"If you call the mother by name when she sees you call her by her name; it makes her feel comfortable". FGD 1*

Participants reported that they should be diligent and provide better service for better outcomes to gain community trust. The community should be informed about the services typically provided and those beyond their capacity. Additionally, HCPs should focus on positive changes, maintain positive aspects, learn from others, and constantly self-evaluate. HCPs should improve patient education and receive mothers well, as the client's first impression can play a role in regaining community trust. HCPs advised the hospital management to determine the community's perceptions of hospital services.

Many participants suggest increasing the staff, especially midwives, to perform normal deliveries, train newcomers, and improve the buildings, notably phasing out the use of curtains. Some participants suggested using soundproofing to maintain the confidentiality of mothers. They recommended using rooms with soundproofing instead of curtains to ensure patient information cannot be overheard by other patients.

They recommended monitoring the mother adequately and teaching her how to behave, position, and breathe during labour. It is suggested that enough equipment like CTG machines be procured based on the number of clients, adequate numbers of beds should be ensured, and

cleanliness in the hospital should be supervised. Participants emphasize working with a heart of love, reinforcing awareness of women's rights on the radio or other platforms, and conducting RMC sensitization in the community. They advise to avoid retaining mothers in the hospital when they fail to clear the medical bill.

## 7.5 Discussion

In the context of this paper, the participants' perceptions highlight the importance of ensuring women-centred care, compassion, privacy, confidentiality, the right to information, autonomy, effective communication, holistic care with family involvement, personal hygiene, and equal care. This aligns with the experience of care dimensions established by the WHO in 2018 and the quality of care framework for maternal and newborn health [289]. Shakibazadeh et al. [243] identified twelve domains of RMC, one of which emphasizes providing woman-centered care.

A study employing Appreciative Inquiry (AI) conducted in Tanzania and Malawi reported that compassionate healthcare provider-woman interactions involve a warm reception, polite language, timely and pertinent care, and the exchange of relevant information [173]. Using Patient-Centered Care leads to positive childbirth experiences and outcomes for mothers and newborns [107].

Moreover, to achieve a significant reduction in maternal mortality, there should be a strong focus on making services truly woman-centred [33]. Surprisingly, in a study conducted in Ghana, midwife students attempted to justify mistreatment; they argue that if a mother in labour is uncooperative, in order to avoid adverse outcomes, the midwives have a reason to beat her a bit to ensure she complies with instructions [230]. Studies highlighted the need to raise awareness among care providers about RMC standards by enhancing client-provider communication, monitoring practices, and strengthening accountability mechanisms for health workers [107,52].

Participants also revealed that compliance with their profession is key to achieving RMC. Professional compliance becomes possible when staff work as a team. Studies argue that teamwork among all HCPs is associated with improved respectful care [33,45]. The positive attitude of HCPs is crucial, even in attracting mothers to utilize health facility childbirth [173,269]. Supportive leadership is key to successful RMC practices [173,144,92,91]. A conducive environment with the necessary equipment and adequate physical setting leads to

positive childbirth experiences [173,152]. Improving infrastructure may be perceived as challenging to implement and could take time. However, HCPs can work with existing resources, such as using partitions and curtains, to maintain mothers' privacy [173]. Though the rights and responsibilities of clients are displayed on the hospital wall, these rights are general patient rights and are not specific to women and newborns. There is a need to post the RMC charter on the maternity wall to create awareness of RMC among service users.

In some hospitals from the study sites, there is a culture of systematically obliging every woman in labour to wear a diaper to prevent attracting or spreading infection and for individual hygiene. However, some women resist, fearing that their babies can die inside. It is crucial to explain to the mothers the importance and reassure them that there is no harm in wearing a diaper before giving birth in order to alleviate the mothers' anxiety. Traditionally, Rwandan women do not even put on underwear during labour because they believe it can delay the descent of the baby, leading to prolonged labour or the baby being asphyxiated inside.

Participants recommended improving services and explaining available services based on the hospital level to build community trust. An interventional study in Kenya suggested using open maternity days to engage the community in maternity services [269]. To foster a sense of belonging and ownership, involving the Rwandan community in maternity service activities during community work, such as building and cleaning health facilities, is essential. The community should also be educated about the rights of women and newborns.

Though this study aimed to explore the positive aspects of what can be done, the participants also narrated the challenges that hinder the RMC provision. They reported several issues affecting RMC, including insufficient labour wards, sharing of beds, inadequate birth companionship, non-use of labour painkiller medicines in all health facilities, staff shortages, client overload, and a lack of equipment. The absence of private rooms hampers confidentiality, privacy, and the ability to stay with a birth companion [100]. Challenges in delivering RMC included logistical difficulties in ensuring privacy, lack of mobility during labour, high workload, absence of alternative birthing positions, negative attitudes from some midwives, and language barriers [100,139].

Supportive leadership was also recommended, which oversees the staff, supervision, and mentorship. Evidence reported that the lack of RMC is not only an individual issue [269,152,126]. According to Kujawski et al. [152], RMC is not attainable through a straightforward single technical solution. Instead, eliminating disrespect and abuse necessitates individual behaviour change, organizational and systemic adjustments, and, ultimately, a more profound societal transformation. Therefore, achieving RMC is a process that requires evidence-based strategies to achieve the deliverables and commitments that healthcare practitioners are called upon and declared upon. These strategies include establishing national laws and policy standards for RMC, adherence to human rights and ethical principles, and effective governance and leadership.

Contributors to RMC encompass having ample HCPs trained in RMC, ensuring the availability of sufficient drugs, equipment, and technology, maintaining a functional information system, and securing financing, such as health insurance. It is essential to have well-equipped health facilities with adequate infrastructure, delivering care with accountability and supervision. Individual and community involvement is crucial, with mothers empowered to autonomously demand RMC and make the community aware of RMC principles. Furthermore, a complaints redress mechanism should be implemented [269,126]. It was proved that multiple interventions are more effective in improving RMC compared to a single intervention [144,91,92,100].

Respect is fundamental to Rwandan culture, influencing various traditional social interactions. Integrating this culture of respect into the journey of childbirth is essential to enhance the contributions of Rwandan women and mothers to the nation-building process [258]. RMC aligns with Rwanda's culture of respecting everyone, especially pregnant women. Rwanda is fostering a culture that values and invests in the well-being of its women and mothers. However, it should be noted that predictors of positive or negative RMC experiences can differ across countries, settings, and cultures.

The methodology we used in this study is appropriate to RMC; appreciative inquiry promotes positive thinking and uplifts and sustains existing best practices rather than struggling to repair harm [173]. The AI method brings suitable solutions for countries with resource-constrained health settings like Rwanda because it fosters a culture of maintaining positive traits, working

with what is available in the field, and appreciating what has been achieved instead of perpetuating blame [173,257].

Rwanda has made progress towards universal health coverage. Presently, 91% of Rwandans have medical health insurance [68], resulting in a significant decrease in post-childbirth hospital detentions due to unpaid bills. RMC is now integrated into Basic Emergency Obstetric and Newborn Care (BEmONC), with healthcare providers receiving RMC training and mentorship through programs such as the Maternal and Child Survival Program [165] and the More Happy Birthdays project [184]. Much has been done to improve RMC in Rwanda, but it is still less documented [101].

### 7.6. Conclusion and recommendations

Pursuing an RMC standard is not a destination but an ongoing journey. It is a journey that has seen some steps taken to improve RMC in Rwanda. In this ongoing process, RMC and the positive childbirth experiences can be enhanced by leveraging existing resources, continuously improving, and sustaining the achievements until we reach the RMC standard. This study proposes a set of specific actions to sustain RMC. These include promoting women-centred care, improving healthcare providers' attitudes, abiding by the profession, building community trust, ensuring a conducive environment in health facilities, and active involvement and support from leadership.

### 7.7 Strengths and Limitations

One strength of this study was the utilization of the Appreciative Inquiry approach, which provided a positive way forward by shifting from problem-focused to solution-seeking perspectives. The recommendations yielded from this study are applied to low-resource health settings and envisage improving RMC and working with the currently available resources. However, a limitation is that the findings rely exclusively on the viewpoints of the individual participants.

## Chapter eight: Development of Strategies to sustain Respectful Maternity Care

### 8.1. Introduction

This is phase 3 of the study, with the specific objective of developing and describing strategies to facilitate and sustain Respectful maternity care for women in labour based on the findings from Phase 1a, Phase 1b, Phase 2a, and Phase 2b. This chapter integrates the findings of the previous phases of the study, reports the major findings, outlines the procedure of strategic formulation, and provides a discussion and conclusion.

### 8.2. Integration of all findings of this study

This study employed the "integration" approach as the method of mixing, which entails merging qualitative and quantitative data [296,109]. The researcher gathered quantitative and qualitative data concurrently, analyzing them independently and merging the findings [296,109]. It's important to mention that the data were collected from five hospitals in Rwanda's Eastern province. The quantitative phase involved a survey with a total of 610 participating mothers. For the qualitative component, interviews were conducted with a subset of mothers, totalling n=30. Furthermore, the researcher conducted 10 FGDs with midwives and nurses, totalling n=95, and 10 IDIs, each with physicians and matrons (maternity unit managers).

#### 8.2.1 Major findings from quantitative and qualitative data

During the data integration process, the author and the Supervisor integrated, interpreted, and synthesized qualitative and quantitative findings. Five themes emerged after data analysis and integration. The formulation and development of the strategies stemmed from the identified themes and sub-themes.

***Promotion of women-centred care and positive childbirth experiences*** with provision of compassionate care & friendly care, and emotional support; timely care provision, enabling environment for privacy and confidentiality preservation, clear communication, enhanced autonomy and self-determination, enhanced mother's satisfaction

**Maintaining and promoting an adequate environment around facility childbirth** by *Improving hospital hygiene, ensuring sufficient equipment and workforce, promoting adequate private rooms and promoting birth companionship*

**Preserving and upholding community trust towards maternity services** by creating awareness of maternity in the community, providing culturally sensitive care, getting feedback, and addressing complaints.

**Professionalism abidance and development** with *developing ownership & accountability, strengthening teamwork*

**Strengthening supportive leadership towards sustaining RMC** with the *establishment of a standard of quality, creating mechanisms for monitoring and evaluation, doing advocacy, conducting appropriate training, and motivating the staff.*

### ***Theme 1. Promotion of Women centred care and positive childbirth experiences***

#### **8.2.1 Provision of compassionate, friendly care and emotional support**

The quantitative results revealed that the least reported aspect among women (37.3%) was the administration of painkillers or anaesthesia for pain relief. Conversely, 69.9% of mothers reported not experiencing humiliation. Participants most valued being treated with dignity and respect, particularly in terms of not being humiliated or verbally abused, and preferred being spoken to in a respectful manner (76.5%).

Consistent with our qualitative findings, women in labour desired treatment characterized by respect, dignity, and cultural sensitivity. They appreciated the use of kind and comforting language, politeness, patience, and gentle expressions of gratitude. They preferred being addressed by name and welcomed courteously. Actively listening to mothers, acknowledging their concerns, fears, and emotions, and offering reassurance, comfort, and encouragement were essential. Empathetic and compassionate care, including psychological support and back massages, was crucial. Additionally, providing labour pain medications, training healthcare professionals to administer and monitor these medications, and avoiding assumptions or judgments were key to managing effective labour support.

#### **1.2. Timely quality & equality care provision**

The quantitative results indicated that 96.1% of women received the services they needed, and 97.4% experienced equitable healthcare. Qualitative findings revealed that women view timely

and equal care as continuous attention throughout their labour. This includes performing triage, promptly addressing emergency cases, treating all mothers equally, and assisting those in need. Additionally, it involves ensuring continuity of care without interruption due to payment issues, remaining close to the mother, and using ultrasound to monitor her condition.

### **1.3. Enabling environment for Privacy and confidentiality preservation**

Regarding privacy and confidentiality, the quantitative results showed that 91.3% of women were provided with privacy, 98.6% were covered during vaginal examinations, and 97.4% had their health conditions kept confidential from other clients. The qualitative findings complement these results, with both women and caregivers recommending that medical staff speak quietly to the mother, especially during rounds. They also suggested using signs or passwords for patient files and employing foreign languages during patient rounds to enhance confidentiality. Additionally, it was recommended to limit access to the cleaners in the delivery room while a mother is giving birth and, where possible, use private rooms.

### **1.4. Clear communication**

Our quantitative results revealed that only 43.9% of mothers received information about newborn care, 39.4% were informed about breastfeeding, and just 28.6% had their general examination findings explained. Participants recommended several improvements to enhance communication between providers and mothers. They suggested providing clear and understandable information on breastfeeding, newborn care, and examination findings. Additionally, they emphasized the importance of active listening, encouraging questions, and allowing adequate time for discussion. Building trust, ensuring mothers' openness, systematically providing information about breastfeeding and newborn care, guiding the labour process, preparing birth companions psychologically, and explaining the need for wearing diapers before giving birth were also highlighted as crucial steps.

### **1.5. Enhance autonomy and self-determination**

The quantitative results showed that the majority of women (98.5%) were allowed to eat and drink, and 96.2% experienced no discrimination. Additionally, 47.1% were asked for consent before palpations and vaginal examinations, while 49.2% were permitted to have a birth companion present during labour before entering the delivery room. Participants recommended respecting women's choices and beliefs, allowing mothers to move, eat, and drink during



labour, involving them in informed decision-making, obtaining consent, and fostering negotiation and mutual understanding. They also suggested encouraging discussions about birth spacing.

### **1.6 Enhance mother's satisfaction.**

The quantitative results revealed that only (55.7%) women experienced the highest level of health care. The qualitative findings recommended helping mothers have good birth outcomes (Healthy baby and healthy mother). They recommended teaching women to avoid taking traditional medicines to fulfil the desires of women and make them feel satisfied. It is recommended to assist the women towards a normal vaginal delivery wherever possible and to help them to experience their set positive expectations.

## ***Theme 2. Maintaining and promoting an adequate environment around facility childbirth***

### **2.1 Improving hospital hygiene**

Participants recommended ensuring a conducive environment by maintaining cleanliness, providing safe access to clean water and sanitation facilities, and ensuring that labour, delivery, and postpartum rooms are safe and well-maintained. They also emphasized the importance of respecting cultural norms and beliefs and regularly monitoring and evaluating the childbirth environment around the facility.

### **2.2 Ensure sufficient equipment and workforce.**

Participants argued that ensuring adequate equipment and staff requires several actions: providing sufficient and properly functioning equipment, maintaining a plan for equipment upkeep, timely requisition of equipment, advocating for increased staff, and having a staffing plan in place.

### **2.3 Promoting adequate private rooms and birth companionship**

Participants recommended advocating for maternity rooms with adequate space and proper ventilation, ensuring privacy and confidentiality, and creating a conducive environment that allows mothers to move freely. They also suggested permitting birth companions if the mothers wish to have them present.

## ***Theme 3. Preservation and upholding community trust towards maternity services***

### **3.1 Create awareness of maternity in the community.**

To raise awareness about RMC in the community, participants suggested several strategies. These include communicating available services through maternity open days, conducting community education programs to highlight RMC, and using social media and radio to encourage mothers to seek maternity services early.

### **3.2 Providing culturally sensitive care, getting feedback and addressing the complains**

Participants emphasized the importance of providing culturally sensitive care that respects the cultural backgrounds, values, and traditions of women and their families. They recommended establishing mechanisms to address complaints, concerns, and feedback from the community while maintaining accountability and transparency. This includes responding promptly and appropriately to complaints, communicating the actions taken to resolve issues, and seeking feedback from women, their families, and healthcare providers. To build mutual trust, they suggested encouraging regular dialogue and discussions, sharing best practices, and promoting a collaborative culture to effectively handle client complaints.

## ***Theme 4. Professionalism abidance and development***

### **4.1 To develop ownership and accountable**

Our qualitative findings revealed that caregivers should be held accountable by adhering to professional codes of conduct, such as avoiding distractions from computers and phones during working hours, regularly re-evaluating their performance, and showing respect to all staff members, including cleaners. Healthcare providers should prescribe appropriate amounts of medication and medical supplies avoiding excess. Caregivers should value and respect mothers, demonstrate empathy, develop emotional intelligence and positive self-confidence, and deliver high-quality care through strict labour monitoring, proper use of partographs, and compliance with accreditation processes. Additionally, they should diligently report any incidents.

### **4.2 Strengthening Teamwork**

Our findings revealed that strengthening teamwork requires effective collaboration among caregivers, including midwives, nurses, doctors, and anesthesiologists. It is essential to promote continuity of care, ensure clear handovers, and make informed decisions.

## ***Theme 5. Strengthening supportive leadership towards sustaining RMC***

### **1. Establish a standard of quality**

Our qualitative findings recommended establishing clear standards, policies, and guidelines for Respectful Maternity Care (RMC) for healthcare providers involved in maternity care. These should be regularly reviewed and updated to reflect current best practices. The process should include obtaining accreditation and conducting quality improvement meetings. Benchmarking through study trips to hospitals with high standards can help identify areas for improvement and outline expectations for healthcare providers. Guidelines should cover communication, decision-making, and fostering a culture of respect and dignity for all involved. Additionally, measures should be taken to avoid unnecessarily retaining mothers and newborns in the hospital by establishing appropriate payment mechanisms, ensuring 24/7 customer care services, and implementing evidence-based practices. Security officers should be trained to respect mothers and allow them to enter the facility.

### **2. Doing advocacy**

Participants recommended advocating for the rights and dignity of women during childbirth and prioritizing Respectful Maternity Care (RMC) as a core organizational value. They suggested promoting charitable actions and social support for mothers in need. To enhance care, they recommended ensuring the provision of necessary equipment, maintaining an adequate number of beds, and up keeping infrastructure. Additionally, they advised renovating hospitals, providing spacious rooms where possible, and improving working conditions.

### **3. Create a mechanism for monitoring and evaluation**

Our findings revealed the importance of obtaining service users' feedback through suggestion boxes, regular audits, assessments, and gathering input from women and their families. It is essential to conduct client satisfaction surveys regularly and continuously assess, monitor, and evaluate the quality of care. Additionally, regular employee evaluations are crucial for maintaining high standards.

### **4. Conducting appropriate training**

Our findings revealed that achieving adequate training in Respectful Maternity Care (RMC) requires several key actions. Regular training and professional development opportunities should be provided for HCPs and newcomers, including workshops, seminars, refresher courses, and mentorship programs. These should focus on leadership skills, communication

strategies, conflict resolution, and fostering a positive work environment. HCPs should be reminded of their responsibilities and accountability.

Collaborating with professional associations and NGOs to organize these trainings is essential. It is important to allow free choice in medical, nursing, and midwifery careers and to use evidence-based practices to inform decision-making and drive quality improvement initiatives. Leaders and staff should stay updated with current RMC evidence, guidelines, and best practices while supporting innovation and quality improvement efforts to enhance RMC. Upgrading training levels, providing continuous onsite training, and including RMC in pre-service curricula are also crucial steps.

## **5. Motivating the staff**

Participants suggested several strategies to motivate staff through recognition and rewards. They recommended recognizing and rewarding healthcare providers and facilities that consistently demonstrate exemplary practices in RMC. Implementing mechanisms to acknowledge and celebrate achievements in respectful care can inspire others to follow suit.

To retain staff and enhance their well-being, creating a supportive environment, showing appreciation, improving living conditions, and providing regular holidays are crucial. Support systems should address burnout, stress, and emotional challenges, while flexibility in managing workloads and schedules should account for staff mood and needs. Promoting a healthy work environment that fosters professional growth, collaboration, and self-care is essential. Providing meals such as lunch, breakfast, and snacks at work and continuing performance-based financing practices are also recommended.

## **8.3 Methodology**

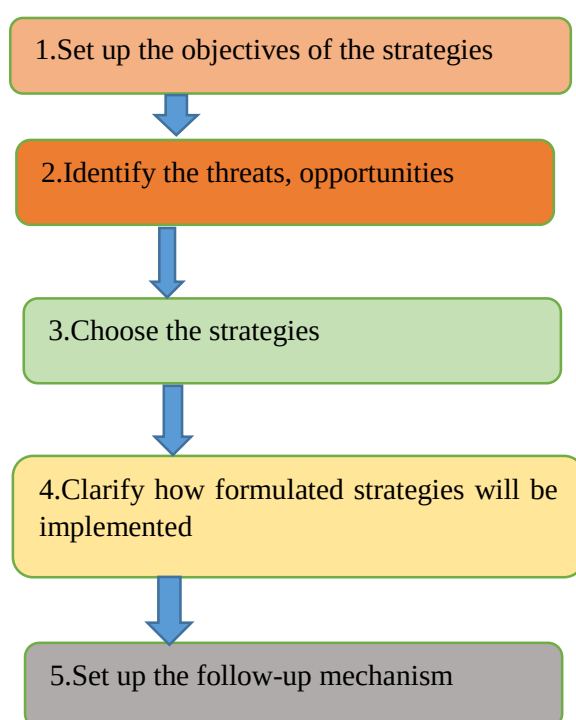
In this phase, each developed strategy consists of an objective and actions regarding facilitating RMC using the steps of the strategic formulation process [115,161]. The definition of strategy varies depending on the chosen method of application [170,129]. Strategy formulation is establishing goals and determining the proper plan of action to achieve those goals [170,129]. In this study, strategies refer to a particular sequence of actions to guide the sustainability of RMC's best practices. The study argues that innovation strategy, organizational structure, and innovation culture can significantly increase firm innovation performance [141].

### 8.3.1 Strategic formulation process

Strategy formulation involves leveraging existing knowledge to articulate the planned course of practical measures to achieve its objectives. This method sets priorities, ensures alignment across the organization, and validates goals [181,214,43].

The author used the following method:

*Table 8.1 Strategic formulation process*



**Source:** Mckeown M. *The strategy book*. Pearson UK; 2019

#### 8.3.1.1 Set up the objectives of the strategies

Establish objectives that are specific, measurable, achievable, relevant, and time-bound (SMART) and that support the strategic priorities.

#### 8.3.1.2 Identify the threats and the opportunities

In the past, significant attention was given to exploring the threats to respectful maternity care (RMC) [269,231,191]. In contrast, this current study focused on the opportunities and positive aspects that can facilitate and promote RMC. The ample **opportunity in Rwanda** is the political determination to promote maternal and child health quality. Rwanda has achieved MDGs number 4 and 5 by significantly reducing neonatal and maternal mortality rates [234]. This accomplishment can be attributed to healthcare policies, interventions, and strategic initiatives to improve the country's maternal and newborn care services standards. Rwanda is

actively working towards the SDGs to make maternal and child health progress further by 2030 [222].

### 8.3.1.3 Existing measures for women's promotion in Rwanda

This part covers Rwandan policy context, health systems, and health programs that contribute to the promotion of women. Rwanda is one of the most successful nations in Africa due to its remarkable social and economic advancements. These achievements are attributed to the strong policies of the government [106,311]. Rwanda has made notable progress in prioritizing women's rights, particularly in advancing gender equality in political representation. The country has surpassed many others in the percentage of women holding parliamentary positions [245], underscoring its commitment to empowering women across various levels of society.

As of December 2023, female representation in the Rwandan parliament stood at 61.3%, positioning Rwanda as the country with the highest proportion of women in parliament globally [245]. This dedication to respect and gender equality contributes significantly to the nation's development and progress. Rwanda sets a positive example for other countries, emphasizing that empowering women is a matter of rights and a strategic investment in social and economic prosperity. Rwanda uniquely emphasizes cultural values, particularly a profound respect for everyone, including pregnant women. This cultural emphasis contributes to fostering a society that values and invests in the well-being of its women population [258].

Rwanda has implemented various programs and initiatives [106] to enhance maternal and neonatal health, thereby contributing to the attainment of MDGs related to reducing maternal and neonatal deaths [51]. These initiatives include the provision of skilled birth attendants and family planning programs, where 91% of births occur in health facilities [219]. In 2009, Rwanda introduced trained Community Health Workers (CHWs) to ensure universal access to healthcare services [43,69]. These CHWs are crucial in promoting maternal and newborn care at the household level. CHWs assist in identifying pregnant women, providing prenatal health education, and encouraging attendance at antenatal care (ANC), which effectively bridges communities with the healthcare system [51,69]. In each village, a designated CHW focuses on maternal and newborn health, identifying danger signs, and referring pregnant women to appropriate health facilities [51,69]. Currently, 99% of mothers in Rwanda attend antenatal consultations [194]. In 2010, Rwanda adopted the innovative mobile technology RapidSMS

for maternal and newborn care, synchronizing health systems and community data to improve health outcomes [202]. The availability of ambulance services has also increased, facilitating the transfer of pregnant women in labour to appropriate health facilities.

In 2004, Rwanda instituted a national policy requiring health insurance coverage by law, which became effective in 2008 [181]. Health insurance subscription fees are determined based on income, with 91% of Rwandans covered by medical health insurance through the Rwanda Social Security Board [181]. Moreover, private health insurance alternatives are accessible. The Ministry of Health aims to attain 100% coverage of community-based health insurance (CBHI) soon. Health insurance has remarkably improved maternal and neonatal outcomes [268]. The Basic Emergency Obstetric and Newborn Care (BEmONC) program includes the RapidSMS Mobile midwife component [202]. Despite advancements in maternal and neonatal health, there is still a need to document the progress in RMC [224]. The Maternal and Child Survival Program (MCSP), funded by USAID and Jhpiego, alongside the "More Happy Birthdays" project, has collaborated with the Ministry of health in Rwanda to enhance RMC [184]. Maternal and newborn stakeholders, in partnership with the Rwanda Association of Midwives, initiated the RMC mentorship program for midwives in some hospitals. RMC has been integrated into the BEmONC guidelines. National consultation meetings with RMC stakeholders were held in Rwanda to address the mitigation of D&A [165].

Based on findings from this study, participants reported notable progress in Rwanda compared to the past. Over the past decade, the healthcare workforce has grown significantly. Participants reported an increase in the number of skilled birth attendants (midwives and nurses) with university education. Additionally, gender balance has improved, with more males joining the midwifery and nursing professions. Many hospitals undergo accreditation processes, engage in performance-based financing, and receive supervision. Quality improvement committees and hospital maternal audits have played a significant role in advancing RMC. Mentorship programs for midwives and patients, as well as patients' general rights and responsibilities displayed on hospital walls, contribute to a positive healthcare environment. However, specific rights for mothers and newborns are not explicitly outlined. The RMC still needs to be documented in the current version of obstetric and newborn care protocols and guidelines. Participants reported that some HCPs sometimes deviate from the standard procedure. For instance, they can perform episiotomy without anaesthesia.

The participants in this study reported that curtains are used to ensure privacy, and neonatology rooms are available in all district hospitals. Maintenance services and a dedicated maternity customer care service are operational. Incidents of disrespect are sometimes addressed. The work schedules and timetables are established for services. The availability of adequate roads in good state and improved ambulance services have alleviated issues during transfers. The policy allowing mothers to decide on their care independently is in place, eliminating the need for spousal consent for the procedures to be performed on her wife, like caesarian sections and other care.

*“We are grateful to the hospital and the authorities for reaching our level. Because where we are today is not where we were 10 years ago, in terms of infrastructure, you see that we have different rooms, neonatology.”* **IDI-Doctor Hospital 1 sex: male age: 37years**

Based on our findings, some of the most critical **threats** to RMC provision are the use of traditional medicines, the absence of private rooms, and staff shortages. Mothers using traditional herbs may experience maternal and neonatal adverse outcomes. The absence of private rooms compromises confidentiality and hinders the accommodation of birth companions. Additionally, staff shortages pose a challenge to providing adequate care.

*“Many mothers in the community have used Kinyarwanda traditional herbs. These medicines can cause harm to babies in the womb, leading to stillbirths or childbirth complications that may require Caesarean section”.* **FGD 3 participants 4, female**

#### 8.3.4 Choose the strategies

The researcher devised strategies based on integrating the overall findings, incorporating quantitative and qualitative approaches. The key areas in RMC that require strategic attention include patient-provider relationships, hospital and childbirth environments, continuous professional development, and support from leadership.

##### 8.3.4.1 Clarify how formulated strategies will be implemented.

In formulating the strategies in this current study, the author, in collaboration with the Supervisor, developed action plans, identified initiatives to achieve goals and objectives, and outlined action steps, tasks, and activities necessary for implementing each proposed strategy. Furthermore, the author assigned the responsibilities, proposed the timelines for completion,



and defined plans for monitoring implementation progress. In the literature, the strategic planner argues that in establishing an implementation plan strategy, resources, such as budget, personnel, technology, and infrastructure, should be allocated to execute the strategic plan effectively [170,161]. The resource allocation should be based on priorities and identified needs [170,161]. Furthermore, communication and engagement with stakeholders are crucial [170,84,232]. The strategic planner should share the plan with key stakeholders, including employees, management, board members, customers, suppliers, and other relevant parties. Clear communication of the plan's goals, objectives, strategies, and expected outcomes is essential. The strategic planner should engage the stakeholders in planning and address any concerns or feedback [170,84,232].

#### 8.3.4.2 Set up the follow-up mechanism.

Conducting regular assessments and reviewing progress towards achieving goals and objectives is essential to ensure an effective strategic plan and a positive impact on organizational performance [141,214,266]. It is crucial to evaluate the strategy's significance in light of changing conditions and make necessary adjustments [203,141]. Creating a culture of constant improvement by fostering education, innovation, and refinement within the business is also crucial [214,266]. Soliciting input from stakeholders and employees and collecting observations from the implementation process can help strengthen the strategic plan [203,141]. Establishing key performance indicators and metrics to track progress towards goals and objectives is essential. Monitoring performance against these parameters and analyzing the data collected can help evaluate the strategy's effectiveness and implement corrective measures [203,141].

### 8.4 Developed strategies, objectives, action plan, activities/tasks

Based on our findings, we have developed five strategic action plans based on participants' suggestions and integrated/ synthesised key findings. These strategies can be implemented at three levels: the community level, health facilities, and policymakers.

#### **Strategy 1. To strengthen women centered-care and childbirth-positive experiences**

**Objective:** To increase mothers self-reporting experiencing RMC from 70% to 90% within the next 12 months

#### **Imperative actions plan**

- ✓ To provide compassionate care & friendly care and emotional support;
- ✓ To provide timely care provision,
- ✓ To improve an environment that enables Privacy and confidentiality preservation
- ✓ To ensure clear and effective communication,
- ✓ To enhance autonomy and self-determination,
- ✓ To enhance mother's satisfaction

**Tasks, activities**

- Conduct regular RMC training for existing HCPs and newcomers; conduct workshops, seminars, refresher training, and mentorship.
- Educate the mothers about their rights and responsibility
- Avail posters in maternity wards with Universal rights of women and newborns. Those posters should be written in Kinyarwanda, English and French

**Responsible:** Maternity unit managers collaborate with hospital management, professional associations, and NGOs to organize training.

**Timeline:** every 3 months

- Conducted client satisfaction survey, conducted study to assess RMC status, read and analysed the reported ideas from the box of ideas.

**Responsible:** Quality assurance in collaboration with the research committee in the hospital

**Timeline:** each 1 year

- Recognition and rewards for motivating staff by recognizing and rewarding healthcare providers and facilities that consistently demonstrate exemplary practices in providing RMC.
- Implement mechanisms for acknowledging and celebrating achievements in respectful care to motivate and inspire others to follow suit.
- To show love to the staff, provide them with regular holidays
- To promote healthcare providers' well-being and self-care and provide support systems to address burnout, stress, and emotional challenges
- Being flexible in making workload and timetable, considering the mood of staff
- Providing lunch, breakfast, and snacks at work
- Continue to practice Performance-based financing

**Responsible:** Maternity Unit manager, Head of clinical and hospital leaders

**Timeline:** Each year

**Strategy 2. To maintain and promote an adequate environment around the facility childbirth**

**Objective:** To enhance the environmental cleanness around facility childbirth to ensure a safe and comfortable experience for mothers and newborns by increasing cleanness satisfaction from 50% to 80% within the next 2 years.

- ✓ To improve hospital hygiene,
- ✓ To ensure sufficient equipment and workforce
- ✓ To promote adequate private rooms and promote birth companionship

**Actions plans**

**Tasks, activities, steps:**

- Provide training and education on cleanliness practices: Conduct training sessions for healthcare staff
- To do regular cleaning schedules and protocols of the hospital environment
- Support personnel on proper cleanliness practices, including hand hygiene, waste management, and infection control.
- To monitor and quality assurance mechanisms to assess the cleanliness of the facility childbirth area regularly and to get updated with advancements in cleanliness technologies and methodologies to ensure the highest standards of cleanliness.
- To evaluate the facility's infrastructure and equipment to identify areas needing more cleanliness.
- To communicate effectively between healthcare providers, mothers, and their families to encourage feedback on cleanliness satisfaction

**Responsible:** Professional cleaning officer in collaboration with the person in charge of maternity service

**Timeline:** Every 2 months

- To Conduct regular inspections and audits to ensure adherence to cleanliness standards
- Regularly evaluate cleanliness satisfaction.

**Responsible:** Hospital quality assurance committee in the hospital

**Timeline:** 6 months

**Tasks, activities, steps.**

- Upgrade or replace equipment, ensure proper ventilation, and maintain functional utilities to support a clean environment.

**Responsible:** hospital maintenance services

**Timeline:** 1 year

**Tasks, activities, step 4.** Actively listen to their concerns, suggestions, and complaints, and take prompt action to address any issues related to cleanliness

**Responsible:** Maternity unit manager

**Timeline:** 3 months

### **Strategy 3. To preserve and uphold community trust towards maternity services**

**Objective:** To create RMC awareness among the community to increase their knowledge to 60%

#### **Actions plan**

- ✓ Create awareness of maternity in the community,
- ✓ Providing culturally sensitive care,
- ✓ Getting feedback and addressing the complaints

**Tasks, activities, steps:**

- To carry out meetings with the community to communicate the available maternity services
- Conducting open days
- Conduct community education programs to raise awareness about RMC

- Use social media like radio to sensitize mothers in the community to seek maternity services early
- Provide culturally sensitive care that considers the cultural backgrounds, values, and traditions of the women and their families
- Address complaints, concerns, and feedback from the community
- Maintaining transparency; responding promptly and appropriately to complaints; handling clients complain
- Communicate the actions taken to address any issues
- Getting feedback from women and their families, as well as healthcare providers
- Increase mutual trust by encouraging regular dialogue, feedback, and discussions to address concerns, share best practices, and promote a culture of collaboration.

**Responsible:** Staff in maternity in collaboration with local leaders

**Timeline:** Every year

#### ***Strategy 4. To pursue the professionalism***

**Objectives:** To develop and implement a professional development program for healthcare providers to enhance their knowledge and skills in providing respectful maternity care and increase the participation rate from 40% to 80% within the next year

#### **Action plan**

- ✓ Being responsible and accountable,
- ✓ Strengthening teamwork
- ✓ To develop ownership in caring mothers
- ✓ To promote continuity of care
- ✓ To follow the standard of care

#### **Tasks, activities, steps:**

- To remind HCPs to be accountable for their professional code of conduct, like avoiding being busy on computers and phones during working hours.
- To do a self-evaluation on how HCPs provide respect to mothers, colleagues and subordinates
- To remind HCPs that the profession is a vocation, they should value the mother to have a love of humanity.

- To report incident report
- Having emotional intelligence, developing positive self-confidence

**Responsible:** Professional council, staff

**Timeline:** Every 6 months

### **Action plan**

#### **Tasks, activities, steps:**

- To remind HCPs to enhance collaboration between midwives, nurses, doctors, anaesthesiologists
- To teach HCPs about effective communication, continuity of care, clear handover and making adequate decision

#### **Task, activities, steps:**

- To remind HCPs of professional ethical practices
- To inform HCPs on current RMC evidence-based care and innovations in RMC
- To teach them about cultural sensitivity care aligning with the strategic priority of sustaining respectful maternity care.

**Responsible:** Director of Nursing, Registrar of Nursing Council

**Timeline:** Every 3 months

#### **Tasks, activities, steps:**

- To remind HCPs to provide quality work like strict labour monitoring, follow partograph, and comply with the accreditation process)
- To prescribe adequate medicines and medical suppliers (avoid surplus)

**Responsible:** Maternity unit manager

**Timeline:** Monthly basis

### ***Strategy 5. Strengthening supportive leadership towards sustaining RMC***

**Objective:** To establish clear policy and mechanism to improve RMC in the hospital from 70% to 90%

### **Action plan**

- ✓ To establish the standard of quality,
- ✓ To create a mechanism for monitoring and evaluation,
- ✓ To make lobby for advocacy,
- ✓ To conduct appropriate training
- ✓ To motivate the staff

**Tasks, activities, steps:1.**

- Regularly review and update them to reflect current best practices and accreditation standards and conduct quality improvement meetings.
- To establish clear standards, policies and guidelines of RMC for HCPs involved in maternity care
- To promote a conducive environment
- Promote a culture of respect and dignity (for both sides) in maternity care settings.
- Enable Customer care services to work 24/7
- Benchmarking by having study trip to the hospital with standards
- employee evaluation
- Regularly monitor and evaluate quality
- Regular conducting audits

**Responsible:** Maternity Unit manager and hospital leaders

**Tasks, activities, steps:**

- To provide the needed equipment, adequate number of beds, keeping well infrastructure,
- Renovating the hospital and providing spacious rooms where possible, improving working conditions

**Responsible:** Maternity Unit manager and hospital leaders

**Timeline:** Every six months

**Tasks, activities, step 3**

- Establish the appropriate payment mechanisms/ Avoid retaining mothers and newborns in the hospital.
- Teaching security officers at the gate about respecting mothers and allowing them to enter
- Advocate charity actions and social support towards mothers in need

**Responsible:** Maternity Unit manager and hospital leaders

**Timeline:** every 6 months

The figure below illustrates the developed strategies and summarized action plans derived from findings gathered from mothers and healthcare providers to sustain and enhance RMC in Rwanda. This figure encompasses five strategies that can be implemented at three levels: policymakers, health facilities, and the community. One strategy can be executed at the policymaker level, while the remaining three are applicable at health facilities, and one is designated for implementation at the community level. (Figure 8.1)



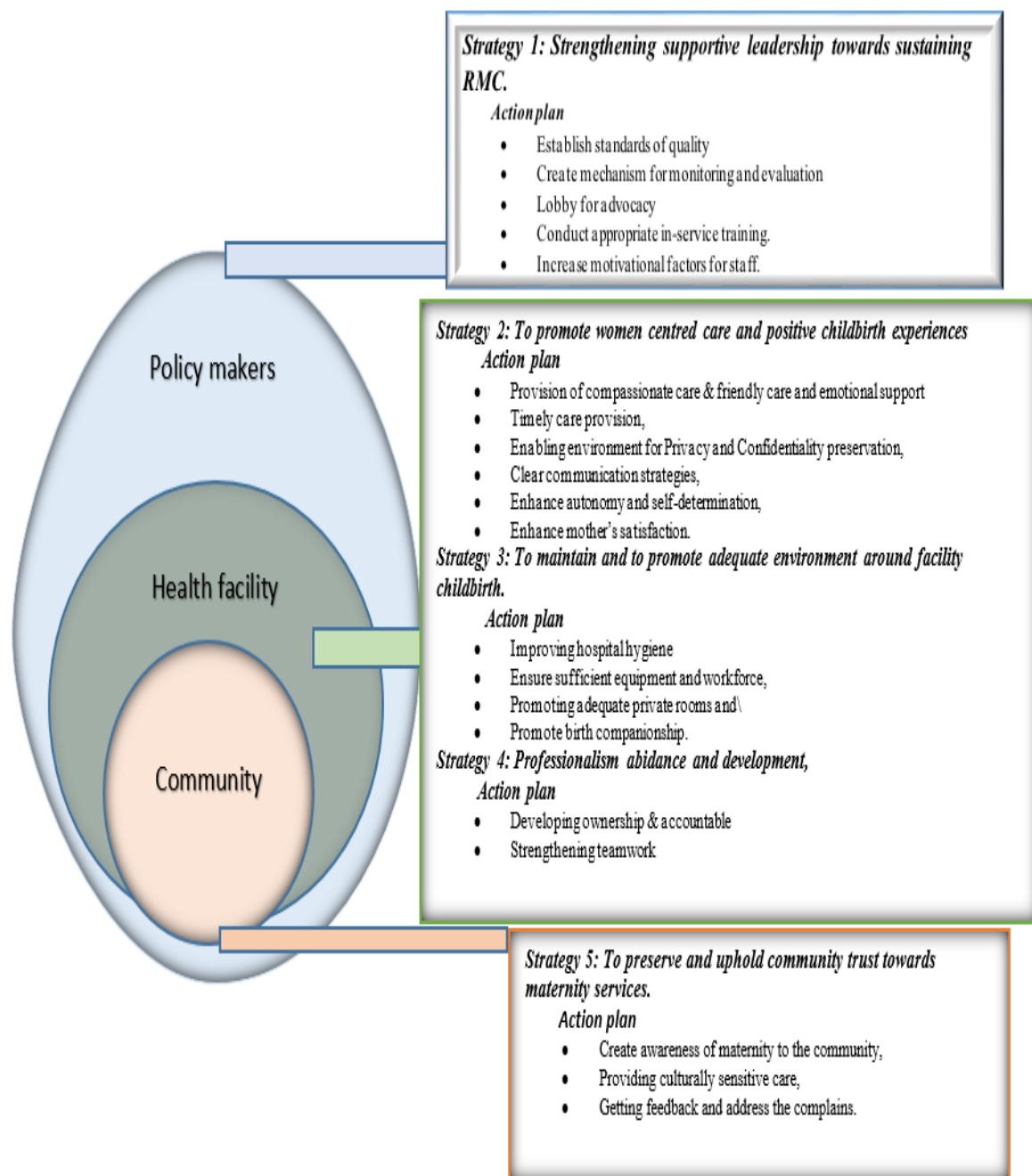


**Figure 8.1.** Strategies and action plan developed from the findings

## 8.5. Conclusion:

This chapter details the process of integrating all findings and developing the five RMC strategies based on those findings. The next chapter discusses the validation of these strategies.

## Chapter nine: Validation of developed RMC strategies, General conclusion and Recommendations of the study

### 9.1 Introduction

This chapter corresponds to phase 4 of the study, addressing the sixth objective, which involves validating the formulated strategies to facilitate Respectful Maternity Care for women in labour. This chapter provides an overview of the validation process, which includes the procedures, participants, tools, feedback, and scores for each strategy. The study involved ten experts/stakeholders in RMC from international and national backgrounds. The study prioritized the strategies based on relevance, feasibility, acceptability, and context. The researcher presented the validated strategies in a table that included objectives, implementation levels, action plans, activities, tasks, responsible parties, timelines, and follow-up. The chapter also presents a proposed logical framework for implementing the RMC-developed strategies and discusses various methodologies and theories used in RMC intervention research. The chapter concludes with a discussion, conclusion, and recommendations.

### 9.2 Validation procedure

Expert review entails seeking guidance from those with extensive expertise, mentorship, teaching, or research experience [105,57,251]. Performing an expert review entails assessing a product using the expertise and knowledge of a seasoned professional [108]. *Expert review* is a process that verifies a particular content or product by comparing it to the best practices, standards, and criteria [108]. It also offers significant insights, comments, or recommendations from experienced professionals. This procedure commonly entails consultations, interviews, surveys, or audits and requires meticulous planning and documentation [105,57]. Expert reviews have been utilized to evaluate the content in other studies [133,105]. Expert evaluations involve seeking input from domain experts or specialists and using their knowledge to obtain significant insights into specific elements or aspects from different perspectives and criteria [108]. These reviews evaluate the product's efficacy in meeting user needs, adherence to design principles, compliance with standards, and technical performance.

According to Escobar-Pérez [105], the steps in expert review validation are:

**Define the purpose and objectives:** The research should clearly and briefly describe the aim of the expert review, clarify the intended achievements, and identify the specific components the expert needs to assess.

**Select an expert:** Identify an individual with the requisite expertise and skills in the relevant field. Look for someone who possesses a deep understanding of the subject matter and is well-versed in industry standards and practices.

**Supply the expert with pertinent details about the items under review:** The researcher furnishes supporting documentation such as background materials, user manuals, design specifications, or any other relevant materials that can offer a comprehensive insight into the context and objectives of the review.

**Establish evaluation criteria:** The researcher clearly defines the standards or criteria the expert will use to assess the product. These criteria may encompass usability, functionality, performance, reliability, accessibility, or other pertinent attributes associated with the reviewed item.

**Conduct the evaluation and document the outcomes:** The researcher delegates the task to an expert conducting a thorough items assessment using the established criteria. This could involve methods such as product inspections or practical testing. Throughout the review process, the researcher should encourage the expert to comprehensively document their observations, highlighting strengths and weaknesses. The experts should explain and propose product improvement ideas, offering specific recommendations or actionable steps.

**Provide recommendations:** Based on the assessment, the expert should suggest practical actions to address identified deficiencies or concerns. These recommendations should be realistic and achievable, considering existing limitations and resources. After the expert review, assemble a thorough report summarizing the expert's findings and recommendations. Present the information in a clear and actionable manner, ensuring that the suggestions offered are concise, practical, and easy to implement.

Please note that the researcher did not conduct the intervention.

During the validation process of this study, the author contacted ten national and international experts in RMC. Among the international experts were Duke University and Utah University faculty members, who specialized in maternal health and typically supervised doctoral research in RMC. Additionally, an Assistant director matron at Rahima Moosa Mother and Child hospital in South Africa, a faculty member, and a CARTA graduate from the University of Ile Ife Awolowolo in Nigeria participated. The national experts included the president of the Rwanda association of midwives, the Director of maternal and child health from the ministry of health Rwanda, two faculty members from the midwifery department of the University of Rwanda, one Director of nursing from a hospital at the study site, and a community

representative who is usually selected to represent the community in various research projects in the country.

The author provided the RMC experts/stakeholders with a request letter, ethical clearances, a Personal Information Sheet (PIS), a socio-demographic data sheet, the strategies to validate, and a document containing the strategies to validate with guidance. This process was conducted individually over four weeks. The investigator requested the experts to rate or evaluate each strategy and action plan based on the criteria of relevance, feasibility, acceptability, and context using a self-administered questionnaire. The questionnaire utilized a four-point Likert scale ranging from 1 to 4, where 1 represented the lowest grade and 4 the highest grade for each item. A free space for explanatory remarks was also provided for the experts to offer additional suggestions based on their expertise.

### 9.3 The tool (Questionnaire for validation)

*Table 9.1 Questionnaire sent to the participants for validation*

You are kindly requested to rate or evaluate each strategy and action plan based on the criteria of relevance, feasibility, acceptability and context using this self-administered questionnaire. The questionnaire comprises a four-point Likert scale of 1 to 4 where 1 is the lowest grade and 4 is the highest grade for each item. A free space for explanatory remarks has also been provided for you to provide additional suggestions based on your expertise.

Operational definitions for the criteria are as follows:

**Relevance:** Refers to a scientific or societal benefit of a topic in the context of Respectful Maternity Care

**Feasibility:** Refers to technical and logistical considerations to uptake the proposed strategies and action plan of Respectful Maternity Care.

**Acceptability:** Focus on how well the strategies and action plan will be received by mothers, the community, health care providers (HCPs), hospital management and the health system, considering what was appreciated by services users (mothers) and HCPs caring for women during labour and childbirth based on culture, ethics, opportunities and collaborations available in Rwanda.

**Context:** Includes various factors, such as the maternity setting, historical background, cultural influences, and relationships between different elements.

### **Grading**

1=Poor

2=Average

3=Good

4=Excellent

| Strategy Number | Strategy                                                          | Action plan                                                                                                                                                                                                                                                                                                                                                                   |               | 1 | 2 | 3 | 4 | Comments |
|-----------------|-------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|---|---|---|---|----------|
| 1               | Strengthening supportive leadership towards sustaining RMC        | •Establish standards and Standard Operating Procedures for quality<br>•Create a mechanism for monitoring and evaluation<br>•Lobby for advocacy<br>•Conduct appropriate in-service training.<br>•Increase motivational factors for staff.                                                                                                                                      | Relevance     |   |   |   |   |          |
|                 |                                                                   |                                                                                                                                                                                                                                                                                                                                                                               | Feasibility   |   |   |   |   |          |
|                 |                                                                   |                                                                                                                                                                                                                                                                                                                                                                               | Acceptability |   |   |   |   |          |
|                 |                                                                   |                                                                                                                                                                                                                                                                                                                                                                               | Context       |   |   |   |   |          |
|                 |                                                                   |                                                                                                                                                                                                                                                                                                                                                                               |               |   |   |   |   |          |
| 2               | To promote women-centred care and positive childbirth experiences | <ul style="list-style-type: none"><li>• Provision of compassionate care &amp; friendly care and emotional support</li><li>• Timely care provision</li><li>• Enabling environment for Privacy and Confidentiality preservation,</li><li>• Clear communication strategies,</li><li>• Enhance autonomy and self-determination,</li><li>• Enhance mother's satisfaction</li></ul> | Relevance     |   |   |   |   |          |
|                 |                                                                   |                                                                                                                                                                                                                                                                                                                                                                               | Feasibility   |   |   |   |   |          |
|                 |                                                                   |                                                                                                                                                                                                                                                                                                                                                                               | Acceptability |   |   |   |   |          |
|                 |                                                                   |                                                                                                                                                                                                                                                                                                                                                                               | Context       |   |   |   |   |          |
|                 |                                                                   |                                                                                                                                                                                                                                                                                                                                                                               |               |   |   |   |   |          |
| 3               | To maintain and promote an adequate                               | <ul style="list-style-type: none"><li>• Uphold hospital hygiene</li></ul>                                                                                                                                                                                                                                                                                                     | Relevance     |   |   |   |   |          |

|   |                                                                           |                                                                                                                                                                                                                                                   |               |  |  |  |  |  |
|---|---------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|--|--|--|--|--|
|   | <b>environment around the childbirth facility.</b>                        | <ul style="list-style-type: none"> <li>• Ensure sufficient equipment and workforce,</li> <li>• Promoting adequate private rooms and\</li> <li>• Promote birth companionship.</li> <li>• Access to food</li> </ul>                                 | Feasibility   |  |  |  |  |  |
|   |                                                                           |                                                                                                                                                                                                                                                   | Acceptability |  |  |  |  |  |
|   |                                                                           |                                                                                                                                                                                                                                                   | Context       |  |  |  |  |  |
|   |                                                                           |                                                                                                                                                                                                                                                   |               |  |  |  |  |  |
| 4 | <b>Professionalism abidance and development</b>                           | <ul style="list-style-type: none"> <li>• Developing ownership &amp; accountability of healthcare providers</li> <li>• Improving attitudes of health care providers</li> <li>• Strengthening teamwork and Inter-collaborative practices</li> </ul> | Relevance     |  |  |  |  |  |
|   |                                                                           |                                                                                                                                                                                                                                                   | Feasibility   |  |  |  |  |  |
|   |                                                                           |                                                                                                                                                                                                                                                   | Acceptability |  |  |  |  |  |
|   |                                                                           |                                                                                                                                                                                                                                                   | Context       |  |  |  |  |  |
|   |                                                                           |                                                                                                                                                                                                                                                   |               |  |  |  |  |  |
| 5 | <b>To preserve and uphold community trust towards maternity services.</b> | <ul style="list-style-type: none"> <li>• Create awareness of maternity care and services in the community,</li> <li>• Providing culturally sensitive care,</li> <li>• Getting feedback and addressing the suggestions and complains</li> </ul>    | Relevance     |  |  |  |  |  |
|   |                                                                           |                                                                                                                                                                                                                                                   | Feasibility   |  |  |  |  |  |
|   |                                                                           |                                                                                                                                                                                                                                                   | Acceptability |  |  |  |  |  |
|   |                                                                           |                                                                                                                                                                                                                                                   | Context       |  |  |  |  |  |

**Qn 1.** Do you have any suggestions for adding strategies and action plans based on your expertise?

If yes explain

.....\*

**Qn 2.** Do you have any suggestions to change/amend any of the above strategies and action plans based on your expertise?

If Yes explain

.....

**Qn 3.** Do you have any suggestions to remove strategies and action plans based on your expertise?

If yes explain

.....

#### 9.4. Results/Feedback from the Validation process

*Table 9.2 Socio-demographic characteristics of participants in validation n=10*

Among 10 experts in RMC, 40% were international, and their education level is PhD and post-doctorate. The majority (60%) have a background education in maternal health (**Table 9.3**).

| Variable               | Categories                                  | Frequency | Percentage% |
|------------------------|---------------------------------------------|-----------|-------------|
| <b>Education level</b> | Masters                                     | 6         | 60          |
|                        | PhD and post-doc                            | 4         | 40          |
| <b>Speciality</b>      | Maternal health                             | 6         | 60          |
|                        | Public health                               | 3         | 30          |
|                        | Maternal and Neonatology                    | 1         | 10          |
| <b>Institution</b>     | International                               | 4         | 40          |
|                        | National                                    | 6         | 60          |
| <b>Position</b>        | National Community research coordinator     | 1         | 10          |
|                        | International RMC researcher leader         | 1         | 10          |
|                        | International researcher in maternal health | 1         | 10          |
|                        | Policy maker                                | 1         | 10          |
|                        | National Faculty of University              | 2         | 20          |
|                        | Director of Nursing                         | 1         | 10          |
|                        | RMC researcher in Africa                    | 1         | 10          |
|                        | President of Association of midwives        | 1         | 10          |
|                        | Leader of Maternity and child hospital      | 1         | 10          |
|                        |                                             |           |             |



*Table 9.3 Summarized validation findings*

The score ranges between 91 to 85 percent. The two strategies with the highest score (91.25%) are 1) To promote women-centred care and positive childbirth experience and 2) To preserve and uphold community trust towards maternity services. The strategy with the lowest score is To maintain and promote an adequate (safe) environment around the childbirth facility (85.6%).

| S/n               | Strategies                                                                             | Criteria      | Score% | Overall score% |
|-------------------|----------------------------------------------------------------------------------------|---------------|--------|----------------|
| 1                 | Strengthening supportive leadership towards sustaining RMC                             | Relevance     | 97.5   | 90             |
|                   |                                                                                        | Feasibility   | 87.5   |                |
|                   |                                                                                        | Acceptability | 90     |                |
|                   |                                                                                        | Context       | 85     |                |
| 2                 | To promote women-centred care and positive childbirth experiences                      | Relevance     | 100    | 91.25          |
|                   |                                                                                        | Feasibility   | 87.5   |                |
|                   |                                                                                        | Acceptability | 90     |                |
|                   |                                                                                        | Context       | 87.5   |                |
| 3                 | To maintain and promote an adequate (safe) environment around the childbirth facility. | Relevance     | 97.5   | 85.6           |
|                   |                                                                                        | Feasibility   | 80     |                |
|                   |                                                                                        | Acceptability | 85     |                |
|                   |                                                                                        | Context       | 80     |                |
| 4                 | Professionalism abidance and development                                               | Relevance     | 97.5   | 90.6           |
|                   |                                                                                        | Feasibility   | 85     |                |
|                   |                                                                                        | Acceptability | 87.5   |                |
|                   |                                                                                        | Context       | 92.5   |                |
| 5                 | To preserve and uphold community trust towards maternity services.                     | Relevance     | 85     | 91.25          |
|                   |                                                                                        | Feasibility   | 87.5   |                |
|                   |                                                                                        | Acceptability | 97.5   |                |
|                   |                                                                                        | Context       | 95     |                |
| Grant Total Score |                                                                                        |               |        | 89.75          |

*Table 9.4 Final Strategies, action plan, activities, follow-up*

The table below indicates the outputs of the validation process. It includes the validated strategy, the objectives, where to implement the strategy, various levels (policy levels, hospital leadership management, health care providers, service users, community), activities/tasks, who is responsible, timeline and the follow-up mechanisms. The validation process was based on the findings from the previous chapters and what experts/stakeholders in RMC added. They advised including more details in each strategy at different levels of implementation (*See Table 9.4*)

## 9.5 Final validated strategies and detailed action plan, activities, and follow-up

| Strategies                                                 | Objective                                                                              | Levels     | Action plan                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Activities/Tasks                                                                                                                                                                                                                                                                                                                                                                                                                                              | Responsible                 | Timeline       | Follow-up                                                                                                                                                                                                                                                                                                                                     |
|------------------------------------------------------------|----------------------------------------------------------------------------------------|------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|----------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Strengthening supportive leadership towards sustaining RMC | To establish clear policy and mechanism to improve RMC in the hospital from 70% to 90% | Polymakers | <ul style="list-style-type: none"> <li>Establish standards and Standard Operating Procedures for RMC</li> <li>Create a mechanism for monitoring and evaluation</li> <li>Integrate RMC in RMNCAH (Reproductive, Maternal, Newborn and Child Adolescent Health) policy and also be part of strategic plans related to MNCH (Maternal, Newborn and Child Health).</li> <li>Advocate for funds and resources to promote RMC</li> <li>Include RMC in the preservice curriculum of doctors and midwives, nurses</li> <li>Work together with all RMC stakeholders (MoH, Policy makers, donors, NGOs, researchers, human rights activists, Faculty, health care providers, women associations, professional associations, community, families, women and their partners, etc.)</li> </ul> | <ul style="list-style-type: none"> <li>Regularly review and update them to ensure they reflect current best practices.</li> <li>Work for accreditation</li> <li>Conduct quality improvement meeting</li> <li>Establish clear standards, policies, and guidelines for RMC for HCPs involved in maternity care.</li> <li>Introduce the RMC concept in the monthly reporting system/reporting</li> <li>Continue the performance-based financing (PBF)</li> </ul> | MoH Health facility leaders | Every 6 months | <p>Evaluate the implementation and effectiveness of quality improvement measures within maternity care services.</p> <p>Assess the effects of performance-based financing (PBF) on healthcare provider behaviour and the quality of RMCH services.</p> <p>Ensure transparent reporting of RMC performance data to promote accountability.</p> |

|  |  |                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |  |
|--|--|--------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|
|  |  |                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |  |  |
|  |  | Hospital leadership/management | <ul style="list-style-type: none"> <li>• Lobby for RMC advocacy</li> <li>• Increase motivational factors for staff</li> <li>• Conduct appropriate in-service training</li> <li>• Integrate RMC into the reporting system</li> <li>• To have orientation sessions on RMC for all staff</li> <li>• The hospitals in Rwanda should aim to be mother- and baby-friendly.</li> <li>• Integrate RMC in the action plan for each hospital</li> <li>• There is a need to train, to recruit and retain more midwives</li> </ul> | <ul style="list-style-type: none"> <li>❖ Communicate the policy to all health care working in maternity services</li> <li>❖ Promote a culture of respect and dignity (for both sides) in maternity care settings.</li> <li>❖ Enable Customer care services to work 24/7</li> <li>❖ Benchmarking by having study trip to the hospital with standards</li> <li>❖ Request a monthly report on RMC</li> <li>❖ Employee monthly evaluation</li> <li>❖ Regularly monitor and evaluation of RMC</li> <li>❖ Regularly conduct audits</li> <li>❖ Provide the needed equipment, adequate number of beds, keeping well infrastructure,</li> <li>❖ Renovate the hospital and provide spacious rooms where possible, improving working conditions.</li> <li>❖ Establish the appropriate payment mechanisms for mothers/ Avoid retaining mothers and newborns in the hospital.</li> <li>❖ Teach the security officers at the gate about respecting mothers and allow them to enter the health facilities when they don't have transfer documents.</li> <li>❖ Advocate charity actions and social support towards mothers in need.</li> </ul> |  |  |  |

|                                                                                 |                                                                                               |                   |                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                    |  |  |                                                                                                                                                   |
|---------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|-------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|---------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                 |                                                                                               | Service providers | <ul style="list-style-type: none"> <li>• Involve Health care providers working in maternity service</li> </ul>                                                                                                          | <ul style="list-style-type: none"> <li>❖ Communicate to the mothers the possible prognosis (If a poor prognosis is expected because of existing complications, communicate to the mother ahead of time)</li> </ul>                                                                                 |  |  |                                                                                                                                                   |
|                                                                                 |                                                                                               | Service users     | <ul style="list-style-type: none"> <li>• Involve the women representative when establishing RMC policy</li> </ul>                                                                                                       | <ul style="list-style-type: none"> <li>❖ Utilize the health service during pregnancy, labour, childbirth and post-partum</li> <li>❖ Have positive expectations when attending health facilities</li> <li>❖ Increase the self-confidence</li> </ul>                                                 |  |  |                                                                                                                                                   |
|                                                                                 |                                                                                               | Community         | <ul style="list-style-type: none"> <li>• Collaborate with the community during the entire process of establishing the RMC policy.</li> </ul>                                                                            | <ul style="list-style-type: none"> <li>❖ Participate in meetings on RMC policy.</li> <li>❖ Communicate the RMC policy information to the rest of the community (Community leaders should do that)</li> </ul>                                                                                       |  |  |                                                                                                                                                   |
| <b><i>To promote women-centred care and positive childbirth experiences</i></b> | To increase mothers self-reporting experiencing RMC from 70% to 90% within the next 12 months | Polymakers        | <ul style="list-style-type: none"> <li>• Enhance policy on preserving dignity and respect towards mothers during labour and childbirth like strengthening birth companionship policy, RMC awareness creation</li> </ul> | <ul style="list-style-type: none"> <li>❖ Allow birth companions to enter into labour wards</li> <li>❖ Privacy and Confidentiality preservation by using curtains, partitions, and private rooms</li> <li>❖ Post the Universal rights of Women and newborns on the hospital wall, in the</li> </ul> |  |  | Ensuring the implementation of regulations that allow women to have birth companions during labour while maintaining privacy and confidentiality. |

|  |                                |                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                  |                                                                                                                                     |                                                                                                      |                                                                                                                                                                                                                                                                        |
|--|--------------------------------|---------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|  |                                |                                                                                                                           | <ul style="list-style-type: none"><li>• Enhance the policy of mothers' autonomy in decision-making</li><li>• This policy exists in Rwanda but should be communicated to the community</li></ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                             | labour wall, and post-partum walls.                                                                                              |                                                                                                                                     |                                                                                                      | <b>Assessment of client satisfaction:</b><br>To introduce routine surveys and feedback mechanisms to assess patients' satisfaction with maternity care services.<br>To take measures to reduce D&A during childbirth.                                                  |
|  | Hospital leadership/management | <ul style="list-style-type: none"><li>• Enhance mother's satisfaction.</li><li>• Clear communication approaches</li></ul> | <ul style="list-style-type: none"><li>❖ Conduct RMC regular training existing HCP and newcomers; conduct workshops, seminars, refresher training, and mentorship.</li><li>❖ Educate the mothers about their rights and responsibility</li><li>❖ Avail posters in maternity wards with Universal rights of women and newborns. Those posters should be written in Kinyarwanda, English and French</li><li>❖ Read and analyse the reported ideas from the box of ideas</li><li>❖ Recognize and reward for motivating staff who consistently demonstrated exemplary practices in providing RMC.</li><li>❖ Implement mechanisms for acknowledging and</li></ul> | <ul style="list-style-type: none"><li>❖ Quality assurance in collaboration with the research committee in the hospital</li></ul> | Maternity unity managers in collaboration with hospital management and with professional associations and NGOs to organize training | <ul style="list-style-type: none"><li>every 3 months</li><li>Each 1 year</li><li>Each year</li></ul> | <b>To conduct an RMC situational analysis study:</b><br>Conduct research to assess RMC among service users and providers in all health facilities.<br><br><b>Investigation of patient rights awareness:</b><br>Investigate and enhance women and newborns knowledge of |

|  |                   |                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                               |  |                                                                              |
|--|-------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------|--|------------------------------------------------------------------------------|
|  |                   |                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                       | <p>celebrating achievements in RMC to motivate and inspire others to follow suit.</p> <ul style="list-style-type: none"> <li>❖ To show love to the staff, provide them with regular holidays</li> <li>❖ Promote healthcare providers' well-being and self-care and provide support systems to address burnout, stress, and emotional challenges <ul style="list-style-type: none"> <li>- Being flexible in making workload and timetable, considering the mood of staff</li> <li>- Provide lunch, breakfast, and snacks at work</li> </ul> </li> </ul> | Maternity Unit manager, Head of clinical and hospital leaders |  | their rights during childbirth through research and educational initiatives. |
|  | Service providers | <ul style="list-style-type: none"> <li>• Provision of compassionate care &amp; friendly care and emotional support</li> <li>• Timely care provision</li> <li>• Preserve Privacy and Confidentiality</li> <li>• Clear communication</li> <li>• Enhance mothers' autonomy and self-determination</li> </ul> | <ul style="list-style-type: none"> <li>❖ Encourage mothers to bring their birth companions</li> <li>❖ Providing the best care to women</li> <li>❖ Prescribe adequate medicines and medical suppliers (avoid surplus)</li> <li>❖ Actively listen to the client's concerns, suggestions, and</li> </ul> | Maternity unit manager                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 3 months                                                      |  |                                                                              |

|                                                          |                                                                               |               |                                                                                                                                                                   |                                                                                                                                                                                                                        |                                                                |  |                                                                                      |
|----------------------------------------------------------|-------------------------------------------------------------------------------|---------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------|--|--------------------------------------------------------------------------------------|
|                                                          |                                                                               |               | <ul style="list-style-type: none"> <li>• Enhance mother's satisfaction</li> <li>• Individualizer the woman care</li> </ul>                                        | complaints and take prompt action to address any issues<br>❖ Address the complaint<br>❖ Redress any D&A issue<br>❖ Refer those who experienced D&A to mental health services                                           | Other staff like accountants, cleaners, security officers, etc |  |                                                                                      |
|                                                          |                                                                               | Service users | Being empowered                                                                                                                                                   | ❖ Demand their rights<br>❖ Speak out the complaints if any<br>❖ Seek help if you experience any issue                                                                                                                  |                                                                |  |                                                                                      |
|                                                          |                                                                               | Community     | <ul style="list-style-type: none"> <li>• Create awareness of women's and newborns' rights</li> <li>• Empower women in the community</li> </ul>                    | ❖ Allow women to have access to the money.<br>❖ Allow women to make decisions on their bodies, like providing independent consent towards some medical procedures such as Caesarian section tubal ligation.            |                                                                |  |                                                                                      |
| To maintain and promote an adequate and safe environment | To enhance the environmental cleanness around facility childbirth to ensure a | Policymakers  | <ul style="list-style-type: none"> <li>• To advocate for the maternity buildings that support birth companions and women's privacy and confidentiality</li> </ul> | ❖ Renovate and extend the settings to meet the requirements for privacy<br>❖ Avail adequate private rooms<br>❖ Continue promoting the use of partitions (curtains) in hospitals to provide privacy and confidentiality |                                                                |  | Conduct regular inspections and audits to ensure adherence to cleanliness standards. |

|                                |                                                                                                                                          |                                |                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                  |                |                                                                                                                                                                                                                                                                |
|--------------------------------|------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------|----------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| around the childbirth facility | safe and comfortable experience for mothers and newborns by increasing cleanliness satisfaction from 50% to 80% within the next 2 years. |                                |                                                                                                                                                                                                                                                                                                                                                                                                                                | for mothers, even in the promotion of birth companionship.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                  |                | Identify any areas that may need more cleanliness.                                                                                                                                                                                                             |
|                                |                                                                                                                                          | Hospital leadership/management | <ul style="list-style-type: none"> <li>• Uphold hospital hygiene</li> <li>• Ensure sufficient equipment and workforce,</li> <li>• Assess the cleanliness of the facility's childbirth area and get updated with advancements in cleanliness technologies and methodologies to ensure the highest standards of cleanliness.</li> <li>• Perform regular cleaning schedules and follow hospital environment protocols.</li> </ul> | <ul style="list-style-type: none"> <li>❖ Provide training and education on cleanliness practices:</li> <li>❖ Write/communicate on the notice board the schedule of bedsheet changing, timetable of wards cleaning/mopping</li> <li>❖ Fumigate the wards regular</li> <li>❖ Clean the childbirth beds and labour wards immediately after using them</li> <li>❖ Use sterile materials where indicated</li> <li>❖ Use clean materials where indicated</li> <li>❖ Support personnel on proper cleanliness practices, including hand hygiene, waste management, and infection control.</li> <li>❖ Upgrade or replace equipment, ensure proper ventilation, and maintain functional utilities to</li> </ul> | Professional cleaning/hygiene officer in collaboration with those in charge of maternity service | Every 2 months | Regularly evaluate cleanliness satisfaction among service users.                                                                                                                                                                                               |
|                                |                                                                                                                                          |                                |                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Hospital quality assurance committee in the hospital                                             | 6 months       | <b>Adherence to RMC procedures:</b><br>Ensure compliance with established procedures for RMC, including maternal audits, mentorship programs, and quality improvement committees. Evaluate adherence to national and international guidelines related to RMCH. |
|                                |                                                                                                                                          |                                |                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Hospital maintenance services                                                                    | 1 year         |                                                                                                                                                                                                                                                                |



|  |                   |                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                          |                              |          |  |                                                                                                                                                                                                                                                                                         |
|--|-------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------|----------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|  |                   |                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                          | support a clean environment. |          |  | <b>Training healthcare providers:</b><br>Prioritize the continuous education of healthcare professionals in RMC principles and practices.<br><br><b>Sharing reporting on RMC progress:</b><br>HCP can share with the community the way the complaints are handled, the RMC status, etc. |
|  | Service providers | <ul style="list-style-type: none"> <li>• Request on-time equipment</li> <li>• Actively listen to the client's concerns, suggestions, and complaints and take prompt action to address any issues related to cleanliness.</li> </ul> | <ul style="list-style-type: none"> <li>❖ Assess the needed equipment and supplies before hands</li> <li>❖ Send on time the requisition to the procurement office</li> <li>❖ Respond on time to the client's complaints related to cleanliness</li> </ul> | Maternity unit manager       | 3 months |  |                                                                                                                                                                                                                                                                                         |
|  | Service users     | Ensure personal hygiene                                                                                                                                                                                                             | <ul style="list-style-type: none"> <li>❖ Ensure personal hygiene, like washing the body regularly</li> <li>❖ Bring accepted personal hygiene items</li> <li>❖ Bring appropriate baby clothes</li> </ul>                                                  |                              |          |  |                                                                                                                                                                                                                                                                                         |
|  | Community         | Participate in community hygiene at health facilities                                                                                                                                                                               | <ul style="list-style-type: none"> <li>❖ Communicate what is needed or not needed to be brought to the hospital during childbirth</li> <li>❖ Prepare what is needed on time, like the baby clothes on time</li> </ul>                                    |                              |          |  |                                                                                                                                                                                                                                                                                         |

|                                                    |                                                                                                                                                                                                                                            |                                                                 |                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                             |                |  |
|----------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|----------------|--|
| Professionalism<br>abundance<br>and<br>development | To develop and implement a professional development program for healthcare providers to enhance their knowledge and skills in providing respectful maternity care and increase the participation rate from 40% to 80% within the next year | <ul style="list-style-type: none"> <li>Policy makers</li> </ul> | <ul style="list-style-type: none"> <li>Establish Mandatory continuous professional development (CPD) in RMC for license renewal for HCPs who work in maternity services.</li> <li>Provide teaching materials and reference documents for HCPs as well as for the community</li> </ul>                                                                          | <ul style="list-style-type: none"> <li>Create in-service training for license renewal on HCPs</li> <li>Create an online CPD</li> <li>Include the RMC course in the curriculum for the pre-service</li> </ul>                                                                                                                                                                                                                                        |                             |                |  |
|                                                    |                                                                                                                                                                                                                                            | Hospital leadership/management                                  | <ul style="list-style-type: none"> <li>Develop ownership &amp; accountability of healthcare providers</li> <li>Establish mentorship programs where experienced midwives can guide and support those new to the profession.</li> <li>Train health professionals who care for mothers about VCAT (Values Clarification and Attitudes Transformations)</li> </ul> | <ul style="list-style-type: none"> <li>To remind HCPs to be accountable for their professional code of conduct, like avoiding being busy on computers and phones during working hours.</li> <li>To remind HCPs that the profession is a vocation.</li> <li>To remind HCPs to enhance collaboration between midwives, nurses, doctors, anaesthesiologists</li> <li>To teach HCPs about effective communication, continuity of care, clear</li> </ul> | Professional council, staff | Every 6 months |  |

|  |  |                   |                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                              |                                            |  |
|--|--|-------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------|--|
|  |  |                   |                                                                                                                                                                   | <p>handover and making adequate decision</p> <ul style="list-style-type: none"> <li>❖ To remind HCPs about professional ethical practices</li> <li>❖ To inform HCPs on current RMC evidence-based care and innovations in RMC</li> <li>❖ To teach them about cultural sensitivity care aligning with RMC</li> <li>❖ To remind HCPs to provide quality work like strict labour monitoring, follow partograph, and comply with the accreditation process)</li> </ul> | <p>Director of Nursing, in collaboration with the Registrar of the National Council of Nurses and Midwives</p> <p>Maternity unit manager</p> | <p>Every 3 months</p> <p>Monthly basis</p> |  |
|  |  | Service providers | <ul style="list-style-type: none"> <li>• Improve personal behaviours and attitudes</li> <li>• Strengthening teamwork and Inter-collaborative practices</li> </ul> | <ul style="list-style-type: none"> <li>❖ To remind HCPs to be accountable and responsible</li> <li>❖ To train HCPs on having emotional intelligence, develop positive self-confidence</li> <li>❖ To do a self-evaluation on how HCPs provide respect to mothers, colleagues and subordinates</li> <li>❖ To report incident report</li> </ul>                                                                                                                       | Maternity unit manager                                                                                                                       | Monthly basis                              |  |

|                                                                    |                                                                                |                                 |                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                     |            |                                                                                                                                              |
|--------------------------------------------------------------------|--------------------------------------------------------------------------------|---------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------|------------|----------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                    |                                                                                |                                 |                                                                                                                                                                                                                                                                                                                                                                                                | <ul style="list-style-type: none"><li>❖ Provide value to the mother, to have a love of humanity.</li></ul>                                                                                                                                                                                                                                                                                                                          |                                     |            |                                                                                                                                              |
|                                                                    |                                                                                | Service users                   | <ul style="list-style-type: none"><li>• Maintain positive relationships with service providers and the hospital environment.</li></ul>                                                                                                                                                                                                                                                         | <ul style="list-style-type: none"><li>❖ Respect the service providers</li><li>❖ Respect other patients</li><li>❖ Respect the health facility regulations</li></ul>                                                                                                                                                                                                                                                                  |                                     |            |                                                                                                                                              |
|                                                                    |                                                                                | Community                       | <ul style="list-style-type: none"><li>• Collaborate with health facility</li></ul>                                                                                                                                                                                                                                                                                                             | <ul style="list-style-type: none"><li>❖ Avoid the use of traditional medicine during labour</li></ul>                                                                                                                                                                                                                                                                                                                               |                                     |            |                                                                                                                                              |
| To preserve and uphold community trust towards maternity services. | To create RMC awareness among the community to increase their knowledge to 60% | Policymakers                    | <ul style="list-style-type: none"><li>• Create awareness of maternity care and services in the community</li><li>• Raise awareness about the importance of RMC</li><li>• Establish the mechanism to avoid the first and second delays</li><li>• To continue training Community Health Workers (CHW) in charge of maternity</li><li>• Sensitize the community about maternity service</li></ul> | <ul style="list-style-type: none"><li>❖ Create community education programs to raise awareness about RMC.</li><li>❖ Provide teaching materials and reference documents for RMC for the community.</li><li>❖ Provide the number to call emergency in case a mother needs an ambulance or in emergency cases.</li><li>❖ Use social media like radio to sensitize mothers in the community to seek maternity services early.</li></ul> |                                     |            | <b><i>Evaluation of community engagement:</i></b><br>Assess the level of community participation in promoting and sustaining RMC activities. |
|                                                                    |                                                                                | Hospital leadership/ management | <ul style="list-style-type: none"><li>• Maintaining transparency</li><li>• Increase mutual trust</li><li>• Promote a culture of collaboration.</li></ul>                                                                                                                                                                                                                                       | <ul style="list-style-type: none"><li>❖ To carry out meetings with the community to communicate the available maternity services</li></ul>                                                                                                                                                                                                                                                                                          | Staff in maternity in collaboration | Every year |                                                                                                                                              |

|  |  |                   |                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                    |  |                                                                                                                                                          |
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|  |  |                   |                                                                                        | <ul style="list-style-type: none"> <li>❖ Conducting open days</li> <li>❖ Provide culturally sensitive care that considers the cultural backgrounds, values, and traditions of the women and their families.</li> <li>❖ Address complaints, concerns, and feedback from the community</li> <li>❖ Respond promptly and appropriately to complaints, handle clients complains</li> <li>❖ Communicate the actions taken to address any issues</li> <li>❖ Getting feedback from women and their families, as well as healthcare providers</li> <li>❖ Conduct regular dialogue, feedback, and discussions to address concerns, share best practices</li> </ul> | with local leaders |  |                                                                                                                                                          |
|  |  | Service providers | <ul style="list-style-type: none"> <li>• Provide culturally sensitive care.</li> </ul> | <ul style="list-style-type: none"> <li>❖ Consider every woman individually; respect her values and believes</li> <li>❖ Communicate to the community about the available services for maternity</li> <li>❖ Train health community workers</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                      |                    |  | <p><b><i>Investigation of women and newborns rights awareness:</i></b></p> <p>Investigate and enhance women and newborns' knowledge of their rights.</p> |

|  |  |               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |  |                                                                                                                                                                                                          |
|--|--|---------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|  |  |               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |  |                                                                                                                                                                                                          |
|  |  | Service users | <ul style="list-style-type: none"> <li>To increase women's self-confidence</li> </ul>                                                                                                                                                                                                                                                                                                                                                                            | <ul style="list-style-type: none"> <li>❖ To encourage poor women to attend childbirth health facility</li> <li>❖ Social service in the community should sign the approval to poor women to help them get services</li> </ul>                                                                                                                                                                                                                                                                                                                                         |  |  |                                                                                                                                                                                                          |
|  |  | Community     | <ul style="list-style-type: none"> <li>Engage with communities to understand their needs</li> <li>Upholding the community trust</li> <li>Health promotion, education on positive change</li> <li>Community involvement initiative</li> <li>To create awareness in the community concerning birth companions (the culture is a big barrier to its implementation)</li> <li>To make women open and enjoy education about their fundamental human rights</li> </ul> | <ul style="list-style-type: none"> <li>❖ Help mothers to attend the hospital on time.</li> <li>❖ Community Health Workers can sensitize the population to maternity care during community meetings and services.</li> <li>❖ Involve both mother and family in decision-making</li> <li>❖ To conduct mobilization/sensitization meetings</li> <li>❖ To involve the community and create awareness of what is done to the population</li> <li>❖ Involve the community in hospital hygiene and build the health facility so that they feel like they own it.</li> </ul> |  |  | <p><b><i>Evaluation of health insurance coverage:</i></b> Ensure that every pregnant woman is enrolled in community-based health insurance programs.</p> <p>Getting feedback on addressed complaints</p> |

## 9.6 The Proposed Logical framework for RMC strategies implementation in Rwanda

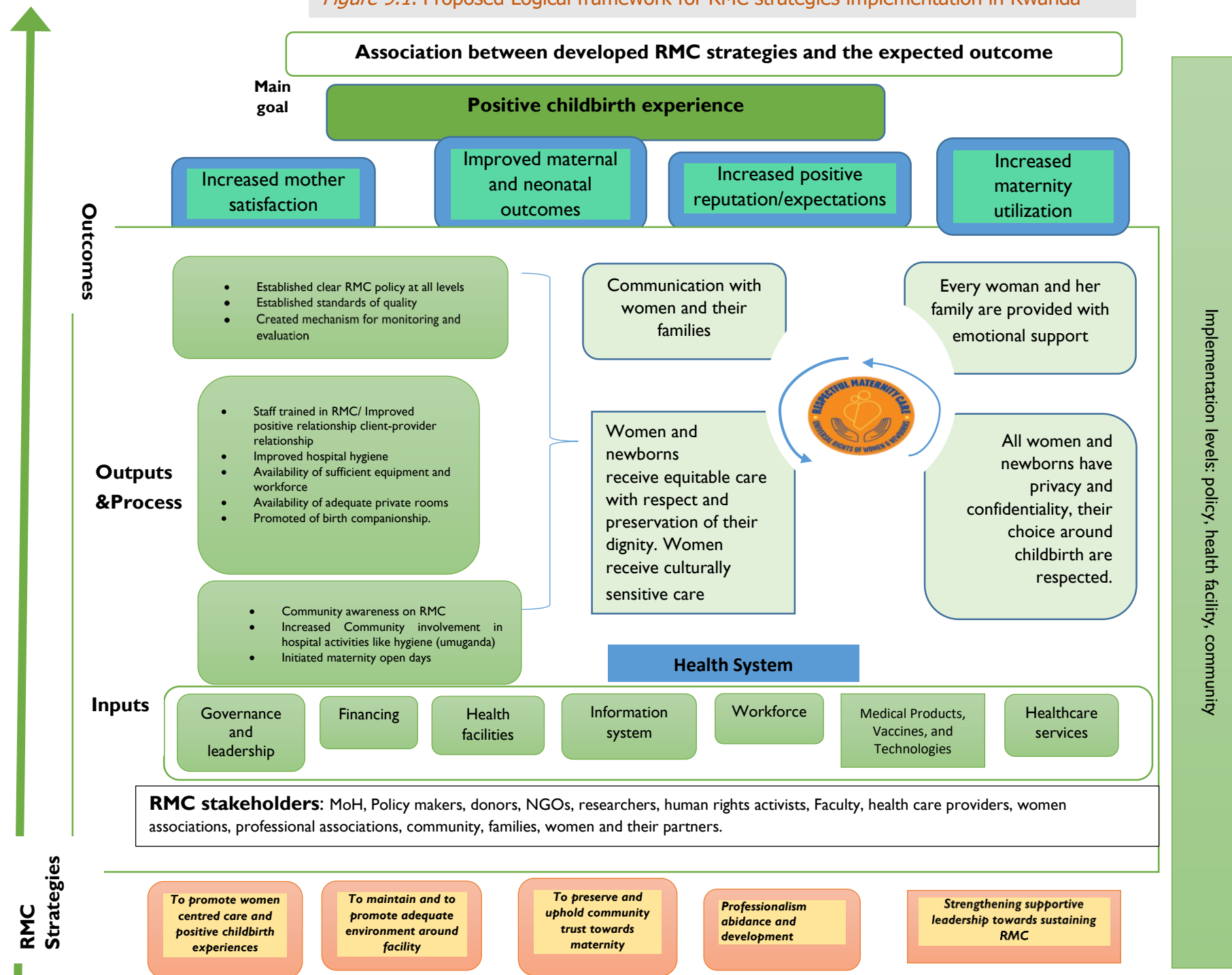
A Logframe, also known as a Logical Framework, is a planning tool comprising a matrix that comprehensively views a project's objectives, activities, and expected outcomes [157,229]. It precisely defines project elements and activities while establishing connections between them [157,228]. The logical framework below illustrates the association between developed RMC strategies and the anticipated outcomes.

The Logical Framework serves as a tool to enhance project design, implementation, and evaluation, making it beneficial throughout the project lifecycle. It aids in organizing thoughts, defining performance indicators, assigning responsibilities, and facilitating effective communication [19]. Note that the researcher developed the general logical framework without details in this study. The Logframe encompasses the project's long-term objective, ensuring that every woman has a positive childbirth experience. The outcomes are achievements expected over time, including increased mothers' satisfaction, improved maternal and neonatal outcomes, enhanced positive reputation and expectations, and increased maternity services utilization.

Outputs are immediate results obtained soon after completing the project or specific activities. [157,229]. Outputs are the achievements or deliverables a project aims to accomplish. These are the key objectives outlined in the project's terms of reference. Outputs represent the tangible results for which the project team is directly responsible and for which resources are allocated [19]. At the policy level, the author expects to establish a clear RMC policy at all levels, set quality standards, and create mechanisms for monitoring and evaluation. The expected achievements at the health facility level include staff training in RMC, improved positive client-provider relationships with improved HCPs behaviours and attitudes, enhanced hospital hygiene, sufficient equipment and workforce availability, adequate private rooms, and promoted birth companionship. All these activities aim to uphold the universal rights of women and newborns, following the guidelines established by the White Ribbon Alliance [284] and WHO components of a positive childbirth experience, which include communication with women and their families, equitable care with respect and preservation of dignity, culturally sensitive care, emotional support, privacy and confidentiality, and respecting women's choices around childbirth [284].

*Figure 9.1. Proposed Logical framework for RMC strategies implementation in Rwanda*

Figure 9.1. Proposed Logical framework for RMC strategies implementation in Rwanda







The figure above (**Figure 9.1**) depicts how the five developed strategies from this study can contribute to positive childbirth. Those strategies are to promote women-centred care, to maintain and promote an adequate environment around the child facility, to preserve and uphold community trust towards maternity services, to abide by and develop professionalism, and to strengthen the supportive leadership for RMC. The RMC should be involved the relevant stakeholders such as the Ministry of Health and policy makers' national professional councils such as nurses and midwives, medical council, researchers, University Faculty, human rights activists, women's associations, health care providers, community, families, women and their partners. Donors and Non-Government Organizations should actively support RMC activities. In addition, a broad system should be involved to support RMC.

The health system is made up of governance and leadership, financing, health facilities, information systems, workforce, medical products, technology, and health care services provision [315,24]. This study proposed an action plan, and when implemented, it will contribute to sustaining and improving RMC in Rwanda.

Actions can be implemented at three levels: policymakers, health facilities, and community. Some action plans were proposed at the policymakers' levels; this study proposed the establishment of clear RMC policy at all levels, establishing standards of quality, and creating mechanisms for monitoring and evaluation. At the health facility, it was proposed that the staff in RMC be trained to improve positive client-provider relationships, improve hospital hygiene, provide sufficient equipment and workforce, provide adequate private rooms, and promote birth companionship. WHO, 2016 defined RMC provision as creating communication with women and their families, providing equitable care with respect and preserving dignity for women and newborns [289]. In addition, RMC provides culturally sensitive care to women and emotional support to women and their families; all women and newborns have privacy and confidentiality, and their choices around childbirth are respected [289].

The expected outcomes of implementing these strategies are:

Increased mothers' satisfaction, improved maternal and neonatal outcomes, increased the positive reputation of maternity services in the community or expectations from mothers [300], and increased utilization of maternity services (**Figure 9.1**).

### 9.7 Implementation Frameworks, theories used in RMC interventional research

The Health Evaluation and Applied Research Development (HEARD) project recently conducted a scoping review to summarise and describe interventions implemented to promote RMC during childbirth in Africa. The study reported that few RMC interventions were conducted in Africa. Most were conducted in East Africa, especially in Kenya and Tanzania. In addition, most interventions focused on RMC training for HCPs, and minimal studies presented the effectiveness of those interventions [92]. There are few examples of engaging women in the community or adopting social accountability approaches [92].

In implementation science, various theories, models, and methodologies are employed to facilitate behaviour change; some have been used in RMC. These approaches are generally classified into six distinct groups [91]:

1. Process models, such as the Exploration, Preparation, Implementation, Sustainment (EPIS) model and the Practical, Robust Implementation, and Sustainability Model (PRISM)
2. Determinant frameworks, including active implementation and the Consolidated Framework for Implementation Research (CFIR)
3. Implementation theories such as organizational readiness
4. Implementation climate, including Reach, Effectiveness, Adoption, Implementation, and Maintenance (RE-AIM), and implementation outcomes
5. Classic theories, including the theory of change, behavioural and organizational theory
6. Evaluation frameworks [91].

The Consolidated Framework for Implementation Research has been utilized in some implementation research in the RMC context. For instance, Esan and colleagues utilized organizational readiness in Nigeria [104]. Additionally, CFIR was employed in an intervention focused on RMC in Kenya [269] and the Behavioral Change Model proposed by Diamond-Smith [91,92]. Diamond-Smith and colleagues recommended utilizing a behaviour change model in designing interventions to promote RMC [91,92]. They highlight that increased implementers and intervention developers could benefit from existing frameworks to guide the design of more effective interventions [91]. Moreover, Diamond-Smith and colleagues emphasized that a behaviour change framework such as the COM-B model, which includes capability, opportunity, and motivation behaviour components, can effectively improve RMC

because respectful care primarily relies on the provider's behaviour [91]. In examining other RMC studies, they stated that D&A are not individual issues but systemic issues within the health system and argue that different types of interventions can be effective [91].

The systematic review investigated potential theories for future RMC intervention studies [254, 91,97,144,147]. The findings generated hypotheses regarding optimal theoretical foundations for implementing RMC change [97,144,147]. The author suggested using the Behavioral Change Wheel to enhance tailored interventions and increase collaborative efforts with local stakeholders [91,254]. The focus should address socio-ecological factors and influence individuals' attitudes at all levels [97]. The author recommended determining the interventions locally and using straightforward principles that facilitate efficient learning across studies [97,144,147]. Researchers can simplify interventions in complex systems by applying simplicity from complexity theory. A common criticism is that maternity care interventions often emphasize behaviour but less emphasize culture and policy. In summary, sustainable change in RMC necessitates addressing attitudes at all socio-ecological levels and involving local stakeholders and theoretically informed tools [97,144,147].

## 9.8 Discussion

Our findings highlighted the importance of implementing multiple strategies and action plans to promote and sustain RMC in Rwanda. This is consistent with a recent review of RMC interventions, which suggests that adopting multifaceted strategies can effectively reduce the mistreatment of women during maternity care and enhance RMC provision. Comprehensive approaches address various factors, including healthcare personnel attitudes, staff morale, community engagement, and removing barriers in healthcare facilities and systems. Interventions beyond a singular focus are more likely to yield meaningful change [144]. Furthermore, a systematic review of RMC highlighted the scarcity of RMC randomized controlled trials (RCTs) and the absence of longitudinal studies on the continuous impact of RMC interventions [90]. In 2018, the World Health Organization emphasized the importance of exploring the complex interaction of various factors in providing respectful care [291]. Interventions with multiple components addressed at different levels are more effective than relying solely on a single intervention [90].

The systematic review findings of the RMC studies have highlighted that a significant number of RMC interventions have been carried out in Africa, prompting the author to recommend developing, assessing, and implementing initiatives that promote RMC in various global settings [90]. In healthcare settings, various strategies have been implemented to inspire and engage staff, such as non-monetary reward systems designed to acknowledge and appreciate their contributions to RMC. Some suggested practices in this study are similar to those found in the systematic review, such as presenting trophies or showcasing photographs of staff members, which may play a role in fostering intrinsic motivation among staff to adhere to RMC principles [269,201].

The research argues that interventions must be customized and address various system levels, including individual, facility, community, and national levels, targeting physical/environmental, behavioural, motivational, informational, and structural drivers of poor RMC [98,195,201,297]. Achieving RMC cannot be done in isolation; therefore, the involvement of stakeholders such as health administrators, political actors, media, and others is essential. Partnerships, alliances, and global coalition movements are necessary. Strong collaboration and advocacy efforts should be established among human rights activists, civil societies, non-governmental organizations (NGOs), healthcare professionals, leaders, and the community [179].

According to our findings, participants emphasized the impact of non-clinical staff on RMC provision. It is crucial to provide RMC training to all staff, encompassing clinicians and non-clinicians. Non-clinicians include security officers at the gate, receptionists, accountants, cleaners, and others who interact with women during childbirth. Non-clinical staff must be educated on all aspects of RMC and how they can contribute to positive childbirth experiences. An interventional study conducted in Iran, which involved training for both clinicians and non-clinicians to promote RMC, demonstrated a significant decrease in the proportion of women experiencing symptoms of anxiety and depression before and after the intervention [26].

## 9.9 Conclusion and recommendations

This study generated multiple strategies to improve RMC in Rwanda, aligning with other studies' recommendations [90,91]. Adopting multifaceted strategies can effectively reduce the mistreatment of women during maternity care and enhance RMC provision because interventions that go beyond a singular focus are more likely to bring about meaningful changes [90,91]. Studies suggested that implementers should establish RMC strategies across multiple

levels, including policymakers, health leaders, health facility managers, communities, and individuals [90,91]. To promote and sustain RMC in Rwanda, I recommend integrating RMC into the broader health system and actively engaging relevant stakeholders. There is a need for studies on RMC during the prenatal and postnatal periods, as well as an examination of whether the rights of neonates are observed, with interventions accordingly. RMC interventions should extend the lifespan continuum, as suggested by previous research [92,140,235]. The next chapter will discuss the integration of the entire thesis, provide general recommendations, and present the overall conclusion.

## SECTION C

### Chapter ten: Integrated discussion, General Conclusion and Recommendations

#### 10.1 Introduction to the chapter

This chapter marks the final chapter of this thesis. It encompasses the integrative discussion of conclusions and recommendations drawn from the analysis and discussion of study findings. The author revisits the objectives of the thesis and provides a concise overview of how each of the manuscripts addressed the research objectives. The chapter delves into a detailed discussion of the key discoveries of the current study, addressing the initial questions posed at the onset of the PhD investigation. While exploring the findings, the researcher assesses their alignment with prior literature. The chapter presents a synthesis of evidence by drawing upon past RMC publications and global RMC initiatives, conceptual framework, and theory to shed light on the study's implications. The limitations and conclusions were discussed. Furthermore, it highlights the scholarly contributions of this PhD work, emphasizing the impact of the findings on healthcare research, midwifery and obstetric education, clinical practices, quality assurance, professional and ethical frameworks, and their relevance to policymakers and human rights advocacy. In addition, the author discussed the strengths and limitations of the study and outlined the way forward.

#### 10.2 Integrated discussion

##### 10.2.1 Summary of key findings

The current study offers insights into developing strategies to uphold RMC during labour and childbirth within the Rwandan context. This study aimed to design the strategies that will be used to sustain and improve RMC in Rwandan health facilities. The study was conducted by exploring the experiences, perceptions, and best practices of maternity care among mothers and healthcare providers using 5 phases of Appreciative Inquiry: Define, Discover, Dream, Design, and Destiny. This study had six objectives. The following are the major findings from each objective. These first and second study-specific objectives corresponded to the **1<sup>st</sup> phase** of the study and were conducted on **mothers** using a **convergent parallel mixed-method approach**. This phase aligned with the **dream** and **design** stages of **appreciative inquiry**.

- ✦ To determine and describe the experiences of mothers regarding RMC during their childbirth in the Eastern province of Rwanda, using a questionnaire (Quantitative approach) (**Phase 1a**)
- ✦ To explore and describe the perceptions and experiences of mothers with regard to RMC during their recent childbirth using Appreciative Inquiry (AI) questions (Qualitative approach) (**Phase 1b**)

The findings from this phase relate to the dream phase of AI. Mothers described their positive experiences during recent childbirth, conveying compassionate treatment and honouring preferences and choices. Participants also noted receiving respectful, equitable care, prompt attention, and required services. The participants upheld privacy, confidentiality, and adequate health status information. Mothers reported recommendations to sustain existing best practices and promote RMC in the design phase. They emphasized the importance of maintaining and promoting RMC for positive childbirth experiences, recommending healthcare providers offer mother-centered care, and focusing on effective communication and empowerment. The study highlights the need for an adequate environment for facility childbirth, addressing professionalism, ethics, and supportive leadership. Additionally, recommendations for RMC improvement include provider training, proper documentation, awareness campaigns on women's rights, enhanced labour support, confidentiality, infrastructure, and education for non-healthcare personnel to enhance RMC.

The third and fourth objectives of the study corresponded with **phase 2** of this study, used **qualitative exploratory** methods and focused on **health care providers**.

- ✦ To explore and describe HCP perspectives on RMC using the AI method (**Phase 2b**)
- ✦ To explore HCPs views on RMC reported by the women from Phase 1 (**Phase 2a**)

HCPs expressed their perspectives on the RMC they provided and their thoughts on mothers' reports from the previous phase. The **third objective** is also aligned with **the dream stage of AI**. Healthcare practitioners perceive RMC as a commitment to advancing women's rights and ensuring privacy, confidentiality, and equality. RMC offers mutual satisfaction, increased maternity service utilization, improved community reputation, enhanced trust, and positive effects on maternal mental health. Drivers of RMC include professional duty, education, religious beliefs, and positive feedback. Providers emphasize the importance of enhancing



duty, ethical professionalism, teamwork, continuous care evaluation, and peer support. The **fourth objective** corresponds to **the design stage of AI**.

Healthcare professionals accentuated the significance of RMC, prioritizing best practices for positive childbirth experiences. They advocate for proactive hospital engagement, increased maternal advocacy, staff motivation, professional development, and better living conditions. Gratitude from mothers highlights progress in RMC, alongside accreditation efforts and stakeholder training. Additionally, they recommend ongoing training, infrastructure improvements, community engagement, and robust policies. HCPs reported that several steps have already been taken. They recommend further enhancing the childbirth experience by utilizing existing resources, consistently improving, and sustaining achievements until reaching the RMC standard. The HCPs suggest promoting women-centred care, improving healthcare providers' attitudes, adhering to professional standards, building community trust, ensuring a supportive environment in health facilities, and actively involving leadership with support.

The fifth objective, corresponding to phase 3 of this study, utilised the **integration of findings** and **strategic formulation process**. Five themes emerged after data analysis and integration of all findings, and those themes correspond to five strategies. This phase is aligned with the **AI design stage**.

- ✦ To develop and describe strategies to facilitate and sustain RMC to women in labour based on the findings from Phase 1, Phase 2a and Phase 2b (**Phase 3**)

Strategies were formulated and developed based on these themes and sub-themes:

- Promoting women-centred care and positive childbirth experiences, including providing compassionate and friendly care, emotional support, timely care, creating an enabling environment for privacy and confidentiality, clear communication, enhancing autonomy and self-determination, and ensuring mother's satisfaction.
- Maintaining and promoting an adequate environment around childbirth facilities, improving hospital hygiene, ensuring sufficient equipment and workforce, promoting adequate private rooms, and supporting birth companionship.

- Preserving and upholding community trust towards maternity services involves creating awareness of maternity care in the community, providing culturally sensitive care, obtaining feedback, and addressing complaints.
- Abiding on Professionalism, focusing on developing ownership and accountability and strengthening teamwork.
- Strengthening supportive leadership towards sustaining RMC, establishing quality standards, creating mechanisms for monitoring and evaluation, advocating, conducting appropriate training, and motivating staff.

The sixth study objective corresponds to phase 4 of this study and aligns with the validation of developed strategies by using an **expert review** approach. In addition, this phase corresponds to **the part of the destiny stage of AI**.

- ✦ To validate the formulated strategies to facilitate RMC to women in labour **(Phase 4)**

The scores ranged between 91% to 85% in the validation process. The strategies scored as follows:

1. To promote women-centred care and positive childbirth experiences (91.25%)
2. To preserve and uphold community trust towards maternity services (91.25%)
3. To abide by professionalism and development (90.6%)
4. To strengthen supportive leadership towards sustaining RMC (90%)
5. To maintain and promote an adequate (safe) environment around the childbirth facility (85.6%).

The researchers presented a table outlining the results of the validation process, including the validated strategy, associated objectives, implementation locations across various levels (policy, hospital leadership, healthcare providers, service users, and community), specified activities, responsible parties, timelines, and follow-up mechanisms. The validation drew from previous chapters and insights contributed by RMC experts/stakeholders, suggesting a need for additional details in each strategy at various implementation levels. Additionally, the researcher developed a logical framework to implement these proposed strategies.

### 10.2.2 Discussion

Based on the overall findings and a comparison with past studies conducted in Rwanda, there is notable progress in RMC in the country. Rwanda's healthcare sector is dedicated to ensuring

dignified and caring treatment for every mother. Progress has been made in Rwanda for universal health coverage. Currently, 91% of Rwandans have medical health insurance [68], which has significantly reduced the number of women held in hospitals after childbirth due to unpaid medical bills. RMC has been integrated into Basic Emergency Obstetric and Newborn Care (BEmONC), and healthcare providers have received RMC training and mentorship through various programs [165,184]. These initiatives have been implemented in recent years in collaboration with the Rwanda Association of Midwives and the Ministry of Health, including the Maternal and Child Survival Program (MCSP) and the More Happy Birthdays project. Despite the progress made in Rwanda concerning RMC, these accomplishments still need to be well documented [101].

Respect is fundamental to Rwandan culture, influencing various traditional social interactions. Integrating this culture of respect into the journey of childbirth is essential to enhance the contributions of Rwandan women and mothers to the nation-building process. RMC is multidimensional and dynamic [131]. A recent systematic review emphasized improving maternal care experiences and addressing disparities in low-income countries [147]. The study in Ethiopian public hospitals asserted that addressing RMC is crucial for improving maternal outcomes and reducing delays in seeking and receiving care [42]. The study contends that despite the importance of RMC, there needs to be more evidence of its adoption, as indicated by inadequate training for HCPs, low awareness among women, and infrastructure deficiencies. The research accentuates the need to develop international guidelines for the global implementation of RMC programs, urging researchers to contribute evidence to enhance the worldwide understanding of RMC [220].

More studies are needed across various country regions, as RMC remains a hot topic [172]. Sustainable solutions for maintaining respectful actions must be identified within the local context. Collaborative efforts involving implementers, advocates, policymakers, researchers, and donors are essential to influence the adoption of RMC. Positive RMC practices have received limited attention, with past interventions primarily focused on repairing damages [173]. Using Appreciative Inquiry as a data collection technique enabled the exploration of commendable aspects of labour care identified by mothers and HCPs. AI emphasizes positive thinking, sustaining existing best practices, and building on positive experiences rather than solely addressing D&A.

This study advocates for a shift towards building on positive experiences rather than placing blame. By focusing on mothers and HCPs and employing triangulation methods, this study aligns with the opportunity to produce improved results. Notably, women's positive experiences during labour and childbirth, including emotional support, positive attitudes from HCPs, and effective communication [33,196]. Our findings are based on a study conducted by Mutaganzwa in Rwandan Health Centers, which revealed that satisfaction with maternal care is individual-specific. This underscores the importance of healthcare interventions aligning with local needs and context, emphasizing patient-centred metrics for quality care. Positive interpersonal relationship factors, such as effective communication, timeliness, and confidentiality, were consistently linked to high satisfaction levels [196,299].

Apart from positive interpersonal interactions, our findings highlight other aspects of RMC and positive childbirth experiences, including a conducive environment, hospital hygiene, availability of materials and equipment, non-sharing of beds, appropriate payment, adherence to professionalism, ethics and standards, etc. The study identified these aspects as crucial and should be considered when promoting RMC. This is similar to the findings from RMC studies, which argue that measures to ensure RMC in LMICs are influenced by interpersonal interactions and facility characteristics. Medical procedures that promote RMC include continuous labour support, effective pain management, personalized treatment, communication, evidence-based approaches, and adherence to ethics and rules supporting non-discriminatory and affordable care [131,6]. It is essential to remember that the absence of D&A does not necessarily guarantee the presence of RMC, as emphasized by Jolivet [139]. Achieving RMC is an ongoing journey. Active promotion of RMC is essential, coupled with efforts to reduce mistreatment [92,6,139]

#### 10.2.2.1 Synthesis of findings vis a vis to the existing literature

Our findings reveal that women-centred care is the primary strategy for RMC. Additionally, promoting HCPs is crucial. This promotion can involve appraisal and providing snacks during working hours., etc. These findings are consistent with a study conducted in Iran to investigate Iranian midwives' views on RMC during labour and childbirth. The study suggested advancing RMC by implementing women-centred, evidence-based, and humanized care and providing supportive care through friendly interactions [186].

The study done in Afghanistan revealed that positive experiences were much more likely where the mother had received continuity of care from a specialist midwife or small team [171],

emphasizing the importance of conducting regular assessments of midwives to have a positive impact and the study recommended that hospital management should take into account the factors that motivate midwives. The study conducted in South Africa concluded that implementing an effective system could make the long-term vision of providing high-quality and respectful obstetric care for birthing women achievable, sustaining innovation in the process [206]. Suggested that D&A in healthcare arise from challenging conditions within the health system, compounded by a supportive sociocultural environment. Providers often behave disrespectfully to secure compliance during stress and perceived helplessness.

This study found that both women and HCPs had the same perceptions of RMC; however, Bhattacharyya's study observed a disparity in the perceptions of good care between women and HCPs [41]. Our findings are similar to those from the study conducted in Sweden exploring women's experiences of highly positive childbirth, highlighting that a supportive environment that fostered a sense of safety was crucial for women to feel in control and utilize techniques for managing labour. Additionally, trust and support from the child's father played a significant role in the overall experience [143]. Achieving lasting behaviour change necessitated continuous support [183]. Daniel and colleagues' study conducted in Nigeria concluded that promoting RMC among midwives requires a multifaceted approach which entails addressing individual behavioural adjustments alongside organizational, attitudinal, and managerial change [82].

One of the more significant findings to emerge from this study is that sustaining and promoting RMC require multiple strategies, which is similar to previous studies [97,269]. Downe suggested that implementing multi-component RMC policies tends to decrease women's overall encounters with D&A [97,21] and reported that delivering respectful and high-quality maternity care to women necessitates comprehensive and multifaceted initiatives [21]. Asefa argues that interventions aimed at promoting RMC should incorporate structural changes [22].

Bohren emphasized that for the provision of respectful care, health facilities and systems should be organized to support and value HCPs while ensuring sufficient infrastructure and organization within the maternity ward. They highlight that RMC is integral to the overall quality of care [45]. In addition, a meta-synthesis conducted by Shiindi-Mbidi and colleagues on midwives' and women's experiences with RMC worldwide uncovered that loyalty to women's rights, proficiency in midwifery expertise, conducive physical surroundings,

enhancement of interpersonal interactions, and the empowerment of women's capabilities and resilience are key themes that can increase positive childbirth [301].

The research conducted by O'Connor and the team illustrates how global health networks can catalyze global and local transformation, providing an evidence-based framework for guiding, organizing, and evaluating future initiatives advocating for global health, human rights, and quality care [204]. By emphasizing the importance of addressing D&A and promoting RMC, elevating women's rights is a foundational step in empowering women to advocate for themselves, driving legal and policy changes to uphold RMC and safeguard women's rights, and improving healthcare facilities and services [77]. A recent systematic review highlighted a lack of evidence regarding the effectiveness of implementing RMC in improving maternal or infant health outcomes [59].

The recent study on evidence-based guidelines for RMC within an intrapartum unit concluded that evaluating nurse attitudes and beliefs about RMC might require prolonged engagement in an RMC program to capture changes over time [127]. A study conducted in Afghanistan on women's experiences with RMC recommended increasing awareness among women and HCPs about women's rights to RMC, offering training to HCPs on this topic, monitoring care to prevent mistreatment, and linking future technical and financial assistance to commitments to uphold RMC [162].

#### 10.2.2.2 Global initiatives to promote RMC

Several global initiatives, associations, and organizations support and promote the practice of RMC worldwide. Some of the prominent ones include the International Childbirth Initiative (ICI), the International Federation of Gynaecology and Obstetrics (FIGO), the International Confederation of Midwives (ICM), the International Pediatrics Association (IPA), and the International MotherBaby Childbirth Organization (IMBCO) [135]. Other notable organizations include the White Ribbon Alliance for safe motherhood (WRA), the American College of Nurse-Midwives, the Bixby Center for Global Reproductive Health-UCSF, the Bumi Sehat Foundation, the China Midwives Alliance, the Commonsense Childbirth National Perinatal Task Force, the Council of International Neonatal Nurses (COINN), DONA International, Every Mother Counts, The Harvard T.H. Chan School of Public Health-Department of Global Health and Population, the International Childbirth Education Association (ICEA), the International Council of Nurses, the Istanbul Birth Academy, Lamaze

International, Mercy in Action, MidwiferyToday, Midwives Alliance, and The Sanctum Natural Birth Center [135].

These RMC initiatives feature the significance of delivering compassionate, respectful, and dignified care to every woman and newborn while avoiding mistreatment [135]. They advocate for culturally sensitive care that respects individual cultures, values, and rights to self-expression, informed decision-making, and privacy, along with providing unbiased, cost-free, or affordable healthcare throughout childbirth [135]. Moreover, these projects emphasize using evidence-based practices in routine mother-baby-family maternity care, prioritizing continuous support during labour, providing comfort measures, and minimizing potentially risky procedures [135]. These programs highlight the importance of integrating interventions to enhance well-being, prevent diseases, and ensure adequate medical care for pregnancy, newborns, and emergencies as essential components of comprehensive care [135]. Recruiting and retaining staff is crucial, requiring a critical human resource policy prioritizing creating a positive working environment. Furthermore, establishing collaborative healthcare partnerships with providers, institutions, and organizations ensures seamless care provision while advocating for breastfeeding and skin-to-skin contact comprehensively enhances overall well-being [135]

The International Confederation of Midwives, in partnership with the White Ribbon Alliance and the United Nations Population Fund (UNFPA), has developed an RMC policy and training guide for HCPs [136]. The White Ribbon Alliance advocates for RMC rights and has formulated a charter outlining the universal rights of women and newborns [284]. They mobilize communities to demand RMC, such as establishing hotlines like in Nigeria [279]. Integrated RMC training standards for HCPs have been implemented in Nepal and Nigeria, where the curriculum supports the delivery of RMC [279]. In Kenya, approaches like Value Clarification and Attitudes Transformation (VCAT) and counselling have enhanced RMC practices [269,279]. The White Ribbon Alliance has also facilitated the incorporation of RMC into national maternity standards, such as Nepal's Safe Motherhood and RMC charter as RMC standards [136].

The White Ribbon Alliance report underscored the effectiveness of human rights litigation in addressing severe violations of human dignity [279]. For example, in Kenya, instances of

mothers and newborns being detained have been resolved through litigation by advocacy organizations [61]. The Human Rights Law Network (HRLN) in India actively tackles various reproductive rights violations, such as denial of services based on social class or religion, breaches of privacy, and unauthorized medical procedures like uterus removal or post-partum intra-uterine device (PP-IUD) insertion without consent [279].

The WRA argues that policy reforms and legal redress, exemplified by Nepal's Safe Motherhood and Reproductive Health Rights Act, are vital for ensuring respectful healthcare and defining fundamental human rights such as consent, privacy, and confidentiality [238]. According to the WRA, the HRLN has filed 150 legal cases across 14 states in the past 16 years to safeguard reproductive rights [279]. However, the approach of legal action differs from the strategies developed in this study, where positive methods are utilized to address issues, believing that positive thinking yields positive results or success.

WRA emphasizes women's involvement in promoting RMC through participatory accountability and feedback mechanisms, empowering them to share experiences [279,284]. This ensures continuous integration within the system to monitor and enhance respectful care [279,284]. One successful social accountability tool was when WRA India partnered with other organizations to create the Mobile Monitor for Quality of Maternal Care (MoM-QC) [280]. The initiative utilized a toll-free number and basic mobile phone technology to inform and collect feedback from expecting mothers on available health services, proving feasible for underserved rural women [280]. Therefore, the feedback mechanism and accountability approach align with the strategies recommended in this thesis.

Several researchers have suggested that solutions utilizing mobile phones to enhance the functions of the health system, commonly referred to as mHealth, have the potential to overcome some of these challenges [233,250,18,114]. In Rwanda, mHealth has supported CHWs in detecting pregnant women in their respective communities and accompanying them to health facilities for ante/postnatal care and delivery. The RapidSMS mHealth program has enabled the transfer of pregnant women in labour to the appropriate health facilities [68,240]. They are contributing to a remarkable increase in facility-based deliveries. Similarly, it is necessary to embrace the use of technology to enhance RMC in Rwanda.

Public and community meetings are crucial in advancing RMC. These assemblies provide a platform for government officials, stakeholders, and community members to collaborate,



deliberate on health services, and collectively formulate action plans and findings [283]. In Malawi, the WRA used "citizen hearings" to draw attention to the needs of women and providers, promoting community engagement in developing mutually beneficial outcomes that enhance the provision of respectful care for women [264,281]. Such gatherings are essential in enlightening the public about their rights. Similarly, WRA created platforms in India where leaders, health workers, clinicians, and women actively participated [280].

In Nigeria, WRA coordinated the "Family Health Days" event in Kwara State; people met and discussed the quality of care between families and healthcare professionals [279]. These programs also helped the community to voice their complaints in cases of disrespect. One of the platform initiatives to gather feedback from community members was Citizens' Voice Reporter by WRA India, which empowered citizens to hold leaders accountable for fulfilling obligations to women and newborns [238,279]. To establish community collaboration in Rwanda with healthcare providers to gather feedback from the community and ensure the respect of women's and newborns' rights, aligning with the thesis findings.

### 10.2.3 Implication of theory, framework and holistic paradigm

The theory, framework, and approach that directed this study all emphasized the positive aspects of care and best practices. Watson's Theory of Caring provided a suitable framework for this investigation, emphasizing preserving human dignity and the significance of trustworthy relationships in the moral concept of caring [273]. This study aligns with Watson's principles by emphasizing positive interpersonal moments [276] and fostering a supportive atmosphere during birthing. Watson's Theory of Human Caring promotes holistic and transformative care, emphasizing the benefits of providing care for patients and caregivers [273,275].

The literature review provided a comprehensive perspective on childbirth, acknowledging the interconnection between the mind, body, spirit, environment, and society. It underscored the mutual influence of these factors on health and healing [197,87]. This perspective regards the body as an energetic field that can establish connections with others [197,87]. The holistic approach underscores the importance of customized care that addresses individual needs [197,87]. Davis-Floyd suggested that combining suitable technologies in obstetric care with humanistic values and embracing holistic principles such as openness to individuality and energy could result in the most outstanding obstetric system ever established [86].

Like the holistic paradigm, Watson's theory focuses on mind-body-spirit caring, emphasizing the integration of the mind, body, and spirit in healthcare [252]. It promotes positive energy exchange between HCPs and patients, with Watson highlighting the influential role of human caring in health, emphasizing authentic connections and recognizing individuality. Watson sees caring as a revitalizing force for HCPs, enhancing overall well-being [154]. The findings of this study align with Watson's Human Caring Theory, urging HCPs to embrace caring values for positive outcomes and professional satisfaction [154]. The theory emphasizes caring relationships, incorporating love-centred care and compassion to enhance patient satisfaction and trust [154]. Similar to the findings of this study, it reports how positive experiences of mothers during childbirth generate feelings of satisfaction in both patients and providers and contribute to the community's positive reputation.

The most important aspect to emphasize is that the approach used in this study fits the overall aim of this study: to develop strategies to sustain and promote RMC in Rwanda. The Appreciative Inquiry enabled our participants to feel free to talk openly, discuss their own experiences and perceptions regarding the topic of interest, and envision the shared future they want. Appreciative Inquiry, a potent change methodology, centres on positive ideas that foster a shared vision through strategic innovation [81,70].

AI is a dynamic strategy for organizational planning, cultural solutions, and large-scale initiatives, emphasizing existing strengths and a positive approach [81,70]. AI elevates traditional organizational development interventions, enhancing power, efficiency, and durability. In this study, the researcher developed strategies to sustain RMC, which aligns with the power of AI in its innovative change strategy to enhance organizational performance by fostering a positive, creative, and constantly innovative environment [81,257]. In this study, the researcher collaborated with the stakeholders as AI also encourages external perspectives, embodying a holistic system approach.

#### 10.2.4 Scholarly contribution of PhD and Methodological innovation

This PhD research is notable for its innovative and unique approach, being the first study in the country to examine RMC from positive perspectives through Appreciative Inquiry. Given Rwanda's resource constraints, applying Appreciative Inquiry led to identifying strategies and actions that resonate with Rwanda's cultural and contextual realities. In low-resource settings where infrastructure, workforce, and equipment are limited, it is essential to explore what is feasible and appreciated [173]. This aligns with findings from a study conducted in Kenya,

which recommended leveraging existing resources [201]. This allows for maintaining successful practices while advancing the country's resources.

The researcher approached positively by employing AI; participants were motivated and eager to offer more comprehensive and valuable information rather than being asked about their negative experiences and perceptions. AI promotes encouragement and appreciation instead of blame, judgment, and suspicion, yielding rich and insightful data [257]. The distinctive contribution to knowledge lies in utilising a mixed-method approach involving maternity service users and providers. This approach facilitated data triangulation, highlighting a specific strength of this study grounded in pragmatism as a philosophical orientation [76]. This approach provides essential evidence for understanding RMC in the Rwandan context. The findings from this research can inform implementation research and RMC interventions.

#### 10.2.5 Implications of the research

At the proposal development stage of this research, the candidate collaborated with the Ministry of Health of Rwanda through the Rwanda Biomedical Center (RBC) (*See Appendix R and Appendix S*). The researcher actively collaborates with the Direction of Maternal and Child Health from MoH Rwanda/RBC to validate this study's strategies. Consequently, this collaboration will facilitate the integration of the study's findings into forthcoming improvements in RMC policies.

The author planned to disseminate all data generated from this thesis as research evidence on RMC in Rwanda. Five original research manuscripts were submitted to peer-reviewed journals, 2 have been published, 1 accepted for publication, and 2 are under review. Furthermore, the recommendations derived from this evidence will be communicated to policymakers to enhance RMC policy in Rwanda. The researcher will continue collaborating and advocating for implementing strategies derived from this research. The candidate plans to secure funds after completing doctoral studies and conducting studies on RMC interventions in health facilities at various levels of hospitals in Rwanda.

This PhD study represents the first research endeavour in Rwanda aimed at developing strategies to sustain and promote RMC practices. Employing a convergent parallel mixed-method approach, participants shared positive experiences, establishing a foundational understanding for future RMC studies. The logical framework proposed offers insight into RMC implementation. This study contributes to the RMC and Appreciative Inquiry literature, providing valuable insights for future research. The findings and recommendations will

significantly contribute to raising RMC awareness in Rwanda, improving RMC provision, and enhancing outcomes for mothers and newborns.

### 10.2.6 Strengths and Limitations of the Study

The data were collected from service users, providers, and stakeholders, ensuring the strategies targeted both sides. The mixed-method approach used in this current study provided a better understanding of the research question than a single approach [77]. AI is an innovative approach that proved effective in understanding the specifics of what respectful care looks like in Rwandan culture, enabling the gathering of enough information and encouraging mothers and HCPs to share their appreciated RMC experiences and best practices. The common appreciation points guided the researcher in developing strategies to sustain RMC in health facilities. AI is particularly suitable for RMC because it focuses on the best aspects, is less threatening for HCPs, and can potentially reveal creative solutions and ideas that may not emerge solely from addressing disrespect and abuse. AI offers the advantages of genuine commitment, creating energy and motivation. AI is engaging, powerful, inspiring, and focuses on the positive aspects of situations [257,73].

The data's limitations stem from sole reliance on participants' self-reported experiences and perceptions. The study's findings lack more generalizability beyond public hospitals in the Eastern province of Rwanda. Although Appreciative Inquiry has its benefits, it also has its limitations. Prioritizing positive narratives and experiences during the discovery phase potentially dismisses participants' negative experiences [55,54]. To overcome this, we recruited mothers who self-reported to have positive experiences. In AI interviews, mothers and HCPs involved were genuinely committed and willing to concentrate on the positive aspects, even though the challenging situations were still around. AI may not be suitable for some circumstances, especially when immediate action is needed [54]. Transitioning to a strength-based approach requires persistence, practice, and patience [54].

## 10.3 General conclusion

The findings of this study brought significant policy implications for promoting RMC in Rwanda. Despite limited documentation on RMC in the country, this study reveals progress in RMC provision. There should be a strong focus on women's needs and preferences, as well as training and motivating healthcare providers to advance RMC. Creating a conducive environment around labour and childbirth and engaging the community and policymakers are also essential. The Ministry of Health of Rwanda should intensify efforts to establish standard

RMC practices in all health facilities. This study's strategic and innovative AI approach emphasizes strengths over traditional problem-focused models. To promote sustainable change by providing RMC in Rwanda, building upon positive experiences and encouraging optimism are crucial. Sustainability requires integrating RMC into the broader health system and collaborating with relevant stakeholders such as implementers, advocates, policymakers, researchers, and donors to influence the adoption of RMC. Sustaining and promoting RMC through a strength-based approach is an ongoing journey requiring consistent practice and perseverance.

## 10.4 Recommendations

This study benefits healthcare research, midwifery and obstetric education, quality assurance, professional and ethical framework, policymakers and human rights advocacy.

### 10.4.1 Future Healthcare Research

Achieving RMC remains an ongoing journey, and future studies are recommended:

- To examine the correlation between RMC implementation and maternal and neonatal health outcomes and to assess RMC across the life course continuum.
- To compare RMC practices between private and public hospitals in Rwanda.
- To assess the perceptions of RMC among the top leaders of health facilities and the broader health system
- To evaluate the health system's role in promoting RMC in Rwanda.
- To investigate the relationship between Rwandan culture and RMC provision and assess social determinants and RMC.
- To compare self-reported RMC experiences obtained from health facility interviews with community follow-up interviews in Rwandan communities and to identify contributing factors to RMC.
- RMC intervention studies, such as randomized controlled trials or quasi-experimental studies, should be conducted to test the RMC strategies developed in this research.

### 10.4.2 Midwifery and obstetric education

RMC should be incorporated into pre-service curricula for midwives, doctors, and nurses. Offer thorough education to healthcare professionals on the core principles of RMC. Encourage the recruitment of males into the midwifery profession, as previous studies have suggested a correlation between male providers and RMC [298,15]. Integrate RMC into on-service

education for HCPs using a low-dose, high-frequency model. Collaborate to include RMC in pre-service Midwifery, Nursing, and Gyne-obstetric education by engaging stakeholders like the National Council of Nurses and Midwives and Continuous Professional Development providers. Incorporate RMC into the curriculum and deliver it to students through blended learning on the Moodle platform.

#### 10.4.3 Clinical practices and Quality assurance

Several approaches must be employed to integrate RMC into healthcare institutions effectively. These include translating the RMC Charter into the local language and prominently displaying it in visible areas within healthcare facilities. HCPs should receive RMC training and mentoring programs, and counselling services should be implemented to address burnout among HCPs. Provider exchange programs led by recognized RMC champions should also be established to promote RMC implementation in hospital settings.

The creation and distribution of instructional resources, such as posters, manuals, and standard operating procedures for RMC, should be endorsed in all healthcare establishments throughout Rwanda. Educational initiatives for women regarding RMC should be incorporated into antenatal clinics to ensure all pregnant women have access to these programs. Encouraging cost-effective resources and techniques in maternity services, such as curtains for maintaining privacy, is also vital in adopting RMC. Hospitals can provide food to mothers whenever possible, especially for those who come from a distance and have limited financial means to buy food. A comprehensive monitoring and evaluation plan with specific indicators should be established to assess the success of healthcare facilities in implementing and adhering to RMC.

#### 10.4.4 Professional and ethical framework

It is advisable to enhance professional accountability and cultivate an environment of ethical consciousness among healthcare professionals, prompting them to contemplate the ethical principles guiding their conduct and choices within maternity care environments. Establish guidelines and protocols for maternity care that prioritize the respectful treatment of women, ensuring universal comprehension and adherence among all healthcare providers.

#### 10.4.5 Policymaking

Establishing national laws and policy standards for RMC and adherence to human rights and ethics is essential. Accountable entities should create guidelines and strategies for overseeing and standardizing practices related to respectful maternal care across all institutions.

Each hospital should establish an RMC committee and designate an individual responsible for overseeing RMC initiatives nationwide.

#### 10.4.6 Community Human Rights Awareness

The researcher recommends raising awareness regarding the universal rights of women of childbearing age and their newborns within the community. Cultivating a sense of connection and community ownership of maternity services is crucial. This can be achieved by engaging the Rwandan community in regular cleanup activities of maternity services during the customary community work "umuganda" on the last Saturday of each month. The establishment of open maternity days is needed so the community knows about the available maternity care at each health facility level and to demystify the maternity services. Promoting knowledge and understanding of RMC among the community through social media platforms is essential. Additionally, establishing technology-based initiatives like the Mobile monitor for RMC can be beneficial. This initiative can utilize a toll-free number and basic mobile phone technology to educate expectant mothers about available maternity services and collect feedback on the RMC they received.

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## TIMELINE

| Event                                            | March-<br>June<br>2021 | July<br>2021 | Sept<br>2021 | Oct<br>2021 | Dec<br>2021 | Feb<br>2022 | June<br>2022-<br>Apr<br>2023 | May-<br>Oct<br>2023 | Nov<br>2023-<br>Feb<br>2024 | March<br>2024 |
|--------------------------------------------------|------------------------|--------------|--------------|-------------|-------------|-------------|------------------------------|---------------------|-----------------------------|---------------|
| Development of proposal                          |                        |              |              |             |             |             |                              |                     |                             |               |
| Submission of Protocol /assessment               |                        |              |              |             |             |             |                              |                     |                             |               |
| Postgraduate Committee Approval                  |                        |              |              |             |             |             |                              |                     |                             |               |
| Ethical application                              |                        |              |              |             |             |             |                              |                     |                             |               |
| Ethical Approval                                 |                        |              |              |             |             |             |                              |                     |                             |               |
| Getting permission from study sites /Pilot study |                        |              |              |             |             |             |                              |                     |                             |               |
| Data collection                                  |                        |              |              |             |             |             |                              |                     |                             |               |
| Data analysis                                    |                        |              |              |             |             |             |                              |                     |                             |               |
| Report writing                                   |                        |              |              |             |             |             |                              |                     |                             |               |
| Submission of PhD thesis                         |                        |              |              |             |             |             |                              |                     |                             |               |

## FUNDING

**Funding:** This research was funded by CARTA and University of Rwanda (UR)/Swedish International Development Cooperation Agency (SIDA) program

| S/N                                                 | Sub-activity                               | Item                                               | Number of days/times | Qty | Unit cost/Rand | Total cost/Rand |
|-----------------------------------------------------|--------------------------------------------|----------------------------------------------------|----------------------|-----|----------------|-----------------|
| Activity1                                           |                                            |                                                    |                      |     |                |                 |
|                                                     | Translation of research tools              |                                                    |                      |     | 8080           | 8080            |
|                                                     | Payment of IRB ethical clearance Rwanda    | IRB approval                                       | 1                    | 1   | 6787           | 6787            |
|                                                     | <b>Sub Total</b>                           |                                                    |                      |     |                | 14867           |
| Activity2                                           | Piloting the research tool                 |                                                    |                      |     |                |                 |
|                                                     |                                            | Printing, stationery                               |                      |     | 4848           | 4848            |
|                                                     |                                            | Hiring a car for Transport to the Eastern Province | 3                    | 1   | 1826           | 5478            |
| Piloting                                            |                                            | Payment of Research Assistant                      | 3                    | 2   | 4848           | 29088           |
|                                                     |                                            | Peridium for researcher team                       | 3                    | 3   | 100            | 900             |
|                                                     | <b>Sub Total</b>                           |                                                    |                      |     |                | 40314           |
| Activity3                                           |                                            |                                                    |                      |     |                |                 |
| Analysing pilot findings                            | Communication                              | Airtime/Internet                                   | 5                    | 3   | 16             | 240             |
|                                                     | Refreshment                                | Water                                              | 5                    | 9   | 9              | 405             |
|                                                     | <b>Sub Total</b>                           |                                                    |                      |     |                | 645             |
| Activity4                                           | Data collection                            |                                                    |                      |     |                |                 |
|                                                     |                                            | Recording device                                   |                      |     |                | 3232            |
| Data collection                                     |                                            | Payment of 2 Research Assistants                   | 90                   | 2   | 485            | 87300           |
|                                                     | Qualitative data collection                | Transport                                          | 10                   | 1   | 1826           | 18260           |
|                                                     |                                            | Peridium for researchers                           | 10                   | 3   | 97             | 970             |
|                                                     | <b>Sub Total</b>                           |                                                    |                      |     |                | 109762          |
| Activity5                                           |                                            |                                                    |                      |     |                |                 |
| Data entry, management and analysis, report writing |                                            | Payment of enumerators                             |                      | 3   | 485            | 11640           |
|                                                     | Data entry/transcribing                    |                                                    | 8                    |     |                |                 |
|                                                     | Quantitative and Qualitative data analysis | Payment of transcribers                            | 6                    | 1   | 808            | 4848            |
|                                                     |                                            | Payment for editor                                 |                      | 1   | 808            | 808             |
|                                                     | <b>Sub Total</b>                           |                                                    |                      |     |                | 17296           |
| <b>TOTAL BUDGET</b>                                 |                                            |                                                    |                      |     |                | 182884          |

The total budget is around 10,000 USD, which equals around 182,884 Rands

## APPENDICES

### Appendix A. Client exit survey tool (For quantitative objective)

| NO  | Questions                                                                                                                                                                                                                  | Options                                                                                                                                                                                                                                                                          |
|-----|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1.  | Gravida                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                  |
| 2.  | How many living children, minus this baby?                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                  |
| 3.  | Gestational age of the current baby                                                                                                                                                                                        | 1. Term<br>2. Preterm<br>3. Post-term                                                                                                                                                                                                                                            |
| 4.  | How old are you?                                                                                                                                                                                                           | Numeric                                                                                                                                                                                                                                                                          |
| 5.  | What is the highest level of school you attended?                                                                                                                                                                          | 1.No formal education<br>2. Primary<br>3. Secondary and tertiary                                                                                                                                                                                                                 |
| 6.  | What is your religion?                                                                                                                                                                                                     | 1. Christian<br>2. Muslim                                                                                                                                                                                                                                                        |
| 7.  | What is your current marital status?                                                                                                                                                                                       | 1 Married<br>2 Cohabitation<br>3. Single mother                                                                                                                                                                                                                                  |
| 8.  | What is your occupation/what kind of work do you mainly do?                                                                                                                                                                | 1. Homemaker<br>2. Farming<br>4. Small business<br>5. Employee                                                                                                                                                                                                                   |
| 9.  | At what time of the day did you deliver?                                                                                                                                                                                   | 1. During the night<br>2. During the day                                                                                                                                                                                                                                         |
| 10. | What was your mode of delivery?                                                                                                                                                                                            | 1. Vaginal delivery<br>2. Caesarean delivery                                                                                                                                                                                                                                     |
| 11. | What was the health condition of the baby at birth?                                                                                                                                                                        | 1. Baby was in good condition<br>2. Baby had birth asphyxia<br>3. Baby died                                                                                                                                                                                                      |
| 12. | During labour for this delivery, have you been free from harm or ill-treatment? This means that you have been taken care of in a gentle and compassionate way and receive assistance when experiencing pain or discomfort. | 1 Yes<br>2 No → GO TO Q14                                                                                                                                                                                                                                                        |
| 13. | During labour, how have you been treated when experiencing pain or discomfort? ( <i>State the one you mostly appreciated</i> )<br>(DO NOT READ; Circle the most appreciated )                                              | 1. Given painkillers and anaesthesia<br>2. Back massage<br>3. Repaired episiotomy/tear with anaesthesia<br>4. Psychological support<br>5. No special thing was done                                                                                                              |
| 14. | During labour, did the HCP explain/provide you the orientation to you about what is being done for you?                                                                                                                    | 1. Yes<br>2.No→ GO TO 16                                                                                                                                                                                                                                                         |
| 15. | What exactly was explained to you that you mostly appreciated?)<br>(DO NOT READ; Circle the most appreciated )                                                                                                             | 1. Ward environment<br>2. Meals time and what to eat or not eat<br>3. General examination and the findings<br>4. Vaginal examination and the findings<br>5. Progress of labour<br>6. Explained the care given and how to behave during labour<br>7. Reason for Caesarean section |



|     |                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                               |
|-----|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|     |                                                                                                                                                                                                       | 8. The sex of the baby<br>9. When to breastfeed/feed my baby                                                                                                                                                                                                                  |
| 16. | Have you been informed of the care your newborn was going to receive?                                                                                                                                 | 1 Yes<br>2 No<br>3 N/A                                                                                                                                                                                                                                                        |
| 17. | During labour for this delivery, have you been provided verbal or written informed consent for care for yourself?                                                                                     | 1 Yes<br>2 No → <b>GO TO Q19</b>                                                                                                                                                                                                                                              |
| 18. | What action/procedure was done with your verbal or written permission that you most appreciated? ( <i>DO NOT READ; Circle the most appreciated</i> )                                                  | 1 Abdominal palpation<br>2 Vaginal examination<br>3 Tubal ligation<br>4 Caesarian section<br>5 Augmentation of labour & induction of labour<br>6 Cut of episiotomy<br>7 Hysterectomy                                                                                          |
| 19. | During labour for this delivery, did the caring team respect your choices and preferences? Have you been allowed what you usually use in your daily living, like food, drinks, visitors, and clothes? | 1 Yes<br>2 No → <b>GO TO Q21</b>                                                                                                                                                                                                                                              |
| 20. | What exact choice or preference was granted to you that you most appreciated? ( <i>DO NOT READ; Circle what is appreciated mostly</i> )                                                               | 1. Allowed to take birth position I wanted<br>2. Allowed to pray<br>3. Allowed to listen to music<br>4. Placed in a calm environment<br>5. Allowed to take foods I wanted<br>6. Allowed to take drinks I wanted<br>7. Allowed to wear clothes I wanted<br>8. Allowed visitors |
| 21. | During labour for this delivery, have you been allowed to stay with your birth companion of your choice in the labour and delivery room?                                                              | 1. Yes<br>2.No                                                                                                                                                                                                                                                                |
| 22. | During labour for this delivery, was your privacy being protected?                                                                                                                                    | 1. Yes<br>2.No → <b>GO TO Q24</b>                                                                                                                                                                                                                                             |
| 23. | How was your privacy respected that you mostly appreciated? ( <i>DO NOT READ; Circle what is mostly appreciated</i> )                                                                                 | 1. There were screens/room walls blocking the view during examination and delivery<br>2. I was covered during vaginal examination                                                                                                                                             |
| 24. | During labour for this delivery, were you treated in a way that respected your confidentiality?                                                                                                       | 1 Yes<br>2 No → <b>GO TO Q 26</b>                                                                                                                                                                                                                                             |
| 25. | What showed you exactly that your confidentiality was respected? ( <i>State the one you mostly appreciated</i> ) ( <i>DO NOT READ; Circle the mostly appreciated</i> )                                | 1 My health conditions during and delivery were not communicated/shown to other clients<br>2 Other health information was discussed when other clients were not listening<br>3 Other health information discussed with only health                                            |
| 26. | During labour for this delivery, did you feel treated with dignity and respect?                                                                                                                       | 1. Yes<br>2.No → <b>GO TO Q28</b>                                                                                                                                                                                                                                             |
| 27. | What did it show you that you were treated with dignity and respect? ( <i>State the one you mostly appreciated</i> ) ( <i>DO NOT READ; Circle the one mostly appreciated</i> )                        | 1. I was not humiliated<br>2. I was not verbally abused/Was spoken in a respectful manner                                                                                                                                                                                     |

|     |                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                      |
|-----|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|     |                                                                                                                                                                                      | 3. My newborn was touched in a dignified or respectful manner.<br>4. I was touched in a dignified or respectful manner<br>5. I was cared for with compassion<br>6. My newborn baby was cared for with compassion.<br>7. I was called by my proper name<br>8. Services was somehow good (fifty-fifty) |
| 28. | During labour for this delivery, were you free from discrimination?                                                                                                                  | 1. Yes<br>2.No→ <b>GO TO 30</b>                                                                                                                                                                                                                                                                      |
| 29. | What indicated to you that you received equitable healthcare? ( <i>State the one you mostly appreciated</i> ) ( <i>DO NOT READ, Circle the one most appreciated</i> )                | 1. I received equitable care like other mothers<br>2. I had the freedom to make decisions about all care provided/what happens to my body<br>3. My newborn was free from discrimination                                                                                                              |
| 30. | During labour for this delivery, did you receive the healthcare you expected?                                                                                                        | 1. Yes<br>2. No→ <b>GO TO 32</b>                                                                                                                                                                                                                                                                     |
| 31. | What exactly indicated that you have received the highest level of health care? ( <i>State the one you mostly appreciated</i> ). ( <i>DO NOT READ; Circle the most appreciated</i> ) | 1. My newborn was attended by a health HCP while he/she needed care<br>2.I was provided care in a timely manner<br>3.I was provided care in a clean and safe environment<br>4.I was attended by a skilled HCP                                                                                        |
| 32. | During labour for this delivery, have you been attended to all the time while you needed care?                                                                                       | 1Yes<br>2 No                                                                                                                                                                                                                                                                                         |
| 33. | During labour and delivery, did you receive all the services you needed even if you cannot pay for those services?                                                                   | 1 Yes<br>2 No                                                                                                                                                                                                                                                                                        |
| 34. | During labour for this delivery, were you allowed by the healthcare providers to take food and fluids?                                                                               | 1Yes<br>2 No                                                                                                                                                                                                                                                                                         |
| 35. | During your labour for this delivery, have you been provided information and support on breastfeeding your newborn?                                                                  | 1Yes<br>2 No<br>3 N/A                                                                                                                                                                                                                                                                                |

## Appendix B: Study information document (For phase 1a: Quantitative)

**Study title: Development of Strategies for Health Care Providers to Sustain Respectful Maternity Care to Women in labour.**

**Good morning/afternoon.**

### Introduction:

My name is ALICE MUHAYIMANA. I am the Principal Investigator in this research study, and I am a PhD student at the University of Witwatersrand (Wits), Johannesburg, South Africa. The supervisor of this study is Dr. Irene Kearns. Research is a process used to seek new knowledge. I am carrying out

the study to explore the status of Respectful Maternity Care (RMC) and to develop strategies to promote RMC in the Eastern Province of Rwanda. Please feel free to ask me as many questions as you wish before deciding upon participation.

**Invitation to Participate:**

I am inviting you to take part in this study because you were recently a maternity ward patient at one of the hospital study sites. Participation would involve taking part in an interview in a private location in the hospital at a time convenient to you. The interview will be conducted face to face, observing the normal COVID protocol, and will last for about 30-40 minutes. Refusal to participate will have no effect on your entitlement to continued care at this hospital.

**What is involved in the study?**

If you agree to take part in this survey, I will ask you questions, and this interview will not be recorded. I will ask you questions from a prepared questionnaire, and I will log your answers. The questionnaire comprises short, closed, and open-ended questions. I'll ask about your demographic data and your own experience of being respected or not by the staff during your recent stay in this hospital. The questionnaire mainly encompasses the rights and dignity of women during labour and childbirth and the rights of their newborns. During the interview, I will not be keeping a record of your identity.

The questions are not a test, so there is no right or wrong answer. My role as an interviewer is to listen and to write your answer. You may refuse to answer any questions that you do not feel comfortable answering. You may also say that you do not know the answer to a question.

**Risks of being involved in the study:**

During the interview, if you feel distressed, please let us know so that we can follow the guidelines to assist you.

1. The interviewer will call a break to the discussion/interview.
2. The interviewer will provide immediate assistance by asking questions about your mental status.
3. If you can proceed, the interviewer will restart the discussion/interview.
4. If you are unable to complete the interview, the interviewer will end the session and accompany you to the hospital's professional counsellor for additional psychological help.
5. In addition, the researcher will refer you to the psycho-social services of your respective living area and supply the Rwanda Ministry of Health emergency contact (114) for requesting psychological support if necessary.
6. The researcher will make a follow-up phone call the next day to confirm that you are okay. During this period, the information previously provided regarding where to find psycho-social assistance will be provided again.

**Benefits of being in the study:**

There will be no immediate or direct benefits to you for participating in this study. However, it is hoped that your participation will help promote RMC in the future. There will be no payments for participating, nor will there be any cost to you.

**Participation is voluntary:**

Taking part in this study is voluntary. You have the right to withdraw from participating at any time or select not to participate in the entire survey. If you withdraw, you will not be asked to identify the

reasons for the withdrawal, and there is no penalty for withdrawal or decision not to participate in the study and any data collected on you will, in default, be destroyed unless you specifically consent to its retention.

**Anonymity:**

Your name and other identifying information will not be recorded anywhere. Confidentiality will be used in the whole process to provide information, to treat it, and to keep it. No individual participant will be identified in any report or publication arising out of this study.

**Outputs:**

Your participation may help to discover issues and good practices with RMC; hence, this study will build on best practices to promote and maintain RMC. I will be pleased to provide a summary of the study results at no cost to any participant requesting it.

**Contact details of researcher/s:**

In case of any further inquiries, you may contact Alice Muhayimana @ +250788687626 or by email at [2495590@students.wits.ac.za](mailto:2495590@students.wits.ac.za) or Dr Irene Kearns, Supervisor, on telephone no +27825940117, or by e-mail at [Irene.kearns@wits.ac.za](mailto:Irene.kearns@wits.ac.za)

**Ethics approval:** I have been given ethical clearance by the Human Research Ethics Committee (Medical) from Wits University and the Institutional Research Board (IRB) from the College of Medicine and Health Sciences (CMHS) of the University of Rwanda. I have also received permission from the Ethics Committees of the five hospital sites where I will be conducting the study. If there is any problem concerning your rights to participate in this study, you can contact the CMHS Institutional Review Board office in Kigali, Rwanda or call +250788563311

This study has been approved by the Human Research Ethics Committee (Medical) of the University of the Witwatersrand, Johannesburg (“Committee”). A principal function of this Committee is to safeguard the rights and dignity of all human subjects who agree to participate in a research project and the integrity of the research.

If you have any concerns over the way the study is being conducted, please contact the Chairperson of this Committee, Professor Clement Penny, who may be contacted by telephone number 011 717 2301 or by e-mail on [Clement.Penny@wits.ac.za](mailto:Clement.Penny@wits.ac.za). The telephone numbers for the Committee secretariat are 011 717 2700/1234, and the e-mail addresses are [Zanele.Ndlovu@wits.ac.za](mailto:Zanele.Ndlovu@wits.ac.za) and [Rhulani.Mukansi@wits.ac.za](mailto:Rhulani.Mukansi@wits.ac.za).

**Consent:**

If you agree to take part in this study, I will ask you to sign a Consent Sheet to record this fact.

**Second Interview:** I intend to conduct a second round of interviews with a small sample (about 30) of the participants who took part in this first round. These interviews will explore a few RMC in greater depth, and the questions will be more open-ended. This second interview will last about one hour. You are asked to indicate your willingness, or otherwise, to be approached for a second interview when you complete the Consent Form.

Thank you for reading this Study Information Sheet.

**Date:** June 2022

*Appendix C: Participant consent sheet*



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**PARTICIPANT CONSENT SHEET**

***Project Title: Development of Strategies for Health Care Providers to Sustain RMC to Women in Labour.***

1. I have been given a Participant Information Sheet, which explains the nature and processes involved in this study, which is attached hereto;
2. I was given time to read it or had it read to me in the language I best understood;
3. I was given time to ask any questions I wanted to and found any answers given to me to be reasonable and satisfactory;
4. I believe I fully understand why the study is being conducted and what the intended outcomes will be;
5. I understand that there will be no immediate benefit to me should I agree to participate, nor will I receive any payment; conversely, participation will not cost me anything but my time;
6. I understand that, even if I initially consent to take part in the study, I may subsequently withdraw at any time and would not be required to give any reasons; if that happened, any data collected about me for the purposes of the study would immediately be destroyed, unless I give consent for it to be retained.
7. I have been given a range of contact details, which are listed below. If I require further information or become concerned about any aspect of this study, I am free to speak to any of these contacts.

**Contact details: Alice Muhayimana, Principal Investigator, telephone no: +250788687626 or by e-mail at [amuhayimana@cartafrica.org](mailto:amuhayimana@cartafrica.org),**

**Dr Irene Kearns, Supervisor, on telephone no +27825940117, or by e-mail at [irene.kearns@wits.ac.za](mailto:irene.kearns@wits.ac.za)**

Professor CB Penny, Chairperson of the Human Research Ethics Committee (Medical) at the University of Witwatersrand, on telephone no. 011 717 2301, or by e-mail at [Clement.Penny@wits.ac.za](mailto:Clement.Penny@wits.ac.za).

Ms. Z Ndlovu or Mr Rhulani Mkansi, Committee Secretariat, telephone nos.: 011 717 2700 or 1234, or by e-mail at: [Zanele.Ndlovu@wits.ac.za](mailto:Zanele.Ndlovu@wits.ac.za) or [Rhulani.Mkansi@wits.ac.za](mailto:Rhulani.Mkansi@wits.ac.za)

Name of Participant: \_\_\_\_\_

Date: \_\_\_\_\_

Place: \_\_\_\_\_

Signature or mark \_\_\_\_\_

Witnessed by:

Name of Witness: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## Appendix D: Translated research questionnaire in Kinyarwanda

| NO  | Ibibazo                                                                                                                                                                                                                                                                              | Ibisubizo bishoboka                                                                                                                                                                                       |
|-----|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 36. | Iyi nda yari iya kangaha?                                                                                                                                                                                                                                                            |                                                                                                                                                                                                           |
| 37. | Abana bariho ni bangahe utabariyemo uyu ?                                                                                                                                                                                                                                            |                                                                                                                                                                                                           |
| 38. | Uyu mwana yavutse angana iki?                                                                                                                                                                                                                                                        | 1.Agejeje igihe<br>2. Atagejeje igihe<br>3. Arengeje igihe                                                                                                                                                |
| 39. | Ufite imyaka ingaha?                                                                                                                                                                                                                                                                 | Numeric                                                                                                                                                                                                   |
| 40. | Ni ikihe cyiciro cya nyuma cy'amashuri wize ?                                                                                                                                                                                                                                        | 1.Ntabwo yize<br>2.Amashuri abanza<br>3.Ayisumbuye na kaminuza                                                                                                                                            |
| 41. | Ni irihe dini ryawe?                                                                                                                                                                                                                                                                 | 1.Umukirisitu<br>2. Umuyisilamu                                                                                                                                                                           |
| 42. | Irangamimerere ry'ubu?                                                                                                                                                                                                                                                               | 1 Yarasezeranye<br>2 Babana batarasezeranye<br>3. Nta mugabo agira                                                                                                                                        |
| 43. | Ukora iki? (vuga akazi ukora buri muni)                                                                                                                                                                                                                                              | 1. Yirirwa mu rugo<br>2. Ubuhinzi-bworozi<br>4. Ubucuruzi buciriritse<br>5.Afite akazi gahoraho                                                                                                           |
| 44. | Wabyaye mu masaha yahe?                                                                                                                                                                                                                                                              | 1.Mu ijoro<br>2.Ku manywa                                                                                                                                                                                 |
| 45. | Wabyaye gute?                                                                                                                                                                                                                                                                        | 1.Mu buryo busanzwe<br>2. Abazwe                                                                                                                                                                          |
| 46. | Uko umwana ameze akimara kuvuka                                                                                                                                                                                                                                                      | 1.Umwana ameze neza<br>2.Yavutse ananiwe<br>3. Yapfuye                                                                                                                                                    |
| 47. | Mu gihe cyose wari kunda hano mu bitaro, waba waravuye udahohoterwa mu buryo ubwo ari bwo bwose bubabaza umubiri, n'umukozi ukora mu bitaro? Ndashaka kuvuga witabwagaho muburyo bwiza kandi bwuzuye impuhwe kandi uhabwa ubufasha mugihe uhuye nububabare cyangwa kutamererwa neza? | 1 Yego<br>2 Oya jya ku kibazo cya14                                                                                                                                                                       |
| 48. | Mu gihe wabaga wagize ububabare cyangwa utamerewe neza bakuvuraga gute?                                                                                                                                                                                                              | 1.Bampaga imiti igabanya uburibwe<br>2.Bankoreraga massage mu mugongo<br>3.Badoze aho banyongereye bakoresheje ikinya<br>4.Nabyaye banteye ikinya (ku babyaye batabazwe) cyangwa umuti ugabanya ububabare |
| 49. | Mu gihe icyo ari cyo cyose uri kunda, uri gusunika umwana, no mu gihe cyo kubara iya nyuma, hari ubwo umuganga wakuvuraga yaba yaragusobanuriye ibiri kugukorerwa, uko ugomba kwitwara cg akakuyobora aho uri ?                                                                      | 1 Yego<br>2 Oya jya ku kibazo cya16                                                                                                                                                                       |
| 50. | Ni ibiki mu by'ukuri bagusobanuriye?                                                                                                                                                                                                                                                 | 1.Icyumba urwariyemo<br>n'ibigikikije ushobora gukenera                                                                                                                                                   |

|     |                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                         |
|-----|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|     |                                                                                                                                                                                                                                                          | <p>Urugero: aho ubwiherero buherereye</p> <p>Amasaha yo kurya, ibyo ugomba kurya nibyo utagomba kurya</p> <p>2.Isuzumwa rusange wakorewe nibyavuyemo</p> <p>3.Isuzumwa ryo munda ibyara nibyavuyemo</p> <p>4.Uko kujya kunda no kubyara biri kugenda</p> <p>5.Kugendagenda uri ku bise</p> <p>6.Bambwiye impamvu bagiye kumbaga</p> <p>7.Igitsina cy'umwana wawe</p> <p>8.Igihe ugomba konkereza umwana wawe</p>        |
| 51. | Ukimara kubyara,mu gihe bitaga cyangwa bavuraga uruhinja rwawe baba baragusobanuriye ibyo barimo barukorera                                                                                                                                              | <p>1 Yego</p> <p>2 Oya</p> <p>3 Ntibijyanye</p>                                                                                                                                                                                                                                                                                                                                                                         |
| 52. | Mu gihe cyose wari uri kunda cg uri kubyara, hano mu bitaro, igihe icyo ari cyose baba barakuvuye bagusabye uburenganzira bwanditse cg butanditse?                                                                                                       | <p>1 Yego</p> <p>2 Oya → jya kuri 19</p>                                                                                                                                                                                                                                                                                                                                                                                |
| 53. | Bakumenyesheje ibyo bari bagiye kugukorerera?                                                                                                                                                                                                            | <p>1.Gufunga urubyaroro bya burundu</p> <p>2 Gukurwamo nyababyeyi</p> <p>3 Gusuzumwa ku nda</p> <p>4 Gusuzumwa muri nyababyeyi</p> <p>5Kongererwa ubyara</p> <p>6 Kubagwa</p> <p>7 Gukoresha ibyuma bikurura abana</p> <p>8 Mu gihe amakuru yanjye yasangizwaga abandi baganga</p> <p>9 Gufata amashusho</p> <p>1 Mu gihe umwana wanjye bamujyanaga kure yanjye</p> <p>2 Gutangizwa ibisa</p> <p>3 Kongererwa ibise</p> |
| 54. | Mu gihe cyose wari uri kunda cg ubyara hano mu bitaro, amahitamo yawe n'ibyo ukunda byaba byarubahirijwe?                                                                                                                                                | <p>1 Yego</p> <p>2 Oya jya kuri 21</p>                                                                                                                                                                                                                                                                                                                                                                                  |
| 55. | Ni ayahe mahitamo yawe cyangwa iby'ukunda mu by'ukuri byubahirijwe?. Wemerewe gukoresha ibyo wakoreshaga cg wakundaga mu buzima busanzwe nk'urugero ibyo kurya ukunda, ibyo kunywa ukunda , gusurwa n'abashyitsi ushaka, kwambara imyambaro ushaka byose | <p>1.Nemerewe kubyara ndi muri pozisiyo nshaka uretse kubyara ndyamiye umugongo</p> <p>2. Nemerewe gusenga</p> <p>3.Nashyizwe ahantu hatuje</p> <p>4.Nemerewe kurya ibyo nshaka</p> <p>5. Nemere kunywa ibyo nshaka</p> <p>6. Nemerewe kwambara ibyo nshaka</p>                                                                                                                                                         |
| 56. | Mu gihe cyose wamaze mu ibi bitaro uri kunda cg uri kubyara uyu mwana, waba wemerewe kuzana umuntu wihitanyemo mugumana mu rwererero?                                                                                                                    | <p>1 Yego</p> <p>2 Oya</p>                                                                                                                                                                                                                                                                                                                                                                                              |

|     |                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                        |
|-----|------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 57. | Mu gihe cyose wari kunda cg uri kubyara, Wigeze uvurwa mu buryo budashyira ku karubanda imyanya y'ibanga yawe cg ibindi bice by'umubiri? | 1 Yego<br>2 Oya jya kuri 24                                                                                                                                                                                                                                                                                                                                            |
| 58. | Mubyukuri mbwira uko ubwo buryo bwo kudashyira ku karubanda imyanya yawe bwubahirijwe?                                                   | 1.Aho bansuzumiraga bashyiragaho ibyo kunkingiriza<br>2. Aho nabyariraga bashyiragaho ibyo kunkingiriza<br>3.Barantwikiraga mu gihe bansuzumaga mu nda ibyara<br>4. Barantwikiraga mu gihe nari ndimo kubyara<br>5. Barantwikiraga nyuma yo kubyara                                                                                                                    |
| 59. | Mu gihe cyose wari ku nda cg uri kubyara, ibi bitaro waba waritaweho mu buryo bwubahiriza ibanga ry'amakuru yawe ?                       | 1.Yego<br>2.Oya jya kuri 26                                                                                                                                                                                                                                                                                                                                            |
| 60. | Ni iki cyakweretse ko ibanga ry'amakuru yawe ryubahirijwe ?                                                                              | 1.Amakuru yerekeranye no kubyara kwanjye yaganiriwe mu ibanga abandi babyeyi baje kubyara batumva<br>2. Andi makuru yerekeranye n'ubuzima bwanjye yaganiriweho mu ibanga mu gihe abandi babyeyi batumvaga<br>3.Abakozi bo kwa muganga bavura niba bonyine gusa beretswe amakuru y'ubuzima/ibibazo by'ubuzima bwanjye                                                   |
| 61. | Igihe cyose wari uri kunda cg ubyara uri hano mu bitaro waje kubyara. Wigeze wiyumva ko uvuranywe icyubahiro gikwiriye ikiremwa muntu?   | 1.Yego<br>2.Oya→ jya kuri 28                                                                                                                                                                                                                                                                                                                                           |
| 62. | Ni iki cyakweretse ko witaweho mu cyubahiro?                                                                                             | 1.Ntabwo bansuzuguye/Ntabwo bancishije bugufi<br>2. Bambwiraga neza<br>3. Umwana wanjye bamukoragaho mu cyubahiro gikwiriye ikiremwa-muntu<br>4. Bankoragaho mu cyubahiro gikwiriye ikiremwa-muntu<br>5. Bamvuraga bangaragariza impuhwe<br>6.Umwana wanjye bamuvuraga bamugaragariza impuhwe<br>7. Baransuhuzaga mbere yo kumvura<br>8.Bampamagaraga mu izina ryanjye |
| 63. | Igihe cyose wari uri hano mu bitaro uri kunda cg urimo ubyara. Wigeze yiyumvamo ko uvurwa ufite kwishyira ukizana/ nta kuvangurwa        | 1.Yego<br>2.Oya jya kuri 30                                                                                                                                                                                                                                                                                                                                            |



|     |                                                                                                                                         |                                                                                                                                                                                                                                        |
|-----|-----------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 64. | Ni iki cyakweretse ko wabonye kwishyira ukwizana mu buvuzi wabonye.                                                                     | 1. Nahawe ubuvuzi buri ku rwego rumwe nurw'abandi babyeyi<br>2. Nari mfitemo amahitamo yo gufata ibyemezo ku buvuzi bwose bwankorerwaga cyangwa amahitamo ku bigomba gukorera umubiri wanjye<br>3. Umwana wanjye yavurwaga atavangurwa |
| 65. | Igihe cyose wari uri hano mu bitaro waje kubyara, waba warahawe ubuvuzi bwo ku rwego rwo hejuru watekerezaga/wifuzaga?                  | 1.Yego<br>2.Oya → <b>jya kuri 32</b>                                                                                                                                                                                                   |
| 66. | Tubwire icyakweretse ko ubuvuzi wahawe bwari ubwo ku rwego rwo hejuru wifuzaga?                                                         | 1.Igihe cyose umwana wanjye yari akeneye ubufasha bw'abaganga<br>2.Nahawe ubufasha mu gihe cyose nari mbukeneye<br>3.Navurirwaga ahantu hasukuye kandi hari umutekano<br>4.Navurwaga nabaganga bashoboye                               |
| 67. | Mu gihe cyose wari uri hano mu bitaro waje kubyara, waba waritaweho n'abaganga mu gihe cyose wari ukeneye ubufasha?                     | 1. Yego<br>2. Oya                                                                                                                                                                                                                      |
| 68. | Mu gihe cyose wari uri hano mu bitaro uri kunda cg uri kubyara, waba warahawe ubufasha/serivise nubwo icyo gihe wabaga utarishyura?     | 1. Yego<br>2. Oya                                                                                                                                                                                                                      |
| 69. | Mu gihe cyose wari uri hano mu bitaro uri kunda cg uri kubyara waba waremere n'abaganga gufata ibyo kurya n'ibyo kunywa?                | 1. Yego<br>2. Oya                                                                                                                                                                                                                      |
| 70. | Mu gihe cyose wari uri hano mu bitaro uri kunda cg uri kubyara, waba warahawe amakuru n'abaganga ku byerekeranye no konsa umwana wawe ? | 1. Yego<br>2.Oya<br>3. Ntibijanye                                                                                                                                                                                                      |

#### Appendix E. Translated Personal Information sheet.

**Intego ya 2:** Gucukumbura imyumvire y'abatanga ubuvuzi kuburyo imikorere myiza yo kubaha ababyeyi yatangajwe n'abagore bo mu cyiciro cya mbere ishobora gukomezwa.

**Ibibazo byubushakashatsi icyiciro cya 2b:** Nigute imikorere myiza yo kubaha ababyeyi mu batanga ubuvuzi bakorera mu Ntara y' Iburasirazuba ishobora gukomezwa?

Umunsi mwiza. Urakoze guhura nanjye. Nitwa Alice Muhayimana. Ndi umunyeshuri wo mu cyiciro cya kane (PhD) mu ishamba ry'uburezi bw'abaforomo, ishuri ry'ubuvuzi muri kaminuza ya Witwatersrand / Afurika y'epfo. Ndimu gukora ubushakashatsi kugirango menye uko kubaha ababyeyi guhagaze mu ntara y'Uburasirazuba bw'u Rwanda. Nshimishijwe no kubasobanurira uburyo bwo kubaha ababyeyi bushobora gukomeza cyangwa kuzamurwa.

Ndabasaba uruhare rwanyu nk'umuntu watanga amakuru y'ingenzi ukora muri serivisi zita ku babyeyi mu bitaro biherereye mu Ntara y'Uburasirazuba. Ikiganiro kizamara iminota 60. Nzafata amajwi y'ibiganiro byacu. Mugihe cy'ikiganiro, urasabwa kwirinda gutangaza amakuru atuma abantu

bakumenya. Niba hari amakuru ajyanye n'amakuru yawe akuranga, mugihe cyo kubazwa, ntabwo azashyirwa mu myandikire.

Ibibazo ntabwo ari ikizamini, kubw'ibyo rero nta gisubizo kiboneye cyangwa kibi. Uruhare rwanjye ni ukugutega amatwi no kubaha igitekerezo cyawe. Ushobora kureka gusubiza ikibazo icyo ari cyo cyose wumva udashaka gusubiza. Ushobora kandi kuvuga ko utazi igisubizo cy'ikibazo. Hari ikindi kibazo wambaza?

Ikiganiro kiyobora icyiciro cya 2b (kizakoresha uburyo bwo kubaza bushimishije kandi kizashingira ku byavuye mu cyiciro cya 1)

Urugero rw'ibibazo bizabazwa

- 1.Ni ubuhe buryo bwiza bwo kuvura bwubaha ababyeyi ushima?
- 2.Ni ibihe bisubizo utekereza ku ngaruka nziza ku kubaha ababyeyi?
- 3.Ni ikihe gikwiye kuba cyiza mu gutanga ubuvuzi bwubaha ababyeyi?
- 4.Ni gute twafatanyaga kubaka ibikorwa byiza byo kubaha ababyeyi?
- 5.Ni gute wakomeza imikorere myiza yo kubaha ababyeyi? / Niki gikora mu kuzamura kubaha ababyeyi?

## Appendix F: Interview guide for Phase 1b

**To explore the perceptions and experiences of mothers about respectful maternity care during recent childbirth using the AI method:**

**1. Tell me the positive events you experienced during your recent labour and childbirth.**

**Probe:** Tell me what you appreciated most or loved the most.

**2. What about the care? Were you happy with/ you appreciated during labour and childbirth?**

**Probe:** Why did you like that?

**Probe:** At any point during labour and delivery for this delivery, tell me any other kind of treatment that made you feel good/dignified or respected?

**Probe:** What do you think has made it possible for your care to be good, dignified, and respected?

**3. What are the important duties/practices of RMC that you expected from HCP during labour and childbirth?**

**4. How do you feel/ perceive that you are being respected during labour and childbirth?**

**Probe:** Tell me what makes you feel good during labour and childbirth

**Probe:** According to you, **What should be done to provide RMC?**

**5. What do you think can be done to increase RMC best practices between HCPs and mothers?**

**Probe:** What would you wish for the best RMC practices to be?

**Probe:** What can be done to sustain/promote RMC?

**7. Is there anything else that you want to share with me or add?,**

*Appendix G: Study information document for phase 1b*



## **STUDY INFORMATION DOCUMENT (For phase 1b: Qualitative)**

**Study title: Development of Strategies for Health Care Providers to Sustain Respectful Maternity Care to Women in Labour.**

**Good morning/afternoon.**

### **Introduction:**

My name is ALICE MUHAYIMANA. I am the Principal Investigator in this research study, and I am a PhD student at Witwatersrand University (Wits), Johannesburg, South Africa. The supervisor of this study is Dr. Irene Kearns. Research is a process used to seek new knowledge. I am carrying out the study to explore the status of Respectful Maternity Care (RMC) and to develop strategies to promote RMC in the Eastern Province of Rwanda. Please feel free to ask me as many questions as you wish before deciding upon participation.

### **Invitation to Participate:**

I recently conducted an interview with you and other new mothers and now wish to explore some of the issues raised in greater detail. You indicated your willingness to take part in a second interview. Participation would involve taking part in an interview in a private location in the hospital at a time convenient to you. The interview will be conducted face to face, observing the normal COVID protocols, and will last for about 60-90 minutes. Refusal to participate will have no effect on your entitlement to continued care at this hospital. With your permission, I will audio record our conversation to ensure I miss nothing you say. The recording will be transcribed and retained for 2 years if a publication comes out of the study or six years if there is no publication. The recording will be erased after transcription. The transcription will be kept on a password-protected computer.

### **What is involved in the study?**

This is an individual interview with the objective of deeply exploring and describing your experiences and perceptions with regard to RMC during your recent childbirth. I'll ask you questions regarding your own experiences of recent labour and childbirth and why you were happy with the care you received. I wish to learn what you actually perceive as being respected during labour and childbirth and what your expectations were of RMC while in the hospital. During the interview, I will not be keeping a record of your identity.

The questions are not a test, so there is no right or wrong answer. My role as an interviewer is to listen and to record your answers. You may refuse to answer any questions that you do not feel comfortable answering. You may also say that you do not know the answer to a question.

### **Risks of being involved in the study:**

There are minimal risks related to participation in this study. If you may feel psychologically uncomfortable to respond to some questions and you feel distressed during the interview:

1. The interviewer will call a break to the discussion/interview.

2. The interviewer will provide immediate assistance by asking questions about your mental status.
3. If you can proceed, the interviewer will restart the discussion/interview.
4. If you are unable to complete the interview, the interviewer will end the session and accompany you to the hospital's professional counsellor for additional psychological help.
5. In addition, the researcher will refer you to the psycho-social services of your respective living area and supply the Rwanda Ministry of Health emergency contact (114) for requesting psychological support if necessary.
6. The researcher will make a follow-up phone call the next day to confirm that you are okay. During this period, the information previously provided regarding where to find psycho-social assistance will be provided again.

### **Benefits of being in the study:**

There will be no immediate or direct benefits to you for participating in this study. However, it is hoped that your participation may help promote RMC in the future. There is no cost to you to participate. An incentive of 7,500 Rwf will be provided to every participant who takes part in the interview.

### **Participation is voluntary:**

Taking part in this study is voluntary. You have the right to withdraw from participating at any time or select not to participate in the entire interview. If you withdraw, you will not be asked to identify the reasons for the withdrawal, and there is no penalty for withdrawal or decision not to participate in the study, and any data collected on you will, in default, be destroyed unless you specifically consent to its retention.

### **Anonymity:**

Your name and other identifying information will not be recorded anywhere. Confidentiality will be used in the whole process to provide information, to treat it, and to keep it. No individual participant will be identified in any report or publication arising out of this study.

### **Outputs:**

Your participation may help to discover issues and good practices with RMC; hence, this study will build on best practices to promote and maintain RMC. I will be pleased to provide a summary of the study results at no cost to any participant requesting it.

### **Contact details of researcher/s:**

In case of any further inquiries, you may contact Alice Muhayimana @ +250788687626 or by email at [2495590@students.wits.ac.za](mailto:2495590@students.wits.ac.za) or Dr Irene Kearns, Supervisor, on telephone no +27825940117, or by e-mail at [Irene.kearns@wits.ac.za](mailto:Irene.kearns@wits.ac.za)

### **Ethics approval:**

I have been given ethical clearance by the Human Research Ethics Committee (Medical) from Wits University and the Institutional Research Board (IRB) from the College of Medicine and Health Sciences (CMHS) of the University of Rwanda. I have also received permission from the Ethics Committees of the five hospital sites where I will be conducting the study. If there is any problem concerning your rights to participate in this study, you can contact the CMHS Institutional Review Board office in Kigali, Rwanda or call +250788563311

This study has been approved by the Human Research Ethics Committee (Medical) of the University of the Witwatersrand, Johannesburg ("Committee"). A principal function of this Committee is to safeguard

the rights and dignity of all human subjects who agree to participate in a research project and the integrity of the research.

If you have any concerns over the way the study is being conducted, please contact the Chairperson of this Committee, Professor Clement Penny, who may be contacted on telephone number 011 717 2301, or by e-mail on [Clement.Penny@wits.ac.za](mailto:Clement.Penny@wits.ac.za). The telephone numbers for the Committee secretariat are 011 717 2700/1234, and the e-mail addresses are [Zanele.Ndlovu@wits.ac.za](mailto:Zanele.Ndlovu@wits.ac.za) and [Rhulani.Mukansi@wits.ac.za](mailto:Rhulani.Mukansi@wits.ac.za).

#### **Consent:**

If you agree to take part in this study, I will ask you to sign a consent sheet to record this fact and a second consent sheet to record your consent to be interviewed.

Thank you for reading this Study Information Sheet.

June 2022

#### *Appendix H: Consent form for audio recording*



#### **CONSENT FORM FOR AUDIO RECORDING OF STUDY PARTICIPATION**

##### ***Project Title: Development of Strategies for Health Care Providers to Sustain RMC to Women in Labour.***

I hereby consent to the audio recording of the interview or focus group discussion.

.

I understand that:

- The recording will be stored in a secure location (a locked cupboard or password-protected computer) with restricted access to the researcher and the research supervisor.
- The recording will be transcribed, and any information that could identify me will be removed,
- The recordings will be erased within either (a) two (2) years of the publication of the research findings or (b) six (6) years if no publications arise from this research.
- Anyone wishing to access this information in the future will first have to obtain the approval of the Human Research Ethics Committee (Medical) of the University of the Witwatersrand, Johannesburg.
- Direct quotes from my interview, without any information that could identify me, may be cited in the research report or other write-ups of research.

#### **Contact details:**

**Alice Muhayimana, Principal Investigator, telephone no: +250788687626 or by e-mail at [amuhayimana@cartafrica.org](mailto:amuhayimana@cartafrica.org),**

**Dr Irene Kearns, Supervisor, on telephone no +27825940117, or by e-mail at [irene.kearns@wits.ac.za](mailto:irene.kearns@wits.ac.za)**

Professor CB Penny, Chairperson of the Human Research Ethics Committee (Medical) at the University of Witwatersrand, on telephone no. 011 717 2301, or by e-mail at [Clement.Penny@wits.ac.za](mailto:Clement.Penny@wits.ac.za).  
Ms. Z Ndlovu or Mr Rhulani Mkansi, Committee Secretariat, telephone nos.: 011 717 2700 or 1234, or by e-mail at: [Zanele.Ndlovu@wits.ac.za](mailto:Zanele.Ndlovu@wits.ac.za) or [Rhulani.Mkansi@wits.ac.za](mailto:Rhulani.Mkansi@wits.ac.za)

Name of Participant: \_\_\_\_\_  
Date: \_\_\_\_\_  
Place: \_\_\_\_\_  
Signature or mark \_\_\_\_\_

Witnessed by:

Name of Witness: \_\_\_\_\_  
Signature: \_\_\_\_\_  
Date: \_\_\_\_\_

*Appendix I: Interview and Focus Groups for Phase 2b*

**Objective 2:** To explore HCP perspectives on RMC

1. What do you understand by RMC?

**Probe:** Who benefits from RMC?

How?

**Probe:** Do you think it is important to provide RMC here, given the context and the conditions of your work environment?

Why?

2. Can you share your positive experiences regarding RMC provision with me?
3. What do you think HCPs can do to ensure RMC during labour?

**Probe:** Among what you have talked about concerning RMC, what do you appreciate most?

4. What do you think facilitates you to provide RMC at your work environment?

**Probe:** How to co-construct the RMC best practices? Between you and other HCPs and between you and mothers?

5. What do you think can be done for HCP to sustain/ incorporate RMC in all care provided to women during labour and childbirth?

**Probe:** How do you think RMC can be sustained?

6. What is the positive feedback? - Do you receive any from the mothers/community/families about the services they receive?

7. What else do you want to add?

## Appendix J: Participant information sheet for Focus Group Discussion, Phase 2b

**Study title: Development of Strategies for Health Care Providers to Sustain Respectful Maternity Care (RMC) to Women in Labour.**

**Objective:** To explore Health Care Providers (Midwives and Nurses) views of RMC

**Good morning/afternoon.**

### **Introduction:**

My name is ALICE MUHAYIMANA, I am the Principal Investigator in this research study, and I am a PhD student in Witwatersrand University (Wits), Johannesburg, South Africa. The supervisor of this study is Dr. Irene Kearns. Research is a process used to seek new knowledge. I am carrying out the study to explore the status of Respectful Maternity Care (RMC) and to develop strategies to promote RMC in the Eastern Province of Rwanda. Please feel free to ask me as many questions as you wish before deciding upon participation.

### **Invitation to Participate:**

I am inviting you to take part in this study because you are a healthcare professional involved in the delivery of maternity care in this hospital. Participation would involve taking part in Focus groups in a private location in the hospital at a time convenient to all of you and would be conducted face to face in groups of 6-8 nurses and midwives, observing the normal COVID protocol and would last for about between 60-90 minutes. Refusal to participate will have no effect on your employment at the hospital.

### **What is involved in the study:**

This is Focused Group Discussion with the objective of getting your views based on your experiences and perceptions related to RMC provision at the hospital. With your permission, I will record the discussion so that I don't miss anything you say. I will not be keeping a record of your identity. The recording will be transcribed and retained for 2 years if a publication comes out of the study or six years if there is no publication. The recording will be erased after transcription. The transcription will be kept in a password-protected computer.

The discussion is not a test, so there is no right or wrong answer. My role is to listen and to record the answers you provide in the Focus group discussion. You may refrain from discussing the item that you do not feel comfortable answering.

### **Risks of being involved in the study:**

There are no risks foreseen in relation to your participation in this study.

### **Benefits of being in the study:**

There will be no immediate or direct benefits to you for participating in this study. However, it is hoped that your participation may help promote RMC in the future. There is no cost to you to participate. An incentive of 5000 Rwf will be provided to every participant who takes part in the Focus Group Discussions.

### **Participation is voluntary:**

Taking part in this study is voluntary. You also have the right to withdraw from participating at any time. If you withdraw, you will not be asked to identify the reasons for the withdrawal, and there is no penalty for withdrawal; any data collected on you will, by default, be destroyed unless you specifically consent to its retention.

### **Anonymity:**



Your name and other identifying information will not be recorded anywhere. No individual participant will be identified in any report or publication arising out of this study. However, because of the group nature of a Focus Group, this activity cannot be either confidential or anonymous (you may recognize one another) during the data collection. I kindly ask you to treat the discussions as confidential.

**Outputs:**

Your participation will help to discover good practices with RMC and hence will build on best practices to develop strategies to promote and maintain RMC. I will be pleased to provide a summary of the study results at no cost to any participant requesting it.

**Contact details of researcher/s:** In case of any further inquiries, you may contact Alice Muhayimana @ +250788687626 or by email at [2495590@students.wits.ac.za](mailto:2495590@students.wits.ac.za) or Dr Irene Kearns, Supervisor, on telephone no +27825940117, or by e-mail at [Irene.kearns@wits.ac.za](mailto:Irene.kearns@wits.ac.za)

**Ethics approval:** I have been given ethical clearance by the Human Research Ethics Committee (Medical) from Wits University and the Institutional Research Board (IRB) from the College of Medicine and Health Sciences (CMHS) of the University of Rwanda. I have also received permission from the Ethics Committees of the five hospital sites where I will be conducting the study to conduct this research.

If there is any problem concerning your rights to participate in this study, you can contact the CMHS Institutional Review Board office in Kigali, Rwanda or call +250788563311

This study has been approved by the Human Research Ethics Committee (Medical) of the University of the Witwatersrand, Johannesburg ("Committee"). A principal function of this Committee is to safeguard the rights and dignity of all human subjects who agree to participate in a research project and the integrity of the research.

If you have any concerns over the way the study is being conducted, please contact the Chairperson of this Committee, Professor Clement Penny, who may be contacted on telephone number 011 717 2301, or by e-mail on [Clement.Penny@wits.ac.za](mailto:Clement.Penny@wits.ac.za). The telephone numbers for the Committee secretariat are 011 717 2700/1234, and the e-mail addresses are [Zanele.Ndlovu@wits.ac.za](mailto:Zanele.Ndlovu@wits.ac.za) and [Rhulani.Mukansi@wits.ac.za](mailto:Rhulani.Mukansi@wits.ac.za).

**Consent:**

If you agree to take part in this study, I will ask you to sign a Consent Sheet to record this fact and a second Consent Sheet to record your consent to participate in this Focus groups.

Thank you for reading this Study Information Sheet.

June 2022

### *Appendix K: Interview guide (Phase 2b)*

1. In line with the RMC components, what is the current status of RMC in this hospital?

**Probe:** What is the positive feedback? - if any that you receive from the Mothers/Community/Families about the services they receive

2. What do you think facilitates RMC here?

3. What are the best practices that are being done here to sustain RMC in all care provided to women during labour and childbirth?

**Probe:** What can be added to the current practices to engage more in RMC practices?

4. What do you think facilitates you in providing RMC in this working environment?

**Probe:** How do we co-construct the RMC best practices? Between you and other HCPs and between you and mothers.

5. Can you share with me your positive experiences regarding RMC provision?

6. Is there anything you can add?

## *Appendix L: Study information document for In-depth Interview (Phase 2b)*

**Study title: Development of Strategies for Health Care Providers to Sustain Respectful Maternity Care (RMC) to Women in Labour.**

**Good morning/afternoon.**

### **Introduction:**

My name is ALICE MUHAYIMANA. I am the Principal Investigator in this research study, and I am a PhD student in Witwatersrand University (Wits), Johannesburg, South Africa. The supervisor of this study is Dr. Irene Kearns. Research is a process used to seek new knowledge. I am carrying out the study to explore the status of Respectful Maternity Care (RMC) and to develop strategies to promote RMC in the Eastern Province of Rwanda. Please feel free to ask me as many questions as you wish before deciding upon participation.

### **Invitation to Participate:**

I am inviting you to take part in this study because you are a healthcare professional involved in the delivery of maternity care in this hospital. Participation would involve taking part in an interview in a private location in the hospital at a time convenient to you. The interview will be conducted face to face, observing the normal COVID protocol, and will last for about 60-90 minutes. Refusal to participate will have no effect on your employment at the hospital.

### **What is involved in the study:**

This is an individual interview with the objective of getting your views on the provision of RMC at the hospital. With your permission, I will record the interview so that I don't miss anything you say. I will not be keeping a record of your identity. The recording will be transcribed and retained for 2 years if a publication comes out of the study or six years if there is no publication. The recording will be erased after transcription. The transcription will be kept in a password-protected computer.

The questions are not a test, so there is no right or wrong answer. My role as an interviewer is to listen and to record your answers. You may refuse to answer any questions that you do not feel comfortable answering. You may also say that you do not know the answer to a question.

### **Risks of being involved in the study:**

There are no risks foreseen in relation to your participation in this study.



**Study title:** Development of Strategies for Health Care Providers to Sustain Respectful Maternity Care to Women during Labour in Rwanda

**Greetings**

**Introduction:**

My name is Alice Muhayimana, and I am an academic staff member at the University of Rwanda, School of Nursing and Midwifery. Currently, I am pursuing a Doctor of Philosophy (PhD) studies in Nursing at the University of the Witwatersrand in South Africa.

I am conducting a research study in Respectful Maternity Care (RMC) as a requirement for the PhD programme. I have conducted a study on 610 mothers to determine the status of Respectful Maternity Care. In addition, I have explored the experiences and perceptions of women and healthcare providers regarding RMC on 30 mothers, 20 In-depth interviews and 10 FGDs. Therefore, I used the findings to develop the strategies to sustain RMC in Rwanda during labour and childbirth.

**Invitation to participate**

I would like to invite you to participate in the individual validation of strategies I developed for healthcare providers to sustain RMC during labour and childbirth in Rwanda.

You will be asked to rate or evaluate each strategy and action plan in the document shared with you based on criteria of relevance, feasibility, acceptability and context using a self-administered questionnaire. The questionnaire comprises a four-point Likert scale of 1 to 4 where 1 is the lowest grade and 4 is the highest grade for each item. A free space for explanatory remarks was provided to indicate whether you can add or remove suggestions, etc. You will also be asked to provide additional suggestions based on your expertise, and in the end, all suggestions will be merged. You are invited to participate in this study because you are experts in maternal and child health, maternity care/leadership, and midwifery education/leadership, and you are a gynecologist, midwife and nurse working in maternity service. By completing and submitting the questionnaire, it means that you consent to participate in the study.

Participation in this study is strictly voluntary. Participation or refusal to participate in this study or any aspects of this study will have no impact on your career.

**What is involved in the study**

If you choose to participate, you will be part of a group of experts who will respond to a self-administered questionnaire, which will take about 15 to 20 minutes to complete. You will respond to the questionnaire at your own time no later than 15 September 2023. You will receive the questionnaire through your email, and you will fill in your responses and send them back to me by email. Please don't record your name on the questionnaire. The questionnaire will be collected by the principal investigator and will not be shared outside of the research team, and all information will be used during data analysis.

The questionnaire is in English language. You will be provided with clarifications at any time when something is not clear. The findings from this study will be presented in national and international conferences; findings will also be published in my doctoral thesis and peer-reviewed journals. No

participant will be identified by name in any report or publication arising out of the study. As a participant, you will be given a summary of the results. The study is expected to take place between 31st August 2023 to 28<sup>th</sup> September 2023.

### **Risks of being involved in the study**

No physical risks are anticipated in this study. However, you may not feel comfortable to respond to some questions.

### **How will these discomforts and risks be alleviated?**

You will be allowed not to answer certain questions that you are not comfortable with without giving a reason. In addition, the findings of this study will only be used to improve the strategies developed by healthcare providers to sustain RMC in Rwanda.

### **Benefits of being in the study**

There may be no direct benefit to every participant in this study. However, it is hoped that the findings of this study will improve the strategies developed to sustain RMC among healthcare providers in Rwanda. The strategies developed will be used in future RMC intervention studies and implementation science. This may help to improve the quality of maternity care during labour and childbirth given to mothers and their newborns, thereby improving their health outcomes. The findings will inform policymakers and educators on what to improve on RMC, and the study will finally lead to the award of PhD qualification to the researcher.

### **Reimbursements for “out of pocket” expenses.**

You are not expected to incur any expenses.

### **Who to contact if you have been harmed or have any concerns**

If you have any concerns about the research or feel that you have been harmed in any way by participating in this study, please contact my supervisor;

Dr Irene Kearns, Nursing Education Department,

Email: [irene.kearns@wits.ac.za](mailto:irene.kearns@wits.ac.za) Tel +27 (82) 5940117, 7 York road, Parktown.2193, University of the Witwatersrand

OR

If you have any concerns over the way the study is being conducted, please contact the Chairperson of this Committee, Professor Paul Ruff, who may be contacted via the Committee secretariat, on telephone numbers +27 11 717 2700/1234 and e-mail address [Zanele.Ndlovu@wits.ac.za](mailto:Zanele.Ndlovu@wits.ac.za) and [Rhulani.Mukansi@wits.ac.za](mailto:Rhulani.Mukansi@wits.ac.za).

Alternatively, here in Rwanda, you can contact the College of Medicine and Health Sciences Institutional Review Board (CMHS/IRB) office, Kigali, Rwanda email: [sundayfrax@gmail.com](mailto:sundayfrax@gmail.com) or call +250788563311

Thank you for reading the Information Sheet

August 2023

[Appendix N: Letter requesting expert in RMC to validate the strategies](#)

Alice MUHAYIMANA  
PhD student  
University of Witwatersrand  
Cell phone number: +250 788687626  
Email: [hayiali@yahoo.fr](mailto:hayiali@yahoo.fr) or [amuhayimana@cartafrica.org](mailto:amuhayimana@cartafrica.org)  
Date: 11 August 2023

Through  
Dr Irene J. Kearns  
Email: [irene.kearns@wits.ac.za](mailto:irene.kearns@wits.ac.za)  
Supervisor

To: The Expert in Respectful Maternity Care

Dear Prof/Dr

**RE: Request related to your participation in the Validation Process of my research**

I am a PhD candidate at the University of Witwatersrand (Wits), Department of Nursing Education Johannesburg, South Africa. In addition, I am an Academic staff member at the University of Rwanda, School of Nursing and Midwifery.

I kindly request your participation in the validation process of my PhD project entitled "*Development of Strategies for Health Care Providers to Sustain Respectful Maternity Care (RMC) to Women in Labour*". Despite the importance of RMC, previous studies have predominantly focused on negative experiences reported by mothers, little attention has been paid to the power of positive RMC experiences. Therefore, this study explored the appreciated positive RMC practices. The study was approved by the Institutional Review Board of the College of Medicine and Health Sciences of the University of Rwanda with a reference 070/CMHS-IRB/2023, the National Health Research Committee from the Ministry of Health of Rwanda with a reference NHRC/2022/PROT/003, and the Health Research Ethical Committee of Wits University with a reference M220265. This study was conducted in four phases and so far, I am done with the three phases. The first two phases were to collect data on mothers, maternity health care providers and maternity unit managers. I used Appreciative Inquiry during data collection. Phase 1 was in the form of mixed method to mothers and Phase 2 was qualitative to Health Care providers. The findings and results (Qualitative and Quantitative Phases) gave rise to the specific Themes. The strategies to sustain Respectful Maternity Care (RMC) were developed (Phase 3) from the emerging themes in order to contribute to the gap that was identified. Hence, the last phase consists of the validation of the developed strategies.

Kindly awaiting your response, upon which I will forward the self-administered questionnaire with the developed strategies for your much valued input and comments.

Your consideration of my request will be highly appreciated.

Yours sincerely,



Alice MUHAYIMANA





UNIVERSITY of  
RWANDA

COLLEGE OF MEDICINE AND HEALTH SCIENCES

DIRECTORATE OF RESEARCH & INNOVATION

**CMHS INSTITUTIONAL REVIEW BOARD (IRB)**

Kigali, 9<sup>th</sup> /December /2021

**Alice Muhayimana**  
School of Nursing and Midwifery, CMHS,UR

**Approval Notice: No 385/CMHS IRB/2021**

Your Project Title *“Development of Strategies for Health Care Providers to Sustain Respectful Maternity Care to Women in Labour”* has been evaluated by CMHS Institutional Review Board.

| Name of Members             | Institute            | Involved in the decision |             |                               |
|-----------------------------|----------------------|--------------------------|-------------|-------------------------------|
|                             |                      | Yes                      | No (Reason) |                               |
|                             |                      |                          | Absent      | Withdrawn from the proceeding |
| Prof Kato J. Njunwa         | UR-CMHS              | X                        |             |                               |
| Dr Stefan Jansen            | UR-CMHS              | X                        |             |                               |
| Dr Brenda Asimwe-Kateera    | UR-CMHS              | X                        |             |                               |
| Prof Ntaganira Joseph       | UR-CMHS              | X                        |             |                               |
| Dr Tumusiime K. David       | UR-CMHS              | X                        |             |                               |
| Dr Kayonga N. Egide         | UR-CMHS              | X                        |             |                               |
| Mr Kanyoni Maurice          | UR-CMHS              |                          | X           |                               |
| Prof Munyanshongore Cyprien | UR-CMHS              | X                        |             |                               |
| Mrs Ruzindana Landrine      | Kicukiro district    |                          | X           |                               |
| Dr Gishoma Darius           | UR-CMHS              | X                        |             |                               |
| Dr Donatilla Mukamana       | UR-CMHS              | X                        |             |                               |
| Prof Kyamanywa Patrick      | UR-CMHS              |                          | X           |                               |
| Prof Condo Umutesi Jeannine | UR-CMHS              |                          | X           |                               |
| Dr Nyirazinyoye Laetitia    | UR-CMHS              | X                        |             |                               |
| Dr Nkeramihigo Emmanuel     | UR-CMHS              |                          | X           |                               |
| Sr Maliboli Marie Josee     | CHUK                 | X                        |             |                               |
| Dr Mudenge Charles          | Centre Psycho-Social | X                        |             |                               |

After reviewing your protocol during the IRB meeting of where quorum was met and revisions made on the advice of the CMHS IRB submitted on 9<sup>th</sup> December 2021, **Approval has been granted to your study.**

Email: [researchcenter@ur.ac.rw](mailto:researchcenter@ur.ac.rw)

P.O Box 3286 Kigali, Rwanda

[www.ur.ac.rw](http://www.ur.ac.rw)

Please note that approval of the protocol and consent form is valid for **12 months**.

You are responsible for fulfilling the following requirements:

1. Changes, amendments, and addenda to the protocol or consent form must be submitted to the committee for review and approval, prior to activation of the changes.
2. Only approved consent forms are to be used in the enrolment of participants.
3. All consent forms signed by subjects should be retained on file. The IRB may conduct audits of all study records, and consent documentation may be part of such audits.
4. A continuing review application must be submitted to the IRB in a timely fashion and before expiry of this approval
5. Failure to submit a continuing review application will result in termination of the study
6. Notify the IRB committee once the study is finished

Sincerely,



Date of Approval: The 10<sup>th</sup> December 2021

Expiration date: The 10<sup>th</sup> December 2022

**Assoc. Prof. Stefan Jansen**  
**Ag. Chairperson Institutional Review Board,**  
**College of Medicine and Health Sciences, UR**

**Cc:**

- Principal College of Medicine and Health Sciences, UR
- University Director of Research and Postgraduate Studies, UR



UNIVERSITY of  
RWANDA

COLLEGE OF MEDICINE AND HEALTH SCIENCES

DIRECTORATE OF RESEARCH & INNOVATION

**CMHS INSTITUTIONAL REVIEW BOARD (IRB)**

Kigali, the 19<sup>th</sup>/01/2023

**Muhayimana Alice**  
School of nursing and midwifery, CMHS, UR

**Notice of Renewal of Approval for Research Project: No 070 /CMHS IRB/2023**

Your Project title *“Development of strategies for health care providers to sustain respectful maternity care to women in labour”* has been evaluated by CMHS Institutional Review Board.

| Name of Members             | Institute            | Involved in the decision |              |                               |
|-----------------------------|----------------------|--------------------------|--------------|-------------------------------|
|                             |                      | Yes                      | No ( Reason) |                               |
|                             |                      |                          | Absent       | Withdrawn from the proceeding |
| Prof Kato J. Njunwa         | UR-CMHS              | X                        |              |                               |
| Dr Stefan JANSEN            | UR-CMHS              | X                        |              |                               |
| Dr Brenda Asiimwe-Kateera   | UR-CMHS              | X                        |              |                               |
| Prof Ntaganira Joseph       | UR-CMHS              | X                        |              |                               |
| Dr Tumusiime K. David       | UR-CMHS              | X                        |              |                               |
| Dr Kayonga N. Egide         | UR-CMHS              | X                        |              |                               |
| Mr Kanyoni Maurice          | UR-CMHS              |                          | X            |                               |
| Prof Munyanshongore Cyprien | UR-CMHS              | X                        |              |                               |
| Mrs Ruzindana Landrine      | Kicukiro district    |                          | X            |                               |
| Dr Gishoma Darius           | UR-CMHS              | X                        |              |                               |
| Dr Donatilla Mukamana       | UR-CMHS              | X                        |              |                               |
| Prof Kyamanywa Patrick      | UR-CMHS              |                          | X            |                               |
| Prof Condo Umutesi Jeannine | UR-CMHS              |                          | X            |                               |
| Dr Nyirazinyoye Laetitia    | UR-CMHS              | X                        |              |                               |
| Dr Nkeramihigo Emmanuel     | UR-CMHS              |                          | X            |                               |
| Sr Maliboli Marie Josee     | CHUK                 | X                        |              |                               |
| Dr Mudenge Charles          | Centre Psycho-Social | X                        |              |                               |

After reviewing your protocol, **Continuation of Approval has been granted to your study.**

Please note that approval of the protocol and consent form is valid for **12 months**.

Email: [researchcenter@ur.ac.rw](mailto:researchcenter@ur.ac.rw)

P.O Box 3286 Kigali, Rwanda

[www.ur.ac.rw](http://www.ur.ac.rw)



You are responsible for fulfilling the following requirements:

1. Changes, amendments, and addenda to the protocol or consent form must be submitted to the committee for review and approval, prior to activation of the changes.
2. Only approved consent forms are to be used in the enrollment of participants
3. All consent forms signed by subjects should be retained on file. The IRB may conduct audits of all study records, and consent documentation may be part of such audits.
4. A continuing review application must be submitted to the IRB in a timely fashion and before expiry of this approval.
5. Failure to submit a continuing review application will result in termination of the study.
6. Notify the Rwanda National Ethics committee once the study is finished.

Sincerely,



**Prof Stefan JANSEN**  
**Ag. Chairperson Institutional Review Board,**  
**College of Medicine and Health Sciences, UR**

Date of Approval: January 19<sup>th</sup>, 2023  
Expiration date: January 19<sup>th</sup>, 2024

**Cc:**

- Principal College of Medicine and Health Sciences, UR
- University Director of Research and Innovations, UR

*Appendix P: Ethical clearance from HREC of Wits University*

|                                                                                                                                                |                                                      |
|------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------|
|  <p>UNIVERSITY OF THE<br/>WITWATERSRAND,<br/>JOHANNESBURG</p> | <p>HUMAN RESEARCH ETHICS<br/>COMMITTEE (MEDICAL)</p> |
|------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------|

**Office of the Deputy Vice-Chancellor (Research and Innovation)**

**TO:** Mr A Muhayimana  
School of Therapeutic Sciences  
Department of Nursing Education  
Medical School  
University

E-mail: [2495590@students.wits.ac.za](mailto:2495590@students.wits.ac.za)

**CC:** Supervisor: Dr I Kearns  
<[Irene.Kearns@wits.ac.za](mailto:Irene.Kearns@wits.ac.za)>  
and <[HREC-Medical Research Office@wits.ac.za](mailto:HREC-Medical Research Office@wits.ac.za)>

**FROM:** Mr Iain Burns  
Human Research Ethics Committee (Medical)  
Tel: 011 717 1252

E-mail: [Iain.Burns@wits.ac.za](mailto:Iain.Burns@wits.ac.za)

**DATE:** 2022/06/06

**REF:** R14/49

**PROTOCOL NO:** **M220265** (This is your ethics application reference number. Please quote it in all enquiries, oral or written, relating to this study.)

**PROJECT TITLE:** *Development of strategies for health care providers to sustain respectful maternity care to women in labour*

Please find attached the Clearance Certificate for the above project. I hope it goes well and that an article in a recognized publication comes out of it. This will reflect well on your professional standing and contribute to Government funding of the University.



MSWorks2000/Iain0007/Clearscan.wps



R49 Mr A Muhayimana

**HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)  
CLEARANCE CERTIFICATE NO. M220265**

**NAME:**  
(Principal Investigator)

Mr A Muhayimana

**DEPARTMENT:**

School of Therapeutic Sciences  
Department of Nursing Education  
Medical School  
University

**PROJECT TITLE:**

*Development of strategies for health care providers to  
sustain respectful maternity care to women in labour*

**DATE CONSIDERED:**

2022/02/25

**DECISION:**

Approved conditionally

**CONDITIONS:**

This clearance covers Phases 1 (a) and 1 (b) [interviews  
with new mothers] and Phase 2 (b) [interviews with doctors  
and hospital management]; subsequent phases should be  
discussed with the HREC (Med) thereafter

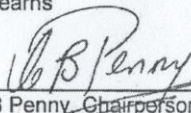
**NOTE:**

If contact information regarding student study participants is required,  
please contact the Registrar's office - <Nicoleen.Potgieter@wits.ac.za>

**SUPERVISOR:**

Dr I Kearns

**APPROVED BY:**

  
Dr CB Penny, Chairperson, HREC (Medical)

**DATE OF APPROVAL:**

2022/06/06

This Clearance Certificate is valid for 5 years from the date of approval. An extension may be applied for.

**DECLARATION OF INVESTIGATORS**

To be completed in duplicate and **ONE COPY** returned to the Research Office secretariat on the 3rd floor, Phillip Tobias Building, Parktown, University of the Witwatersrand, Johannesburg.

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 submit details to the Committee. I agree to submit a yearly progress report. When a funder requires annual re-certification, the application date will be one year after the date when the study was initially reviewed. In this case, the study was initially reviewed in **February** and therefore reports and re-certification will be due in the month of **February** each year. Unreported changes to the study may invalidate the clearance given by the HREC (Medical).

Alice Muhayimana  
Signature of Principal Investigator

06.06.2022  
Date





R49 Ms A Muhayimana

**HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)  
CLEARANCE CERTIFICATE NO. M220265**

**NAME:**  
(Principal Investigator)

Ms A Muhayimana

**DEPARTMENT:**

School of Therapeutic Sciences  
Department of Nursing Education  
Medical School  
University

**PROJECT TITLE:**

*Development of strategies for health care providers to  
sustain respectful maternity care to women in labour*

**DATE CONSIDERED:**

2022/02/25

**DECISION:**

Approved conditionally

**CONDITIONS:**

Phases 1 (a) and 1 (b) and 2 (b) approved on 2022/06/06  
Phase 2 (a) approved on 2023/04/06

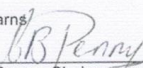
**NOTE:**

If contact information regarding student study participants is required,  
please contact the Registrar's office - <Nicoleen.Potgieter@wits.ac.za>

**SUPERVISOR:**

Dr I Kearns

**APPROVED BY:**

  
Dr CB Penny, Chairperson, HREC (Medical)

**DATE OF APPROVAL:**

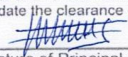
2022/06/06

This Clearance Certificate is valid for 5 years from the date of approval. An extension may be applied for.

**DECLARATION OF INVESTIGATORS**

To be completed in duplicate and **ONE COPY** returned to the Research Office secretariat on the 3rd floor, Phillip Tobias Building, Parktown, University of the Witwatersrand, Johannesburg.

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 submit details to the Committee. **I agree to submit a yearly progress report.** When a funder requires annual re-certification, the application date will be one year after the date when the study was initially reviewed. In this case, the study was initially reviewed in **February** and therefore reports and re-certification will be due in the month of **February** each year. Unreported changes to the study may invalidate the clearance given by the HREC (Medical).

  
Signature of Principal Investigator

08 April 2023  
Date

R49 Ms A Muhayimana

**HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)**  
**CLEARANCE CERTIFICATE NO. M220265**

**NAME:**  
(Principal Investigator)

Ms A Muhayimana

**DEPARTMENT:**

School of Therapeutic Sciences  
Department of Nursing Education  
Medical School  
University

**PROJECT TITLE:**

*Development of strategies for health care providers to  
sustain respectful maternity care to women in labour*

**DATE CONSIDERED:**

2022/02/25

**DECISION:**

Approved conditionally

**CONDITIONS:**

Phases 3 and 4 approved on 2023/08/22

[Phases 1 (a) and 1 (b) and 2 (b) approved on 2022/06/06]  
[Phase 2 (a) approved on 2023/04/06]

**NOTE:**

If contact information regarding student study participants is required,  
please contact the Registrar's office - <Nicoleen.Potgieter@wits.ac.za>

**SUPERVISOR:**

Dr I Kearns

**APPROVED BY:**

Professor P Ruff, Chairperson, HREC (Medical)

**DATE OF APPROVAL:**

2022/06/06

**EXPIRY DATE:**

2027/06/05

This Clearance Certificate is valid for 5 years from the date of approval. An extension may be applied for.

**DECLARATION OF INVESTIGATORS**

To be completed in duplicate and **ONE COPY** returned to the Research Office secretariat on the 3rd floor, Phillip Tobias Building, Parktown, University of the Witwatersrand, Johannesburg.

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 submit details to the Committee. **I agree to submit a yearly progress report.** When a funder requires annual re-certification, the application date will be one year after the date when the study was initially reviewed. In this case, the study was initially reviewed in February and therefore reports and re-certification will be due in the month of February each year. Unreported changes to the study may invalidate the clearance given by the HREC (Medical).

Signature of Principal Investigator

Date

26 August 2023

## Appendix Q: Approval from post-graduate assessors of Wits University



Private Bag 3 Wits, 2050  
Fax: 027117172119  
Tel: 02711 7172076

Reference: Mrs Sandra Benn  
E-mail: [sandra.benn@wits.ac.za](mailto:sandra.benn@wits.ac.za)

07 January 2022  
Person No: 2495590  
PAG

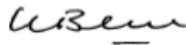
Mrs A Muhayimana  
P.O Box:3286  
Kigali  
Remera campus  
CMHS  
3286 KIGALI  
Rwanda

Dear Mrs Alice Muhayimana

### Doctor of Philosophy: Approval of Title

We have pleasure in advising that your proposal entitled *Development of strategies for Health Care Providers to sustain respectful maternity care to women in labour* has been approved. Please note that any amendments to this title have to be endorsed by the Faculty's higher degrees committee and formally approved.

Yours sincerely

A handwritten signature in black ink, appearing to read 'S. Benn'.

Mrs Sandra Benn  
Faculty Registrar  
Faculty of Health Sciences





## Appendix R: Approval from NHRC of Ministry of Health Rwanda

Republic of Rwanda



MINISTRY OF HEALTH

National Health Research Committee  
Ref: NHRC/2022/PROT/003

To: **Mrs. MUHAYIMANA Alice**  
**Principal Investigator**

### Scientific Review Approval Notice

With reference to your request for approval of the Research Protocol entitled; **“Development of strategies for health care providers to sustain respectful maternity care to women in labour”**;

We are pleased to inform you that, following a thorough review and critical analysis of your proposal (NHRC/2022/PROT/003), National Health Research Committee has approved your Research Protocol.

However,

- 1) Changes amendments on approach and methodology must be submitted to the NHRC for review and approval to validate the changes.
- 2) Submission to NHRC of final results using the attached template is mandatory
- 3) Failure to fulfill the above requirements will result in termination of study

Once again National Health Research Committee appreciates your interest in research.

Your final approval reference number is NHRC/2022/PROT/003.

Sincerely,

**Dr. Parfait UWALIRAYE**  
**Chairperson of NHRC**

Date: 18/01/2022

Appendix S: Collaboration letter from Rwanda Biomedical Center



RWANDA  
BIOMEDICAL  
CENTER

A Healthy People. A Wealthy Nation

Kigali, ...../...../ 2022  
Ref: No ..... /RBC/2022

*Maternal, Child and Community Health Division*

**To the chair of National Health Research Committee  
KIGALI**

**Re: Research study “Development of Strategies for Health Care Providers to Sustain  
Respectful Maternity Care to Women in Labour”**

This is to confirm that the Division of Maternal, Child and community Health under RBC is recognizing the importance of the research study “Development of Strategies for Health Care Providers to Sustain Respectful Maternity Care to Women in Labour”. This study will be conducted in Eastern Province of Rwanda. The study will be submitted to NHRC and RNEC for approval.

This project has the potential to offer substantial benefit to the Rwandan population especially the component of women and newborns health.

**Felix SAYINZOGA, MD, MSc, PhD**

**Division manager  
Maternal, Child, and Community Health  
Rwanda Biomedical Center**



## Appendix T: Approval letters from five study sites

1  
REPUBLIC OF RWANDA



MINISTRY OF HEALTH  
EASTERN PROVINCE  
NGOMA DISTRICT  
KIBUNGO REFERRAL HOSPITAL  
E-mail: Kibungohospital@gmail.com

KIBUNGO REFERRAL HOSPITAL INDEPENDENT ETHICS COMMITTEE (KRH\_IEC)

Name of the applicant: MUHAYIMANA Alice Kibungo, on 22/02/2022

Address: UNIVERSITY OF RWANDA

Mount Kenya University

Approval Notice: No... /Kibungo Referral Hospital Independent Ethics  
Committee/ 2022

Your project entitled "**Development of Strategies for Health Care Providers to Sustain Respectful Maternity Care to Women in Labor**" has been evaluated by Kibungo Referral Hospital Independent Ethics committee members.

1 of 2

A handwritten signature in blue ink, appearing to be 'AB', is written over a horizontal line.

| Name of members           | Involved in the decision |              |                                  |
|---------------------------|--------------------------|--------------|----------------------------------|
|                           | Yes                      | no<br>Absent | Withdraw from the<br>proceedings |
| Dr Jean de Dieu TUYISHIME |                          | √            |                                  |
| Adeo NSANZUBUHORO         | √                        |              |                                  |
| Genevieve MUHIMPUNDU      | √                        |              |                                  |
| Dr Eric MURWANASHYAKA     |                          | √            |                                  |
| Thadee NSANZUMUNYURWA     | √                        |              |                                  |
| MUKAMWIZA Rachel          | √                        |              |                                  |
| MUREKATETE Marie Denyse   | √                        |              |                                  |

After reviewing your protocol during the IEC meeting of where quorum was met, approval letter has been granted to your study.

Please note that approval of the research protocol/proposal and consent form is valid for 12months and shall be renewed on request.

You are requested to respect the ethical principles, policy and procedures. At the end of your work, you are obliged to share the results of your research and recommendations to the Kibungo Referral Hospital Independent Ethical Committee before publication.

Sincerely,

Date of approval. 22./02/2022

Expiration date: 21/02/2022

Chairperson of KRH\_IEC

Dr Jean de Dieu TUYISHIME



*for*  *Co-chairperson*

CC:

- Administration-KRH

REPUBLIC OF RWANDA

Kiziguro, March , 24<sup>th</sup> 2022

Nº...152...HOPKIZ/2022



EASTERN PROVINCE

GATSIBO DISTRICT

KIZIGURO DISTRICT HOSPITAL

TELEPHONE: 0781501352

P.O.box:53 RWAMAGANA

Email: kiziguro.hospital@moh.gov.rw/hopitalkiziguro@yahoo.fr

To: The Alice MUHAYIMANA

Dear Madam,

**Re: Respond your letter**

Reference is made to your letter of the 2<sup>nd</sup> February 2022, requesting for a permission of data collection in our hospital on the purpose of exploring the status of respectful maternity care and to develop strategies to sustain RMC in Eastern Province of our country in relation with reaching your research project entitled: <<Development of strategies for Health care providers to sustain respectful Maternity Care to Women in Labor>> ;

I write this letter in order to inform you that Kiziguro District Hospital is interested in facilitating you as it was requested. As a facilitation, you may contact **Mr. GATO Silas, Customer Care Officer** of the Hospital and **Focal Person** of **Ethic and Research Committee**, phone number **0788329851** or email: **gatosilas12@gmail.com**

I thank you for your commitment to conduct a research in our hospital

Sincerely,

**Dr. Vedaste MBAYIRE**

**Director General of Kiziguro District Hospital**

for   
JAR



|                                                                                                                                       |                                                                                                                                                                                                                                                      |
|---------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>REPUBLIC OF RWANDA</p>  <p>MINISTRY OF HEALTH</p> | <p>RWAMAGANA PROVINCIAL HOSPITAL<br/>NR3, KIGALI-KAYONZA RD<br/>RWAMAGANA DISTRICT<br/>EASTERN PROVINCE<br/>PO BOX 06 RWAMAGANA<br/>Tel: 0252567783<br/>E-mail: <a href="mailto:rwamagana.hospital@moh.gov.rw">rwamagana.hospital@moh.gov.rw</a></p> |
|---------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

Rwamagana, 31/03/2022  
N° 14/162/16/03/2022

To: Alice MUHAYIMANA  
C/O: UR – CMHS RWAMAGANA CUMPUS  
General Nursing Department

RE: Your request for Authorization for data collection

Dear Alice

Reference is made on your letter of 02<sup>nd</sup> February 2022, requesting authorization to collect data in Rwamagana Provincial Hospital for health research, entitled "**Development of strategies for health Care Providers to sustain Respectful Maternity Care to women in Labour**", based on Ethics committee requirements and Research Committee recommendations, we are glad to inform you that the permission to collect data, is given to you. Therefore, you are requested to inform to Rwamagana Provincial Hospital Ethics Committee all modifications on your Research protocol and you will submit a copy of your research findings at the end of your work to Research committee.

Best regards.

  
Dr UTUMATWISHIMA Jean Népô Abdallah  
Director General



March 29<sup>th</sup> 2022

Ref No. 17/2022

Mrs Alice MUHAYIMANA

**RE : DATA COLLECTION PERMISSION**

After reviewing your research proposal entitled: "Development of Strategies for Health Care Providers to Sustain Respectful Maternity Care to Women in Labour." as PHD project; the Nyamata Hospital Ethics Committee have decided to give you permission to continue your research procedures.

The Ethics Committee finally recommends you to:

- Ensure if consent forms are signed before interview and administration of questionnaires to the participants,
- Ensure confidentiality of individual information,
- Submit a final copy of your Research findings after completion of the study,
- Consult Nyamata Hospital administration in case you need to publish the findings.

Yours sincerely.

Prepared by

**Dr Dyna NYAMPINGA**

Chairperson Ethic Committee

Approved by

**Dr William RUTAGENGWA**

Director General Nyamata District Hospital



P.O Box 7112 Kigali Rwanda, Phone :0780637766, Email : nyamata.hospital@moh.gov.rw



REPUBLIC OF RWANDA



Date: 10<sup>th</sup> April 2022

No.....Hop.Nyaga/2022

800

EASTERN PROVINCE

NYAGATARE DISTRICT

NYAGATARE DISTRICT HOSPITAL

**RESEARCH AUTHORISATION**

Dear Alice,

Please note that permission have been granted to conduct your research at Nyagatare District Hospital for the study **“Development of Strategies for Health Care Providers to Sustain Respectful Maternity Care to Women in Labor at Nyagatare District Hospital”**

We are happy to participate in this study and contribute to the important research and you are requested to present results of your study to Nyagatare District Hospital before publication

Thank you

Best regards

Dr NDAYAMBAJE K. Eddy

A handwritten signature in blue ink, appearing to be 'Eddy'.

Director General Nyagatare District Hospital



## Appendix U: Interview and Focus groups for phase 2a

1. To explore Health Care Providers **views of RMC** as reported by the women from Phase 1 of the study using **FGDs and Key Informant Interviews (Phase 2A)**

IDs are for maternity unit managers and doctors working in maternity services.

FGD are for nurses and midwives working in maternity services

---

**Q1. The mother appreciates receiving compassionate care. Tell me what you think can be done to achieve this.**

Probe: What do you propose to provide as care that is free from harm and ill-treatment?

Probe: What do you think can be done to show empathy to the mothers during labour?

**Q2. The mother appreciates having autonomy/independence in the care received. What do you think can work to achieve this?**

Probe: What do you propose to provide liberty to mothers in decision-making?

Probe: What can work to allow the mother to make her own choices and preferences during labour?

Probe: What do you think can be done to sustain informing the mother of her own health information and that of the newborn?

**Q3. The mother appreciates getting efficient care. What do you think can work to achieve this?**

**Q4. How do you think dignified care and respect can be sustained?**

**Q5. How would you maintain the privacy and confidentiality of women in labour?**

**Q6 Mothers desire to give birth by normal delivery.**

Probe: How can these aspects be upheld?

**Q7 Mothers desire to have a healthy baby.**

Probe: How can these aspects be upheld?

**Q8 Mothers desire to stay in a clean and tidy environment.**

Probe: How can these aspects be upheld?

**Q9. Mothers perceive that RMC is associated with love of persons and love for the profession.**

Probe: How can these aspects be sustained?

**Q10 The Community has different perspectives (either good or bad) on the care that women, receive during labour and the birth process.**

Probe: How can you propose to gain the community's trust back?

**Q11. What interventions or actions from the HCP would display RMC?**



Probe: What approaches to the woman in labour do you consider to be respectful by a healthcare provider?

Probe: What approaches to the woman in labour do you consider as respectful by hospital management?

Probe: What approaches to the woman in labour do you consider as respectful by health facilities?



#### [Appendix V: study information document for HCP \(Phase 2a\)](#)

#### **STUDY INFORMATION DOCUMENT for Unit managers and medical doctors (In-depth Interview)**

**Study title: Development of Strategies for Health Care Providers to Sustain Respectful Maternity Care (RMC) to Women in Labour.**

**Specific objective:** To explore Health Care Providers **views of RMC** as reported by the women from Phase 1 of the study

**Good morning/afternoon.**

#### **Introduction:**

My name is ALICE MUHAYIMANA. I am the Principal Investigator in this research study, and I am a PhD student in Witwatersrand University (Wits), Johannesburg, South Africa. The supervisor of this study is Dr. Irene Kearns. Research is a process used to seek new knowledge. I am carrying out the study to explore the status of Respectful Maternity Care (RMC) and to develop strategies to promote RMC in the Eastern Province of Rwanda. Please feel free to ask me as many questions as you wish before deciding upon participation.

#### **Invitation to Participate:**

I am inviting you to take part in this study because you are a healthcare professional involved in the delivery of maternity care in this hospital. Participation would involve taking part in an interview in a private location in the hospital at a time convenient to you. The interview will be conducted face to face, observing the normal COVID protocol, and will last for about 60-90 minutes. Refusal to participate will have no effect on your employment at the hospital.

#### **What is involved in the study:**

The objective of this individual interview is to get your views on what mothers have reported/recommended based on their experiences and perceptions related to RMC provision at the hospital. With your permission, I will record the interview so that I don't miss anything you say. I will not be keeping a record of your identity. The recording will be transcribed and retained for 2 years if a

publication comes out of the study or six years if there is no publication. The recording will be erased after transcription. The transcription will be kept on a password-protected computer.

The questions are not a test, so there is no right or wrong answer. My role as an interviewer is to listen and to record your answers. You may refuse to answer any questions that you do not feel comfortable answering. You may also say that you do not know the answer to a question.

#### **Risks of being involved in the study:**

There are no risks foreseen in relation to your participation in this study.

#### **Benefits of being in the study:**

There will be no immediate or direct benefits to you for participating in this study. However, it is hoped that your participation may help promote RMC in the future. There is no cost to you to participate. An incentive of 5000 Rwf will be provided to every participant who takes part in the interview.

#### **Participation is voluntary:**

Taking part in this study is voluntary. You also have the right to withdraw from participating at any time. If you withdraw, you will not be asked to identify the reasons for the withdrawal, and there is no penalty for withdrawal; any data collected on you will, by default, be destroyed unless you specifically consent to its retention.

#### **Anonymity:**

Your name and other identifying information will not be recorded anywhere. Confidentiality will be used in the whole process to provide information, to treat it, and to keep it. No individual participant will be identified in any report or publication arising out of this study.

#### **Outputs:**

Your participation will help to discover good practices with RMC and hence will build on best practices to develop strategies to promote and maintain RMC. I will be pleased to provide a summary of the study results at no cost to any participant requesting it.

#### **Contact details of researcher/s:**

In case of any further inquiries, you may contact Alice Muhayimana @ +250788687626 or by email at [2495590@students.wits.ac.za](mailto:2495590@students.wits.ac.za) or Dr Irene Kearns, Supervisor, by telephone no +27825940117, or by e-mail at [Irene.kearns@wits.ac.za](mailto:Irene.kearns@wits.ac.za).

#### **Ethics approval:**

I have been given ethical clearance by the Human Research Ethics Committee (Medical) from Wits University and the Institutional Research Board (IRB) from the College of Medicine and Health Sciences (CMHS) of the University of Rwanda. I have also received permission from the Ethics Committees of the five hospital sites where I will be conducting the study to conduct this research.

If there is any problem concerning your rights to participate in this study, you can contact the CMHS Institutional Review Board office in Kigali, Rwanda or call +250788563311

This study has been approved by the Human Research Ethics Committee (Medical) of the University of the Witwatersrand, Johannesburg ("Committee"). A principal function of this Committee is to safeguard the rights and dignity of all human subjects who agree to participate in a research project and the integrity of the research.

If you have any concerns over the way the study is being conducted, please contact the Chairperson of this Committee, Professor Clement Penny, who may be contacted on telephone number 011 717 2301 or by e-mail at [Clement.Penny@wits.ac.za](mailto:Clement.Penny@wits.ac.za). The telephone numbers for the Committee secretariat are 011 717 2700/1234, and the e-mail addresses are [Zanele.Ndlovu@wits.ac.za](mailto:Zanele.Ndlovu@wits.ac.za) and [Rhulani.Mukansi@wits.ac.za](mailto:Rhulani.Mukansi@wits.ac.za)

#### **Consent:**

If you agree to take part in this study, I will ask you to sign a Consent Sheet to record this fact and a second Consent Sheet to record your consent to being interviewed.  
Thank you for reading this Study Information Sheet.

February 2023



#### *Appendix W: Participant information sheet Focus Group Discussion (Phase 2a)*

**Study title: Development of Strategies for Health Care Providers to Sustain Respectful Maternity Care (RMC) to Women in Labour.**

**Objective:** To explore Health Care Providers' (Midwives and Nurses) **views of RMC** as reported by the women from Phase 1a and Phase 1b of the study.

**Good morning/afternoon.**

#### **Introduction:**

My name is ALICE MUHAYIMANA. I am the Principal Investigator in this research study, and I am a PhD student in Witwatersrand University (Wits), Johannesburg, South Africa. The supervisor of this study is Dr. Irene Kearns. Research is a process used to seek new knowledge. I am carrying out the study to explore the status of Respectful Maternity Care (RMC) and to develop strategies to promote RMC in the Eastern Province of Rwanda. Please feel free to ask me as many questions as you wish before deciding upon participation.

#### **Invitation to Participate:**

I am inviting you to take part in this study because you are a healthcare professional involved in the delivery of maternity care in this hospital. Participation would involve taking part in Focus groups in a private location in the hospital at a time convenient to all of you and would be conducted face to face in groups of 6-8 nurses and midwives, observing the normal COVID protocol and would last for about between 60-90 minutes. Refusal to participate will have no effect on your employment at the hospital.

**What is involved in the study:**

This is Focused Group Discussion with the objective of getting your views on what mothers have reported/recommended based on their experiences and perceptions related to RMC provision at the hospital. With your permission, I will record the discussion so that I don't miss anything you say. I will not be keeping a record of your identity. The recording will be transcribed and retained for 2 years if a publication comes out of the study or six years if there is no publication. The recording will be erased after transcription. The transcription will be kept in a password-protected computer.

The discussion is not a test, so there is no right or wrong answer. My role is to listen and to record the answers you provide in the Focus group discussion. You may refrain from discussing to the item that you do not feel comfortable answering.

**Risks of being involved in the study:**

There are no risks foreseen in relation to your participation in this study.

**Benefits of being in the study:**

There will be no immediate or direct benefits to you for participating in this study. However, it is hoped that your participation may help promote RMC in the future. There is no cost to you to participate. An incentive of 5000 Rwf will be provided to every participant who takes part in the Focus Group Discussions.

**Participation is voluntary:**

Taking part in this study is voluntary. You also have the right to withdraw from participating at any time. If you withdraw, you will not be asked to identify the reasons for the withdrawal, and there is no penalty for withdrawal; any data collected on you will, by default, be destroyed unless you specifically consent to its retention.

**Anonymity:**

Your name and other identifying information will not be recorded anywhere. No individual participant will be identified in any report or publication arising out of this study. However, because of the group nature of a Focus Group, this activity cannot be either confidential or anonymous (you may recognize one another) during the data collection. I kindly ask you to treat the discussions as confidential.

**Outputs:**

Your participation will help discover good practices with RMC and build on best practices to develop strategies to promote and maintain RMC. I will be pleased to provide a summary of the study results at no cost to any participant requesting it.

**Contact details of researcher/s:**

In case of any further inquiries, you may contact Alice Muhayimana @ +250788687626 or by email at [2495590@students.wits.ac.za](mailto:2495590@students.wits.ac.za) or Dr Irene Kearns, Supervisor, on telephone no +27825940117, or by e-mail at [Irene.kearns@wits.ac.za](mailto:Irene.kearns@wits.ac.za).

## **Ethics approval:**

I have been given ethical clearance by the Human Research Ethics Committee (Medical) from Wits University and the Institutional Research Board (IRB) from the College of Medicine and Health Sciences (CMHS) of the University of Rwanda. I have also received permission from the Ethics Committees of the five hospital sites where I will be conducting the study to conduct this research.

If there is any problem concerning your rights to participate in this study, you can contact the CMHS Institutional Review Board office in Kigali, Rwanda or call +250788563311

This study has been approved by the Human Research Ethics Committee (Medical) of the University of the Witwatersrand, Johannesburg ("Committee"). A principal function of this Committee is to safeguard the rights and dignity of all human subjects who agree to participate in a research project and the integrity of the research.

If you have any concerns over how the study is being conducted, please contact the Chairperson of this Committee, Professor Clement Penny, who may be contacted by telephone at 011 717 2301 or by e-mail on [Clement.Penny@wits.ac.za](mailto:Clement.Penny@wits.ac.za). The telephone numbers for the Committee secretariat are 011 717 2700/1234, and the e-mail addresses are [Zanele.Ndlovu@wits.ac.za](mailto:Zanele.Ndlovu@wits.ac.za) and [Rhulani.Mukansi@wits.ac.za](mailto:Rhulani.Mukansi@wits.ac.za)

## **Consent:**

If you agree to take part in this study, I will ask you to sign a Consent Sheet to record this fact and a second Consent Sheet to record your consent to participate in this Focus group.

Thank you for reading this Study Information Sheet.  
2023

February

## **Appendix Y: Co-Author Agreement**

### **Co-Author Agreement**

#### **Declaration: Student's contribution to article(s) and agreement of co-author(s)**

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**Date:** 05 February 2024

**Name of Supervisor:** Dr Irene Josephine Kearns

**Signature of Supervisor:** Irene. J. Kearns

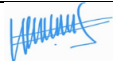
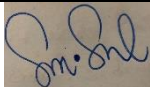
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**Article1. Title:** Muhayimana A, Kearns IJ, Gishoma D, Tengera O, Uhawenimana TC. Reported Respectful Maternity Care received during childbirth at health facilities: a cross-sectional survey in Eastern province, Rwanda. (2023)

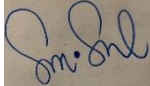
**Journal name:** Journal of Midwifery, Elsevier

**Status (Under reviewer)**

| Authors                | Names                            | Signatures                                                                         | Dates                          |
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| 1 <sup>st</sup> author | Alice Muhayimana                 |   | 05 February 2024               |
| 2 <sup>nd</sup> author | Dr. Irene Josephine Kearns       | <i>Irene. J. Kearns</i>                                                            | 09 <sup>th</sup> February 2024 |
| 3 <sup>rd</sup> author | Prof. Darius Gishoma             |  | 14 <sup>th</sup> February 2024 |
| 4 <sup>th</sup> author | Olive Tengera                    |  | 12 February 2024               |
| 5 <sup>th</sup> author | Dr. Thierry Claudien Uhawenimana |  | 10 February 2024               |

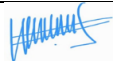
**Article 2. Title:** Muhayimana A, Kearns IJ, Gishoma D, Tengera O, Uhawenimana TC. Experiences and perceptions of respectful maternity care during childbirth in health facilities of Eastern province of Rwanda: An Appreciative Inquiry. (2024)

**Journal name:** Plos One      **Status (Under reviewer)**

| Authors                | Names                            | Signatures                                                                           | Dates                          |
|------------------------|----------------------------------|--------------------------------------------------------------------------------------|--------------------------------|
| 1 <sup>st</sup> author | Alice Muhayimana                 |   | 05 February 2024               |
| 2 <sup>nd</sup> author | Dr. Irene Josephine Kearns       | <i>Irene. J. Kearns</i>                                                              | 09 <sup>th</sup> February 2024 |
| 3 <sup>rd</sup> author | Prof. Darius Gishoma             |  | 14 <sup>th</sup> February 2024 |
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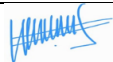
**Article 3. Title:** Muhayimana A, Kearns I. " I credit the midwives for saving my child's life": Providers' Perceptions on Respectful Maternity Care and Reflections on their Best Practices Experiences with Mothers in Rwanda (2024).

**Journal name:** *Clinical Services Research Journal*      **Status (Under reviewer)**

| Authors                | Names                      | Signatures                                                                        | Dates                          |
|------------------------|----------------------------|-----------------------------------------------------------------------------------|--------------------------------|
| 1 <sup>st</sup> author | Alice Muhayimana           |  | 05 February 2024               |
| 2 <sup>nd</sup> author | Dr. Irene Josephine Kearns | <i>Irene. J. Kearns</i>                                                           | 09 <sup>th</sup> February 2024 |

**Article 4. Title:** Muhayimana A, Kearns I. Healthcare Providers' Perspectives on Sustaining Respectful Maternity Care Appreciated by Mothers in Five Hospitals of Rwanda (2024)

**Journal name:** *BMC, Nursing*      Status (**Under reviewer**)

| Authors                | Names                      | Signatures                                                                        | Dates                          |
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| 1 <sup>st</sup> author | Alice Muhayimana           |  | 05 February 2024               |
| 2 <sup>nd</sup> author | Dr. Irene Josephine Kearns | <i>Irene. J. Kearns</i>                                                           | 09 <sup>th</sup> February 2024 |

Appendix Z. Originality Report

**Submission date:** 14-Mar-2024 02:39AM (UTC+0300)  
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