HEALTHCARE PROVIDERS' POSITIVE AND CHALLENGING EXPERIENCES IN IMPLEMENTING THE NON-MEDICAL ELEMENTS OF RESPECTFUL MATERNITY CARE AT NYAMAGANA DISTRICT HOSPITAL IN TANZANIA

Ivony Issack Kamala, RN

Master of Public Health Dissertation
Muhimbili University of Health and Allied Sciences
October 2024

Muhimbili University of Health and Allied Sciences

School of Public Health and Social Sciences

HEALTHCARE PROVIDERS' POSITIVE AND CHALLENGING EXPERIENCES IN IMPLEMENTING THE NON-MEDICAL ELEMENTS OF RESPECTFUL MATERNITY CARE AT NYAMAGANA DISTRICT HOSPITAL IN TANZANIA

By

Ivony Issack Kamala

A Dissertation Submitted in (Partial) Fulfilment of the Requirements for the Degree of Master of Public Health of

Muhimbili University of Health and Allied Sciences
October 2024

CERTIFICATION

The undersigned certifies that they have read and hereby recommends for acceptance by Muhimbili University of Health and Allied Science a dissertation titled; **"Healthcare providers' positive and challenging experiences in implementing the non-medical elements of respectful maternity care at Nyamagana District Hospital in Tanzania"**, in (partial) fulfilment of the requirement for the degree of Master of Public Health of the Muhimbili University of Health and Allied Sciences.

_____

Dr. Emmy Metta

(Supervisor)

_____

Date

_____

Dr. Amani Anaeli

(Co-Supervisor)

_____

Date

DECLARATION AND COPYRIGHT

I, **Ivony Kamala**, declare that this **dissertation** is my original work. It has not been presented and will not be presented to any other university for a similar or any other degree award.

Signature…… **Date**…….…….

This dissertation is a product of my intellectual labour and is therefore protected under the Berne Convention, the Copyright Act 1999, and other international and national enactments. It may not be reproduced by any means, in full or in part, except for short extracts in fair dealing, for research or private study, critical scholarly review or discourse with an acknowledgement, without the written permission of the Directorate of Postgraduate Studies, on behalf of both the author and the Muhimbili University of Health and Allied Science.

ACKNOWLEDGEMENTS

First and foremost, I would like to express my profound gratitude to the most gracious and merciful God for His continuous blessings throughout this study.

This dissertation is the culmination of dedication and support from various individuals and institutions in two semesters.

I extend my heartfelt thanks to the Laerdal Foundation (LF) for their financial support, which enabled me to pursue my MPH studies at Muhimbili University of Health and Allied Sciences, conduct this study, and ultimately complete this course.

I am deeply grateful to my supervisors, Dr. Emmy Metta and Dr. Amani Anaeli, for their invaluable supervision, constructive criticism, and constant encouragement throughout the development and completion of this research.

My appreciation goes to Ms. Elisa Vandervort from The University of Vermont Health Network, Ms. Sara Lafontan from Oslo Metropolitan University, Alen Kinyina RMNCAH Technical Advisor, and Prime Health Initiative Tanzania from Geita Region for their guidance during the development of the respectful maternity care concept. Their steadfast support, companionship, and active involvement greatly contributed to the successful completion of this study.

I would also like to sincerely thank the Council Medical Officer, Dr. Sebastian Pima of Nyamagana district council, for his swift response and permission to conduct this study in their facilities.

Lastly, I am immensely grateful to my family for their endless support, patience, and encouragement during this journey. Their belief in me was a constant source of motivation.

DEDICATION

I would like to dedicate this work to my beloved mother, Mrs. Revina Kamala, whose unwavering love and dedication have been the cornerstone of my journey. She inspires me daily to strive towards providing respectful maternity care. Her constant check-ins, prayers, and words of encouragement have been my source of motivation and strength. I owe everything I am today to her nurturing spirit and relentless support. It is my deepest hope that this study will illuminate the path to implementing respectful maternity care for women in Tanzania and beyond, reflecting the compassion and commitment she embodies.

ABSTRACT

Background: The World Health Organization emphasizes integrating and providing respectful maternity care (RMC) as a universal human right to improve maternal and neonatal health outcomes. However, despite this emphasis, exploring RMC through the healthcare workers' perspective, particularly regarding the non-medical elements, remains inadequately documented, especially in Low—and Middle-Income Countries (LMICs) like Tanzania. The relationship between non-medical RMC and quality of care is crucial in shaping the birth experience and influencing birth outcomes, particularly in the Tanzanian context. Therefore, a deeper exploration of how this is implemented from a provider's perspective is needed to understand the implications on maternal health outcomes better.

Objective: To explore the experiences of health care providers in implementing non-medical elements of respectful maternity care at Nyamagana District Hospital in the Mwanza region.

Methods: This qualitative study employed the phenomenological design using in-depth interviews with 12 nurses selected through purposive sampling. The interviews were audio recorded, transcribed, translated, and thematically analyzed using Braun and Clarke's method. The thematic analysis enabled the identification of key themes regarding dignity, confidentiality, and communication in the provision of RMC.

Results: Three main themes emerged: dignity, confidentiality and communication, each with specific barriers and facilitators affecting RMC implementation. Study participants reported several challenges, including high patient load, inadequate facilities and insufficient training, which affected their ability to uphold dignity and maintain confidentiality. Shared spaces hindered privacy, with high workloads and limited communication skills training impeded effective communication with patients. Despite these barriers, the participants highlighted the significance of small acts of kindness and emphasized the positive impact of maintaining respect and empathy during maternity care.

Conclusion: The study highlights the need for ongoing training on RMC for healthcare providers. However, training alone is not enough; it must be coupled with efforts to strengthen health systems such as improving infrastructure for patient privacy, ensuring essential resources, cultivating a supportive work environment, and providing cultural competence training to enhance the quality of RMC, ensuring that all women receive dignified, respectful and confidential care during childbirth.

TABLE OF CONTENTS

CERTIFICATION i
DECLARATION AND COPYRIGHT ii
ACKNOWLEDGEMENTS iii
DEDICATION iv
ABSTRACT v
TABLE OF CONTENTS vi
LIST OF TABLES ix
LIST OF FIGURES x
ABBREVIATIONS xi
OPERATIONAL DEFINITIONS xii
CHAPTER ONE 1
1.0 INTRODUCTION 1
1.1 Background 1
1.2 Statement of the problem 3
1.3 Conceptual framework 4
1.4 Rationale 5
1.5 Research question(s) 6
1.5.2 Specific research questions 6
1.6 Research objective(s) 6
1.6.1 Main research objective 6
1.6.2 Specific objectives 6
CHAPTER TWO 7
2.0 LITERATURE REVIEW 7
2.1 Communication in the implementation of RMC 7
2.2 Dignity in the implementation of RMC 8
2.3 Confidentiality in the implementation of RMC 9
CHAPTER THREE 11
3.0 METHODOLOGY 11
3.1 Study design 11
3.2 Study context 11

3.3 Study population 13
3.4 Sampling procedures 13
3.5 Sample size 13
3.6 Data collection methods 13
3.7 Data collection procedure 14
3.8 Data management 15
3.9 Data analysis 16
3.10 Ethical considerations 16
3.11 Trustworthiness 17
CHAPTER FOUR 19
4.0 FINDINGS 19
4.1 Introduction 19
4.2 Dignity in RMC implementation 20
4.2.1 Support from colleagues and administration 21
4.2.2 Personalized care 21
4.2.3 Cultural and social factors 22
4.2.4 Barriers and best practices 23
4.3 Confidentiality in RMC 23
4.3.1 Policies and procedures 23
4.3.2 Privacy and information management 24
4.4 Communication in RMC 26
4.4.1 Support from colleagues and administration 26
4.4.2 Training and awareness 26
4.4.3 Communication strategies 27
4.4.4 Interpersonal Communication 28
4.4.5 Feedback mechanisms 28
CHAPTER FIVE 30
5.0 DISCUSSION 30
5.1 Introduction 30
5.2 Dignity in RMC implementation 30
5.2.1 Support from colleagues and administration 31
5.2.2 Personalized care 31

5.2.3 Cultural and social factors 32
5.2.4 Barriers and best practices 33
5.3 Confidentiality in RMC implementation 33
5.3.1 Policies and procedures 34
5.3.2 Privacy and information management 34
5.4 Communication in RMC implementation 35
5.4.1 Support from colleagues and administration 35
5.4.2 Training on communication in RMC 35
5.4.3 Communication strategies 35
5.4.4 Cultural and social factors 36
5.6 Policy Implications 37
5.6 Strengths and limitations of the study 37
5.6.1 Study strengths 37
5.6.2 Study limitation 38
CHAPTER SIX 39
6.0 CONCLUSION AND RECOMMENDATION 39
6.1 Introduction 39
6.2 Conclusion 39
6.3 Recommendations 40
REFERENCES 41
APPENDICES 51
Appendix 1: Consent form English version 51
Appendix 2: Consent form – Swahili version 53
Appendix 3: Interview guide –English version 55
Appendix 4: Interview guide – Swahili version 58
Appendix 5: Approval for ethical clearance 61
Appendix 6: Permission letter 63
Appendix 7: Digital receipt 64
Appendix 8: Plagiarism report 65

LIST OF TABLES

Table 1: Perinatal indicators in Mwanza region of Tanzania..... 12

Table 2: Participants' characteristics 19

Table 3: Identified themes and sub-themes related to the experience of implementing RMC at Nyamagana DH, Mwanza..... 20

LIST OF FIGURES

Figure 1: The implementation of non-medical elements of RMC..... 4

Figure 2: Map of Mwanza (in bright yellow) and other surrounding regions in the Lake Zone of Tanzania. 12

ABBREVIATIONS

ANC	Antenatal Care
BEMONC	Basic Emergency Maternal Obstetric and Neonatal Care
DH	District hospital
ERB	Ethical Review Board
HC	Health Centers
HCP	Health Care Provider
HF	Health Facility
IDI	In-Depth Interview
IRB	Institutional Review Board
LMICs	Low and Middle-Income Countries
MIS	Malaria Indicator Survey
MUHAS	Muhimbili University of Health and Allied Sciences
PNC	Postnatal Care
RMC	Respectful Maternity Care
RRH	Regional Referral Hospitals
SBBC	Safer Births Bundle of Care
TDHS	Tanzania Demographic and Health Survey
TZS	Tanzanian Shillings
WHO	World Health Organization

OPERATIONAL DEFINITIONS

Professional culture in healthcare is a set of beliefs, values, and practices shared among healthcare providers within a facility that influence their approach to providing RMC. (Bohren et al., 2020)

Health care provider: Any member of the health workforce who engages directly with patients to provide care and treatment, including but not limited to doctors, nurses, midwives, and other allied health professionals who can deliver maternity care (Kruk et al., 2018),

Health facility (HF): Any location where health care services are provided, including hospitals, clinics, and maternity homes, particularly those that offer antenatal, childbirth, and postnatal care (McCauley M et al 2018).

Respectful Maternity Care (RMC): A healthcare approach that upholds a woman's dignity, ensures her privacy and confidentiality, protects her from harm and mistreatment, and supports her right to make informed decisions about her health, guaranteeing continuous support throughout labour and childbirth (Shakibazadeh et al., 2018).

The non-medical elements of respectful maternity care (RMC) refer to the non-clinical components of maternity care that involve delivering healthcare services. These are actions and behaviours that acknowledge and prioritize women's psychological, emotional, cultural, and social needs throughout labour and childbirth, thereby affecting the labour and delivery experience (Bohren et al., 2015; Afulani et al., 2019).

Dignity in RMC: This refers to active respect for recognition of each woman's inherent value and worth during maternity care, ensuring her comfort, privacy, and respect throughout childbirth. It is achieved by healthcare providers who engage in empathetic interactions, uphold the woman's rights to make informed decisions about her care, and support her emotional and psychological well-being (Jolivet et al., 2018; Bradley et al., 2016).

Confidentiality in RMC involves the obligation to protect personal and sensitive information shared by women during maternity care, ranging from medical history to individual concerns and preferences, and keep it secure and disclosed only with explicit consent or as required by law. This protection extends to all patient interactions and records,

emphasizing creating a trusted environment where personal information is safeguarded against unauthorized access, use, or disclosure (Shakibazadeh et al., 2018).

Communication in RMC: This involves providing a transparent, understandable, respectful, and empathetic exchange of information between healthcare providers and pregnant women and their families. It also involves actively listening to the women's concerns and preferences about care options, procedures, and any medical interventions, ensuring that women are fully informed and able to participate in decision-making regarding their care (Kruk et al., 2018; Bohren et al., 2017).

Communication strategies in RMC: Techniques and methods used by healthcare providers to effectively engage with and understand the needs of pregnant women, ensuring a respectful and supportive environment (Bohren et al., 2019).

Low and middle-income countries (LMICS): Countries classified by the World Bank based on gross national income per capita and usually riddled with healthcare delivery challenges, including limited resources and infrastructure i.e. Tanzania, Ethiopia, Bangladesh, Nigeria and Ghana. (Afulani et al., 2019).

Quality of care in LMICs: Measured by how health care services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge, such as the context of RMC (Tunçalp et al., 2015).

Patient abuse: Any form of verbal, physical, or emotional abuse directed towards pregnant women by healthcare providers contrary to the principles of RMC (Bohren et al., 2019).

In-depth interviews (IDIs): This is a qualitative research method involving detailed, one-on-one interviews designed to explore deep insights into individuals' behaviours, attitudes, and experiences (Jolivet et al., 2018; Filby et al., 2016).

Institutional review board (IRB): A committee tasked with reviewing research proposals to ensure ethical standards are maintained, participants are protected from harm, and research is conducted with integrity and in compliance with ethical guidelines (Freedman et al., 2018).

Tanzanian shillings (TZS): The currency of Tanzania as the budgetary unit for the study.

CHAPTER ONE

1.0 INTRODUCTION

1.1 Background

Respectful Maternity Care (RMC) is a healthcare model that advocates for a woman's dignity and privacy and the right to make informed decisions during childbirth. RMC ensures women's dignity, promotes their right to informed decision-making during maternity care, and enhances the effective use of health facilities to reduce maternal mortality and improve perinatal outcomes. This is especially critical in Low-and Middle-Income Countries (LMICs) like Tanzania, where challenges in the healthcare system affect both maternal and neonatal outcomes. The current state of the health system calls for immediate improvements focusing on the importance of women's autonomy and informed choice as key to enhancing maternal and neonatal outcomes, highlighting the necessity for a fundamental change in how healthcare is delivered (1,2). There are 12 principles of RMC, which are a combination of non-medical elements like communication, informed consent, autonomy, privacy and confidentiality, dignity, protection against harm and mistreatment and the provision of comprehensive information, with medical components like continuous maternity care, efficient and effective care and skilled human resources (3). RMC is an indicator of healthcare quality and is acknowledged as an essential strategy for enhancing the standard and utilization of maternity care (4). Respected and dignified women are highly likely to feel empowered to make decisions about their care and have more pleasant birth experiences a benefit that comes with improved maternal and better perinatal outcomes (5).

Despite the clear benefits of RMC, disrespect and abuse (D&A) during childbirth remains a prevalent public health issue of concern globally with profound implications in Sub-Sahara Africa. For instance, 44.09% of women in the region reported experiencing D&A during childbirth in medical facilities (6) and in Eastern Africa, one in five faced humiliation during labour (7). The impact of such experiences is profound, contributing to delays in seeking care, distrust in the healthcare system, and poor maternal health outcomes. Early research in Tanzania highlighted this loss of trust and its negative impact on health-seeking behaviour (8). Tanzania presents a concerning picture where 15-25% of mothers reported mistreatment, attributing it to a mix of social, cultural, medical, and personal concerns (9) and a staggering

70% during community follow-up after facing D&A immediately post-partum (10). Despite subsequent calls to action for research and improved RMC practices through the human-rights lens (11), RMC violations are not uncommon, identifying discrepancies in the appropriate provision and perception of RMC among healthcare providers (7) and the issue of inadequate infrastructure.

In the context of Tanzania, where resource constraints and cultural norms can significantly influence the practice of RMC (12–16), the provider is an essential component in implementing RMC. As a nation, Tanzania has seen remarkable progress in enhancing its health system, particularly in the medical sector, as evidenced by the significant strides in expanding infrastructure. (17,18), health financing (19) and referral systems (20). Furthermore, innovative projects in the lake zone, such as Safer births Bundle of Care (SBBC) (21), have been launched to tackle maternal and neonatal mortality and morbidities, showcasing innovative tools, simulation training and use of data whereby empowering healthcare works to decrease perinatal mortality by up to 50% (22). However, the appropriate implementation of RMC non-medical elements at the healthcare provider level remains understudied.

RMC literature has mainly focused on mothers' (or their partner's) experiences of D&A (15,23–25), which often has villainized and overshadowed the healthcare providers' viewpoint. Such evidence became instrumental in identifying the effects of inadequate RMC on maternal and neonatal outcomes, thereby advocating for improved policies and practices that uphold dignity and respect in childbirth (26,27). Exploration into the experiences of healthcare providers has been done but in different settings, such as the healthcare system's medical interventions (28–31) and the healthcare provider's role in power dynamics. (28).

Additional research conducted in Nigeria (29) and Iran (30) both highlighted the significance of non-medical elements, particularly effective communication, directly influencing the quality of women's birthing experiences. By taking insights from similar backgrounds, the study seeks to add value to the importance of non-medical elements of RMC and yet it points out that implementation of RMC across different healthcare settings remains an open question.

1.2 Statement of the problem

Respectful maternity care is critical for protecting a woman's dignity during one of the most vulnerable times in her life. In Tanzania, the lack of appropriate implementation of RMC continues to compromise maternal health as one in five women in Eastern Africa who report experiencing humiliation during labour (7). Despite efforts like the Safer births Bundle of Care (SBBC) in Tanzania, which have improved maternal and perinatal outcomes through innovative tools, training and documentation (22,31–33), disrespect and abuse remain pervasive in the healthcare system. Tanzania has seen the maternal mortality rate decrease from 556 to 104 per 100,000 women, suggesting improved quality of care (5), however, with minimal investment in RMC, these achievements are fragile and if not checked, the country risks backtracking on this progress.

Known intrapartum care models, remain provider-centric, (34) often resulting in unnecessary clinical interventions, which violate women's rights to a dignified childbirth experience (12). This contributes to the mistrust in the healthcare system (9,10), further discouraging women from seeking care at the health facilities. RMC topic at least for Tanzania, focus either on victimizing the mother or placing blame on healthcare providers, neglecting the complex dynamics both parties face during the process of childbirth (35). Concurrently, studies also reveal numerous challenges in achieving consistent RMC, including lack of accountability mechanisms across healthcare settings, limited autonomy, and excessive workloads, which hinder the practical application of RMC principles (3,7,9,12,36). Understanding healthcare providers' experiences, especially their approach to delivering non-medical elements of RMC, is crucial in addressing these gaps, as the absence of D&A does not equate to RMC implementation.

Therefore, it is important to explore provider-specific definitions and experiences to ensure consistent application of RMC principles across different healthcare settings as an essential for improving care quality (37). Healthcare providers are essential in translating RMC principles into practice, and their insights can help identify systemic barriers that hinder the full implementation of respectful care. Exploring their experiences will offer valuable perspectives on overcoming challenges and improving maternity care quality, ensuring that all women in Tanzania receive the dignity and respect they deserve during childbirth.

1.3 Conceptual framework

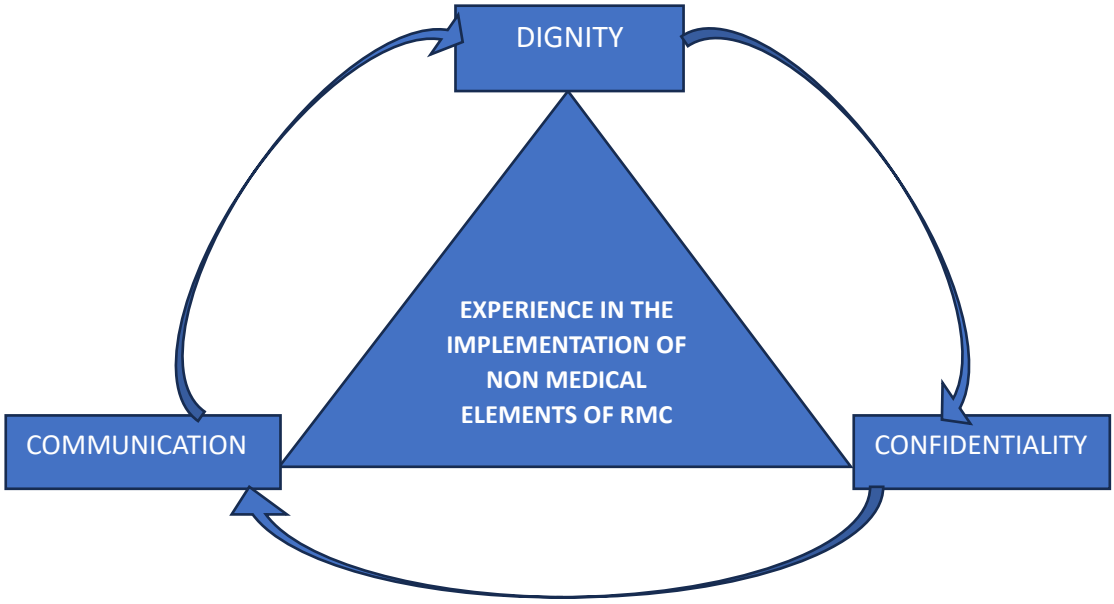


Figure 1: The implementation of non-medical elements of RMC

This framework illustrates that the successful implementation of non-medical elements of RMC requires a balanced and integrated approach where dignity, communication, and confidentiality are interdependent and equally prioritized. It also informs of the practical application of these three elements in maternity care settings, whereby the arrows connecting these elements indicate that improvements in one area can positively impact others, creating a holistic and supportive environment for both patients and healthcare providers in a maternity care setting. So, rather than a linear cause-and-effect relationship, these elements are mutually reinforcing, each strengthening the others to implement better and overall care. *Dignity and communication:* Effective communication can enhance the perception of dignity, as women feel valued and respected when they are listened to, informed, or involved in their care health decisions and interventions.

Communication and confidentiality: Clear communication about confidentiality policies reassures women that their privacy is protected, which can encourage openness and trust.

Dignity and confidentiality: Ensuring confidentiality is key to treating women with dignity, as it respects their privacy and personal boundaries.

1.4 Rationale

Mwanza region is a great area for understanding RMC due to its high fertility rate of 4.9 and the increasing demand for facility-based deliveries. Mwanza region offers comprehensive reproductive, maternal, and newborn health services across 359 reproductive child health facilities, (5) with 309 providing basic emergency obstetric and newborn care (BEMONC) and comprehensive emergency obstetric and newborn care (CEMONC) services. Mwanza benefits from over twenty active implementing partners, the highest in Tanzania, which have strengthened medical infrastructure through training, equipment, provision, and transport services in the region (38). Nyamagana district hospital, one of the largest public health facility, serving over 7,000 deliveries a year in a growing urban population and is central to the region's maternal health outcomes, making this a suitable setting for the study.

It is important to gain insight into healthcare providers' perspectives on RMC practices in Mwanza, a region experiencing a rise in facility-based deliveries and economic growth. This study seeks to understand providers' experiences, drive positive changes in maternity and newborn care, and ensure that policies are aligned with providers' experiences.

1.5 Research question(s)

1.5.1 Main research question

What is the experience of healthcare providers in implementing the non-medical elements of respectful maternity care at Nyamagana district hospital?

1.5.2 Specific research questions

1. What is the experience of healthcare providers in upholding dignity when providing respectful maternity care?
2. What is the experience of healthcare providers ensuring confidentiality when providing respectful maternity care?
3. What are the communication experiences among healthcare providers when providing respectful maternity care?

1.6 Research objective(s)

1.6.1 Main research objective

To explore healthcare providers' experiences in implementing non-medical elements of respectful maternity care at Nyamagana district hospital.

1.6.2 Specific objectives

1. To explore the experience of healthcare providers in upholding dignity when providing respectful maternity care.
2. To identify healthcare providers' experience in maintaining patient confidentiality while delivering respectful maternity care
3. To explore communication experiences among healthcare providers when providing respectful maternity care.

CHAPTER TWO

2.0 LITERATURE REVIEW

It is not uncommon for critics to say that healthcare providers do not offer adequate or appropriate RMC based on available medical domains without considering their experience in providing non-medical domains, such as effective communication and confidentiality. While medical elements have a direct association with maternal and perinatal outcomes (40), a mother's decision to seek medical care may be influenced by non-medical factors such as dignified care, communication, and confidentiality provided by service providers. This study sought to explore the healthcare providers' experiences providing those non-medical elements, concentrating on their viewpoint. Additionally, it aims to learn manageable ways to improve RMC delivery and ensure that mothers get respectful care before, during, and after childbirth.

2.1 Communication in the implementation of RMC

It is globally known that building trust and understanding in a multicultural hospital setting requires effective, goal-oriented, culturally sensitive communication (39). This enables nurses to recognise patients' individuality and build strong interpersonal relationships. In an Iranian study (30) the midwives' perspectives suggested it was important to maintain effective interpersonal communication between caregivers and women during labour and delivery. While midwives recognize the importance of communication, the findings indicate that practical strategies to implement such communication effectively, particularly under high-stress conditions, are often lacking. Standardized protocols and continuous training are needed to ensure consistent and culturally competent communication across diverse healthcare settings.

In LMICs, communication norms are not uniformly implemented, which is frequently caused by differences in healthcare practitioners' educational backgrounds, among other factors (40). This lack of consistency shows the need for standardized communication practices, especially towards vulnerable populations like birthing mothers.

In Tanzania, the function of effective communication is inconsistent in application. Cultural inadequacy and timely communication procedures indicate the need for open norms and recommendations in healthcare settings (1). The country continues to struggle with a lack of thorough grasp of the policy and structural changes implemented in the RMC that was published in 2017 and 2019 (26). Mothers or partners are quick to judge health provided with a lack of communication and would even blame the outcome on their layman's perceptions. However, there is an absolute need for a study to explore the experiences of giving RMC since several reports reveal varying degrees of knowledge and practice that impact the level, timeliness, and comprehensiveness of information communicated to the mother, especially if there was a negative outcome (41) Therefore, the study seeks to explore how healthcare providers utilize communication to ensure RMC and the effect of this on the provision of care.

2.2 Dignity in the implementation of RMC

Health providers have the duty and responsibility to uphold the dignity of their patients in addition to ethical and legal obligations to provide the best care possible (42). Maintaining dignity could be defined as when the healthcare providers allow their inner powers to act in a way that is beneficial to the patient, taking time and revering the patient with kindness and patience and having the courage to see what they are not ready to see (42)

In a global address on RMC, the right to dignified care during childbirth is emphasized. Despite this understanding, non-consented care is a persistent problem in real practices, which frequently falls short (24). The prevalence of patient abuse reported features a systemic issue not isolated to a single region, such as inadequate staffing, and high patient-to-provider ratios, emphasizing the need for cultural and behavioural shifts in healthcare provision. However, the absence of mistreatment alone does not automatically mean the maternal care provided is respectful and dignified (37)

Within the context of LMICs, the complexities of RMC provision are increasingly documented, emphasizing its significance for both healthcare providers and recipients (30,34). These complexities often stem from deeply ingrained cultural norms and resource constraints, which require multifaceted interventions to address effectively (43). Lack of

resources burdens inequalities in health care, and the large volume of clients in the service provision centres overwhelm the health care providers who become emotionally fatigued towards women in labour (7,44,45); hence, they do not hold patience nor dignity towards them (28). Emotional fatigue among healthcare providers is a critical barrier to RMC and suggests the need for supportive workplace policies and mental health resources for staff.

Regional barriers—such as inadequate training and infrastructure—hinder the implementation of RMC in Sub-Saharan Africa. It is also because inequities in comprehensive documentation and actual practice as established protocols for protecting privacy during childbirth are known (46), but not much is done to rectify the situation. It was then coined by (28) in Namibia as the notion of power dynamics, where healthcare providers undermine and dominate birthing mothers, especially when they are alone with helpless individuals. The larger socio-political issues significantly impacted their opinions, such as inadequate pay, excessive workloads, understaffing, and a lack of proper training and supervision. The cultural control and lack of accountability within healthcare institutions frequently compromise the dignity of maternity care (47).The implementation of dignified care in Tanzania has been addressed by two consecutive policies (26,27) on respectful maternity care in 2017 and 2019 respectively. However, structural inadequacies, gaps in reports and varied understanding stem from healthcare providers' practice and experience (48). In similar settings, the physical environment and professional culture influence the attitudes and actions of healthcare personnel and can either support or undermine the dignity of treatment (9,10). In 2022, nurse-midwives faced considerable challenges, including a lack of supportive supervision and essential medical supplies (49). Situations like these often result in the provision of inappropriate and undignified care for mothers. Given the improvement in infrastructure and support, the question arises: how can RMC be enhanced? Addressing the gap in healthcare experiences, particularly in the delivery of dignified care, is imperative to improving RMC for mothers.

2.3 Confidentiality in the implementation of RMC

Confidentiality between a healthcare professional and a patient is a fundamental duty that has long been established. Whether a patient is a murderer or a model citizen seeking treatment in a hospital, they have the right to feel secure in the knowledge that information

about his condition and course of treatment will be kept private between him and his medical team (50). It is universally acknowledged that confidentiality is a keystone of RMC and is necessary to preserve the integrity of the patient-provider relationship.

In LMICs, building confidence and guaranteeing that women receive courteous and secure maternity care are two reasons why confidentiality in healthcare is very important. A breach of a woman's health confidentiality can gravely endanger her well-being, bodily autonomy, and her right to be free from discrimination (51,52). However, structural issues, such as loose policy enforcement, can compromise the application of confidentiality requirements, leading to uneven adherence within the healthcare system. Issues including scarce healthcare resources, packed hospitals, and cultural traits, including the mother-in-law required at the bedside post-partum, which might not value personal privacy, make it more difficult to preserve confidentiality. A common deficiency of private areas in healthcare institutions leads to unintentional disclosures of personal information. The consequences of these breaches are severe; they may discourage women from seeking necessary intrapartum care out of concern or fear of shame and public exposure (53).

Confidentiality in healthcare refers to the ethical obligation to preserve authorized restrictions on access to and disclosures of sensitive personal information gathered in association with the care of a patient. This should not be just a concept; it is a pressing problem that influences the application of RMC.

An examination of Tanzanian medical practices in further detail indicates a scenario where demand for private care exceeds supply, making privacy maintenance challenging in a resource-constrained society (11). Despite their understanding of the need for privacy, medical practitioners may find it challenging to establish consistent procedures due to factors such as shared patient rooms and a scarcity of private consultation spaces.

Therefore, the study aims to explore how Tanzanian healthcare providers maintain confidentiality, dignity, and communication in RMC, addressing the gap between standard practices and actual implementation. It also examined privacy concerns and cultural contexts and how they affect the provision of RMC to improve practice-policy alignment and raise the bar for maternity care in Tanzania.

CHAPTER THREE

3.0 METHODOLOGY

3.1 Study design

The qualitative phenomenological design was adopted to enrich this study so as to capture the essence of these lived experiences (54) in the context of implementing and providing RMC. This study sought to understand how individuals experience, articulate, and interpret phenomena, in this case, the RMC. It involved in-depth interviews with individuals with direct, lived experiences of phenomena in the study, which is RMC rather than secondhand experiences, to gather rich, descriptive data.

3.2 Study context

The study was conducted in Mwanza region at Nyamagana District Hospital. Maternal health services in Mwanza region cover antenatal care, childbirth, and postpartum care, provided at various healthcare levels, including Health Centers (HC), District Hospitals (DH), and Regional Referral Hospitals (RRH). Specialized attention for high-risk pregnancies is directed to secondary and tertiary centres, with additional support from private and faith-based clinics.

Nyamagana District Hospital is a Local Government Authority (LGA) public healthcare facility in the Butimba ward, Ziwa Street, in Nyamagana District, Mwanza Region. It is the public health facility in Mwanza region, with over 7000 deliveries annually. It was registered under the Ministry of Health of the United Republic of Tanzania in 1990. This facility is overseen by the Nyamagana Municipal Council (MC), and predominantly serves urban people in the Mwanza Region. Since its establishment on July 9, 1990, it has been offering comprehensive clinical care, including reproductive and child health services, health promotion, diagnosis and treatment for tuberculosis, malaria, cardiovascular illnesses, and HIV/AIDS.

Table 1: Perinatal indicators in Mwanza region of Tanzania (5)

Indicators	**Tanzania**	**Mwanza**
Total Population	61,741,120	3,699,872
Female Population	31,687,990	1,897,689
Women Of Reproductive Age	13,847,652	886,221
Number Of Women Childbearing Age	31,687,990	890,667
% women of reproductive age (from the female population)	43.7	46.7
Maternal Mortality Rate	104	NR
Neonatal Mortality Rate	24	NR
% Percentage Receiving ANC from A Skilled Provider	85	97.8
% Percentage births Delivered by Skilled HCP at HF	85	80.1
% Births Delivered by Skilled Provider	85	83.9
Total Fertility Rate	4.8	4.9
Teenage Pregnancy	22	16
Median First Pregnancy	20	19.6



Figure 2: Map of Mwanza (in bright yellow) and other surrounding regions in the Lake Zone of Tanzania.

3.3 Study population

The study included all nurses and medical attendants involved in maternal care, particularly those directly engaged in childbirth care within the labour ward. Eligible participants were healthcare providers—specifically nurses and medical attendants—who had worked in the maternity ward for at least 12 months, providing intrapartum, antenatal, and postnatal care.

3.4 Sampling procedures

Nurses with a minimum of 12 months of experience in the maternity department at Nyamagana district hospital were selected through purposive sampling. This approach targeted providers who had been actively involved in intrapartum, antenatal, or postnatal care prior to data collection and were willing to participate in interviews. The purposive sampling method was employed to intentionally select experienced providers in diverse roles within the maternity care setting, ensuring a comprehensive understanding of RMC practices and capturing the complexity and variability of their implementation at Nyamagana district hospital.

3.5 Sample size

The study utilized a range of 5 to 25 participants which is recommended for a phenomenological study (55). A total of 12 participants participated in this study. The final sample size was determined when no new themes emerged in the course of the interview of the participants. Data was continuously evaluated, interviews were concluded once the information became repetitive, and no further insights were gained.

3.6 Data collection methods

Data were collected using in-depth interviews (IDIs) conducted in Kiswahili to ensure clear communication and comfortable expression among nurses and medical attendants. The interviews were held in a convenient and comfortable environment within the health facility to facilitate thorough involvement and accurate data collection.

3.7 Data collection procedure

Prior to data collection, ethical approval was obtained from the relevant ethics committee. A research permit was secured from the region, municipal and finally health facility management to allow access to the labour ward and interaction with staff.

An initial meeting was held with the nursing manager and key personnel to introduce the study's objectives, procedures, and timelines. The purpose of this meeting was to ensure their support and address any concerns regarding the study.

Upon gaining permission, a rapport-building phase was initiated. Informal visits to the labour ward were conducted to observe the environment, meet the staff, and familiarize them with the study objectives. This phase was crucial to build trust and minimize disruption during formal data collection.

Nurses and medical attendants working in the labour ward were identified as potential participants based on their role and direct involvement in labour ward activities.

Each participant was approached individually and provided with detailed information about the study, including its purpose, confidentiality assurances, and voluntary nature of participation. Participants were given time to consider their involvement.

Consent was obtained in written form from all participants before any data collection commenced. A consent form outlining their rights, the study's purpose, and the use of collected information was provided, and participants signed after expressing willingness to participate.

In-depth Interviews (IDIs) were conducted with each participant using a structured interview guide. The guide was initially developed in English, then translated into Kiswahili to accommodate participants' language preferences and ensure clear understanding.

Interviews were conducted in a secluded setting within the labour ward or an adjacent designated room to ensure confidentiality and comfort for the participant.

Each interview lasted between 20 to 40 minutes and was audio-recorded with the participant's permission. Field notes were also taken during the interview to capture any non-verbal cues or additional observations.

The interview guide was designed to explore the healthcare providers' experiences, challenges, and suggestions related to their work in the labour ward. It allowed for probing questions based on the participant's responses to gather detailed insights.

At the end of each day, audio recordings were reviewed and skimmed through to evaluate the depth and relevance of the data collected. Emerging themes or notable patterns were identified and used to refine subsequent interview questions, ensuring a deeper exploration of relevant topics as they arose.

Adjustments to the interview guide were made when necessary to capture any new themes or emerging issues identified during the daily review.

Once data collection was completed, a debriefing session was conducted with the ward staff to thank them for their participation and to provide a summary of the study's next steps.

Participants were reminded that their data would be anonymized and securely stored. They were also informed about how to access the study's findings once it had been completed.

Any concerns or questions from the healthcare staff were addressed, and a summary of key takeaways was shared with the facility management to maintain a collaborative relationship.

The research process officially concluded with the submission of a formal report to the ethics committee.

3.8 Data management

Audio recordings from the interviews were transcribed verbatim in Kiswahili and later translated into English for analysis. Both versions were compared to ensure consistency and accuracy. Transcripts were stored securely on a password-protected computer, online to OneDrive, to which only the research team had access. After the final compilation of the record, the data was transcribed into a Word document and translated into English verbatim to keep the original meaning in the context of the collected data.

To ensure data quality, several measures were implemented. A pre-test was conducted to refine the interview guide, and standardised protocols ensured consistent data collection. All interviews were audio-recorded, transcribed verbatim, and cross-checked with field notes. Daily debriefing sessions identified emerging themes and guided adjustments. Triangulation,

member checking, and peer review validated the data, while anonymisation protected confidentiality. Data were securely stored, regularly backed up, and continuously monitored for quality, ensuring reliable and trustworthy findings.

3.9 Data analysis

A thematic analysis was utilized for the study, to enable the understanding and expansion of the experience of the implementation of non-medical elements of RMC by identifying, analyzing, and reporting emerging themes and patterns within the data. The thematic analysis utilized Braun and Clarke's 6-step method to examine the information gathered (56) . In the first step, familiarization with the data collected was thoroughly done which involved transcription and translation. Secondly, the transcript was read and reread, and coding was applied to the data to discover occurring and recurring patterns. Thirdly, themes were created from codes to represent re-occurring concepts. Fourth, a reflective process examined and improved the themes for validity and relevance. The fifth step was defining and naming themes, and finally, the sixth step was producing the report. The data was analyzed using NVivo software version 14 to manage and organize the qualitative data. The software facilitated the coding process, allowing the identification of recurring themes and patterns across the interviews. Braun and Clarke's six-step thematic analysis was applied to ensure a systematic approach to examining the experiences of healthcare providers in implementing RMC.

3.10 Ethical considerations

Before commencing the study, ethical approval was sought from the Institutional Review Board (IRB), which was then reviewed and approved by the Senate Research and Ethics Committee of the Muhimbili University of Health and Allied Health Sciences (MUHAS). Ethical clearance was granted with Ref. No.DA.282/298/01.C/221. In Mwanza Region, the Regional Health Office permitted the investigator and provided approval to proceed in the municipal of the research study. The council medical officer of Nyamagana also permitted the research to be conducted at Nyamagana district hospital and allowed the medical officer in charge (MOI) to introduce the investigator to the facility matron and later the labour ward in charge. This approval process also enabled the research to be conducted responsibly and

ethically across different governance and community engagement levels, particularly for Nyamagana District Hospital in Mwanza region.

Participants in the study were given clear and easy-to-understand information about its purpose and were reassured that they could withdraw at any time without facing any consequences. To protect the participants' anonymity and confidentiality, their names were not collected, and instead, only unique identifiers such as LW1, LW2, LW3 and so forth were used to represent participants and their working areas. This ensured their identities were safeguarded while allowing for accurate data tracking.

Rapport was first established, and the interviews were conducted afterwards to maintain participants' comfort. The questions were designed to be sensitive, relevant, and adjusted based on feedback when participants were unclear. Participants provided written informed consent after they were satisfied with the information before taking part in the study.

3.11 Trustworthiness

The study ensured the findings' reliability and validity, credibility, transferability, dependability, and confirmability (57)

i. **Triangulation**: The study ensured data richness by including healthcare providers from various units, such as the labour ward, antenatal ward, and post-natal ward, and different professional cadres and experiences to enhance the depth and credibility of the findings.
ii. **Credibility**: The study involved in-depth interviews (IDIs) and thorough reviews of relevant training materials, guidelines, and meeting records that discuss RMC in both general and specific terms to support the study findings. It provided comprehensive descriptions of the study context and procedures to facilitate the application of the findings to similar contexts. Additionally, it included direct quotes from providers.
iii. **Member checking**: After analyzing the interview data, the findings were shared with the healthcare providers to ensure accuracy and resonance with their experiences to clarify any ambiguities and add additional insights. By incorporating participants' feedback, the study aimed to ensure the authenticity and credibility of the data.

iv. **Peer debriefing**: The data and initial findings were discussed with researchers and experts in maternal health to gain diverse perspectives. Peer debriefing was carried out to identify biases, validate the analytical framework, and provide alternative perspectives. This feedback enhanced the study's reliability and ensured a more rigorous analysis.

v. **Thick description**: Detailed and contextualized accounts of participants' experiences were provided to convey the depth of data, helping readers understand the findings.

vi. **Reflexivity**: The researcher maintained a reflexive journal to record interactions, thoughts, and potential biases throughout the research process. All stages of the research, including participant recruitment and data analysis, were documented to ensure transparency. An audit trail documented all study decisions, ensuring replicability and enhancing the reliability of the findings.

vii. **Thorough literature review**: The study conducted a comprehensive review of existing literature to frame the study within the context of current knowledge, aiding in situating the findings and providing a basis for comparison.

viii. **Transferability**: This was addressed by providing an in-depth description of the research context, methodology, and findings. This detailed documentation would enable other researchers to assess the applicability of our study's findings to different settings, potentially broadening the impression and relevance of the study across various contexts.

ix. **Confirmability**: This was maintained by detailing a journal of events throughout the research process. This journal documented the researchers' reflections, biases, and decision-making process, providing a transparent account of how research influence was managed and minimized. This ensures that the findings are rooted in the collected data and are not unduly influenced by the researchers' preconceptions, allowing for the audit trail.

CHAPTER FOUR

4.0 FINDINGS

4.1 Introduction

This chapter presents the findings on healthcare providers' experience implementing the non-medical elements of RMC at Nyamagana District Hospital in the Mwanza region. Based on the literature and the participants' responses, this study's findings are presented in four thematic areas with identified subthemes. Below, each thematic area addresses the objectives of this study.

Characteristics of the participants

The participants had a mean age of 40 years and an average of 12 years of work experience. Among the 12 participants, 3 were male and 9 were female, all belonging to the nursing cadre. They held various roles, including in-charge positions, anaesthetists, midwives, and medical attendants. All participants had completed secondary education (Form 4); 8 had earned diplomas in nursing, and 1 held a bachelor's degree in nursing and midwifery. The table below shows their characteristics:

Table 2: Participants' characteristics

SN	Sex	Age	Level Of Education	Education Cadre	Years Of Experience	Years of Experience working in the labour ward	Code
1	F	32	Diploma	Nursing	10	7	LW1
2	F	54	Diploma	Nursing	11	7	LW2
3	F	34	Diploma	Nursing	9	9	LW3
4	F	35	Form four	Attendant	13	10	LW4
5	F	35	Diploma	Nursing	10	6	LW5
6	F	34	Diploma	Nursing	11	11	LW6
7	F	43	Diploma	Nursing	18	6	LW7
8	F	52	Diploma	Nursing	20	7	LW8
9	M	37	Form four	Attendant	10	4	LW9
10	M	30	Bachelor	Nursing	3	2	LW10
11	M	50	Form four	Attendant	20	10	LW11
12	F	41	Diploma	Nursing	14	13	LW12

Table 3: Identified themes and sub-themes related to the experience of implementing RMC at Nyamagana DH, Mwanza

THEME NUMBER	THEMES	SUB-THEMES
1	Dignity in RMC implementation	Support from colleagues and administration
		Personalized care
		Cultural and social factors
		Barriers and best practices
2	Confidentiality in RMC implementation	Policies and procedures
		Privacy and information management
3	Communication in RMC implementation	Support from colleagues and administration
		Training and Awareness
		Communication strategies
		Interpersonal communication
		Feedback mechanisms

The findings were inductively analysed, drawing on the experiences of healthcare providers and organised into thematic areas that aligned with the study's objectives. Each theme explored key factors influencing the implementation of RMC, focusing on dignity, confidentiality, and communication. The theme of dignity examined how healthcare providers ensured respectful treatment and upheld the patients' self-worth throughout care. Confidentiality focused on practices that protected patient privacy, fostering trust and comfort in the clinical environment. Communication addressed the importance of clear, compassionate, and effective interactions between providers and patients, essential for delivering quality RMC. These themes collectively provided a comprehensive view of the facilitators and challenges in RMC implementation.

4.2 Dignity in RMC implementation

The first theme was dignity in RMC implementation, consisting of four subthemes: support from colleagues and administration, personalized care, cultural and social factors, barriers, and best practices. The initial study objective was to explore the experience of healthcare

providers in upholding dignity when providing respectful maternity care. Therefore, the details regarding the subthemes are as follows:

4.2.1 Support from colleagues and administration

Under this subtheme, data analysis revealed challenges in ensuring and upholding dignity; therefore, teamwork and administrative support were very evident in delivering RMC. The nurses shared that the support from fellow providers and the administration was influential in ensuring they solved challenges and provided patients with respectful, best care. One of the participants stated:

> *"... if the administration provides sufficient support in addressing the challenges I encounter, we will find solutions together. Similarly, if team members in the ward show cooperation when challenges arise, we can solve them together, unlike if I were to handle them alone. Therefore, all three areas need to work together to achieve the common goal of helping the patient in a respectful and dignified manner"* (LW1).

4.2.2 Personalized care

The results showed that in order to uphold dignity, providers ensured women were treated with respect and individual consideration. Regarding personalised care, nurses tried to ensure women were treated with respect and individual consideration. They took intentional measures to ensure patient privacy, explaining procedures beforehand to create a comfortable environment and using gentle techniques. There were deliberate efforts to minimize discomfort and guarantee a dignified experience, especially during medical procedures. One of the study participants said:

> *"...if I need to examine the abdomen, I will not expose the breasts. When I need to examine the private parts, I will cover the abdomen and only expose the area I am working on"* (LW1).

The findings of this study show that due to the high volume of deliveries at Nyamagana district hospital, the labour ward would sometimes be overwhelmed by infrastructure constraints and inadequate beds, medical supplies, and screens. One of the participants said:

> *"...The target number is small compared to the reality; our facility was meant for 180 women, and up to 500 to 700 mothers deliver here. When it is time to deliver,*

> *and we involve the mothers, they do not understand because they have already heard that the equipment is free. This creates a challenge because we serve many mothers compared to the available equipment…"* (LW2).

Findings also indicate that patients are often relocated before completing the recommended observation period due to room shortages, contrary to standard protocols. Additionally, ethical standards would be upheld more consistently if adequate space were available. One of the participants also said:

> *"After a mother gives birth, we are supposed to monitor her for one hour, but due to a lack of rooms, we have to move her before the hour is up. If we had enough rooms, we could provide better care"* (LW3).

Curtains and screens during examinations and treatments help maintain physical privacy and uphold dignity. Personal attributes include incorporating patient values by recognizing and respecting each patient's personal values and preferences, which includes understanding their cultural, spiritual, and individual beliefs and incorporating these into the care plan. One of the study participants said:

> *"Do not see them just as someone with a problem but as human beings with dignity. Consider their humanity from the moment they arrive, how you receive them and talk to them. When you do that, the person will feel valued and appreciated for the care they received"* (LW7).

4.2.3 Cultural and social factors

The findings further revealed that, there were complex cultural dynamics in implementing dignified care. This involved understanding and respecting cultural norms while advocating for practices that ensure the dignity and comfort of the patients. Some strategies included engaging family members, using culturally appropriate communication, and requesting support from fellow staff members who understand the patients' cultural context. Nurses often utilize culturally appropriate contexts and respect patients' cultural and spiritual needs to ensure dignified and personalized care. One of the participants said:

"Regarding religion and culture, I always try to meet the patient's needs within my capacity. If something is beyond my ability, I inform them that I need to consult with someone else or that we should address it later. This ensures that the patient's cultural and spiritual needs are respected" (LW4).

4.2.4 Barriers and best practices

Several challenges to dignity were frequently mentioned, including how they were overcome. The providers utilized respectful language, obtained informed consent, and actively involved patients in decision-making. At times, providers demonstrated consideration by informing and involving mothers if they needed to attend to another patient requiring assistance, even during an ongoing medical procedure. A study participant shared:

"... If I am attending to a patient and suddenly the patient in the next room needs to deliver, I must inform the patient I am attending to that I need to help someone else and will return soon so they do not feel neglected" (LW3).

4.3 Confidentiality in RMC

The second theme was promoting confidentiality, with two subthemes: policies and procedures as well as privacy and information management. The initial study objective was to explore healthcare providers' practices in maintaining patient confidentiality while delivering respectful maternity care. The subthemes and their elaboration are as follows:

4.3.1 Policies and procedures

Findings from the study shows that, strict guidelines for maintaining patient privacy were reportedly well understood, outlining clear standards for protecting patient information and ensuring adherence among all providers. There were also strict protocols in place to regulate who can access patient information and under what circumstances. One of the participants said:

"There is a policy that states you are not allowed to share a patient's information without their consent. The patient must specify who can receive their information. You cannot tell any relative if the patient does not want anyone to be informed. Even if a relative asks for the patient's information, only the patient can inform the relative, not the healthcare provider" (LW1).

Compliance with known and unknown confidentiality policies at Nyamagana district hospital shaped their experiences in implementing and ensuring respectful maternity care. Participants of this study presents evidence that, maintaining confidentiality involved following strict protocols to protect patient information, which in turn influences patients' perceptions of being '*treated well*.' For instance, nurses described the importance of conducting private conversations in designated areas and using secure electronic systems for patient records. Adherence to confidentiality protects patient privacy and was meant to foster a sense of trust and respect within the healthcare environment. Providers reported that patients feel more secure and respected when they see their personal information is handled with care, knowing it will only be shared with authorized individuals. A study participant said:

> *"... I assure the mother that whatever we discuss or during examinations or when she has to undress, her body is only seen by me, and it remains confidential. When I explain this, the mother understands..."* (LW4).

Some study participants were unaware of the policies or did not acknowledge their existence. Instead, they relied on their personal and professional ethics to maintain patient confidentiality. Other nurses were aware of an unwritten policy promoting confidentiality but were very cautious in ensuring patient information remained confidential. One of the participants said:

> *"...I am not sure what kind of policies these are. However, the confidentiality I understand is about not disclosing or spreading a patient's information carelessly"* (LW7).

4.3.2 Privacy and information management

Confidentiality extends beyond just information handling; it also encompasses the physical environment in which care is provided. For instance, continuous comings and goings of people in the area where a patient is being attended to can compromise confidentiality. The study participants shared that they often ensured a controlled environment to guarantee privacy. However, constant traffic in the area where they attend to the patient undermines confidentiality. One of the study participants said:

> *"...the area where I attend to the patient should not have people coming and going to ensure privacy between the patient and me"* (LW1).

In their efforts to implement confidentiality, providers often received direct requests or signals from patients to keep their information strictly private. This occasionally included requests to withhold information from patients' partners, underlining the importance of respecting patients' wishes and maintaining their trust. One of the participants said:

> *"Another case is when a mother comes in, and her husband knows she is pregnant but does not know the details. After examining her, she tells you, 'I know my pregnancy is full term, but I have not told my husband.' This becomes a secret between you and her, even though it is a burden we share. During the examination, the mother might tell you, 'My husband thinks this pregnancy is seven or eight months along, but I know it is nine months.' When you ask, 'Why?' she responds, 'Do not tell him; the baby is not his.' So, you keep this secret and provide the necessary care* (LW4).

Secure electronic health records (EHR) systems and encrypted communication channels were beneficial in protecting patient information from unauthorized access. There was an emphasis on the security of these secure systems, noting that patient data is only accessible to those directly involved in the patient's care. On these measures, one of the respondents shared:

> *"With technology, we no longer rely on physical files. In the past, you might write a patient's information, and the file could get lost, or someone could take it and take pictures of it. With our system now, you must log in with your account and password and then log out, which means that information is only accessible through the relevant person's account* (LW1).

Evidence from this study shows that, sometimes inconsistent system performance, such as connectivity issues or breakdowns, can result in them returning to using paper-based information systems. Although there have been reports of inconsistent system performance, there were no reports whatsoever of breaches of patient information or confidentiality issues.

One of the participants said:

> *"The system is inconsistent; one day, it is working, and the next day, it is different or broken. You might find that they switch from digital records back to paper files, compromising confidentiality. Sometimes, patients are asked to buy notebooks, and doctors treat them using these notebooks, which patients then take home with all their information exposed"* (LW).

4.4 Communication in RMC

The third theme was communication, with five subthemes such as support from colleagues and administration, training and awareness, communication strategies, interpersonal communication, and feedback mechanisms. The initial study objective was to explore communication experiences among healthcare providers when providing respectful maternity care. Hence, the details on the subthemes proceed as follows:

4.4.1 Support from colleagues and administration

The study findings reveal that support from team members and administrative leadership was critical in addressing various challenges encountered during the implementation RMC. Participants reported that this collaborative support was instrumental in overcoming numerous obstacles, including those stemming from inadequate infrastructure and resource limitations. Effective teamwork, coupled with robust leadership support, was highlighted as a key factor in mitigating these implementation challenges. Often, the consultative process integral to patient care is demonstrated through open dialogue and collaboration among healthcare providers. One of the study participants said:

> *"...for me and my colleague, we must use medical language, discuss the patient, consult each other, and finally approach the patient to provide good care…."I see this patient is not doing well, so what do we do?" After discussing and agreeing, then we counsel the patient on what to do, something like that"* (LW9).

4.4.2 Training and awareness

The findings highlighted the need for training and education to improve communication strategies among healthcare providers. Several study participants noted insufficient training in RMC, particularly in client communication. They expressed that increased awareness

through targeted training could significantly enhance RMC implementation. One experienced study participant said:

> *"...I studied many years ago, so some things have changed. For example, how we used to remove the placenta years ago is different from how we do it now. The way we deliver a baby is different from the current practices. There have been changes over the years. Therefore, if we receive training, I think we can keep up with these changes. For example, in the past, a relative of the mother was not allowed in the labour ward, but now we allow it"* (LW2).

4.4.3 Communication strategies

The study found that, various strategies were used to communicate and implement RMC, with a strong focus on clear, appropriate language and simplifying complex information. Providers were often attentive listeners, offering straightforward explanations of medical procedures and using non-technical language to build trust and ensure patients felt respected and understood. However, in critical situations during labour, providers sometimes used a more assertive approach, viewing it as essential for ensuring the safety of both mother and child. As one study participants said:

> *"You find a patient in labour, right? The patient's baby is in the final stage of coming out, but she is struggling to push the baby out. If you are not strict with the patient, she might harm the baby. The strictness of the nurses at that moment is what the patient refers to as "the nurse is harsh." You cannot be too gentle with a patient in that stage because if she loses the baby, it will be a bigger issue. It is better to be strict with the patient so she can deliver safely, and afterwards, you can be friends"* (LW9).

The participants reported that differences in language and literacy levels could lead to misinterpretations and reduced patient satisfaction. They recommended the use of interpreters and culturally sensitive communication strategies to address these challenges. One study participant highlighted this approach by stating:

> *"Professional communication significantly affects the delivery of respectful maternity care. For example, when we talk about a "case," some people might*

> *misunderstand it as a legal case (K-E-S-I) instead of a medical case (C-A-S-E). To clarify, I explain that when we say "case," we are referring to our medical cases, such as case number two or three, not a court case. This helps avoid misunderstandings"* (LW8).

The study results presented the importance of tools and resources, such as interpreters, visual aids, and educational materials, for effective communication. Nurses recommended training in communication techniques and cultural competence to ensure clear, respectful interactions, helping mothers feel heard and supported.

4.4.4 Interpersonal Communication

Interpersonal dynamics and professional communication among healthcare providers were reported as integral to daily practice. Effective team communication and collaboration were essential for delivering coordinated, high-quality care. Mutual respect, clear communication, and teamwork fostered a supportive and collaborative environment, enabling nurses to work together effectively to ensure optimal patient care. This approach included side discussions about the patient, involving her actively in her care, and providing effective counselling.

4.4.5 Feedback mechanisms

Collecting and responding to patient feedback was recognised as essential for implementing and enhancing RMC for clients. One experienced nurse described the feedback process, stating:

> *"The feedback system here is not formal. Patients can directly tell you or even inform your supervisor that they appreciate a certain service. Sometimes, they might bring a gift to show their gratitude"* (LW1).

Despite varied perspectives among study participants, established systems for gathering patient feedback on their care experiences were in place and seen as essential for continuous improvement. Feedback was gathered through informal surveys, suggestion boxes, and direct conversations with patients and their families. As one of the study participants said:

> *"Patients have the freedom to give feedback through suggestion boxes, so they can provide their feedback, or relatives can do so, either by expressing gratitude or complaining about poor performance"* (LW2).

From the study, it was found that patient feedback was actively used to drive concrete improvements in care practices. This process involved analysing feedback, pinpointing areas for enhancement, and implementing changes to uphold respect and dignity in care delivery. At the facility, patient feedback—whether verbal or written—was systematically reviewed to identify recurring issues and refine communication strategies and practices. Follow-up measures were then put in place to assess the effectiveness of these adjustments and reinforce to patients that their input was valued. This approach was seen as instrumental in building trust and enhancing overall care quality. One of the study participants said:

> *"When reviewing the feedback, the first step is to contact the relevant department to address the complaints and confirm the existence of the issues. I think it is important not to blame specific individuals right away. It has generally handled it this way in the past, as it has been effective"* (LW3).

CHAPTER FIVE

5.0 DISCUSSION

5.1 Introduction

The literature highlights the twelve “domains” of respective RMCs, varying across countries and cultures (3)The focus on biomedical care often overshadows the importance of humanized care; whereby to address this disparity, it is imperative to explore how nonmedical aspects of RMC are put into practice (58,59)Elements like dignity, confidentiality, and communication greatly affect the experience of childbirth and how care is perceived. The study's findings indicate significant variations in healthcare providers' experiences, starting with dignity, confidentiality, and communication.

Dignity: Most study participants emphasized the importance of maintaining dignity during childbirth. However, systemic barriers such as staff shortages and workload often compromised their ability to provide personalized care. Participants mentioned that, despite their best efforts, they sometimes struggled to respect women’s dignity due to insufficient time and resources (47,60).

Confidentiality: study participants reported that ensuring patient confidentiality was often difficult due to the hospital’s infrastructural limitations. Shared wards and overcrowded delivery rooms made it challenging to protect patients’ personal information (61).

Communication: The study found that effective communication between healthcare providers and patients was inconsistent. Many providers acknowledged the importance of clear, respectful communication, yet they highlighted the lack of training in communication strategies, which hindered their ability to effectively engage with patients. Similar challenges have been documented in other low- and middle-income countries (62).

5.2 Dignity in RMC implementation

Dignity refers to respecting and recognizing a woman’s inherent value and worth during maternity care, ensuring her comfort, privacy and respect throughout childbirth (47) Providers who engage in empathetic interactions uphold the woman’s right to make informed

decisions about her care and support her emotional and psychological well-being to achieve this.

5.2.1 Support from colleagues and administration

Administrative support and backing up were important in promoting dignified care. The strong advocating leadership was instrumental in the implementation of policies and the provision of the necessary resources, even in other similar settings (63). On the other hand, a lack of administrative support can undermine efforts to improve dignified care, as observed in cases where inadequate funding and poor management practices led to inconsistent application of RMC principles (6). The study *"Caring for Providers to Improve Patient Experience"* in Kenya illustrated the benefits and challenges of supporting healthcare providers. While mentorship and peer support were beneficial, challenges such as high workloads and limited resources often hindered the consistent practice of dignified care (62). This indicates that despite the provision of support, management should also be effective.

5.2.2 Personalized care

The study revealed that at Nyamagana, factors such as the availability of cubicles contributed to providing mothers with dignified birthing experiences. However, due to the high volume of deliveries, labour ward staff were often overwhelmed, occasionally requiring mothers to be moved to the postnatal ward before they were fully ready for postnatal recovery.

This is consistent with a study in Ghana, the availability of essential resources like privacy screens and adequate space was critical for respecting patient privacy and ensuring comfort during childbirth (64). However, the resource limitation often led to compromised care, as seen in cases where overcrowded facilities and lack of basic amenities hindered the ability of providers to provide routine and even dignified care (65). Patient privacy is the core component of RMC. Providers took intentional steps to respect privacy and ensure dignity. The study by Kassa et al., (6) featured that non-confidential care was a significant issue in sub-Saharan Africa maternity wards, where physical infrastructure often failed to provide adequate privacy. To address this issue, it recommended training healthcare providers on the importance of privacy and creating private spaces within facilities.

Effective practices to uphold dignity included using covered examination areas, seeking consent before procedures to ensure privacy and respect, and prioritizing patients' comfort by covering them even when in examination (60,66,67). The providers nurses at Nyamagana made it a top priority to minimize patient discomfort. They ensured that procedures were explained beforehand and took measures to provide a comfortable environment. This aligns with a study in Tanzania, where providers emphasized compassionate care and effective pain management to reduce discomfort during labour and delivery (8) as advocated by the global standards for the humane treatment of (68)

5.2.3 Cultural and social factors

The study indicated that personal values and attitudes of healthcare providers significantly impact the delivery of respectful care. At Nyamagana, the importance of recognizing and respecting each patient’s unique values and preferences was emphasized, including understanding cultural, spiritual, and personal beliefs and integrating these into the care plan. Similarly, a study conducted in Morogoro, Tanzania (24) found that nurses with strong ethical values and empathy towards patients were more inclined to consistently practice respectful and dignified care. On the contrary, providers with negative attitudes and biases were often associated with disrespectful and abusive behaviours (24). Slapping, beating or pinching women during delivery, while sometimes used as a last resort to ensure the safety of the mother and child, is highly controversial and raises significant ethical and professional concerns (6,24). This practice can undermine the principles of RMC by violating the patient's dignity and autonomy, potentially leading to feelings of humiliation, trauma, and mistrust in healthcare providers (9,10,12). This issue also reflects negatively on the quality of maternal care, indicating gaps in effective communication and the use of non-coercive intervention strategies (24). Such actions can have long-term psychological implications for the mother and may deter her from seeking future medical assistance (8). Healthcare providers should be trained and mentored in alternative, non-physical methods of encouraging patient cooperation during childbirth to maintain the standards of respectful and compassionate care (27). Scientific evidence supports that such training can significantly improve maternal outcomes and patient satisfaction.

A meta-analysis review of 19 countries emphasized that women's childbirth expectations are influenced by familial and socio-cultural norms, shaping their preferences for natural birth, the presence of family members, and compassionate communication (69). Additionally, culturally competent care, which involves understanding and respecting cultural differences, has been shown to improve maternity care experiences (9)

Providers at Nyamagana District Hospital navigate complex cultural dynamics to deliver RMC. They understand and respect cultural norms while ensuring patients' dignity and comfort. Study participants noted that, in some tribes, men do not prioritise staying with their wives during clinic visits; respecting these cultural preferences meant implementing more personalised care. Similarly, a study in Tanzania (45) found that cultural sensitivity in care impacted RMC provision by building trust and improving care outcomes. Adapting care practices to diverse cultural backgrounds enhances patient satisfaction and strengthens the dignity and overall quality of care provided (43,70).

5.2.4 Barriers and best practices

Maintaining dignity in maternity care faces several barriers. Providers identified high patient volumes, inadequate staffing, and resource constraints as significant challenges. These issues often result in rushed care, lack of personalized attention, and instances of disrespect and abuse. A study by (65) in Ethiopia also highlighted these challenges, noting that they often lead to compromised care and instances of disrespectful and abusive behaviour.

Implementing best practices in RMC involves a combination of training, resource allocation, and supportive policies. Structured training programs and supportive supervision significantly improved the practice of respectful care among healthcare providers. Additionally, policies that enforce patient rights and promote accountability were found to be effective in sustaining respectful care practices (46).

5.3 Confidentiality in RMC implementation

Confidentiality is a crucial aspect of RMC, which is ensured by safeguarding the personal and sensitive information and interaction between providers and patients during the provision of care (50) promoting trust and assurance. Two subthemes were identified in confidentiality: policies and procedures and privacy and information management.

5.3.1 Policies and procedures

The study participants reported compliance with confidentiality policies at Nyamagana, which shaped their experiences in implementing and ensuring respectful maternity care. There was an emphasis on the importance of maintaining patient confidentiality to ensure patients feel well-treated. This involves following strict protocols to protect patient information, such as conducting private conversations in designated areas and using secure electronic systems for patient records. Patients feel more secure and respected when they see their personal information being handled with care and only being shared with authorized individuals. Adhering to confidentiality not only protects patient privacy but also fosters a sense of trust and respect within the healthcare environment (63)

However, some study participants were either unaware of formal confidentiality policies or chose not to acknowledge them, relying instead on their personal and professional ethics to safeguard patient confidentiality. In contrast, other participants recognised an informal policy promoting confidentiality and remained vigilant in ensuring patient information was protected.

5.3.2 Privacy and information management

In their efforts to maintain confidentiality, providers often receive direct requests from patients to keep information strictly private, sometimes even from their partners, which shows the importance of respecting patients' wishes and maintaining their trust. Secure electronic health records (EHR) systems and encrypted communication channels have been beneficial in protecting patient information from unauthorized access. However, nurses reported occasional system performance issues that necessitated a return to paper-based records. Despite these challenges, there were no reports of patient information breaches, indicating the overall effectiveness of the electronic health records in place to maintain privacy and information security.

Continuous training and awareness programs for healthcare providers were highlighted as crucial for upholding confidentiality standards(64). Study participants remarked that ongoing training sessions on confidentiality and privacy protocols are essential for maintaining high standards of care (64,71). Participants also stressed that confidentiality extends beyond managing information, including the physical environment where care is

provided. For instance, the constant movement of people near a patient receiving care can breach confidentiality. This commitment aligns with global standards for patient confidentiality, emphasizing the importance of protecting personal information.

5.4 Communication in RMC implementation

Communication in healthcare involves maintaining transparent, understandable, respectful, and empathetic information exchanges between healthcare providers, pregnant and birthing women and their families. This includes actively listening to the women's concerns and preferences about care options, procedures, and any medical interventions, as well as ensuring that women are fully informed and able to participate in decision-making regarding their care.

5.4.1 Support from colleagues and administration

At Nyamagana, overcoming obstacles in implementing RMC was facilitated by strong support from team members and administration. Good communication, effective teamwork, and leadership support helped mitigate challenges arising from infrastructure limitations. Peer support groups allowed nurses to debrief after challenging work experiences and discuss common issues privately, fostering a supportive environment where they could openly share experiences and receive mutual support (72).

5.4.2 Training on communication in RMC

The impact of RMC training on nurses' communication skills is substantial. These training programs help dispel misconceptions about women's care during delivery and highlight the importance of comprehensive training. By enhancing communication, RMC training fosters stronger nurse-client relationships and promotes positive attitudes among nurses, ultimately improving provider-client interactions. (73–75).

5.4.3 Communication strategies

Effective communication is a cornerstone of RMC (78), ensuring patients are well-informed, can participate in decision-making, and feel respected during care. The study's findings align with existing literature emphasizing the significance of clear, compassionate, and culturally sensitive communication. Such communication builds trust between healthcare providers and patients, ensuring a positive birth experience (30). Similarly, in Ghana, midwives

accentuated the importance of providing patients with sufficient information about their care, explaining medical interventions to receive dignified informed consent, and ensuring patient comfort (76)(77).

A study in the UK (78) found that effective communication with women during childbirth involved clear explanations and active listening to their needs, allowing women to feel heard and make informed decisions about their care. Nurses at Nyamagana DH emphasized the importance of small acts of kindness and patience, aligning with global RMC guidelines that stress empathetic interactions and respect for patients' rights to informed decision-making. This emphasis is also highlighted in a study (79) where compassionate and respectful care significantly enhanced the childbirth experience for women in Ethiopian facilities.

Researchers in East Africa, (7,8,45) pointed out that overcrowded facilities and the absence of essential resources compromised the care they provided, (28) and repeated incidences such as these caused providers to become emotionally fatigued (8).

Literature has shown that effective communication-based care, which includes empathetic communication, active listening, and shared decision-making, enhances the childbirth experience for mothers. A study in 2022 in Iran found that women who received effective communication-based care reported higher levels of support and control during childbirth, which contributed to a more positive birth experience and greater satisfaction (80). Additionally, non-pharmacological pain relief methods, like comfort, counselling, support, massages, breathing techniques, and companion presence, help reduce the need for physical interventions and improve patient well-being(81). The WHO's guidelines advocate for continuous support during labour, which has been shown to improve outcomes for both mothers and babies (82).

Moreover, in rural Tanzania, (83) the necessity of effective and sensitive communication was highlighted as a key feature of WHO standards for improving maternal and newborn care. This included timely assessment, appropriate medical care, and emotional support, all requiring transparent communication to ensure patient understanding and comfort (68).

5.4.4 Cultural and social factors

Nurses noted that understanding and respecting patients' cultural norms significantly enhances the patient's birth experience. The literature also supports this finding, suggesting

that culturally sensitive communication helps build meaningful connections (70) and improves patient satisfaction (43,84).

Despite the recognized importance of effective communication, challenges such as high patient volumes and diverse educational backgrounds among nurses lead to inconsistent communication practices. This inconsistency can result in misunderstandings and inefficiencies in care delivery. Literature highlights the importance of standardized communication protocols and training to overcome these barriers. With challenges from workload limiting the interaction (85), there is a need for future initiatives to improve communication.

5.6 Policy Implications

The findings of this study underscore the need for policies that provide healthcare providers with adequate resources, training, and support to fully implement RMC. Policymakers need to focus on improving the infrastructure in delivery rooms to protect patient confidentiality and introduce regular communication training programs for healthcare workers to ensure respectful, effective patient-provider interactions. Furthermore, monitoring and accountability mechanisms should be put in place to ensure that the principles of RMC are upheld in healthcare facilities.

5.6 Strengths and limitations of the study

5.6.1 Study strengths

The strength of the study is its comprehensive qualitative approach and involvement of participants from diverse experiences. By focusing on non-medical elements and prioritizing strong ethical considerations, the study's findings are more credible and in-depth through:

1. The study used a phenomenological design and in-depth interviews with nurses, which allowed for a deep understanding of their experiences and perspectives. This method provided rich, detailed data and revealed the complexities of implementing RMC in a low-resource setting
2. The study included nurses and medical attendants with various roles, experience levels, and educational backgrounds. This diversity ensured a comprehensive understanding of the challenges and facilitators of RMC from multiple viewpoints within the healthcare system.

3. By concentrating on non-medical elements like dignity, confidentiality, and communication, the study addressed the often-overlooked aspects of maternal care that significantly impact patient experiences and outcomes.
4. To avoid homogeneous sampling, expert purposeful sampling with maximum variation was adhered to. This involved selecting participants from the maternity department, i.e., labour ward, antenatal ward, and postnatal ward, with diverse age distributions and education levels. This aimed to gather a wide range of perspectives on the implementation of non-medical elements of RMC from participants who share the same phenomenon.

5.6.2 Study limitation

While this study provides valuable insights into implementing non-medical elements of RMC at Nyamagana DH, several limitations must be acknowledged to ensure a comprehensive understanding of the findings. Addressing the mentioned limitations in the future could enhance the vigour and generalizability of the findings, offering a more nuanced understanding of the implementation of RMC in diverse healthcare settings.

1. Reliance on self-reported data: The data collected through IDIs might be inherently subjective, relying on the participants' perceptions. Providers were assured that their information would be anonymous and handled confidentially to reduce bias. This allowed for more open reporting of both negative and positive experiences. Participants were assured of anonymity and encouraged to provide honest responses to address this. Additionally, neutral prompts were used to reduce bias.
2. Resource and infrastructure limitations: The study's findings are influenced by the study setting's specific resource and infrastructure constraints. These limitations may have impacted the ability to fully implement RMC. Understanding how similar constraints affect other settings can help contextualize the results.
3. Interview context and environment: The environment and context in which the interviews were conducted might have influenced participants' responses. Even though it was a secluded area, conducting interviews within the hospital setting may have caused participants to be more cautious in their responses due to perceived repercussions.

CHAPTER SIX

6.0 CONCLUSION AND RECOMMENDATION

6.1 Introduction

This chapter provides the study's conclusion, some key conclusions, and key recommendations for improving RMC based on the findings from nurses at Nyamagana DH.

6.2 Conclusion

This study has emphasized the critical role and significance of implementing non-medical elements of RMC, such as dignity, confidentiality, and communication, to ensure that women feel respected, valued, and dignified during childbirth. By focusing on nurses' experiences, the study provides in-depth insights into the challenges, facilitators, and complexities of maintaining respectful maternity care in a resource-limited setting like Nyamagana District Hospital. These findings reinforce the importance of improving provider training and resource allocation to enhance the quality of maternity care.

Effective communication, maintaining confidentiality, and upholding dignity are vital components that significantly influence the birthing experience. However, systemic challenges such as high patient volumes, inadequate resources, and insufficient training pose significant barriers to the consistent implementation of RMC. Addressing these systemic issues through policy interventions and enhanced training programs will be crucial for sustaining progress in maternal care.

Despite these challenges, the findings demonstrate a strong commitment among healthcare providers to deliver the most respectful and dignified care possible. This study provides a basis for policy reform, encouraging the integration of non-medical elements of RMC into broader maternal health strategies. Moving forward, the recommendations for improving provider training and addressing systemic barriers should be adopted to ensure that RMC is delivered consistently, ultimately contributing to better maternal outcomes and reinforcing patient trust in healthcare systems.

6.3 Recommendations

Based on this study's findings, discussions, and conclusions, the government, through the Ministry of Health, as well as other stakeholders, should address the following recommendations and gaps with specific recommendations and future research.

1. Council and facility health management to provide comprehensive and ongoing on-the-job training and mentorship focused on understanding the concept of RMC, its components, and the most effective ways to provide it in a cultural, social, and context-specific manner is needed. Mentoring healthcare providers is crucial to respecting and addressing patients' diverse cultural and societal needs. Also, as end users, mothers should be educated on their rights to RMC and be aware of available healthcare support.
2. Health facilities to improve or upgrade existing physical infrastructure to accommodate patient privacy and confidentiality, including a birth companion. Build and strengthen a supportive work environment through teamwork and administrative support and build sustainability in facility improvement teams for continuous improvement.
3. Hospital management to implement formal feedback mechanisms, such as suggestion boxes, at the facilities to improve RMC practices and ensure dignified care. Unlike informal verbal feedback, these tools provide consistent and anonymous ways for women to share their experiences. This feedback can be regularly reviewed and used to guide improvements in care quality at the facility.

REFERENCES

1. Wilson-Mitchell K, Eustace L, Robinson J, Shemdoe A, Simba S. Overview of literature on RMC and applications to Tanzania. Vol. 15, Reproductive Health. BioMed Central Ltd.; 2018.

2. Bohren MA, Tunçalp Ö, Miller S. Transforming intrapartum care: Respectful maternity care. Vol. 67, Best Practice and Research: Clinical Obstetrics and Gynaecology. Bailliere Tindall Ltd; 2020. p. 113–26.

3. Shakibazadeh E, Namadian M, Bohren MA, Vogel JP, Rashidian A, Nogueira Pileggi V, et al. Respectful care during childbirth in health facilities globally: a qualitative evidence synthesis. Vol. 125, BJOG: An International Journal of Obstetrics and Gynaecology. Blackwell Publishing Ltd; 2018. p. 932–42.

4. Van Roosmalen J, Van Den Akker T. Continuous and caring support right now. Vol. 123, BJOG: An International Journal of Obstetrics and Gynaecology. Blackwell Publishing Ltd; 2016. p. 675.

5. Tanzania Demographic and Health Survey and Malaria Indicator Survey (TDHS-MIS). 2022.

6. Kassa ZY, Husen S. Disrespectful and abusive behavior during childbirth and maternity care in Ethiopia: A systematic review and meta-analysis. Vol. 12, BMC Research Notes. BioMed Central Ltd.; 2019.

7. Abuya T, Warren CE, Miller N, Njuki R, Ndwiga C, Maranga A, et al. Exploring the prevalence of disrespect and abuse during childbirth in Kenya. PLoS One. 2015 Apr 17;10(4).

8. Mselle LT, Moland KM, Mvungi A, Evjen-Olsen B, Kohi TW. Why give birth in health facility? Users' and providers' accounts of poor quality of birth care in Tanzania at Comprehensive Community Based Rehabilitation in Tanzania and Temeke hospitals in Dar es Salaam, and Mpwapwa district in Dodoma region [Internet]. 2008. Available from: http://www.biomedcentral.com/1472-6963/13/174

9. Ratcliffe HL, Sando D, Mwanyika-Sando M, Chalamilla G, Langer A, McDonald KP. Applying a participatory approach to the promotion of a culture of respect during childbirth. Vol. 13, Reproductive Health. BioMed Central Ltd.; 2016.

10. Sando D, Ratcliffe H, McDonald K, Spiegelman D, Lyatuu G, Mwanyika-Sando M, et al. The prevalence of disrespect and abuse during facility-based childbirth in urban Tanzania. BMC Pregnancy Childbirth. 2016 Aug 19;16(1).

11. Dynes MM, Twentyman E, Kelly L, Maro G, Msuya AA, Dominico S, et al. Patient and provider determinants for receipt of three dimensions of respectful maternity care in Kigoma Region, Tanzania-April-July, 2016 Prof. Suellen Miller. Vol. 15, Reproductive Health. BioMed Central Ltd.; 2018.

12. Bohren MA, Vogel JP, Hunter EC, Lutsiv O, Makh SK, Souza JP, et al. The Mistreatment of Women during Childbirth in Health Facilities Globally: A Mixed-Methods Systematic Review. PLoS Med. 2015 Jun 1;12(6).

13. Ishola F, Owolabi O, Filippi V. Disrespect and abuse of women during childbirth in Nigeria: A systematic review. PLoS One. 2017 Mar 1;12(3).

14. Downe S, Lawrie TA, Finlayson K, Oladapo OT. Effectiveness of respectful care policies for women using routine intrapartum services: A systematic review. Vol. 15, Reproductive Health. BioMed Central Ltd.; 2018.

15. Hagaman AK, Hagaman AK, Hagaman AK, Singh K, Singh K, Abate M, et al. The impacts of quality improvement on maternal and newborn health: Preliminary findings from a health system integrated intervention in four Ethiopian regions. BMC Health Serv Res. 2020 Jun 8;20(1).

16. Kawish AB, Umer MF, Arshed M, Khan SA, Hafeez A, Waqar S. Respectful Maternal Care Experience in Low- and Middle-Income Countries: A Systematic Review. Vol. 59, Medicina (Lithuania). Multidisciplinary Digital Publishing Institute (MDPI); 2023.

17. Kapologwe NA, Kalolo A, Kibusi SM, Chaula Z, Nswilla A, Teuscher T, et al. Understanding the implementation of Direct Health Facility Financing and its effect

on health system performance in Tanzania: A non-controlled before and after mixed method study protocol. Health Res Policy Syst. 2019 Jan 30;17(1).

18. Kapologwe NA, Meara JG, Kengia JT, Sonda Y, Gwajima D, Alidina S, et al. Development and upgrading of public primary healthcare facilities with essential surgical services infrastructure: A strategy towards achieving universal health coverage in Tanzania. BMC Health Serv Res. 2020 Mar 17;20(1).

19. Mwakatumbula H. The Implementation of Direct Health Facility Financing (DHFF): Prospects and Challenges [Internet]. 2021. Available from: http://www.tzdpg.or.tz/fileadmin/documents/dpg_internal/dpg_working_groups_clusters/cluster_2/health/JAHSR_2018/9.

20. Njiro BJ, Ngowi JE, Mlunde L, Munishi C, Kapologwe N, Kengia JT, et al. Towards sustainable emergence transportation system for maternal and new born: Lessons from the m-mama innovative pilot program in Shinyanga, Tanzania. PLOS Global Public Health. 2023 Jun 21;3(6):e0002097.

21. Kamala BA, Ersdal HL, Mduma E, Moshiro R, Girnary S, Østrem OT, et al. SaferBirths bundle of care protocol: a stepped-wedge cluster implementation project in 30 public health-facilities in five regions, Tanzania. BMC Health Serv Res. 2021 Dec 1;21(1).

22. Ersdal H, Mdoe P, Mduma E, Moshiro R, Guga G, Kvaløy JT, et al. "Safer Births Bundle of Care" Implementation and Perinatal Impact at 30 Hospitals in Tanzania—Halfway Evaluation. Children. 2023 Feb 1;10(2).

23. Bowser D, Hill MPHK. Exploring Evidence for Disrespect and Abuse in Facility-Based Childbirth Report of a Landscape Analysis. 2010.

24. McMahon SA, George AS, Chebet JJ, Mosha IH, Mpembeni RNM, Winch PJ. Experiences of and responses to disrespectful maternity care and abuse during childbirth. BMC Pregnancy Childbirth. 2014 Aug 12;14(1):268.

25. Chou VB, Walker N, Kanyangarara M. Estimating the global impact of poor quality of care on maternal and neonatal outcomes in 81 low- And middle-income countries: A modeling study. PLoS Med. 2019;16(12).

26. UNITED REPUBLIC OF TANZANIA Ministry of Health, Community Development, Gender, Elderly and Children National Guideline for Gender and Respectful Care Mainstreaming and Integration Across RMNCAH services in Tanzania. 2019.

27. THE UNITED REPUBLIC OF TANZANIA NATIONAL GUIDELINES ON RESPECTFUL AND COMPASSIONATE NURSING AND MIDWIFERY CARE. 2017.

28. Wesson J, Hamunime N, Viadro C, Carlough M, Katjiuanjo P, McQuide P, et al. Provider and client perspectives on maternity care in Namibia: Results from two cross-sectional studies. BMC Pregnancy Childbirth. 2018 Sep 5;18(1).

29. Esan OT, Maswime S, Blaauw D. Directly observed and reported respectful maternity care received during childbirth in public health facilities, Ibadan Metropolis, Nigeria. PLoS One. 2022 Oct 1;17(10 October).

30. Moridi M, Pazandeh F, Hajian S, Potrata B. Midwives' perspectives of respectful maternity care during childbirth: A qualitative study. PLoS One. 2020;15(3).

31. Mdoe P, Mduma E, Rivenes Lafontan S, Ersdal H, Massay C, Daudi V, et al. Healthcare Workers' Perceptions on the "SaferBirths Bundle of Care": A Qualitative Study. Healthcare (Switzerland). 2023 Jun 1;11(11).

32. Safer Births Bundle of Care: A national scale-up program in Tanzania (Update May 2023).

33. Kamala BA, Ersdal H, Moshiro R, Mduma E, Baker U, Guga G, et al. Improvements in Obstetric and Newborn Health Information Documentation following the Implementation of the Safer Births Bundle of Care at 30 Facilities in Tanzania. Healthcare [Internet]. 2024 Jan 26;12(3):319. Available from: https://www.mdpi.com/2227-9032/12/3/319

34. Kruk ME, Kujawski S, Mbaruku G, Ramsey K, Moyo W, Freedman LP. Disrespectful and abusive treatment during facility delivery in Tanzania: A facility and community survey. Health Policy Plan. 2018 Jan 1;33(1):e26–33.

35. Asefa A, Morgan A, Bohren MA, Kermode M. Lessons learned through respectful maternity care training and its implementation in Ethiopia: An interventional mixed methods study. Reprod Health. 2020 Jul 2;17(1).

36. Freedman LP, Ramsey K, Abuya T, Bellows B, Ndwiga C, Warren CE, et al. Defining disrespect and abuse of women in childbirth: A research, Policy and rights agenda. Vol. 92, Bulletin of the World Health Organization. World Health Organization; 2014. p. 915–7.

37. Jolivet RR, Gausman J, Kapoor N, Langer A, Sharma J, Semrau KEA. Operationalizing respectful maternity care at the healthcare provider level: a systematic scoping review. Reprod Health. 2021 Dec 1;18(1).

38. MoH Jakaya Mrisho Kikwete Foundation MNH Mapping Report REPORT ON THE MAPPING OF INTERVENTIONS FOR MATERNAL AND NEWBORN HEALTH IN TANZANIA MAINLAND Ministry of Health.

39. Larsen R, Mangrio E, Persson K. Interpersonal Communication in Transcultural Nursing Care in India: A Descriptive Qualitative Study. Journal of Transcultural Nursing. 2021 Jul 1;32(4):310–7.

40. D-Zomeku VM, Mensah BAB, Nakua EK, Agbadi P, Lori JR, Donkor P. Exploring midwives' understanding of respectful maternal care in Kumasi, Ghana: Qualitative inquiry. PLoS One. 2020 Jul 1;15(7 July).

41. Mselle LT, Moland KM, Mvungi A, Evjen-Olsen B, Kohi TW. Why give birth in health facility? Users' and providers' accounts of poor quality of birth care in Tanzania at Comprehensive Community Based Rehabilitation in Tanzania and Temeke hospitals in Dar es Salaam, and Mpwapwa district in Dodoma region [Internet]. 2008. Available from: http://www.biomedcentral.com/1472-6963/13/174

42. Lindwall L, Lohne V. Human dignity research in clinical practice – a systematic literature review. Vol. 35, Scandinavian Journal of Caring Sciences. John Wiley and Sons Inc; 2021. p. 1038–49.

43. Kibakaya EC, Oyeku SO. Cultural Humility: A Critical Step in Achieving Health Equity. Vol. 149, Pediatrics. American Academy of Pediatrics; 2022.

44. Burrowes S, Holcombe SJ, Jara D, Carter D, Smith K. Midwives' and patients' perspectives on disrespect and abuse during labor and delivery care in Ethiopia: a qualitative study. BMC Pregnancy Childbirth. 2017 Aug 22;17(1):263.

45. Shimoda K, Horiuchi S, Leshabari S, Shimpuku Y. Midwives' respect and disrespect of women during facility-based childbirth in urban Tanzania: A qualitative study. Reprod Health. 2018 Jan 10;15(1).

46. Puthussery S, Bayih WA, Brown H, Aborigo RA. Promoting a global culture of respectful maternity care. Vol. 23, BMC Pregnancy and Childbirth. BioMed Central Ltd; 2023.

47. Actis Danna V, Bedwell C, Chimwaza A, Chisuse I, Lyangenda K, Petross C, et al. Promoting respectful maternal and newborn care using the Dignity game: A quasi-experimental study. Nurse Educ Pract. 2023 Jan 1;66.

48. Manu A, Billah SM, Williams J, Kilima S, Yeji F, Matin Z, et al. Institutionalising maternal and newborn quality-of-care standards in Bangladesh, Ghana and Tanzania: a quasi-experimental study. BMJ Glob Health. 2022 Sep 20;7(9).

49. Mselle L, Sirili N, Anaeli A, Massawe S. Understanding barriers to implementing referral procedures in the rural and semi-urban district hospitals in Tanzania: Experiences of healthcare providers working in maternity units. PLoS One. 2021 Aug 1;16(8 August).

50. Peterson JLH. Confidentiality in medicine: How far should doctors prioritise the confidentiality of the individual they are treating? Postgrad Med J. 2018 Oct 1;94(1116):596–600.

51. Bulto GA, Demissie DB, Tulu AS. Respectful maternity care during labor and childbirth and associated factors among women who gave birth at health institutions in the West Shewa zone, Oromia region, Central Ethiopia. BMC Pregnancy Childbirth. 2020 Aug 3;20(1).

52. The prevention and elimination of disrespect and abuse during facility-based childbirth [Internet]. Available from: http://www.figo.org/figo-committee-and-working-group-

53. Oladapo OT, Bohren MA, Fawole B, Mugerwa K, Ojelade OA, Titiloye MA, et al. Negotiating quality standards for effective delivery of labor and childbirth care in Nigeria and Uganda. International Journal of Gynecology and Obstetrics. 2017 Dec 1;139:47–55.

54. Qualitative Research Evaluation Methods Integrating Theory and Practice by Michael Quinn Patton (z-lib.org).

55. Creswell JW, Creswell JW. Qualitative inquiry & research design : choosing among five approaches. Sage Publications; 2007. 395 p.

56. Maguire M, Delahunt B. Doing a Thematic Analysis: A Practical, Step-by-Step Guide for Learning and Teaching Scholars. * [Internet]. 2017. Available from: http://ojs.aishe.org/index.php/aishe-j/article/view/335

57. Shenton AK. Strategies for ensuring trustworthiness in qualitative research projects. Education for Information. 2004;22(2):63–75.

58. Behruzi R, Hatem M, Fraser W, Goulet L, Ii M, Misago C. Facilitators and barriers in the humanization of childbirth practice in Japan [Internet]. Vol. 10, BMC Pregnancy and Childbirth. 2010. Available from: http://www.biomedcentral.com/1471-2393/10/25

59. Conesa Ferrer MB, Canteras Jordana M, Ballesteros Meseguer C, Carrillo García C, Martínez Roche ME. Comparative study analysing women's childbirth satisfaction and obstetric outcomes across two different models of maternity care. BMJ Open. 2016;6(8).

60. Eduardo Pereira Dutra P, Quagliato LA, Nardi AE. Improving the perception of respect for and the dignity of inpatients: a systematic review. BMJ Open. 2022 May 13;12(5):e059129.

61. Bohren MA, Mehrtash H, Fawole B, Maung TM, Balde MD, Maya E, et al. How women are treated during facility-based childbirth in four countries: a cross-sectional study with labour observations and community-based surveys. The Lancet. 2019 Nov 9;394(10210):1750–63.

62. Afulani PA, Phillips B, Aborigo RA, Moyer CA. Person-centred maternity care in low-income and middle-income countries: analysis of data from Kenya, Ghana, and India. Lancet Glob Health. 2019 Jan 1;7(1):e96–109.

63. Sheferaw ED, Bazant E, Gibson H, Fenta HB, Ayalew F, Belay TB, et al. Respectful maternity care in Ethiopian public health facilities Prof. Suellen Miller. Reprod Health. 2017 May 16;14(1).

64. Dzomeku VM, Boamah Mensah AB, Nakua EK, Agbadi P, Lori JR, Donkor P. Midwives' experiences of implementing respectful maternity care knowledge in daily maternity care practices after participating in a four-day RMC training. BMC Nurs. 2021 Dec 1;20(1).

65. Asefa A, Bekele D, Morgan A, Kermode M. Service providers' experiences of disrespectful and abusive behavior towards women during facility based childbirth in Addis Ababa, Ethiopia. Reprod Health. 2018 Jan 5;15(1):4.

66. Lauwers EDL, Vandecasteele R, McMahon M, De Maesschalck S, Willems S. The patient perspective on diversity-sensitive care: a systematic review. Vol. 23, International Journal for Equity in Health. BioMed Central Ltd; 2024.

67. Östlund U, Blomberg K, Söderman A, Werkander Harstäde C. How to conserve dignity in palliative care: Suggestions from older patients, significant others, and healthcare professionals in Swedish municipal care. BMC Palliat Care. 2019 Jan 24;18(1).

68. Weltgesundheitsorganisation, Special Programme of Research D. WHO recommendations on maternal and newborn care for a positive postnatal experience. 224 p.

69. Downe S, Finlayson K, Oladapo O, Bonet M, Gülmezoglu AM. What matters to women during childbirth: A systematic qualitative review. Vol. 13, PLoS ONE. Public Library of Science; 2018.

70. Liu TT, Chen MY, Chang YM, Lin MH. A Preliminary Study on the Cultural Competence of Nurse Practitioners and Its Affecting Factors. Healthcare (Switzerland). 2022 Apr 1;10(4).

71. Mduma E, Kvaløy JT, Soreide E, Svensen E, Mdoe P, Perlman J, et al. Frequent refresher training on newborn resuscitation and potential impact on perinatal outcome over time in a rural Tanzanian hospital: An observational study. BMJ Open. 2019 Sep 1;9(9).

72. Afulani PA, Oboke EN, Ogolla BA, Getahun M, Kinyua J, Oluoch I, et al. Caring for providers to improve patient experience (CPIPE): intervention development process. Glob Health Action. 2023;16(1).

73. Shiindi-Mbidi TSN, Downing C, Temane A. Midwives' and women's experiences with respectful maternity care around the globe: A meta-synthesis. Women and Birth. 2023 Sep 1;36(5):e461–70.

74. Helfand M, Peterson K, Mccleery E, Anderson J, Waldrip K. Evidence Brief: Comparative Effectiveness of Appointment Recall Reminder Procedures for Follow-up Appointments. 2015.

75. Balqis-Ali NZ, Saw PS, Anis-Syakira J, Fun WH, Sararaks S, Lee SWH, et al. Healthcare provider person-centred practice: relationships between prerequisites, care environment and care processes using structural equation modelling. BMC Health Serv Res. 2022 Dec 1;22(1).

76. Dzomeku VM, Mensah ABB, Nakua EK, Agbadi P, Okyere J, Donkor P, et al. Promoting respectful maternity care: challenges and prospects from the perspectives of midwives at a tertiary health facility in Ghana. BMC Pregnancy Childbirth. 2022 Dec 1;22(1).

77. Kinnersley P, Phillips K, Savage K, Kelly MJ, Farrell E, Morgan B, et al. Interventions to promote informed consent for patients undergoing surgical and other invasive healthcare procedures. Vol. 2013, Cochrane Database of Systematic Reviews. John Wiley and Sons Ltd; 2013. p. 1–247.

78. Collins B, Hall J, Hundley V, Ireland J. Effective communication: Core to promoting respectful maternity care for disabled women. Midwifery. 2023 Jan 1;116:103525.

79. Jiru HD, Sendo EG. Promoting compassionate and respectful maternity care during facility-based delivery in Ethiopia: Perspectives of clients and midwives. BMJ Open. 2021 Oct 11;11(10).

80. Shamoradifar Z, Asghari-Jafarabadi M, Nourizadeh R, Mehrabi E, Areshtanab HN, Shaigan H. The impact of effective communication-based care on the childbirth experience and satisfaction among primiparous women: an experimental study. Journal of the Egyptian Public Health Association. 2022 Dec 1;97(1).

81. McCauley M, Actis Danna V, Mrema D, Van Den Broek N. 'we know it's labour pain, so we don't do anything': Healthcare provider's knowledge and attitudes regarding the provision of pain relief during labour and after childbirth. BMC Pregnancy Childbirth. 2018 Nov 14;18(1).

82. Shakibazadeh E, Namadian M, Bohren MA, Vogel JP, Rashidian A, Nogueira Pileggi V, et al. Respectful care during childbirth in health facilities globally: a qualitative evidence synthesis. Vol. 125, BJOG: An International Journal of Obstetrics and Gynaecology. Blackwell Publishing Ltd; 2018. p. 932–42.

83. Webber G, Chirangi B, Magatti N. Promoting respectful maternity care in rural Tanzania: Nurses' experiences of the 'health Workers for Change' program. BMC Health Serv Res. 2018 Aug 22;18(1).

84. Lauwers EDL, Vandecasteele R, McMahon M, De Maesschalck S, Willems S. The patient perspective on diversity-sensitive care: a systematic review. Vol. 23, International Journal for Equity in Health. BioMed Central Ltd; 2024.

85. Moyer CA, McNally B, Aborigo RA, Williams JEO, Afulani P. Providing respectful maternity care in northern Ghana: A mixed-methods study with maternity care providers. Midwifery. 2021 Mar 1;94:102904.

APPENDICES

Appendix 1: Consent form English version

Informed consent form for health care providers participating In-Depth Interviews (IDIs)

Title of the study: Healthcare providers' experience in the implementation of non-medical elements of respectful maternity care.

Invitation to participate: Before deciding against participating, you need to understand why this research is being conducted and what it would involve.

Purpose of the study: This research aims to gain thorough experience in the implementation of respectful maternity care (RMC) through non-medical factors such as (communication, dignity and confidentiality) of health provision. Your valuable perspectives as a healthcare provider are vital to the success of this endeavour.

Study procedures: If you choose to participate, you will be asked to join in an in-depth interview (IDI). These sessions are designed to probe into your views and experiences regarding providing RMC. For accurate data collection and analysis, these discussions will be audio-recorded.

Risks and benefits: Participating in the IDI carries minimal risks. Your confidentiality will be strictly maintained, and any information shared will be de-identified. By participating, you will contribute valuable insights that can enhance maternity care in Tanzania.

Voluntary participation: It is entirely voluntary to participate in this study; hence, you are allowed to withdraw at any time without facing any consequences. Your decision will not affect your relationship with the healthcare facility nor with the study.

Confidentiality: Your identity will remain confidential. All data will be securely stored, and published results will not include personally identifiable information.

Questions and further information: If you have any questions or require further clarification about the study, you can contact the Principal Investigator, Ivony Kamala, at +255769010999 and email ivonykamala@gmail.com or the Chairperson of the Senate's Research and Publications Committee, Dr. Bruno Sunguya, at MUHAS, P.O. Box 65001, Tanzania, or by calling +2552150302/6.

Consent: By signing this form, you confirm that you have read, understood, and accepted the information and voluntarily agree to participate in the study.

Participant'sName: **Date:**

_____ _____

Participant's signature: _____

Appendix 2: Consent form – Swahili version

Fomu ya idhini kwa watoa huduma za afya wanaoshiriki mahojiano ya kina (IDIs)

Jina la utafiti: *uzoefu wa watoa huduma za afya katika utekelezaji wa vipengele visivyo vya kitabitu vya huduma ya heshima na staha katika uzazi.*

Mwaliko wa kushiriki: kabla ya kuamua kushiriki, ni muhimu uelewe kwa nini utafiti huu unafanyika na utahusisha nini.

Madhumuni ya utafiti: utafiti huu unalenga kupata uzoefu wa kina katika utoaji wa huduma ya uzazi yenye heshima na staha kupitia vipengele visivyo vya kimatibabu kama (heshima, usiri na mawasiliano ya utoaji huduma. Mitazamo yako ina thamani kama mtoa huduma ya afya na ni muhimu kwa mafanikio ya juhudi hii.

T**aratibu za utafiti:** ikiwa ukichagua kushiriki, utaombwa kujiunga katika mahojiano ya kina *(IDIs)*. mahojiano haya yamebuniwa kuchunguza maoni na uzoefu wako kuhusu utoaji wa huduma ya heshima na staha wakati wa uzazi. Kwa ajili ya ukusanyaji na uchambuzi sahihi wa taarifa hizi, majadiliano haya yatanakiliwa kwa kifaa cha elektroniki kwa sauti.

Hatari na faida: hatutarajii kuwepo kwa hatari zinazohusiana na kushiriki katika *IDIs*. usiri wako utadumishwa kwa umakini sana, na taarifa zozote zilizoshirikiwa zitafichwa utambulisho au kutenganishwa na utambulisho wako. Kwa kushiriki utafiti huu, unachangia mitazamo yenye thamani ambayo inaweza kuboresha huduma ya uzazi nchini Tanzania.

Ushiriki wa hiari: ushiriki wako katika utafiti huu ni wa hiari kabisa hivyo unaruhusiwa kujitoa wakati wowote bila kukabiliwa na madhara yoyote. Uamuzi wako hautaathiri uhusiano wako na kituo cha huduma ya afya wala utafiti huu.

Usiri: Utambulisho wako utabaki kuwa siri. Takwimu zote zitahifadhiwa kwa usalama, na matokeo yaliyochapishwa hayatajumuisha taarifa binafsi zinazotambulika.

Maswali na taarifa zaidi: ikiwa una maswali yoyote au unahitaji ufafanuzi zaidi kuhusu utafiti, unaweza kuwasiliana na Mchunguzi Mkuu, Ivony Kamala, kwa +255769010999 na barua pepe ivonykamala@gmail.com au Mwenyekiti wa Kamati ya Utafiti na Machapisho ya Seneti, Dkt. Bruno Sunguya katika Chuo Kikuu cha Afya na Sayansi Shirikishi Muhimbili (MUHAS) S.L.P 65001, Tanzania au kwa kupiga simu +2552150302-6.

Ridhaa: Kwa kusaini fomu hii, unathibitisha kwamba umesoma na kuelewa taarifa hii na umekubali kwa hiari yako kushiriki katika utafiti

Jina la mshiriki: _____

Sahihi ya mshiriki: _____

Tarehe: _____

Appendix 3: Interview guide –English version

Introduction

- Start by briefly introducing the study's purpose and explaining how the interviewee's participation contributes to the research.
- Assure confidentiality and anonymity of responses. Obtain informed consent.

Icebreaker: *Warmly welcome the participant and express sincere appreciation for their time. Briefly explain the study's aim, focusing on non-medical aspects of RMC, and highlight the value of their unique perspectives. Define and elaborate on the non-medical aspects of RMC.*

Main question: what is your experience implementing the non-medical elements of respectful maternity care, and how do these practices manifest in your daily interactions with patients?

Sub-question 1: Factors influencing RMC provision

1. **Infrastructure and resources:** can you describe how the availability of the following affects your provision of respectful maternity care? a) resource b) setup of the maternity care?

2. **Training and education:** Have you ever been trained on respectful maternity care? When was the last time you received that training? How has your training in respectful maternity care influenced your practice? What areas do you feel additional training could further improve the care provided?

3. **Cultural and social factors:** how does cultural and societal norms influence your approach to providing respectful maternity care? what influences your approach to providing respectful maternity care? How do you navigate these influences in your practice?

4. **Support and collaboration:** can you discuss the role of the following in the provision of respectful maternity care? a) teamwork, b) support from colleagues and c) administration in facilitating or hindering the provision of respectful maternity care?

Sub-question 2: Ensuring dignity

1. **Personalized care:** how do you ensure that patient's privacy is respected in your practice, both in terms of physical space and in conversations?

   -What measures are in place to prevent breaches of privacy?

   -In situations where patients feel vulnerable or exposed, such as during examinations or discussions about personal health issues, how do you ensure their comfort and maintain their dignity?

   -What specific actions do you take to mitigate client discomfort?

   -Can you provide examples of how you adjust your care practices to align with your patients' unique cultural, spiritual, or personal values? How do these adjustments reflect your commitment to their dignity?

2. **Overcoming barriers:** what is your experience in ensuring patient dignity? what are the challenges in providing dignity? How have you addressed these challenges?

3. **Best practices:** what do you consider the best practices in your dignity provision? can you share examples of practices or behaviours you have adopted that you believe significantly contribute to upholding patient dignity?

4. **Feedback and improvement:** do patients share feedback regarding dignity service? how? how do you utilize patient feedback to improve the way dignity is upheld in your care?

Sub-question 3: Promotion of confidentiality

1. **Policies and procedures:** what are the existing policies and procedures to ensuring confidentiality? do you follow specific policies and procedures to ensure patient confidentiality? How are these implemented to/for patients?

2. **Challenges in confidentiality:** What is the experience in ensuring confidentiality? What are the challenges in maintaining confidentiality? How were these addressed?

3. **Training and awareness:** what is the existing training, if any, on confidentiality? how are they conducted? How does ongoing training ensure all staff members understand and uphold confidentiality standards?

4. **Technological and physical measures:** can you discuss the technological and physical safeguards in place in your facility to protect patient information?

Sub-question 4: Communication

1. **Effective strategies:** what communication strategies do you use with patients to ensure respectful maternity care? What strategies have you found most effective in ensuring clear, compassionate patient communication?

2. **Overcoming communication barriers:** what experiences do you have in language and communication when providing respectful maternity care? How do you overcome language barriers or other communication challenges in your practice?

3. **Feedback mechanisms:** how is patient feedback collected and used to improve communication practices?

4. **Interprofessional communication:** How does interprofessional communication affect the delivery of respectful maternity care?

Ending

- Allow the interviewee to share any additional thoughts or experiences related to providing respectful maternity care.
- Encourage exchanging ideas regarding possible areas for enhancement or creativity in respectful maternity care practices.
- Inform them about the next steps and how the information will be used.

Conclusion

- Thank them for their participation and time.
- Inform them about the next steps and how the information will be used.

Appendix 4: Interview guide – Swahili version

Mwongozo wa mahojiano_ Toleo la Kiswahili

Utangulizi

- Anza kwa kuelezea kwa ufupi madhumuni ya utafiti na jinsi ushiriki wa mhojiwa unavyochangia katika utafiti. Hakikisha usiri na kutotambulika kwa majibu. Pata ridhaa ya kushiriki.

Kibwagizo

- Karibisha mshiriki kwa moyo mkunjufu na uonyeshe shukrani za dhati kwa muda wao. Eleza kwa ufupi lengo la utafiti, ukilenga vipengele visivyo vya kimatibabu vya huduma ya uzazi yenye heshima (RMC), na taja umuhimu wa mitazamo yao ya pekee. Eleza na ufafanue vipengele visivyo vya kimatibabu vya huduma ya uzazi yenye heshima (RMC).

Swali kuu

- *Je, ni uzoefu gani unao katika kutekeleza vipengele visivyo vya kimatibabu vya huduma ya uzazi yenye heshima, na vipi hivi vipengele vinavyojitokeza katika mwingiliano wako wa kila siku na wagonjwa?*

Maswali ya ziada

1. Vipengele vinavyoathiri utoaji wa huduma ya uzazi yenye heshima?
    - **Miundombinu na rasilimali**: Je, unaweza kuelezea jinsi upatikanaji wa mambo yafuatayo yanavyo athiri utoaji wako wa huduma ya uzazi yenye heshima? a) rasilimali b) muundo wa huduma ya uzazi?
    - **Mafunzo na elimu**: Je, umewahi kupata mafunzo kuhusu huduma ya uzazi yenye heshima? Mafunzo yako ya mwisho yalikuwa lini? Mafunzo haya yameathirije utendaji wako wa kazi? Ni maeneo gani unahisi mafunzo zaidi yanaweza kuboresha huduma inayotolewa?
    - **Vipengele vya kitamaduni na jamii**: Jamii na mila zinaathirije jinsi unavyotoa huduma ya uzazi yenye heshima? Unazikabili vipi changamoto hizi katika kazi yako?
    - **Usaidizi na ushirikiano**: Je, unaweza kujadili jukumu la yafuatayo katika utoaji wa huduma ya uzazi yenye heshima? a) ushirikiano wa timu, b) usaidizi

kutoka kwa wenzako na c) usimamizi katika kurahisisha au kukwamisha utoaji wa huduma ya uzazi yenye heshima?

2. Kuhakikisha utu
    - **Huduma binafsi**: Je, unahakikishaje heshima ya faragha ya mgonjwa wako katika huduma yako kwa mama, iwe kimwili au katika mazungumzo?

- Je, kuna hatua gani zilizowekwa kuzuia uvunjaji wa faragha?

- Katika mazingira ambapo wagonjwa wanajihisi hatarini au wazi, kama vile wakati wa uchunguzi au majadiliano kuhusu masuala ya afya binafsi, unahakikishaje wanaweza kupata na kudumishiwa utu wao?

- Je, unachukua hatua gani maalum kupunguza usumbufu kwa mteja?

- Je, unaweza kutoa mifano ya jinsi unavyobadilisha utoaji wa huduma kwa akina mama ili kuendana na utaratibu wao kiutamaduni, kiroho, au binafsi?

- Mambo haya yanadhihirishaje kujitolea kwako kwa utu wao?

- **Kukabiliana na vikwazo:** Je, una uzoefu gani katika kuhakikisha utu wa mgonjwa? Ni changamoto zipi unazokutana nazo katika kutoa hduma yenye utu? Umezishughulikiaje changamoto hizi?
- **Mbinu bora:** Ni mbinu zipi unazozingatia kuwa bora katika utoaji wa huduma yenye utu? Je, unaweza kunishirikisha mifano ya mbinu au tabia ulizozichukua ambazo unadhani zinachangia kwa kiasi kikubwa katika kudumisha utu wa mgonjwa?
- **Maoni na uboreshaji:** Je, wagonjwa wanatoa maoni kuhusu huduma ya utu? Wanafanya hivyo vipi? Unayatumiaje maoni ya wagonjwa kuboresha jinsi utu unavyodumishwa katika huduma yako?

3. Kuendeleza usiri
    - **Sera na taratibu**: Ni sera na taratibu gani zilizopo za kuhakikisha usiri? Je, unafuata sera na taratibu maalum kuhakikisha usiri wa mgonjwa? Hizi zinatekelezwa vipi kwa wagonjwa?
    - **Changamoto katika usiri**: Ni uzoefu gani unaufahamu unaohusiana na kuhakikisha usiri? Ni changamoto gani katika kudumisha usiri? Hizi uliweza kuzikabilije?

- **Mafunzo na uelewa**: Ni mafunzo gani yaliyopo, kama yapo, kuhusu usiri? Yanafanywa vipi? Mafunzo yanayoendelea yanahakikisha vipi wafanyakazi wote wanafahamu na kudumisha viwango vya usiri?

4. Mawasiliano
    - **Mbinu zinazofaa**: Ni mbinu gani za mawasiliano unazotumia kwa wagonjwa kuhakikisha huduma ya uzazi yenye heshima? Mbinu gani umegundua kuwa bora zaidi katika kuhakikisha mawasiliano wazi na yenye huruma/ utu kwa wagonjwa?
    - **Kukabili vikwazo vya mawasiliano**: Una uzoefu gani katika lugha na mawasiliano wakati wa kutoa huduma ya uzazi yenye heshima? Unazikabili vipi changamoto za lugha au vikwazo vingine vya mawasiliano katika kazi yako?
    - **Mbinu za maoni**: Maoni ya wagonjwa yanakusanywaje na kutumika kuboresha mazoezi ya mawasiliano?
    - **Mawasiliano ya kitaalamu baina ya wataalamu wa afya:** Je, mawasiliano baina ya watoa huduma wenzako unaona yanaathiri vipi utoaji wa huduma ya uzazi yenye heshima?

Hitimisho

- Ruhusu mhojiwa kushiriki mawazo au uzoefu wowote zaidi kuhusiana na utoaji wa huduma ya uzazi yenye heshima.
- Hamasisha kubadilishana mawazo kuhusu maeneo yanayowezekana ya uboreshaji au ubunifu katika mazoezi ya huduma ya uzazi yenye heshima.

Mwisho

- Mshukuru kwa ushiriki wao na muda wao.
- Mjulishe kuhusu hatua zinazofuata na jinsi taarifa itakavyotumika.

Appendix 5: Approval for ethical clearance

UNITED REPUBLIC OF TANZANIA

MINISTRY OF EDUCATION, SCIENCE AND TECHNOLOGY

MUHIMBILI UNIVERSITY OF HEALTH AND ALLIED SCIENCES

OFFICE OF THE DIRECTOR – RESEARCH, PUBLICATIONS AND INNOVATIONS

Ref. No.DA.282/298/01.C/2251 Date: 17/05/2024

MUHAS-REC-05-2024-2251
IVONY KAMALA
SCHOOL OF PUBLIC HEALTH AND SOCIAL SCIENCES
MUHAS

RE: APPROVAL FOR ETHICAL CLEARANCE FOR A STUDY TITLED: HEALTHCARE PROVIDERS' EXPERIENCES IN THE IMPLEMENTATION OF NON-MEDICAL ELEMENTS OF RESPECTFUL MATERNITY CARE AT NYAMAGANA DISTRICT HOSPITAL

Reference is made to the above heading,

I am pleased to inform you that the Chairperson has on behalf of the University Senate, approved ethical clearance of the above-mentioned study, on recommendations of the Senate Research and Publications Committee meeting accordance with MUHAS research policy and Tanzania regulations governing human and animal subjects research.

APPROVAL DATE: 17/05/2024
EXPIRATION DATE OF APPROVAL: 17/05/2025

STUDY DESCRIPTION:
Purpose:
The purpose of this qualitative phenomenological study is to explore healthcare providers' experiences in implementing non-medical elements of Respectful Maternity Care in Nyamagana District Hospital, Mwanza region

The approved protocol and procedures for this study is attached and stamped with this letter, and can be found in the link provided: https://irb.muhas.ac.tz/storage/Certificates/Certificate%20-%2015629.pdf and in the MUHAS archives.

The PI is required to:

1. Submit bi-annual progress reports and final report upon completion of the study.
2. Report to the IRB any unanticipated problem involving risks to subjects or others including adverse events where applicable.
3. Apply for renewal of approval of ethical clearance one (1) month prior its expiration if the study is not completed at the end of this ethical approval. You may not continue with any research activity beyond the expiration date without the approval of the IRB. Failure to receive approval for continuation before the expiration date will result in automatic termination of the approval for this study on the expiration date.
4. Obtain IRB amendment (s) approval for any changes to any aspect of this study before they can be implemented.
5. Data security is ultimately the responsibility of the investigator.
6. Apply for and obtain Data Transfer Agreement (DTA) from NIMR if data will be transferred to a foreign country.
7. Apply for and obtain Material Transfer Agreement (MTA) from NIMR, if research materials (samples) will be shipped to a foreign country.
8. Apply for and obtain permission to publish the results from National Institute for Medical Research. The application should be before submitting to a publisher and not concurrently through the email publications@nimr.or.tz.
9. Any researcher, who contravenes or fail to comply with these conditions, shall be guilty of an offence and shall be liable on conviction to a fine as per NIMR Act No. 23 of 1979, PART III section 10 (2)
10. The PI is required to ensure that the findings of the study are disseminated to relevant stake holders.
11. PI is required to be versed with necessary laws and regulatory policies that govern research in Tanzania. Some guidance is available on our website https://drp.muhas.ac.tz/.

Dr. Nahya Salim Masoud,
Chairperson, MUHAS Research and Ethics Committee

Muhimbili University of Health and Allied Sciences
DIRECTOR
Research, Publications & Innovations
Box 65001

Appendix 6: Permission letter

UNITED REPUBLIC OF TANZANIA
MINISTRY OF EDUCATION, SCIENCE AND TECHNOLOGY
MUHIMBILI UNIVERSITY OF HEALTH AND ALLIED SCIENCES
OFFICE OF THE DIRECTOR – POSTGRADUATE STUDIES

In reply quote;
Ref. No. HD/MUH/T.649/2023

06th June, 2024

District Medical Officer,
P.O. Box 119,
MWANZA

Re: **INTRODUCTION LETTER IVONY KAMALA**

We would like to inform you that the bearer of this letter is **Ivony Kamala** with Reg. No. **HD/MUH/T.649/2023** is a student at Muhimbili University of Health and Allied Sciences (MUHAS) "pursuing **MPH-Regular Track.**

As part of her studies, she will be doing an elective research titled: "**Health Care Providers' Experiences in the Implementation of Non-Medical Elements of Respectful Maternity Care at Nyamagana District Council".**

The research has been approved by the Chairman of University Senate.

Kindly provide her the necessary assistance to facilitate the conduct of her research.

We thank you for your cooperation.

Ms. Victoria Mwanilwa
For: DIRECTOR, POSTGRADUATE STUDIES

c.c Ivony Kamala

9 United Nations Road; Upanga West; P.O. Box 65001, Dar Es Salaam: Tel. G/Line: +255-22-2150302/6; Ext. 1015; Direct Line:+255-22-2151378;Telefax:+255-22-2150465;E-mail:dpgs@muhas.ac.tz;Web:https://www.muhas.ac.tz

Appendix 7: Digital receipt

turnitin

Digital Receipt

This receipt acknowledges that Turnitin received your paper. Below you will find the receipt information regarding your submission.

The first page of your submissions is displayed below.

Submission author:	Ivony Kamala
Assignment title:	DISSERTATION
Submission title:	20072024_Kamala_RMC_research.docx
File name:	20072024_Kamala_RMC_research.docx
File size:	3.71M
Page count:	76
Word count:	18,632
Character count:	110,825
Submission date:	24-Jul-2024 01:45PM (UTC+0300)
Submission ID:	2327745468



Copyright 2024 Turnitin. All rights reserved.

Appendix 8: Plagiarism report

20072024_Kamala_RMC_research.docx

ORIGINALITY REPORT

24%	21%	16%	18%
SIMILARITY INDEX	INTERNET SOURCES	PUBLICATIONS	STUDENT PAPERS

PRIMARY SOURCES

1	Submitted to Muhimbili University of Health and Allied Sciences Student Paper	3%
2	dspace.muhas.ac.tz:8080 Internet Source	2%
3	www.researchsquare.com Internet Source	1%
4	www.massgeneral.org Internet Source	1%
5	journals.plos.org Internet Source	1%
6	www.medrxiv.org Internet Source	1%
7	Submitted to London School of Hygiene and Tropical Medicine Student Paper	1%
8	assets.researchsquare.com Internet Source	<1%
9	bmcpregnancychildbirth.biomedcentral.com	