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IMPROVING RESPECTFUL MATERNITY CARE IN ETHIOPIA:

Health System Constraints and Mitigation Approaches

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Abstract

The mistreatment of women during facility-based childbirth is a violation of women's human rights that jeopardises their right to a safe, satisfying, and positive childbirth experience. In addition, such mistreatment is a significant deterrent to the utilisation of skilled birth services. In Ethiopia in 2019, 52.5% of women gave birth outside a health institution. There is compelling evidence that the level of mistreatment of women in the country is very high and women prefer home birth in part due to experienced or perceived mistreatment. Respectful maternity care (RMC) is a recommended practice that promotes the rights, dignity, confidentiality, and privacy of women during facility-based childbirth. However, there is a research gap on the barriers to the promotion of RMC and the effectiveness of RMC interventions in mitigating the mistreatment of women globally and in Ethiopia.

This dissertation reports a study conducted in Ethiopia that aimed to identify health system constraints to the promotion of RMC in public hospitals and test a multicomponent intervention (staff training, placement of wall posters, and post-training onsite support for quality improvement) that was designed to promote RMC. The study used an interventional mixed methods design that included surveys of both women and service providers before and after the intervention, focus group discussions with service providers before and after the intervention, and in-depth interviews with key informants before the intervention. The quantitative and qualitative methods were integrated at the design, methods, and interpretation and reporting levels. Multilevel mixed effects modelling was used to evaluate the effectiveness of the intervention in reducing mistreatment. Hybrid thematic analysis that was guided by complex adaptive systems theory was used to identify health system constraints to the promotion of RMC and the complex interactions between various elements in the maternity care system.

The study identified that the number of mistreatment components experienced by women was reduced by 18% after the RMC intervention and mistreatment was higher among

women who had complications during childbirth and those who gave birth vaginally. Additionally, 29.7% of service providers who participated in the RMC training reported they had mistreated a woman in the 30 days before the training. The training improved the service providers' awareness of the rights of women during childbirth and their perceptions and attitudes about RMC were positively influenced. Structural and systemic issues were the main challenges providers reported when trying to implement RMC in their contexts. Constraints in both system hardware (bed availability, infrastructure and supplies, financing, and health workforce) and system software domains (service providers' mindset, staff motivation, and awareness of RMC) exhibited complex relationships and affected the promotion of RMC.

This study substantiated that maternity care should be approached from a system-oriented perspective to bring a sustainable and lasting contribution. Additionally, the lessons learned through the implementation of the piloted RMC intervention, mainly the RMC training, are believed to play a significant role in future implementation studies aimed at scaling up a standalone or integrated pre-service or in-service RMC training in Ethiopia. The complex interactions between the various system elements in the maternity care system, which resulted in the poor status of RMC translates into the need for a broad spectrum and system-oriented RMC promotion approaches. There is a long journey ahead if the mistreatment of women in health facilities is to be eliminated in Ethiopia.

Declaration

I, Anteneh Asefa Mekonnen, declare that

- i. the thesis comprises only my original work towards the Doctor of Philosophy except where indicated in the Preface,
- ii. due acknowledgement has been made in the text to all other material used,
- iii. the thesis is fewer than 100,000 words in length, exclusive of tables, maps, bibliographies and appendices.

Signature:

A handwritten signature in blue ink, consisting of a stylized, cursive 'A' followed by the name 'Anteneh Asefa' written in a clear, legible script.

Date:

09 September 2020

Preface

Before starting this PhD in November 2016, I was employed by the School of Public Health, Hawassa University as Assistant Professor. I commenced the PhD with a developed research idea of exploring health system challenges to the promotion of RMC in Ethiopian health facilities and testing an intervention to promote RMC. In my first PhD year, under the supervision of Associate Professor Michelle Kermode and Associate Professor Alison Morgan, I developed a complete PhD protocol, a RMC intervention package, an electronic data collection platform, applied for ethics approval from the University of Melbourne and Ethiopia, prepared a financial proposal for the proposed intervention and secured funding from an international partner organisation through the Ministry of Health, Ethiopia.

From November 2017 to November 2018, I conducted my field research work in Ethiopia that involved frequent meetings with various stakeholders especially Ministry of Health and the Southern Nations Nationalities and Peoples Region Health Bureau, and the three study hospitals (Adare General Hospital, Leku Primary Hospital, and Yirgalem General Hospital) where the intervention was implemented. Additionally, I oversaw the financial and administrative aspects of the intervention, coordinated the review of the intervention package by local experts, trained data collectors for the women's survey, supervised the data collection and managed the database, facilitated two rounds of respectful maternity care training for service providers, coordinated onsite supportive visits, conducted focus group discussions and in-depth interviews, and transcribed qualitative interviews.

From December 2018, I analysed the quantitative (surveys of women and service providers) and qualitative (focus groups with service providers and in-depth interviews with key informants) data that were used to draft manuscripts for publication in peer-reviewed international journals. In 2019, I was accepted as a fellow in the prestigious Policy Communications Fellows program of the Population Reference Bureau and participated in

the virtual and face-to-face sessions of the program. I developed a policy brief drawing from findings of my PhD study for the Ministry of Health, Ethiopia.

This PhD thesis is ‘thesis with publications’ that reports findings of the PhD study using two published papers and one paper under review. Additionally, a commentary which is currently under review and appended to this thesis was used to present a summarised description of the role of RMC in mitigating maternal health inequities (Appendix A). My contribution to these papers exceeds 80%; I took responsibility for drafting manuscripts, corresponding with journals, and making revisions. There were nine co-authors across these publications.

Co-author	Affiliation
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Sintayehu Abebe	Amref Health Africa in Ethiopia
Dr Hema Magge	Institute for Healthcare Improvement

Publications

Publications arising from the PhD study described in this thesis

1. Asefa A*, Morgan A, Gebremedhin S, Tekle E, Abebe S, Magge H, Kermode M: Mitigating the mistreatment of women during facility-based childbirth: Evaluation of respectful maternity care intervention in Ethiopian hospitals. *BMJ Open*. 2020;10:e038871
2. 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. *Reproductive Health*. 2020;17:103.
3. Asefa A*, McPake B, Langer A, Bohren MA, Morgan A (2020): Imagining maternity care as a complex adaptive system: understanding health system constraints to the promotion of respectful maternity care. *Sexual and Reproductive Health Matters* (under review)
4. Asefa A* (2020): Unveiling respectful maternity care as a buffer against global maternal health inequities. *BMJ Global Health* (under review)

Relevant publications produced during the period of candidature, some bridging to this PhD study (*italicised*)

1. Asefa A*, Morgan A, Hailemariam T, Shiferaw M, Mekonnen E, Birhan Y. Task shifting of emergency caesarean section in south Ethiopia: Are we repeating the brain drain? *Pan African Medical Journal*. 2020; 36:145.
2. Medhanyie A, Alemu H, Asefa A, KMC Scale-Up Study Group, et al. Kangaroo Mother Care implementation research to develop models for accelerating scale-up in India and Ethiopia: study protocol for an adequacy evaluation. *BMJ Open* 2019;9:e025879.
3. Gebremedhin S, Asefa A. Treatment-seeking for vaginal fistula in sub-Saharan Africa. *PLoS ONE* 2019; 14(11): e0216763.
4. Asefa A*, Gebremedhin S, Messele T, Letamo Y, et.al. *Mismatch between antenatal care attendance and institutional delivery in south Ethiopia: A multilevel analysis. BMJ Open* 2019; 9:e024783.

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5. Teshome M, Wolde Z, Gedefaw A, Asefa A*. *Improving surgical informed consent in obstetric and gynecologic surgeries in a teaching hospital in Ethiopia: A before and after study. BMJ Open* 2019;9:e023408.
6. Gebremedhin S, Asefa A. Association between type of contraceptive use and haemoglobin status among women of reproductive age in 24 sub-Saharan Africa countries. *BMJ Sexual and Reproductive Health* 2019;45:54-60.
7. Teshome M, Wolde Z, Gedefaw A, Tariku M, Asefa A. Surgical informed consent in obstetric and gynecologic surgeries: experience from a comprehensive teaching hospital in Southern Ethiopia. *BMC Medical Ethics*. 2018; 19:38.
8. Nana C, Asefa A. Prolactal feeding and associated factors among newborns in rural Sidama, south Ethiopia: a community based cross-sectional survey. *International Breastfeeding Journal*. 2018; 13:7.
9. 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. Reproductive Health*. 2018; 15:4.
10. Sando D, Abuya T, Asefa A, Banks KP, Freedman LP, Kujawski S, et al. Methods used in prevalence studies of disrespect and abuse during facility-based childbirth: lessons learned. *Reproductive Health*. 2017; 14:127.
11. Asefa A*. Respectful maternity care to end mistreatment during facility-based childbirth: a people-centred care approach to accelerate Universal Health Coverage. *International Health Policies*. 2017. (Blog)

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I owe a debt of extraordinary gratitude to my former primary supervisor Associate Professor Michelle Kermode, who surprised me with her retirement in my third year of candidature, for having confidence in me and giving me the academic space to conduct my field research intervention in Ethiopia. Michelle's exceptionally organised mentorship and intelligent feedback, which started since my application for admission into the PhD program, was instrumental in the timely completion of my dissertation. I am very fortunate to have my PhD Advisory Committee members Professor Barbara McPake (chair), Dr Gregory Armstrong (member), and Professor Ana Langer for keeping your eyes on my PhD milestone, and your support and encouragement. Having Barbara in one of my PhD papers and collaborating with her in one of Nossal's projects has been a wonderful experience to tap from her extensive expertise in complexity science and health policy and systems research.

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My dreams of testing a respectful maternity care intervention to improve childbirth experiences of women in Ethiopia would not have been realised without the incredible support of key partners in Ethiopia. I would like to pass my sincere appreciation to Dr Ephrem Tekle and Sintayehu Abebe for aligning the intervention I proposed with the priorities of the Maternal and Child Health Directorate, Ministry of Health (Ethiopia). My appreciation extends to the Institute for Healthcare Improvement for financially supporting the respectful maternity care intervention that was made possible by the leadership of Dr Hema Magge. I am also grateful to Tilahun Tesfaye and his team at the Regional Health Bureau for steering the respectful maternity care implementation in collaboration with the administrators of the study hospitals. Equally, I would like to sincerely thank all study participants and data collectors who took part in the study for their time and partnership.

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Abbreviations

ANC	Antenatal Care
BEmOC	Basic Emergency Obstetric Care
CEmOC	Comprehensive Emergency Obstetric Care
CI	Confidence Interval
CQI	Continuous Quality Improvement
D&A	Disrespect and Abuse
FGD	Focus Group Discussion
HIV	Human Immunodeficiency Virus
HPSR	Health Policy and Systems Research
HSDP	Health Sector Development Plan
HSS	Health System Strengthening
IDI	In-depth Interviews
LMIC	Low- and Middle-Income Countries
MCH	Maternal and Child Health
MDG	Millennium Development Goals
MDSR	Maternal Death Surveillance and Response
MMR	Maternal Mortality Ratio
PHC	Primary Health Care
RMC	Respectful Maternity Care
SBA	Skilled Birth Attendant
SDG	Sustainable Development Goals
SNNPR	Southern Nations Nationalities and Peoples Region
SSA	Sub-Saharan Africa
UHC	Universal Health Coverage
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WHO	World Health Organization

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Chapter 1: Introduction

1.1 Overview

More than 800 women die each day due to preventable conditions that emerge in the course of pregnancy and childbirth, despite remarkable declines in maternal mortality in the past decades¹. According to the World Health Organization's (WHO) estimates, 295,000 maternal deaths occurred in 2017, of which 4.7% occurred in Ethiopia¹. Low uptake of maternal health care services, especially skilled birth attendance, remains a key challenge to reducing maternal mortality in low- and middle-income countries (LMICs)^{2, 3}. A significant portion of the low uptake of services is attributable to poor quality of care which spans both clinical and non-clinical aspects of care, and which includes the mistreatment of women⁴.

The mistreatment of women during facility-based childbirth—an issue that is gaining international scrutiny—is a violation of women's human rights and a significant deterrent to the utilisation of skilled birth services⁴⁻⁶. Mistreatment also jeopardises women's right to a safe, satisfying, and positive childbirth experience⁴. Additionally, the mistreatment of women leads to detrimental sequelae to the health of women, their newborns, and families. A novel study from Brazil reported that the mistreatment of women during facility-based childbirth is also associated with a higher level of postpartum depression⁷. Despite deep-rooted existence and normalisation of mistreatment, focused mitigative measures are minimal, due predominantly to the lack of evidence in the field.

Mistreatment takes various forms including verbal abuse, physical abuse, sexual abuse, stigma and discrimination, detention, neglect and abandonment, non-confidential care, non-consented care, and poor health system conditions and constraints^{5, 8}. Several studies from sub-Saharan Africa, including WHO-led studies, reported high levels^{9, 10} and diverse manifestations^{5, 11} of the mistreatment of women during facility-based childbirth. Studies from Ethiopia also revealed high levels of the mistreatment of women during childbirth in health

facilities¹²⁻¹⁴. There is also compelling evidence that Ethiopian women prefer home birth in part due to experienced or perceived mistreatment of women in health facilities¹⁵⁻²³.

In the past decade, the growing reports of the mistreatment of women globally led to the development and adoption of the “Respectful Maternity Care Charter”²⁴ and the release of WHO’s statement on the “Prevention and Elimination of Disrespect and Abuse During Facility-Based Childbirth”⁶. With the aim of meeting the maternal mortality targets of the Sustainable Development Goals (SDG), strategies for ending preventable maternal mortality were introduced in 2015. The strategy calls for health systems not to neglect respectful maternity care (RMC) while endeavouring to deliver effective clinical interventions ²⁵. WHO’s framework for quality maternal and newborn health care reinforces the important role of RMC, and identifies respect and preservation of dignity as one of the eight domains of quality of care²⁶.

There is a growing body of literature on the prevalence of the mistreatment of women both globally and in Ethiopia. However, there is a research gap on the barriers to the promotion of RMC and the effectiveness of RMC interventions in mitigating the mistreatment of women, especially in LMICs. To the best of my knowledge, there have been no prior studies that investigated RMC from a health system perspective. This study conducted in Ethiopia responds to the contemporary evidence gap in two aspects: through identifying health system constraints to the promotion of RMC in public hospitals, and through designing and testing an RMC intervention package.

1.2 Country profile: Ethiopia

Ethiopia is a low-income country located in the horn of Africa and has a federal structure encompassing nine administrative regions and two city administrations (Figure 1.1). The country had an estimated total population of 112 million (male to female sex ratio of 0.99) as of 2019 and an annual population growth rate of 2.5%²⁷. Nearly 80% of the population resides in rural areas and women of reproductive age group constitute 24.7% of the total

population^{27, 28}. Between 1990 and 2018, total fertility rate in Ethiopia declined from 7.7 to 4.2^{29, 30}; contraceptive prevalence rate increased from 5% to 41% in the same period^{30, 31}. The Southern Nations Nationalities and Peoples Region (SNNPR), where this study was conducted, had an estimated total population of 19.2 million in 2017ⁱ (83.4% rural population)²⁸, total fertility rateⁱ of 4.4 in 2016³², and contraceptive prevalence rate of 45% in 2019³¹.

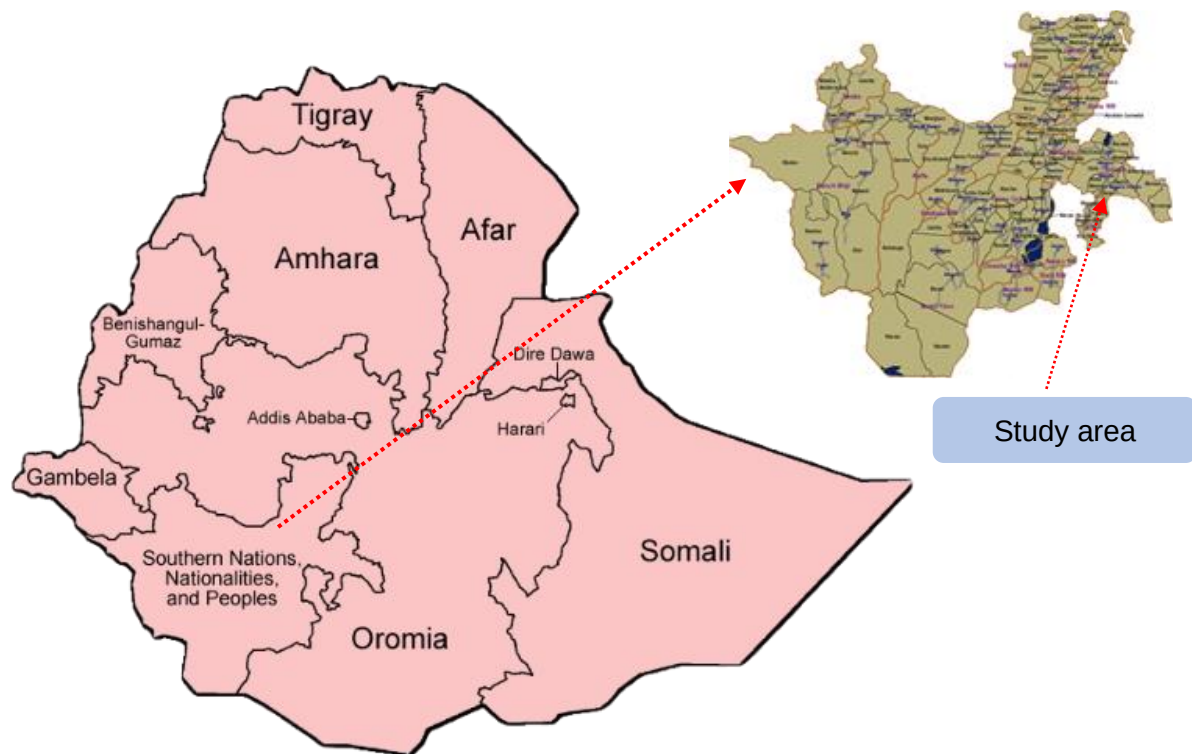


Figure 1.1 Administrative map of Ethiopia (Source: https://en.wikipedia.org/wiki/Regions_of_Ethiopia)

Ethiopia is a multicultural and multiethnic country with more than 80 languages, the official language at federal level being Amharic²⁸. The SNNPR, administratively divided into 17 zones and four special districts, is inhabited by more than 80 ethnic groups. Sidama zone, the largest and populous zone in the region, is in the process to be the tenth regional state in Ethiopia after 98.5% of voters in a referendum held in November 2019 were supporting its regional statehood³³. Hawassa city is the seat of both the SNNPR government and Sidama zone administration. One of the hospitals included in this study (Adare General Hospital) is

ⁱ Recent data or estimate for the region not available

situated in Hawassa city. The remaining two study hospitals are situated in Shededino (Leku Primary Hospital) and Dale districts (Yirgalem General Hospital) of Sidama Zone.

According to the World Bank, gross domestic product in Ethiopia in 2018 was 84 billion USD, and per capita income was 561 USD for the same year, an increase from 374 USD in 2013³⁴. Government expenditure on health as a share of total government expenditure was 8.7% in 2016/17³⁵, lower compared with the Abuja Declaration goal of 15%³⁶; health expenditure as a percentage of gross domestic product was 3.5% in the same year, almost one-third of the global figure (9.9%) and lower than the minimum recommended level (5%) required to achieve universal health coverage (UHC)^{34, 37}. Per capita health expenditure in Ethiopia was 25.3 USD in 2017, government spending taking only 32% of the total health expenditure; out of pocket payment takes 33% share of the total health expenditure^{34, 35}. The total federal government budget for 2019/2020 budget year was 13.4 billion USD which was later boosted by a supplementary budget totalling 0.85 billion USD in May 2020 to cover additional expenditures, including healthcare, in response to the COVID-19 pandemic crisis³⁸.

Overall, there have been significant improvements in health in Ethiopia in recent years. In the ten years between 2008 and 2017, life expectancy at birth increased from 59.6 years to 66.2 years and lifetime risk of maternal death decreased from 3.7% to 1.8%³⁴. These improvements were achieved because of a broad socioeconomic reform coupled with policy measures and transformative strategies in the various sectors, including the Health Sector Development Plan and the Health Sector Transformation Plan³⁹. However, there are inequities in mortality and morbidity related health indicators between regions⁴⁰.

1.3 The researcher

I was born in 1984 in Ethiopia and completed my secondary school education in 2002 with very high distinction and admitted to the then Debub University, Currently Hawassa University, and earned my Bachelor of Science in Nursing in 2006. In 2009, I received my

Master of Public Health from Addis Ababa University, Ethiopia. Since 2006, I have been serving in academia in the rank of graduate assistant, assistant lecturer, lecturer, and assistant professor chronologically. I did my master's thesis on assessing the overall quality of prevention of mother-to-child-transmission of HIV in health facilities in Oromia region, Ethiopia. Since my academic career as a lecturer in 2009, I have been working in Health Systems Management and Policy Unit of the School of Public Health, Hawassa University. During my career, I engaged in teaching, research, and community support, including the provision of technical support to various governmental and non-governmental organisations.

Pertaining to managing research, I have served as a principal and co-principal investigator of Ethiopia-based studies on maternal, sexual, and reproductive health services that were supported by various organisations including Save the Children International, WHO, UNFPA, Center for International Reproductive Health Training, the Maternal Health Task Force, and Comic Relief. Barriers to the uptake of facility-based childbirth, task shifting of emergency caesarean section, informed consent for obstetric and gynaecologic surgeries, the mistreatment of women, respectful sexual and reproductive health services, improving the uptake of family planning services, and improving retention in HIV care were some of the research thematic areas in which I engaged. Additionally, since 2010 I have been serving as a lead trainer for two in-service training programs, namely the Prevention of Mother-to-Child Transmission of HIV, and Leadership, Management and Governance in Health.

In November 2016, I joined the Nossal Institute for Global Health, Melbourne School of Population and Global Health at the University of Melbourne to pursue my PhD. As part of my endeavour and accomplishments in global health, I was selected as a fellow of the Maternal Health Young Champions (Maternal Health Task Force, 2013), New Voices in Global Health (World Health Summit, 2013), Emerging Voices for Global Health (Health Systems Global, 2014), Mandela Washington Fellowship for Young African Leaders (Department of State, USA, 2016), and Policy Communication Fellow (Population Reference Bureau, 2019).

1.4 Conception of the study

I conceived this PhD study based on two of my previous research projects that sparked a keen interest in studying what Ethiopian health facilities and the health system, in general, require to provide RMC. The first study was a quantitative study on the mistreatment of women in health facilities that showed high levels of mistreatment of women both in a hospital and health centres^{12, 41}. The second was a region-wide mixed methods study conducted in SNNPR led by the PhD candidate. The study revealed perceived mistreatment in health facilities as one of the major impediments to maternal health services utilisation in all settings of the region (agrarian, pastoralist, and urban); findings of the quantitative study are published⁴².

1.5 Outline of the thesis

This thesis is organised in eight chapters. Chapter 2 describes the progress to date in reducing maternal mortality and improving maternal health globally and in Ethiopia and remaining challenges in Ethiopia, with emphasis on the quality and woman-centredness of intrapartum care. Chapter 2 then examines concepts, definitions, contributors, measurement and prevalence, and consequences of the mistreatment of women during facility-based childbirth and finishes with describing the concepts of RMC and evidence gap in the effectiveness of interventions to promote RMC globally and in Ethiopia.

Chapter 3 makes a case for the application of systems thinking and health systems research to investigate the barriers to RMC and the challenges of implementing RMC in health facilities. The chapter draws on the complex adaptive systems theory to demonstrate how it could be used to understand complexities in maternity care settings specifically and RMC generally.

Chapter 4 outlines the aim of the study and the methods used to respond to the study objectives. It provides a detailed description of the advanced mixed methods design

(interventional mixed methods design) used in the study, the RMC intervention, and actions taken to ensure rigour in the quantitative and qualitative methods and the strategy used to integrate these.

The results of the study are organised in three chapters in the form of two peer-reviewed journal articles and one manuscript currently under review. Chapter 5 reports the evaluation of the RMC intervention through examining its effect on the level of mistreatment of women using data from a pre- and post-RMC intervention surveys of women who gave birth in the study hospitals. The findings provide quantitative evidence of what could be achieved by training service providers and pave the way for exploring what should be done to increase its yield—described in Chapters 6 and 7.

Chapter 6 reports lessons learned in the RMC training and its implementation in the study hospitals drawing from the perceptions and experiences of service providers who participated in the RMC training. The chapter pools findings of a pre- and post-RMC training surveys of service providers and post-RMC intervention focus group discussions with trained providers.

Chapter 7 explores health system factors that constrain the promotion of RMC in the hospitals using the tenets of complex adaptive systems theory to portray the complexities and patterns of relationships between various elements in maternity care settings. It expands on findings reported in Chapter 6 to reveal how health systems factors affected RMC even in the presence of the RMC intervention highlighting the need for promoting RMC using a health system strengthening approach.

Chapter 8 discusses the key findings of the study and describes opportunities for increasing the potential efficacy of the RMC intervention in promoting positive childbirth experience. The chapter also explains implications of the study for improving RMC in Ethiopia and other similar settings from the perspectives of health system strengthening, indicating future research priorities on RMC, and integrating RMC in pre-service training curriculums.

Chapter 2: Overview of maternal mortality and maternal health globally and in Ethiopia

In this chapter, I start with the status of maternal mortality and maternal health both globally and in Ethiopia, highlighting the determinants, progress to date, and opportunities and challenges. I describe the mistreatment of women and make a case for how it affects the uptake of life-saving maternal health services in LMICs and how it could be prevented through the promotion of RMC.

Synthesis of published literature included in Tables 2.1, 2.3, and 2.5 in this chapter was done in two steps. First, a literature search was done using key search terms that cover the topic areas under investigation (barriers to maternal health services utilisation, barriers to institutional birth in Ethiopia, and mistreatment during facility-based childbirth in Africa) using PubMed and Google Scholar. Then, the selection of articles from the search results was made using JBI quality assessment checklists developed by the Joanna Briggs Institute⁴³; quantitative, qualitative, and mixed methods studies reporting reliable results were included upon my evaluation. Articles that achieved a minimum JBI quality score of 0.7 (out of 1) were included.

2.1 Overview of maternal mortality

2.1.1 Maternal mortality globally

In 2017, the global Maternal Mortality Ratio (MMR)ⁱ was 211 per 100,000 live births (uncertainty interval: 199 - 243) and the lifetime risk of maternal mortality was 1 in 170⁴⁴. As displayed in Figure 2.1, there was remarkable progress in reducing maternal mortality globally between 1990 and 2017, resulting in a 45.2% reduction in the number of women dying during pregnancy or as a consequence of childbirth complications^{1, 44}. The total number of maternal deathsⁱⁱ that occur in a single year has also fallen from 532,000 in 1990

ⁱ Maternal mortality ratio (MMR) is defined as the number of maternal deaths during a given time period per 100,000 live births during the same time period, usually one year.

ⁱⁱ Maternal death is the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and the site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes.

to 295,000 in 2017^{1, 44}. The proportion of deaths attributed to maternal causes among women aged 15 - 49 also declined by 26.3% between 2000 and 2017⁴⁴. However, the pace and extent of reduction varied significantly across regions.

Because MMR is both a global health and development indicator, its reporting and use has a paramount political and accountability significance⁴⁵. However, it is difficult to accurately measure maternal mortality in many settings⁴⁴.

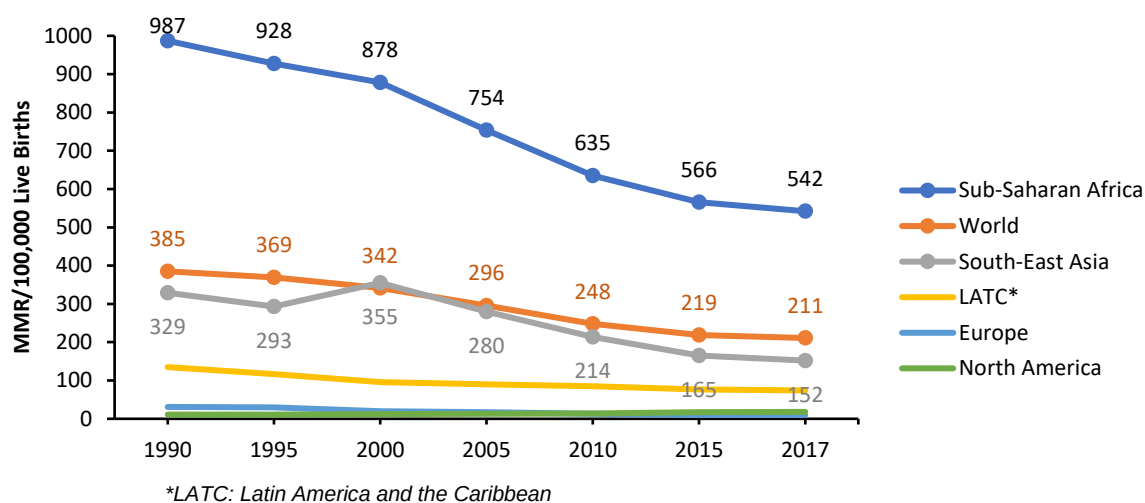
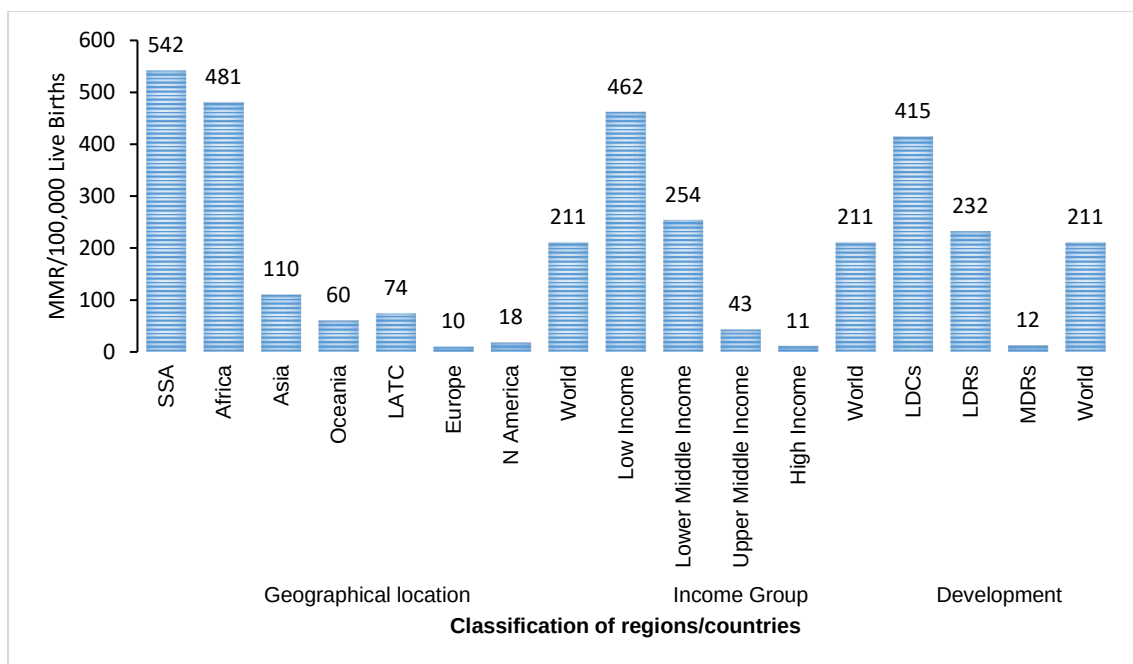


Figure 2.1 Trends in maternal mortality ratio by regions: 1990 – 2017, ^{1, 44}

From the total number of global maternal deaths in 2017, almost all (99%) happened in LMICs. Sub-Saharan African (SSA) countries contributed to 67.8% of global maternal deaths, followed by South Asian countries (19.3%). Moreover, nearly half (47.6%) of the global maternal deaths happened in Nigeria (22.7%), India (11.9%), Democratic Republic of the Congo (5.4%), Ethiopia (4.7%), and Pakistan (2.8%). Africa reported more than double the global MMR (Figure 2.2)⁴⁴.



*LATC: Latin America and the Caribbean; LDC: Least Developed Countries; LDR: Least Developed Regions; MDR: More Developed Regions; SSA: sub-Saharan Africa

Figure 2.2 Disparities in maternal mortality ratio across regions, 2017, ⁴⁴

Referring to the World Bank classification of regions by income, the MMR in low-income regions was nearly 42 times that of high-income regions in 2017 (462 vs 11 per 100,00 live births, respectively)⁴⁴ (Figure 2.2).

2.1.2 Maternal mortality in sub-Saharan Africa

Overall the MMR of SSA reduced from 987 per 100,000 live births in 1990 to 542 per 100,000 live births in 2017 (Figure 2.1)⁴⁴. However, similar to the global picture, there is significant variation across the region. In 2017 alone, 67,000 (29.6% of the total maternal deaths in the region) maternal deaths happened in Nigeria; Democratic Republic of the Congo and Ethiopia follow with 8.2% and 7.1%, respectively⁴⁴.

However, the number of maternal deaths should not be used as the single criterion to show the severity of the condition; instead, MMR gives a better impression as it takes the population at risk into account^{1, 46}. In this regard, South Sudan had the highest MMR in SSA and the world in 2017 (1150 per 100,000 live births); followed by Chad (1140 per 100,000 live births), Sierra Leone (1120 per 100,000 live births), and Nigeria (917 per 100,000 live

births). Fragile health systems as a result of war, conflict, and displacement in SSA countries⁴⁴—compounded by the Ebola outbreak in western Africa including Guinea, Liberia, and Sierra Leone^{47, 48}—is still impeding the progress in improving maternal health.

2.1.3 Causes and determinants of maternal mortality

Causes of maternal mortality

The majority of maternal deaths are due to directly preventable causes. According to the WHO's review of global maternal deaths, between 2003 and 2009 more than a quarter (27.1%) of maternal deaths were due to haemorrhage, mostly postpartum haemorrhage; followed by pre-eclampsia and eclampsia (14%), infection (10.7%), and other direct causes (9.6%). However, indirect causes such as embolism contribute to the majority of maternal deaths of women in high-income countries⁴⁹.

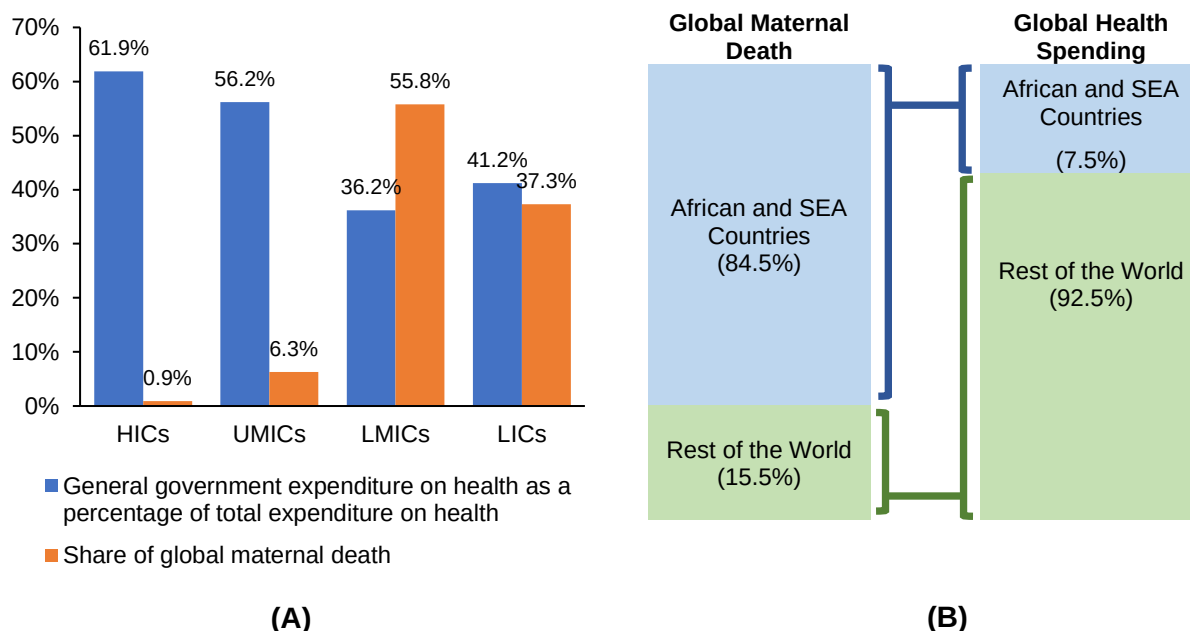
Determinants of maternal mortality

Understanding the determinants of maternal mortality is critical to identify the root causes of maternal deaths and design evidence-informed preventative strategies. There is a complex web of events that drive maternal mortality including women's disempowerment, poverty, lack of education, poor access to and utilisation of reproductive and maternal health services, and demographic features such as younger age at first pregnancy². Gender biases and inequalities and systemic discrimination entrenched in society not only result in the disempowerment of women but increase their vulnerability to early marriage, sexual violence, unwanted pregnancies, infections including HIV, and mortality from other preventable causes^{25, 50}. Accordingly, scholars suggest that in sub-Saharan Africa, it is important to frame maternal mortality from a human rights perspective to foster accountability to end preventable maternal deaths,^{50, 51}. Apart from these, other potent predictors of maternal mortality, such as political instability and disease outbreaks, have not been adequately addressed by previous studies. West African countries hit by the Ebola outbreaks are facing huge impediments to improving maternal health services³.

2.1.4 The nexus between investment in health and maternal mortality

The level of maternal mortality is a powerful indicator of economic growth and development⁵². Likewise, adequate investment in health is the engine behind the implementation of evidence-based interventions that aim to reduce maternal mortality. Such investments result in substantial returns through transforming the lives of women, their families, and communities⁵³. Without adequate investment in maternal health, achieving the ambitious maternal health targets of the SDGs will be unlikely⁵⁴. Nevertheless, per-capita health expenditure is deficient (< 86 USD) in 79% of low-income countries, that are home to 37% of the global maternal deaths and whose health systems are highly reliant on international aid⁵⁵. Between 2010 and 2014, a 14% increase in health expenditure was associated with a 10% maternal mortality reduction globally, after controlling for the effects of human development index⁵⁶

A review conducted in 2014 shows that government share of expenditure in health is low (41%) in low-income countries, though it is growing over time (Figure 2.3-A)^{1, 57}. Both total health expenditure and government expenditure on health are important; the latter reflects a commitment to investing in health by governments. In 2011, ten years after the Abuja Declaration—signed by heads of states of the then African Union member countries—only Tanzania reached the target to allocate 15% of the government budget to the health sector³⁶. Additionally, there is a mismatch between global health spending and global maternal mortality burdens. Figure 2.3-B shows that south-east Asian and African countries, home to nearly 85% of the global maternal deaths, contribute only 7.5% of the share of global health spending^{1, 57}.



HIC: High-Income Country; UMIC: Upper Middle-Income Country; LMIC: Lower Middle-Income Country; LIC: Low-Income Country; SEA: South-East Asia

Figure 2.3(A) Government health expenditure and share of global maternal death, ^{1, 44, 57}

Figure 2.3(B) Global health spending and global maternal death, ^{37, 57}

Although data on earmarked financing on maternal health is not available, it is reasonable to conclude that financing gaps in LMICs are one of the key challenges leading to the drivers of maternal mortality—low access to and poor quality of life-saving maternal, sexual, and reproductive health services⁵⁸. With this regard, the overarching aim of UHC to ensure that people have equitable access to a wide array of good quality health services plays a paramount role in reducing maternal mortality if successfully financed⁵⁹. Thus, strengthening the path to UHC to ensure women’s access to life-saving maternal, sexual, and reproductive services needs a high-level commitment from governments and allied partners⁵⁸. In this regard, the “Addis Ababa Action Agenda” is historic and vital as it envisages the level of financial commitment required to achieve the SDGs, including SDG3^{56, 60, 61}.

2.2 Overview of maternal health

2.2.1 Maternal health revisited

Maternal health before the Millennium Development Goals era

In the 1970s, despite the high and steady level of maternal mortality in low-income regions, the issue was not duly emphasised by high-level decision-makers and political elites⁵².

Replicating the western health care system in low-income countries left most of their population devoid of access to and utilisation of life-saving health services, including maternal health services⁶².

The poor access to health services led to a paradigm shift. The Alma Ata declaration, the birth of the Primary Health Care (PHC), was adopted in 1978 to bridge the gaps in health needs and inequalities⁶³. One of the key aims of PHC was to reduce maternal and child mortalities. However, the purposed reduction in maternal mortality was not achieved until 1985, partly due to the selective PHC model's lack of focus on the leading causes of maternal death⁶⁴.

In 1987, nine years after the Alma Ata, the Safe Motherhood Initiative was launched in Kenya aiming to reduce maternal mortality by 50% by 2000 through improving access to maternal health (antenatal, safe delivery, and obstetric care) services⁶⁵. Synergistically, the 1994 International Conference on Population and Development held in Cairo put forward a program of action—adopted by 179 countries—to promote women's reproductive health and rights⁶⁶. Following these two major conferences, the WHO and other international development agencies convened and developed guidelines and standards of care⁶⁷.

However, the target of the Safe Motherhood (reducing maternal mortality by half in the year 2000) could not be realised as hoped for, and global maternal mortality remained as high as in the 1970s. Maine and Rosenfield claimed that the failure to show progress in maternal mortality was not due to lack of resources, but due to the unwise use of existing resources⁶⁸.

Furthermore, the dysfunctional health systems in which maternal health programmes operated hampered the potential yields of proven interventions⁶⁹.

Maternal health during the Millennium Development Goals era

Millennium Development Goal 5 (MDG5), “Improve Maternal Health” with its two targets and six indicators, was the goal envisioned to substantially reduce MMR. That brought a new opportunity for the advancement of maternal health through better investment to improve the health and well-being of women across the globe⁷⁰. In the 25 years from 1990 to 2015, MMR was reduced by 45%, far less than the target envisioned (75%)⁷¹. The proportion of births attended by skilled health personnel increased from 59% to 71% in the 25 years period; 43% to 52% in SSA; most of the improvement in maternal health indicators happened between 2000 and 2015⁷¹. To accelerate the progress towards the achievement of the MDG maternal health targets, several global initiatives were launched in the first decade of the millennium. The Countdown 2015, the Partnership for Maternal, Newborn and Child Health, the Women Deliver, the Maternal Health Task Force, and White Ribbon Alliance for Safe Motherhood played a catalytic and advocacy role to gain accountability and commitment to maternal health at governmental and global levels⁷².

Maternal health in the Sustainable Development Goals era

In September 2015 world leaders renewed their development promise to end all forms of poverty through sustained actions⁷³; the “2030 Agenda for Sustainable Development” which consists of 17 SDGs was launched⁷³. Maternal health is included as one of the 13 targets of the SDG3, “*Ensure healthy lives and promote the well-being for all at all ages*”. In response to the need to accelerate the achievement of SDG3, several strategies have been designed and are currently in use⁵³

The “Every Woman Every Child” movement, launched by the former United Nations Secretary-General Ban Ki-moon in 2010, has been playing a crucial advocacy role in gaining financial and political commitment for sexual, reproductive, maternal, newborn, child, and

adolescent health, globally⁷⁴. Later, the movement published the “Global Strategy for Women’s, Children’s and Adolescents’ Health” in 2015 as a roadmap to achieve the SDG targets related to women’s, children’s and adolescent health through its “Survive, Thrive, Transform” objectives³. The 2015’s WHO Strategies for Ending Preventable Maternal Mortality also put forward strategies which are being implemented to reduce inequities in maternal and newborn health between and within countries²⁵.

Furthermore, in 2016, WHO launched its Standards for Improving Quality of Maternal and Newborn Care in Health Facilities to strengthen efforts towards improving the quality of care women and their newborns receive in health facilities around the time of childbirth. The standard defined quality of care in the context of maternal and newborn care as “the degree to which maternal and newborn health services (for individuals and populations) increase the likelihood of timely, appropriate care for the purpose of achieving desired outcomes that are both consistent with current professional knowledge and take into account the preferences and aspirations of individual women and their families.”^{26(p15)} In the move to translate the definition into practice, the standard included a quality of care framework—which consists of eight domains of quality of care—designed to assess, improve, and monitor the quality of maternal and newborn health services (Figure 2.4).

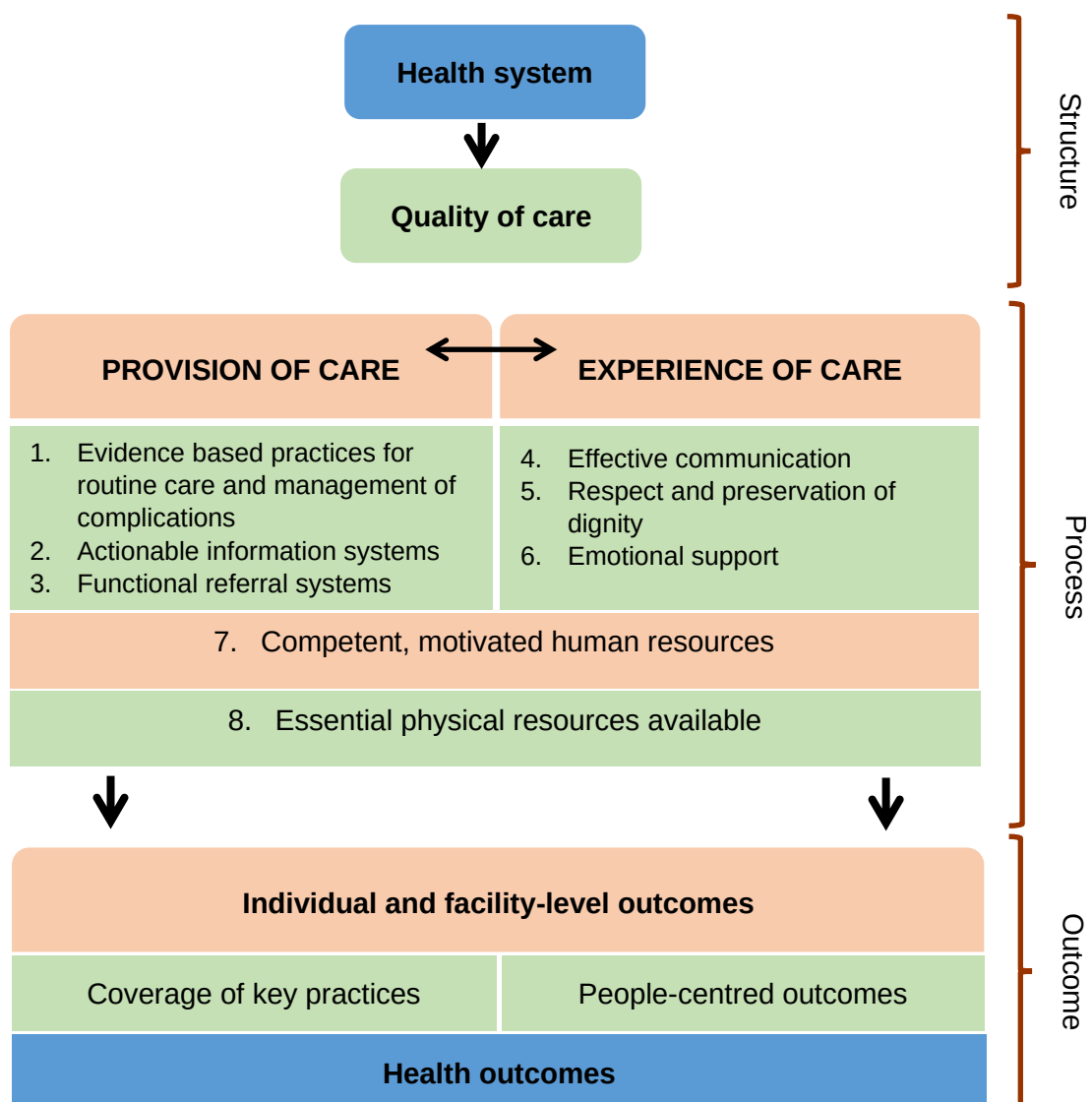


Figure 2.4 Framework for the quality of maternal and newborn health care, ^{26(p16)}

2.2.2 Challenges to improving maternal health services utilisation in sub-Saharan Africa

Cultural barriers, poverty, resource constraints, gender inequities, poor governance, inadequate public health spending, corruption, conflict and displacement, disasters, and urban-rural inequities have long been compromising the access to and utilisation of maternal health services in SSA^{50, 75-78}. Working towards achieving the health-related SDGs and UHC in SSA warrants adoption of context-specific national strategies and guidelines, multi-stakeholder collaboration, and engagement with the community at large⁵³. A review of the

supply- and demand-side factors and macro-level bottlenecks that affect the utilisation of maternal health services in SSA are summarised in Table 2.1.

Several innovative and cost-effective approaches such as task shifting of obstetric care, mHealth (mobile health), maternity waiting homes, maternal death reviews, integration of services, CQI, community engagement, and community-based maternal health services are currently being implemented in most low-income settings to combat the bottlenecks mentioned above, and their yield is commendable⁷⁹.

Table 2.1 Summary of the literature describing barriers to maternal health services utilisation in SSA

Country (Author/s, Year)	Challenges		
	Macro level	Demand side	Supply side
Nigeria ⁸⁰ (Babalola et al., 2009)	-	• Being a rural resident • Poor access to the media • Fear of moving out of community norms	• Inadequate health facilities
Ghana ⁸¹ (Banchani et al., 2014)	• Transportation challenges, access to roads	-	• Lack of in-service training • Unmotivated staff • Shortage of labour rooms • Poor occupational safety
Malawi ⁸² (Kambala et al., 2011)	• Poor accessibility of services	-	• Lack of supplies and logistics • Long waiting time • Shortage of midwives • Unfriendly health workers
SSA countries - Review ⁸³ (Kyei-Nimakoh et al., 2017)	• Lack of access to transport	• Household poverty • Cultural beliefs • Low perceived susceptibility to complications	• Direct and indirect costs • Weak referral mechanism • Long waiting time • Lack of respect for women
SSA countries - Review ⁷⁸ (Moyer et al., 2013)	• Poor women's education • Poor accessibility of services	• Influence from the community	-
Tanzania ⁸⁴ (Mpenbeni et al., 2007)	• Poor accessibility of services	• Lack of open discussion with male partner • Low knowledge of risk factors of pregnancy	-
Three SSA and Six Asian countries - Review ⁸⁵ (Tey et al., 2013)	• Poverty • Poor women's education and empowerment • Poor accessibility of services	• Being a rural resident • Poor access to media • Pressure from family and husbands	• Service cost • Indirect health cost: transport • Intermittent services
South Africa ⁸⁶ (Tsawe et al., 2014)	-	• Lack of knowledge about maternal health care • Being a rural resident	• Shortage of health workers • Service cost • Indirect health cost: transport
Kenya ⁸⁷ (Wamalwa et al., 2015)	-	-	• Inadequate supplies • Inadequate financing • Staff shortage • Unmotivated staff • High workload

2.3 Maternal health in Ethiopia

Over recent decades, maternal health in Ethiopia improved remarkably primarily due to the significant progress in the accessibility of maternal health services^{40, 88}. The country's flagship health extension program along with the rapid expansion of emergency obstetric care service delivery outlets played key roles in that regard³⁹.

2.3.1 Maternal mortality in Ethiopia

There was a significant reduction in maternal mortality in Ethiopia between 2000 and 2017. The WHO's MMR estimates show that MMR fell from 1030 in 2000 to 401 in 2017 per 100,000 live births (Figure 2.5)⁴⁴. In 2017, the lifetime risk of maternal death was 1 in 55 (1.82%)⁴⁴.

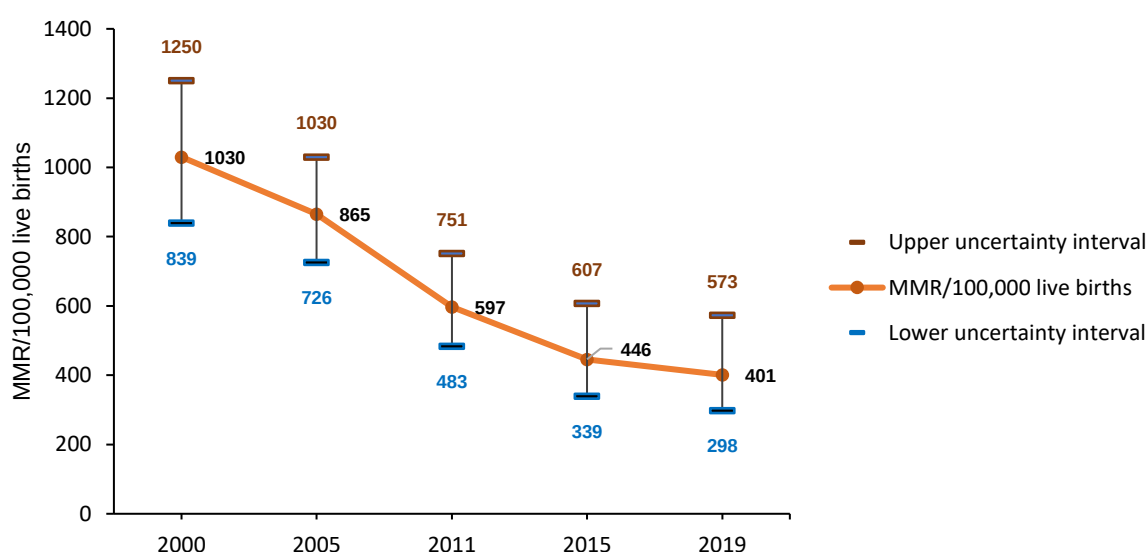


Figure 2.5 Trends of maternal mortality ratio in Ethiopia: 2000 - 2017, ⁸⁹

A 23-year (1990 - 2013) analysis of MMR in Ethiopia reported that the country is experiencing a 1.6% annual rate of reduction in MMR. Complications from other direct maternal causes (25.7%), complications from abortion (19.6%), maternal haemorrhage (12.2%), hypertensive disorders during pregnancy (10.3%), and all types of infections (9.6%) were the leading causes of maternal death⁹⁰. These estimates should be interpreted with caution given the absence of comprehensive civil registration systems^{91, 92}. For example in

2018, the maternal death surveillance and response (MDSR) recorded only 10% of the total maternal deaths in the country, 72% of which occurred at health facilities, indicating a significant gap in understanding the causes of maternal deaths that occur outside health facilities⁹³.

2.3.2 Access to and utilisation of maternal health services

The availability of health facilities has improved over the 15-year period between 2000 and 2015. In 2015, there were 309 and 3605 functional hospitals and health centres, respectively, which provided maternal health services⁹⁴. Similar improvements were reported in terms of human resources for health. (Figure 2.6). However, inequity in the distribution of human and infrastructural resources between the urban-rural, and rich-poor remains a challenge, though declining^{75, 88}.

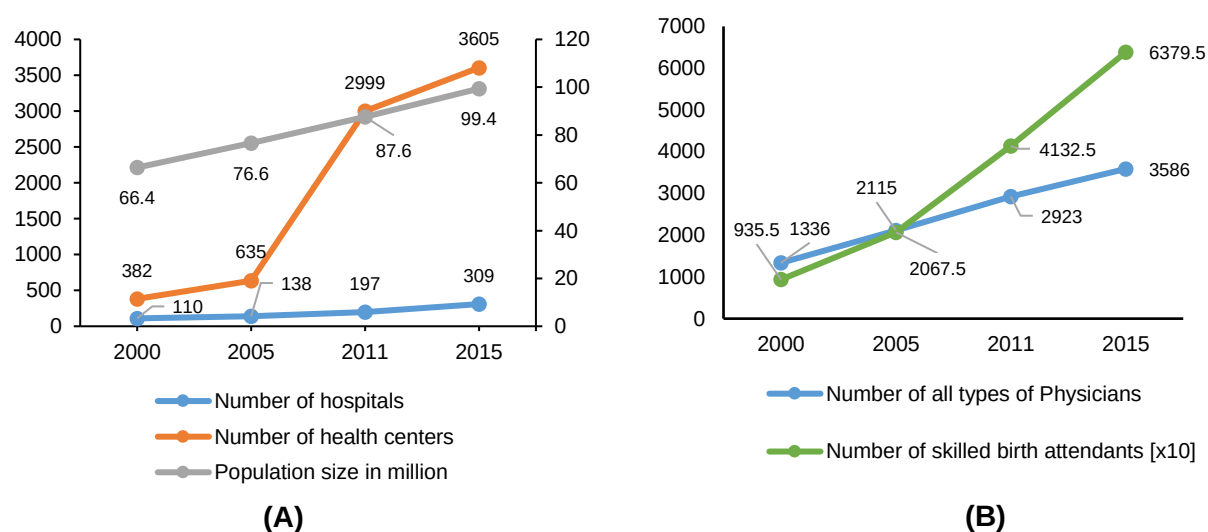


Figure 2.6(A) Trends of available health facilities in Ethiopia: 2000 - 2015*

Figure 2.6(B) Trends of available health professionals in Ethiopia: 2000 - 2015*

**Summarised from yearly health and health-related indicators of the Federal Ministry of Health Ethiopia⁹⁴*

In 2015, there were 696 comprehensive emergency obstetric care (CEmOC) and 1724 basic emergency obstetric care (BEmOC) facilities in Ethiopia (Table 2.2)⁹⁴. The status of emergency obstetric care indicators in the SNNPR, where this study is situated, is relatively better than the national average. According to the WHO process indicators for obstetric services, for a population of 500,000, there should be five obstetric care facilities, and at

least one should be a CEmOC facility⁹⁵. Ethiopia meets the standard. However, ensuring continuous availability of the CEmOC signal functions is a challenge due to constraints in human resources, supplies, and infrastructure⁹⁶; as it is in many other LMICs⁹⁷⁻¹⁰¹.

Table 2.2 Summary of obstetric care indicators in Ethiopia and SNNPR, 2015

Obstetric care indicators	National	SNNPR
Total population ²⁸	90,076,012	18,062,165
Number of CEmOC facilities	696	204
Ratio of CEmOC facilities to total population	1:129420	1:88540
Ratio of CEmOC facilities to women aged 15-49 years	1:25952	1:17774
Number of BEmOC facilities	1724	428
Ratio of BEmOC facilities to total population	1:52248	1:42201
Ratio of BEmOC facilities to women aged 15-49 years	1:10476	1:8472
Ratio of Nurses in the public sector to the total population	1:2053	1:1952
Ratio of Midwife in public sector to women aged 15-49 years	1:2267	1:2608
Ratio of skilled birth attendants to population	1:1391	1:1457
Ratio of skilled birth attendants to women aged 15-49 years	1:293	1:289

There has been a fivefold increase in the proportion of births attended by skilled providers between 2011 and 2019^{30, 31}. The 2019 Ethiopian Mini-Demographic and Health Survey reported that 47.5% of births between 2014 and 2019 occurred in health facilities, and skilled providers attended 49.8 % of births³². This discrepancy between the proportion of facility-based delivery and births attended by skilled providers is because there are women who give birth at home assisted by level 4 health extension workers (health extension workers who received additional two years competency-based training on top of the regular one-year training to become diploma holders) who are considered as skilled birth attendants by the Ethiopian government according to WHO's definition¹⁰² (Figure 2.7).

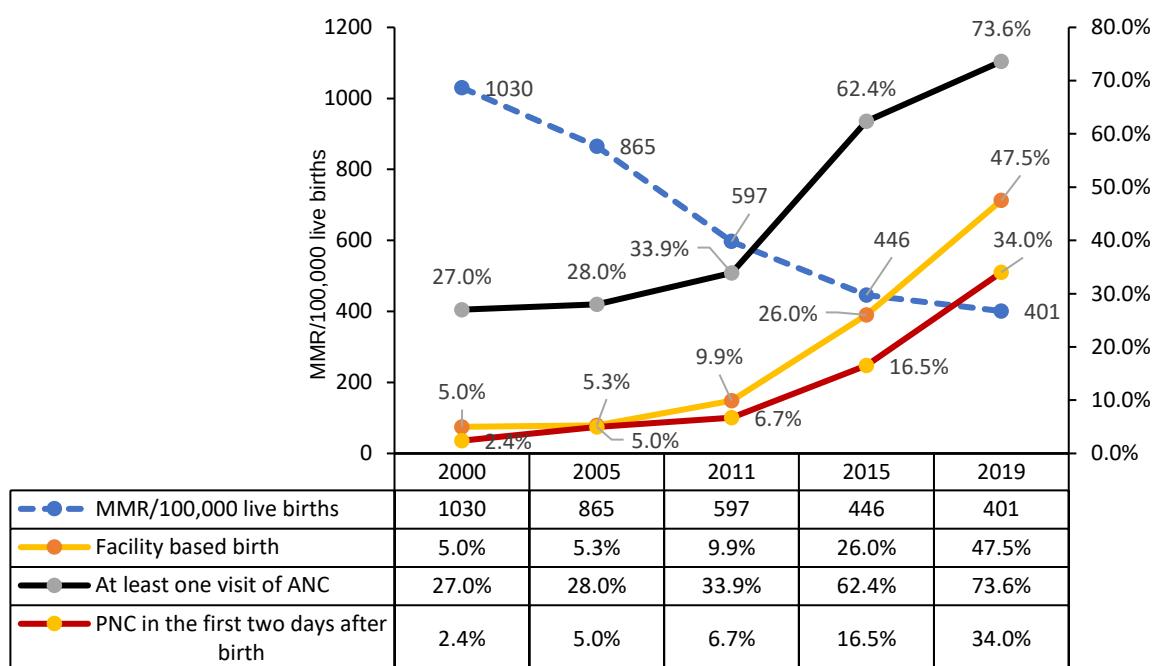


Figure 2.7 Trends of maternal health care utilisation in Ethiopia: 2000 - 2019, ^{30, 32}

In 2011, 47% of births attended by skilled providers (10% of total births) took place at primary health centres, 32% (6% of total births) in 2005⁷⁵, which goes in line with the 372% increase in the number of health centres in the country in the same time period (Figure 2.6 A) in the country. The remaining births attended by skilled providers in 2005 occurred in hospitals and private higher clinics⁷⁵.

Between 2000 and 2011, improvement in the uptake of maternal health services was gradual at best. Significant improvements in the utilisation of antenatal care (ANC), institutional birth and postnatal care were achieved in recent years (Figure 2.7). However, there is a huge mismatch in the continuum of maternal health service utilisation. The main missed-opportunity is the high drop-out of women across the maternal health continuum; a significant proportion of women who receive ANC give birth at home (Figure 2.7). A large community-based survey conducted by the PhD candidate in SNNPR revealed that 62.2% of women who had at least one ANC visit during their index pregnancy gave birth outside health facilities⁴².

2.3.3 Deterrents to facility-based childbirth in Ethiopia

Prior studies indicate that perceived poor quality of care, distant health facilities, previous uncomplicated home birth experiences, competing tasks at home, non-utilisation of ANC, fear of exposing body parts to strangers, and the cost of services at health facilities are among the common factors contributing to home birth among Ethiopian women^{15, 20, 21, 23, 42, 103-107}. Disapproval from elderly women, night-time labour, lack of transportation facilities, women's low economic and educational status, and women's limited decision-making power are also reasons for preference of home birth^{20, 42, 104-106}. These studies are summarised in Table 2.3.

Women's negative experiences and/or other women's negative experiences of facility-based childbirth are commonly reported reasons for not attending a health facility at the time of birth^{15, 20, 21, 104}. These experiences include hostile or insensitive staff²¹, disallowance of birth companions^{20, 21}, disrespectful care^{19, 108, 109}, women's lack of autonomy¹⁰⁴, poor reception at health facilities²⁰, lack of privacy^{20, 21}, unfriendly staff¹⁸, abusive care¹⁸, shortage of beds at referral facilities¹¹⁰, and poor readiness of health facilities¹⁸. The attitudes, actions and system barriers that contribute to such negative experiences are nowadays labelled as disrespect and abuse (D&A) or mistreatment.

Table 2.3 Summary of the literature reporting barriers to institutional birth in Ethiopia

Study area (Author/s, year)	Method of inquiry	Deterrents to institutional birth; Deterrents that relate to mistreatment are in bold text	
All administrative regions ²¹ (Rural); (Sipsma et al., 2013)	Qualitative	- Resource constraint at HFs: staff, logistics Hostile or insensitive staff Being ashamed of showing body to strangers - Cost of facility-based services: indirect costs	Uncomfortable birthing couches Disallowance of family members in labour wards - Environmental barriers: topography, weather - Non-regular service of health facilities Previous bad experience
Northwest Ethiopia: Gagusa district ¹¹¹ (Rural) (Alemayehu et al., 2015)	Quantitative	- Long distance to arrive at health facility - Facility-based birth not customary - Parental influence	- Women's low decision-making power Disrespectful care at HFs
North Ethiopia: Tsegede and Adwa ^{15, 108} (Rural) (Hailu et al., 2014 & Jackson et al., 2016)	Quantitative	- Women's low educational status - Long distance	- Women's low decision-making power Disrespectful care at HFs
All administrative regions ^{104, 106} (Tarekegn et al., 2014 & Yebyo et al., 2015)	Quantitative	- Women's and male partners' low educational status - Women's non-use of ANC Women's poor autonomy Perceived poor quality of care - Women's low decision-making scope	- Being a rural resident - Women's low economic position - High parity - Long distance from health facilities - Being a rural resident
Central Ethiopia: southwest Shoa ¹¹² (Urban and semi-urban) (Wilunda et al., 2015)	Quantitative	Perceived poor quality of care - Women's low decision-making scope	Perceived poor quality of care Disrespect in health facilities
Addis Ababa ^{19, 22} (Urban) (Mirkuzie et al., 2014 & Tebekaw et al., 2015)	Qualitative	- Social influences - Physical access to health facility	Perceived poor quality of care Disrespect in health facilities
Northwest Ethiopia: Sekela and Chilga ^{17, 23} (Rural) (Teferra et al., 2012 & Kebede et al., 2013)	Quantitative	- Poor economic status - Long distance	Poor approach of service providers - Poor attitude towards care during childbirth
South-central Ethiopia: Butajira ²⁰ (Rural) (Roro et al., 2014)	Qualitative	- Women's low decision-making power - Misconception of services provided at health facility Disallowance of birth companions Traditional and/or spiritual factors - Economic factors	- Accessibility to health care facilities Poor reception of women at HFs Lack of privacy - Poor competence of health care providers Inadequate resources at HFs
North-east Ethiopia: Afar ¹⁸ (Rural) (King et al., 2015)	Qualitative	- Women's limited decision-making opportunities Perception of poor quality of SBA care Poor structural readiness of HFs Unfriendly or even abusive service	- Long distances and no access to roads - Costs of travel and medicines - Domestic workloads - Women's non-use of ANC
South Ethiopia: Hadiya ¹⁰³ (Rural) (Asseffa et al., 2016)	Quantitative	Previous history of uncomplicated birth at home	Poor economic status

*ANC: Antenatal Care; HFs: Health Facilities; SBA: Skilled Birth Attendant; TBA: Traditional Birth Attendant

2.3.4 Health workforce in Ethiopia

In Ethiopia, there has been a significant expansion of health facilities and health services as a result of the health sector development plans (HSDP) I – IV (1998 - 2015) and then the Health Sector Transformation Plan (2016-2020)^{39, 113}. Between 2006 and 2015, the HSDP III and IV implementation period, remarkable improvement in health workforce development was achieved; both the expansion of health professional education and teaching programs throughout the country and the launch of accelerated programs to train physicians, integrated emergency surgical officers, midwives, anaesthetists, and health officers played key roles in that regard. In 2017, there were a total of 142,657 health professionals working in the public sector in Ethiopia, of which 12,069 (8.5%) were midwives, 5411 (3.8%) were physicians (all levels), and 9746 (6.8%) were non-physician clinicians (health officers and integrated emergency surgical officers).

However, a significant gap remains in the availability of an adequate number and skill mix of health professionals, especially in rural settings, in addition to the inequitable distribution of health workforce between and within geographical regions^{114, 115}. Table 2.4 shows health workforce density in Ethiopia in 2016 in comparison with international standard; the density of total health professionals per 1000 population was 1.63 (1.4 in SNNPR). Total health workforce density, including those working in the private sector, per 1000 population in 2018 was 2.52¹¹⁶.

Table 2.4 Health workforce density in Ethiopia in 2016^{114pp23}

Indicators	Ethiopia*	International Benchmark ⁸⁹
Total Health professionals per 1000 population	1.63 per 1000	Not available
Physician, nurse, and midwife to population ratio	0.8 per 1000	4.45 per 1000
Physician to population ratio	1 per 17,720	1 per 10,000
Nurse to population ratio	1 per 2,132	1 per 5,000
Midwife to population ratio	1 per 8,200	1 per 5,000

**only includes health professionals in public sectors*

The annual enrolment of medical students showed a 20-fold increase between 2000 and 2016¹¹⁴. Similarly, the number of institutions that train midwives more than doubled between 2009 and 2016, increasing from 23 in 2009 to 49 in 2016¹¹⁴. In addition to health professionals, there were 42,336 health extension workers—cadres who received a one-year training to provide basic curative, health promotive and disease preventive services at health posts and in the community—in the country in 2016¹¹⁴.

In Ethiopia, health professionals are trained in both public and private medical colleges and universities. Training health professionals in public universities is under the mandate of the Ministry of Education. In contrast, training of health professionals in regional public colleges is under the mandate of the Ministry of Health, which is delegated to regional and city administration health bureaus. Private universities and colleges train health professionals upon accreditation by the Higher Education Relevance and Quality Agency which is also responsible for accrediting public institutions¹¹⁷. In 2016, there were 35 public universities that offer medical education; 34 of these provide teaching to four or more health science disciplines¹¹⁴. Teaching institutions use harmonised curriculums prepared by teams of experts from various universities and colleges for training health professionals in the country.

Evidence shows that there are still significant challenges that impede health workforce development including suboptimal quality of health professions education and teaching,

inequitable geographical distribution of health professionals, weak human resource management capacity, limited budget for health workforce salary and benefits, weak human resources for health information system, and lack of strong health workforce regulation¹¹⁴⁻¹¹⁶. According to a study conducted among 484 midwifery students in 25 public institutions in Ethiopia, more than 50% of students had negative perceptions regarding the adequacy of classroom learning resources, the number of instructors, skills lab resources, skills lab assistants, the support given for students during skills lab sessions, the number of preceptors in practicum sites, support given for students during practicum, and practical experience to master midwifery competencies¹¹⁸. Based on the Objective Structured Clinical Examination given to the students, only 66% were found competent to assist normal vaginal birth¹¹⁸. Strengthening in-service training and continuing professional development have been the strategies deployed to address the knowledge, skill and attitude gaps among health professionals¹¹⁴. The Health Sector Transformation Plan (2016 - 2020) also outlined a multipronged approach to promote respectful care that includes revisiting and modifying health professionals education curriculums to integrate concepts of respectful care³⁹.

Working conditions, pay, and remuneration

Several studies conducted in various parts of Ethiopia revealed that job satisfaction is low among health professionals working in public facilities—31.7% in northern Ethiopia¹¹⁹, 38.5% in eastern Ethiopia¹²⁰, 53.8% in central Ethiopia¹²¹, and 41.5% in western Ethiopia¹²². Low remuneration, lack of recognition by supervisors, working in labour and childbirth and emergency care units, and lack of management support were among the main factors associated with job dissatisfaction among nurses and midwives^{123, 124}. Additionally, a follow-up study conducted in four regions (Addis Ababa, Amhara, Oromia, and Somali) of Ethiopia between 2003 and 2009 reported that health professionals' overall job satisfaction increased

over the years. However, satisfaction with remuneration and benefits and satisfaction with availability of facility resources decreased¹²⁵.

Attitude towards midwifery profession

There are varied attitudes toward the midwifery health workforce in Ethiopia, encompassing gender, professional status and passion. A study conducted in eastern Ethiopia reported that 18% of high school students had an intention to choose midwifery as their future profession; 54% among those whose parent/s were health professionals¹²⁶. Three-fifths (60%) of the students perceived that midwifery is culturally regarded as gender-specific and only suitable for female students, reinforcing the feminisation of the midwifery profession. Additionally, more than half (53%) of the students perceived that midwifery is not a well-regarded profession in the society¹²⁶. Another qualitative study conducted with midwifery students and new graduates in Addis Ababa revealed that there are students who joined the midwifery profession without their choice as the government assigned students arbitrarily and that has affected their passion, commitment to the profession, and intention to remain in the profession¹²⁷.

2.3.5 Current initiatives to improve maternal health in Ethiopia

The Ethiopian Health Sector Transformation Plan (2015/16-2020/21), the current five-year plan, was envisaged to accelerate the momentum for achieving health for all³⁹. Two of the four transformation agendas of the plan—transformation in equity and quality of health care, and the caring, respectful, and compassionate health workforce transformation—relate directly to the promotion of RMC in health facilities. Within the plan, there are focal areas to improve access to quality maternal health services. These include strengthening emergency obstetric care, health workforce development, task shifting of maternal health services, community engagement, health facilities expansion, the introduction of standards of care, and information, education and communication initiatives¹²⁸. The transformation plan also aims to reserve 14% of the health care budget for maternal health services. Included in the plan is strengthening of the

MDSR system, which was launched in 2013, to strengthen evidence-oriented public health actions to reduce maternal mortality³⁹.

To realise the quality-related ambitions of the plan, the Ministry of Health launched the National Health Care Quality Strategy (2016-2020) that prioritises the maternal health services as key action areas¹²⁹. The strategy underscored the need to have harmonised quality standards for maternal health services and outlined a national quality indicator framework for monitoring and evaluation purpose (Figure 2.8). The framework depicts facility-level and health system-level action areas that need to be assessed as part of the progress towards improving quality of care, including patient-centredness of care.

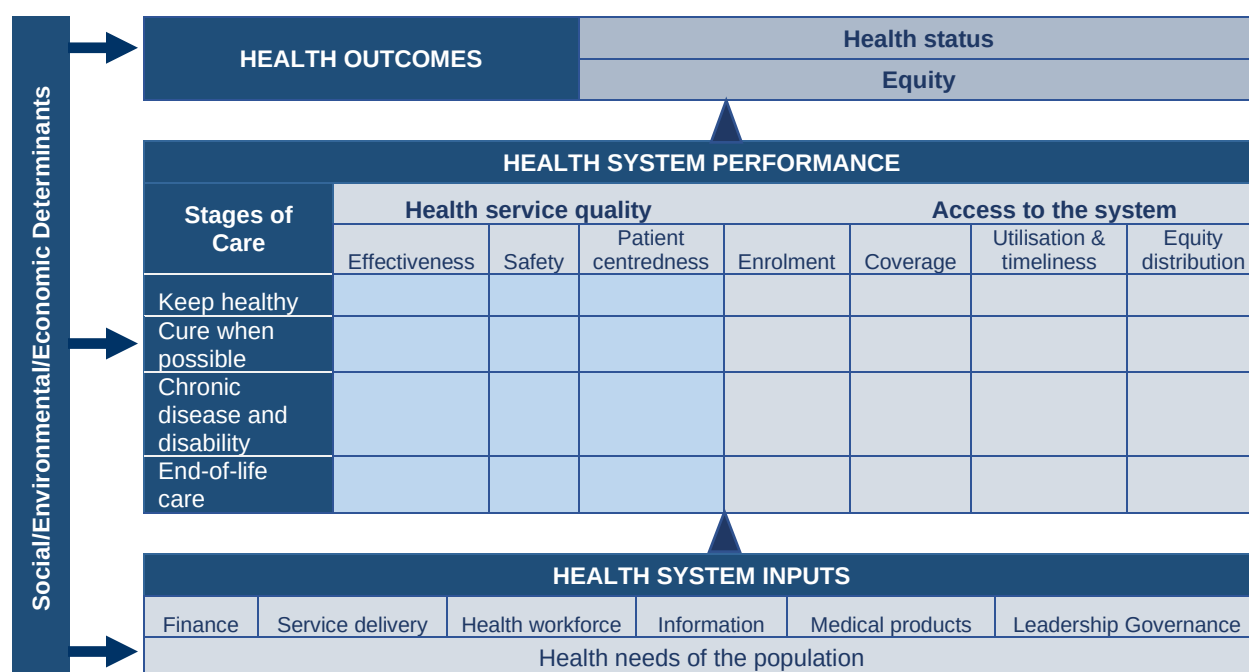


Figure 2.8 National health care quality indicator framework, Ethiopia, ^{129(p36)}

More recently, in November 2019, the Government of Ethiopia introduced the second *Essential Health Services Package*, which supersedes the 2005's first health services package. The document reiterates the need to advance the quality of health services, in addition to

strengthening the health system to meet the rising demand of the population and to build momentum for UHC⁴⁰.

In general, despite gradual achievements, the alarmingly high maternal mortality in Ethiopia remains a challenge. Improving access to quality and woman-centred maternal health services is crucial to prevent maternal deaths that primarily occur due to preventable causes. However, a multitude of barriers are at play leading to the low utilisation of life-saving services that women require during and immediately after childbirth. Reviewing existing literature identified that the mistreatment of women in health facilities is one of the major supply-side and health system factors that deter women from having facility-based childbirth.

2.4 The disease “Mistreatment” and the cure “Respectful Maternity Care”

The mistreatment of women and RMC are evolving areas of focus internationally, and these aim at understanding, identifying, measuring, and improving the experiences of women during facility-based childbirth. The growing body of knowledge in the field has a multidisciplinary nature and spans the boundaries of human rights, quality of care, and legal recourse.

2.4.1 Definition and characteristics of disrespect and abuse or mistreatment

Various terms such as disrespect and abuse, mistreatment, cruelty, obstetric violence, dehumanisation, and inhumane treatment are used by scholars or organisations to describe the negative experiences of women during childbirth in health facilities^{5, 6, 130, 131}. The inconsistent terminology and the dearth of standard definitions makes the synthesis and comparison of studies complex. In Latin America, obstetric violence is the commonly used term which emerged out of women’s groups movements to end the mistreatment of childbearing women in the region, which includes the over-medicalisation of childbirth¹³². On the other hand, some scholars recommend the use of “respectful maternity care” claiming it is a way of approaching the issue of disrespectful care from a positive perspective¹³³. However, that may miss recognising any

intentional humiliation and undignified treatment of women and it might further lead to the normalisation of these behaviours. Eventually, RMC evolved as not a term to describe the type of care that women should receive, but as a strategy to prevent D&A and improve women's childbirth experience from the angle of woman-centredness of care, quality of care and human rights^{4, 6, 24}.

WHO and other international organisations initially used D&A and recently shifted to mistreatment based on evidence from emerging literature^{4, 26}. However, there is still mixed use of these terms in the scientific literature highlighting the need for further research and consensus in the field. The 2014's WHO's statement on D&A also underscores the need for an internationally agreed definition and measurement indicators of D&A⁶. Contextual differences across countries with varying norms of acceptable care and the absence of a standard D&A framework are the main issues that complicate the path to an agreed definition⁵.

In 2014, Freedman and colleagues conceived a preliminary definition of D&A by drawing up lessons from their two studies in Kenya and Tanzania¹³⁴. The authors indicated that legal definitions without actual and field implementation do not provide a workable definition that can be used in different settings. They defined D&A as "interactions or facility conditions that local consensus deems to be humiliating or undignified, and those interactions or conditions that are experienced as or intended to be humiliating or undignified"^{134(p916)}. The definition captures individual (behaviours experienced during childbirth) and structural (systemic problems that create disrespectful and abusive environment) aspects of D&A. However, these two facets of D&A may or may not be perceived as D&A by individuals (Figure 2.9). The acts that lead to D&A may not necessarily be intentional¹³⁴. The definition is an important milestone in the evolving field, and it helps to synthesise disrespectful behaviours or conditions and develop locally appropriate measurement tools and indicators that can be used for planning purposes.

However, the development of international indicators for mistreatment remains challenging as what is disrespectful in one context may not be recognised as such in another^{8, 135}.

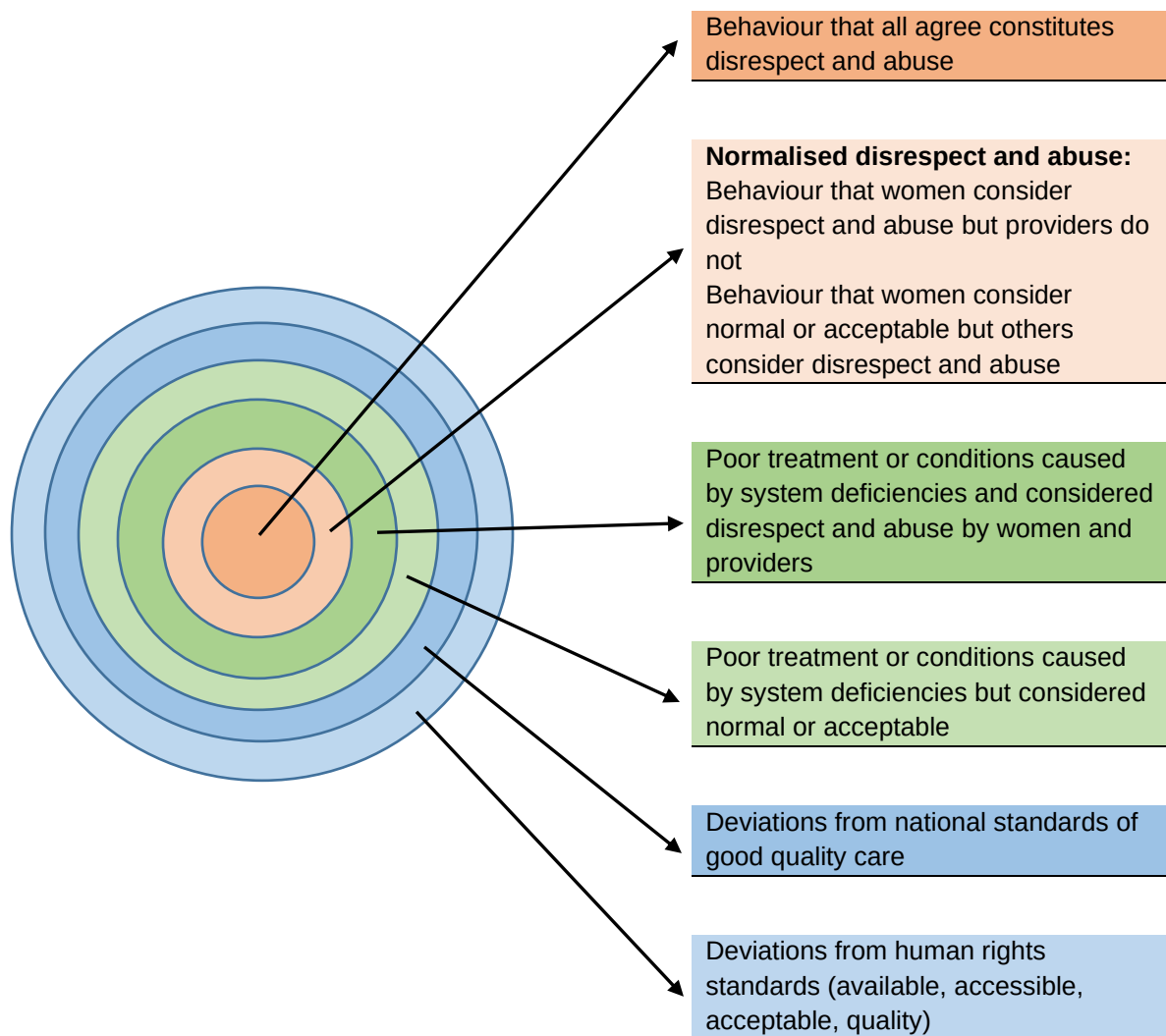


Figure 2.9 Scopes of disrespect and abuse definition, ^{134(p116)}

A mixed-methods systematic review commissioned by the WHO in 2015 (Bohren and colleagues) to synthesise an evidence-based typology of behaviours that constitute mistreatment recommended the use of the term “mistreatment”⁵. The review used existing literature to develop the conceptual domains of behaviours that constitute mistreatment at a global level which is believed to contribute to efforts to develop a consensual definition of

mistreatment. The authors claimed that “mistreatment” is more inclusive in capturing the full range of women’s and service providers’ experiences, and individual and health system conditions that jeopardise a woman’s rights to respectful care.

Later in 2018, Sen and colleagues, in their commentary entitled “Beyond measurement: the drivers of disrespect and abuse in obstetric care” suggested use of “disrespect and abuse” claiming that it is “inclusive and incisive”^{133(p8)}. Furthermore, they explicitly drew a distinction between actions considered as “disrespect” and “abuse”. The entire definition set forward by the group is quoted below. Sen and colleagues argued that their definition: captures intentional behaviours and unintended consequences; enables the exploration of the contributors to D&A; considers institutionalised practices and inequalities; and recognises consequences of negative behaviours.

“In the context of obstetric care, we define disrespect as the violation of a woman’s dignity as a person and as a human being on the basis of her economic status, gender, caste, race, ethnicity, marital status, disability, sexual orientation, or gender identity. Disrespect is often revealed in the biased normative judgements that health workers make about women and the resulting acts of omission or commission. Abuse refers to actions that increase the risk of harm to the woman and are not in the best interests of her health or well-being. Such actions may be learned and reproduced through the practices of institutional medicine. They may or may not be intended to cause harm and are often justified by resource constraints that can become a cover for prioritising the convenience of health providers over the well-being of the woman.”^{133(p8)}

The above definition contributes to the nuanced understanding of disrespectful behaviours that happen at the interpersonal level. However, in light with the evolving body of knowledge in the field, the definition falls short of spanning health system and policy level issues that form an integral part of D&A, for example, leadership and governance.

Characteristics of disrespect and abuse

Until the Bowser and Hill landscape analysis in 2010, there was no structured categorisation of D&A⁸; most previous studies only generated qualitative evidence of women's negative experiences or dissatisfaction with care during facility-based childbirth^{131, 136-152}. Bowser and Hill's analysis used a landscape review of evidence extracted from desktop reviews, expert meetings, and in-depth stakeholder interviews. Seven categories of D&A emerged from their analysis; physical abuse, non-consented care, non-confidential care, non-dignified care, discrimination, abandonment of care, and detention in facilities⁸. However, a specific form of D&A may belong to one or more category, making the categories a continuum and overlapping which warrants further categorisation effort to minimise space for subjective variation and thereby inconsistent prevalence estimates. Box 2.1 shows some examples of the forms of D&A along with their respective categories^{8, 153}.

Box 2.1 Forms of disrespect and abuse

Physical abuse

- Slapping, hitting, pinching, pushing, kicking, physically restraining, or sexually harassing

Non-consented care

- Denying women's right to choose between positions of choice during childbirth
- Failure to provide updates on the progress of labour, and provide informed consent for any procedure
- Failure of providers to ask a woman's permission before conducting a vaginal examination

Non-confidential care

- Lack of physical privacy
- Lack of confidentiality of sensitive information, including HIV status
- Publicly divulging private patient information

Non-dignified care

- Intentional humiliation, blaming, rough treatment, scolding, shouting, publicly divulging private patient information, and negative perceptions of care

Discrimination

- Discriminating women based on ethnicity, age, economic status, traditional beliefs, etc.

Abandonment of care

- Leaving women along for a prolonged period of time without attention

Detention

- Detention of women or their babies or both due to unpaid bills

The contribution of Bowser and Hill's categories was immense in the advancement of research and implementation of RMC globally. Several local and multi-country studies used these categories to qualitatively explore or quantitatively describe the mistreatment of women in childbirth^{12, 154-159}. Furthermore, the RMC charter developed by the White Ribbon Alliance launched the universal rights of childbearing women corresponding to each of these categories²⁴. The Maternal and Child Health Integrated Program also used these categories to develop RMC standards for quality improvement purposes that were used in several countries¹⁶⁰.

However, contextual differences across countries necessitate modifications of Bowser and Hill's categories and operationalisation of measurement indicators^{12, 154}. Accordingly, Bohren and colleagues conducted a thematic evidence synthesis that included 65 studies conducted across 34 countries. They identified seven themes of mistreatment namely: physical abuse, sexual abuse, verbal abuse, stigma and discrimination, failure to meet professional standards of care, poor rapport between women and providers, and health system conditions and constraints⁵. The last category (health system conditions and constraints) constitutes those disrespectful factors not resulting due to individual behaviour of service providers but structural and system deficiencies of the health system. These categories allow for a more robust approach to capture the various forms of mistreatment and designing and validating measurement tools, especially those focused on health system or structural issues.

Generally, regardless of which category a specific mistreatment behaviour belongs to, the following are experiences reported by women attending facility-based childbirth: being pinched, slapped, hit, pushed, kicked, shouted at, scolded, yelled at, detained, denied pain relief, left unattended, unnecessarily separated from their baby, treated without consent and confidentiality, physically exposed to strangers, neglected, emotionally abused, not informed about labour progress, physically restrained, discriminated based on skin colour or social class,

gave birth on a floor, not cleaned after birth, called by insulting names, and laughed at or scorned^{5, 8, 12, 135, 151, 152, 154, 157, 158, 161-165}.

Over the course of my PhD candidature, there has been a maturing of the discourse around the framing of RMC. Notably, the consideration of disrespectful care to go beyond behavioural and interpersonal interactions, to include structural and health system factors was a crucial factor in determining the appropriate terminology for my dissertation work. After weighing up these recent developments and evidence, from this section onwards, I use the term “mistreatment” unless I am reporting on original definitions or frameworks. Because this PhD study focuses on health system issues, the use of D&A would mask what the health system is lacking to advance RMC even in the face of respectful providers who have excellent attitudes towards women. Accordingly, the concept of mistreatment allows capturing the full range of women’s and service providers’ experiences, and individual and health system conditions that jeopardise a woman’s rights to respectful care.

2.4.2 Prevalence of mistreatment during childbirth in LMICs and Ethiopia

Recent studies on the prevalence of mistreatment during childbirth have adopted different approaches to measurement. While a metanalysis is consequently not possible, the following sections provide a summary of reported levels of mistreatment. Table 2.5 displays the results from six prevalence studies from Africa that used Bowser and Hill’s categories of D&A.

Prevalence studies conducted between 2018 and 2019 in different parts of Ethiopia including western Ethiopia (74.8%)¹⁶⁶, Jimma (91.7%)¹⁶⁷, four regions of Ethiopia (74%)¹⁴, and Bahir Dar (43%)¹⁰⁹ reported high levels of mistreatment of women during childbirth in public health facilities. Another study in Tigray region reported a mistreatment level of 22% in 2018¹⁶⁸; the level is lower as compared to the other studies because this particular study reported only selected indicators of mistreatment measurement.

Table 2.5 Prevalence of mistreatment during facility-based childbirth in Africa

Characteristics of review Study description	Ethiopia ¹²	Kenya ¹⁵⁴	Tanzania (1) ¹⁵⁸	Countries		Nigeria ¹⁶⁹	Multi-country ^{*170}
				Tanzania (2) ¹⁵⁵			
Study design	Cross-sectional	Cross-sectional	Cross-sectional	Cross-sectional		Cross-sectional	Cross-sectional
Sample size	173	641	1914	1779		446	2164
Data collection tool	Based on Bowser's and Hill's classification	Based on Bowser's and Hill's classification	Based on Bowser's and Hill's classification	Based on Bowser's and Hill's classification		Based on Bowser's and Hill's classification	Direct observation of labour, based on the White Ribbon Alliance's RMC charter; and Bowser's and Hill's classification
Method of data collection	Exit interview with mothers upon discharge after childbirth	Exit interview with postnatal mothers	Exit interview with postnatal mothers	Exit interview with mothers upon discharge after childbirth		Exit interview with postnatal mothers	Clinical observation
Type of health facilities included	A teaching hospital and health centres	Hospitals, health centres, referral facilities, and nursing homes	Hospital (Dar es Salaam)	Hospitals, health centre, a dispensary (northeastern Tanzania)		University teaching hospital	Hospitals and health centres
Prevalence of D&A by categories							
Physical abuse	32.9%	4.2%	5.0%	2.9%		35.7%	0.8%
Non-confidential care	21.4%	8.5%	2.0%	4.4%		26.0%	0.4%
Non-consented care	94.8%	4.3%	0.2%	0.1%		54.5%	0.8%
Non-dignified care	12.1%	18.0%	6.0%	12.9%		29.6%	0.3%
Discriminatory care	19.7%	NA	NA	NA		20.2%	0.4%
Abandonment of care	39.3%	14.3%	8.0%	8.5%		29.1%	3.8%
Detention in facilities	0.6%	8.1%	0.2%	0.2%		22.0%	None
Overall prevalence of D&A	78.6%	20.1%	15.0%	19.5%		98.0%	6.2%

**included countries: Ethiopia, Tanzania, Kenya, Madagascar, Zanzibar, and Rwanda*

Physical abuse

Recent studies from Africa revealed varying levels of physical abuse in facility-based childbirth: Kenya 4.2%¹⁵⁴; Dar es Salaam, Tanzania 5%¹⁵⁸; northeastern Tanzania 5%¹⁵⁵; Ethiopia 5.8%¹²; and Nigeria 35.7%¹⁶⁹. Direct observation of labour in six east and southern African countries also reported 18 incidents of physical abuse from 2164 (0.8%) labours observed¹⁷⁰. Most physical offences are usually accompanied by verbal abuse, a form of non-dignified care that is traumatising for women and their communities^{5, 156}.

What comes after the physical abuse of a woman varies across contexts and mainly depends on the extent of women's empowerment and the presence and functionality of regulatory frameworks. In some occasions, it is not surprising to see revenge by women in response to physical abuse. A Ghanaian study revealed women slapping nurses/midwives after birth as a response to the mistreatment meted out by the nurses/midwives¹⁷¹. In one Nigerian hospital a woman testified what she observed as below;

"The labour started, they carried the woman to hospital, as they reached the hospital, so the woman was shouting and crying. That nurse, immediately, when she reach there, she gave the woman "baa!" (slap). Hey! The woman was just looking at her like 'please you don't know what is wrong with me and you slapped me, okay thank you.' As the woman deliver, she said, she did everything for her. As the woman wanted to go...wanted to leave the hospital, the woman called the nurse, "please I want to see you", she gave her (nurse) "fiam!" (slap). She said 'the thing you did to me, that is what I did back to you.'"

Woman, Nigeria^{151(p7)}

On the other hand, there are women who do not respond or react to physical abuse. There are complex reasons for why this might be, such as a fear of poor treatment for the remaining course of birth process (power imbalance), the assumption that service providers rightly abuse women to make them motivated, the lack of facility-level redressal system, normalisation of

violence or abuse against women, the experience of intimate partner violence^{8, 11}. Regardless of where it is perpetrated, violence against women originates from gender inequality in societies forcing women to accept deprivation of their rights that in turn systematically results in the normalisation of abuse in the community and in health facilities¹⁷². As such, health professionals may use that opportunity to control power, reprimand and silence women throughout the birthing process^{11, 172}. Women with lower socioeconomic status are more prone to abuse, discrimination, and unnecessary procedures in health facilities, whereas literate women and women from affluent societies confront abusive service providers¹³³. A study from rural Tanzania also reported that women who knew their rights were best suited to demand their rights in maternity care, although that comes with a repercussion—deterioration of care¹⁷³.

Non-confidential care

Vaginal examination is a sensitive and intimate procedure that causes much concern for women which can result in a feeling of powerlessness, vulnerability, and physical pain. Women and their birth companions are embarrassed by this procedure, especially in shared labour or delivery rooms^{5, 8}.

“The vaginal examinations that the midwives did on my partner put me off. Much as it is a procedure to monitor the progress of labour, it was an invasion of our privacy.”

45 years old Malawian male Engineer^{174(p5)}

According to Bowser and Hill, this lack of privacy is non-confidential care. Studies from Ethiopia (21.4%),¹² Kenya (8.5%),¹⁵⁴ Tanzania (53%),¹⁵⁸ and Nigeria (26%)¹⁶⁹ reported high level of non-confidential care. Furthermore, a multi-country study also reported high levels of non-confidential care (lack of both visual and auditory privacy) in Ethiopia (73%), Kenya (35%), Zanzibar (78%), Rwanda (23%), Madagascar (28%), and Tanzania (47%) (Table 2.5)¹⁷⁰.

Non-consented care

Non-consented care includes conducting a vaginal examination and other procedures without seeking women's permission and denying women's right to choose between positions of choice during childbirth⁸. As displayed in Table 2.5, almost all surveyed women (98.4%) experienced at least one episode of non-consented care during facility-childbirth in Ethiopia. Additionally, nearly half (48%) of women were not asked for their consent before any procedure during labour¹².

Using all elements of non-consented care, including the failure of providers to introduce themselves, to ascertain non-consented care would lead to such high prevalence reports.

Non-dignified care

In most cases, non-dignified care is manifested as verbal abuse and unpleasant facial expressions, though women's perception of it is dependent upon contextual situations^{8, 175}. As depicted in Table 2.5, the practice of non-dignified care in facility-based childbirth ranged from 0.3%-29.6%. An intervention study from Dar es Salaam showed that there is a significant difference in the prevalence of non-dignified care between reports of an exit survey (6%) and a community follow-up survey (54%)¹⁷⁵. The variation might have resulted from courtesy bias as women fear insecure to report their real experience at the point of service¹⁰. This disparity hints that the prevalence estimates summarised in Table 2.5 are likely to have been underreported as all reported findings from exit surveys.

Abandonment of care/neglect

Leaving women unattended during childbirth and withholding continuous labour support is a common practice in health facilities in LMICs^{5, 152, 176}. A systematic review that included 82 studies revealed that 40% of African and 59% of Asian studies had reported neglect and abandonment by maternal health care providers¹⁷⁷. In Addis Ababa, Ethiopia, 23% of women have ever been left alone/unattended in the labour room during their facility-based childbirth¹². Women fear nighttime labour when the risk of being left alone and unattended is particularly

high. In hospital setups, where labour attendants live in the same compound, some providers are unreceptive to calls¹⁵⁶.

“...I was calling ‘Nurse, Nurse!’ she reached there and ... the baby came out and she ran to catch her. After catching her she held her and then found gloves to wear before continuing with other services. What I see is that providers should be very close (in proximity) to mothers. A labouring mother can deliver at any time.”

Woman, Tanzania^{156(p4)}

Detention in health facilities

In many circumstances, service providers detain mothers in health facilities for not being able to pay service fees associated with childbirth; international treaties and human rights organisations recognise this act as deprivation of liberty¹⁶². Mothers also face cruel treatment by health professionals for being unable to pay service fees; some women are obliged to sleep on the floor until they manage to pay as a requirement of discharge from a facility¹⁷⁸. There have also been reports from Tanzania, Benin, Ghana, Kenya, and Sierra Leone, where babies are detained if a mother or her families fail to pay the bills^{5, 8}. Even women who have lost their babies during or immediately after childbirth were detained, according to one Kenyan study¹⁷⁹.

2.4.3 Contributors to mistreatment in facility-based childbirth

Factors contributing to facility-based mistreatment in childbirth are multifaceted and vary across contexts. For example, structural and facility-related differences between a teaching hospital and a small district hospital can function to either drive or prevent mistreatment¹⁵⁹.

Institutional procedures and conditions

Restrictive health facility rules and regulations or the respective guidelines at a higher level deny the entertainment of women’s rights in health facilities. A qualitative study from Japan revealed that health facility rules and procedures restrict birth companions in labour rooms; fathers are

only conditionally accepted as a birth companion if they have attended a mandatory prenatal course¹⁸⁰. The same study also highlighted that suboptimal physical structures in health facilities infringe women's privacy. Thirdly, the type of hospital is a barrier to respectful care. When coupled with numerous health profession students, as is the case in university teaching hospitals, the privacy of women becomes seriously endangered^{12, 180}. Additionally, overburdening of staff and low pay in facilities contributed to the mistreatment of women^{11, 180}.

Power dynamics

A hierarchical management system in health service organisations creates a supervisor-subordinate relationship between different levels of health workers and between health workers and women. Such power imbalance exhibits in a command and control approach that usually leads to the legitimisation of mistreatment behaviour and practices^{5, 181}. A review of experiences from 25 countries also revealed that staff appointments based on political or economic criteria of non-merited decision-makers who have insufficient knowledge about the operation of health services contribute to mistreatment¹⁵⁹.

Multidimensional framework

Bowser and Hill's framework further details what contributes to facility-based mistreatment in childbirth considering opinions from experts and a review of literature⁸. Accordingly, drivers of D&A may arise as a consequence of individual- and community-level factors; gaps in national laws and policies and lack of enforcement of existing ones; problems of governance and leadership; service delivery challenges; and provider-related factors (biases, neglect, misconduct, staff shortage, and poor quality training) (Figure 2.10). Portions of these drivers of mistreatment were also reported by a Kenyan study that involved qualitative interviews with policymakers, program managers, service providers, women, men, and community members. The authors concluded that existential gender norms and inequalities rooted in families and societies perpetuate the culture of mistreatment¹⁸².



Figure 2.10 Contributors to mistreatment in facility-based childbirth, Adapted from ^{8(p8)}

Many studies report that one potent driver of mistreatment is where health workers consider mistreatment practices during childbirth as an acceptable part of health care^{12, 154, 158, 183, 184}. Due to fear of negative administrative measures or blame in response to adverse outcomes of labour, there are health workers who commit physical abuse to force women to adhere to their advice¹⁸⁵.

2.4.4 Measurement of mistreatment during childbirth

Evidence-based clinical and health care decisions are often based on results from randomised controlled trials, but the use of qualitative synthesis in decision making is growing^{186, 187}. As most studies on mistreatment were qualitative in design, evidence on the magnitude of the problem at

national, regional or global levels was limited^{6, 11, 20, 134, 151, 152, 156, 157, 165, 188-192}. International organisations, including the WHO, underscored the need to have standard measurement indicators to track progress and assess the effectiveness of interventions^{6, 134, 192}. In response, there are recent developments in the review of available tools and the development and validation of novel measurement approaches^{9, 10, 193-197}.

A psychometric analysis of a tool designed to assess person-centred maternity care in Kenya suggested 30 items in three domains (dignity and respect, communication and autonomy, and supportive care) that can be used to assess women's perception of maternity care¹⁹⁷. The same researchers also tested the tool in India using the same approach¹⁹⁸. The tool development passed through rigorous steps—including cognitive assessment and expert reviews—and was tested in both rural and urban settings; the items yielded high validity and reliability scores. The tool focuses on the interpersonal aspects of maternity care.

Similarly, an urban-based Ethiopian study that used an inductive item generation technique developed an RMC scale with 15 items that showed acceptable validity and reliability under four categories (friendly care, abuse-free care, timely care, and discrimination-free care)¹⁹⁹. The items used a five-point Likert scales administered to postnatal clients as opposed to the Indian study, which used a reduced Likert scale (three-point scales). Caution in interpreting the findings is necessary given that a study conducted in northern India using the same questions used by the Ethiopian and Kenyan studies found that the Likert scale items were generally incomprehensible and could be interpreted differently¹⁹³.

A WHO-led multi-country study conducted in Ghana, Guinea, Myanmar, and Nigeria developed and tested a labour observation tool and a community-based survey using 2016 and 2672 women, respectively¹⁹⁶. The study also linked data from labour observations with the community survey to check for congruence of women's responses with the observations. The study involved rigorous phases of item development, testing and validation, is a commendable asset

in further review and contextualisation of mistreatment or RMC assessment tools in various settings. To mention one, the labour observation tool may not be logistically feasible in resource-constrained settings and cumbersome to use where two or more women give birth in a single room concurrently. In such cases, using the community-based survey only may lead to recall bias. Therefore, adapting the questionnaire for an exit survey would be appropriate to address the drawbacks of community survey partially; likewise, the shortcomings of the exit survey would be addressed by the community survey leading to a methodologically sound tool for low-resource settings.

Researchers in the field of RMC, including the PhD candidate, conducted a methodological review entitled “Methods used in prevalence studies of disrespect and abuse during facility-based childbirth: lessons learned” in 2017. The review aimed to critique measurement approaches, systematic errors, and sources of biases that might have been introduced and to recommend a consensual approach for comparing prevalence measures of mistreatment¹⁰. The review identified that substantial differences in the prevalence of mistreatment exist between surveys made with the same women in health facility and later in the community. Therefore, the timing of surveys should be chosen cautiously aiming to minimise the chance of courtesy bias (during a survey in health facilities) and recall bias (during a late postpartum survey in communities). In most scenarios, exit surveys and labour observations result in underreporting of mistreatment due to courtesy bias and the Hawthorne effect, respectively. Early postpartum community surveys are strategic since delaying these surveys after four weeks postpartum adds to recall bias further, leading to either under-reporting or over-reporting²⁰⁰. Generally, given the pros and cons of all the commonly used prevalence measures (exit survey, community survey, and labour observation), triangulation of methods would be recommended depending on the balanced consideration of resource availability, methodological rigour and contexts.

2.4.5 Consequences of mistreatment

There is compelling evidence from Ethiopia and several other countries on the negative impact of mistreatment on the uptake of facility-based childbirth. An evidence synthesis of studies from 16 LMICs revealed that mistreatment during childbirth is a powerful deterrent to facility-based childbirth¹⁹⁰. Additionally, studies from Afghanistan²⁰¹, Bolivia²⁰², Ghana²⁰³, Kenya^{188, 204}, Tanzania²⁰⁵, Malawi¹⁴⁵, and India²⁰⁶ have reported similar findings. The consequence exceeds the individual level; at the community level, mistreatment can result in eroding the collective trust in the health system²⁰⁷. A recent study from Brazil also indicated that the mistreatment of women during facility-based childbirth increased the likelihood of postpartum depression among women who were surveyed three months after childbirth⁷.

Moreover, mistreatment affects the experiences of childbearing women, a critical component of high-quality and woman-centred labour and childbirth care^{4, 26}. The WHO defines positive childbirth experience as “one that fulfils or exceeds a woman’s prior personal and sociocultural beliefs and expectations, including giving birth to a healthy baby in a clinically and psychologically safe environment with continuity of practical and emotional support from a birth companion(s) and kind, technically competent clinical staff.”^{4(p1)} Promoting positive childbirth experience involves a holistic and human rights-based approach to ensure that the intrapartum care of women is based on effective communication, respect and preservation of dignity, and emotional support²⁶. Accordingly, the mistreatment of childbearing women is a serious violation of women’s human rights, which has far-reaching negative consequences on women, their families and communities^{6, 162}.

2.5 Respectful maternity care

2.5.1 Meaning and scope of respectful maternity care

As it is for the mistreatment of women, there has been no standard definition for RMC so far. The WHO describes RMC as “the care organised for and provided to all women in a manner that maintains their dignity, privacy and confidentiality, ensures freedom from harm and mistreatment, and enables informed choice and continuous support during labour and childbirth”^{4(p3)} and recommends RMC for all women. The contents of this description stem from the categories of mistreatment that were discussed earlier in Section 2.4.1. Before WHO’s definition, the Population Council used a very general description of RMC as “the humane and dignified treatment of a childbearing woman throughout her pregnancy, birth, and the period following childbirth”^{208(p1)}. Without explicitly including what humane and dignified treatment encompasses, RMC can be overlooked by service providers. Pertaining to the timing of RMC, RMC is a continuum of care that spans the periods of pregnancy, childbirth, and breastfeeding, albeit labour and delivery is the most crucial phase in the continuum as it is the period when the majority of facility-based mistreatment of women occurs²⁰⁸⁻²¹⁰.

Compassionate care is empathetic and loving care that goes beyond the boundary of a professional relationship with a client and is a sub-set of RMC rather than a synonym²¹¹. In its broader context, RMC embodies: respecting woman’s choices and rights, treating her with reverence, and demonstrating supportive communications and actions^{208, 212-214}. Facilitating a climate of mutual trust between health care workers and childbearing women is also a vital dimension of RMC^{66, 178, 215, 216}. Therefore, RMC is a cross-cutting issue that spans the health, legal/human rights, political, and social aspects of care.

The WHO’s quality of care framework broadens the characteristics of quality health care and acknowledges RMC as one of the eight domains of quality of care and a critical component to

improving the experience of women during facility-based childbirth²⁶ (Figure 2.4). RMC is a vital strategy to attract more women for childbirth in health facilities and ensuring that women's rights to health care are enacted where birthing at home is common. In settings where the proportion of women birthing in health facilities is already high, RMC remains critical in ensuring that women's rights to health care are enacted^{141, 170, 217, 218}.

Additionally, birth companionship, emotional support, effective communication, pain relief measures, respecting women's preferred birth position, and allowing mobility during labour are practices recommended in the 2018 intrapartum care guideline prepared by the WHO (Figure 2.11)⁴. These practices form key dimensions of woman-centred intrapartum care leading to positive childbirth experience if supported by essential resources, including motivated staff, supplies and infrastructure.

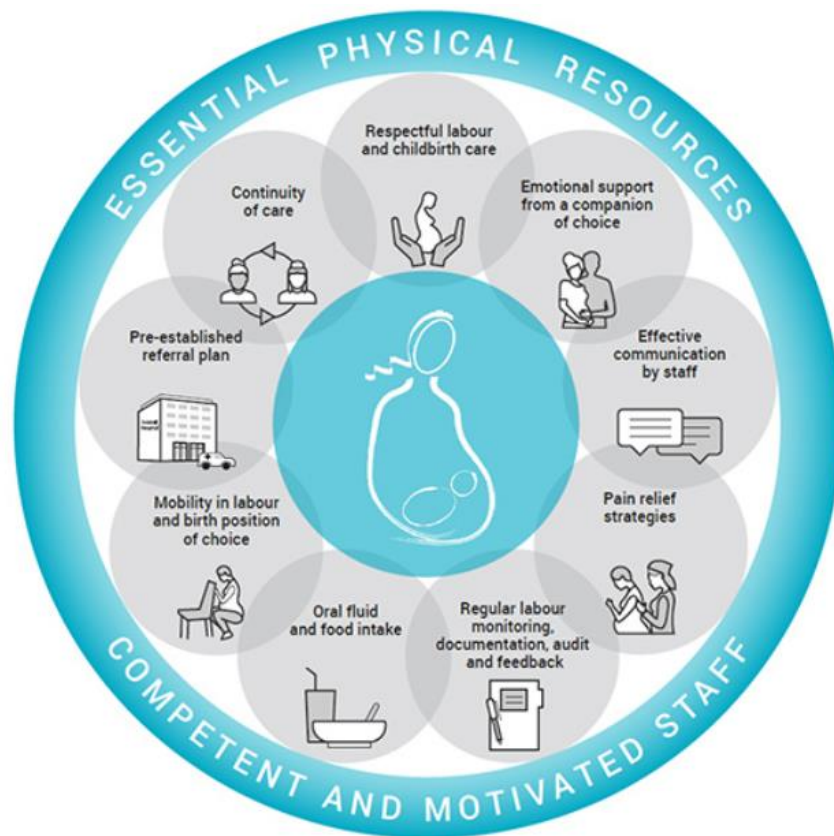


Figure 2.11 WHO intrapartum care model, ^{4(p170)}

2.5.2 Respectful maternity care from the perspective of people-centred health care

The people-centred health care initiative originated in the Western Pacific region to nurture health from a holistic approach that considers the cultural, spiritual, emotional, and psychological dimensions of individuals, families, and communities in addition to just their medical needs²¹⁹. The people-centred health care policy framework endorsed was then endorsed in 2007 during the 58th session of the Western Pacific regional committee meeting held in the Republic of South Korea. Afterwards, the concept became a priority of concern for health systems internationally²¹⁹. In the 69th World Health Assembly held in 2016, the executive board of the WHO passed a resolution in order to integrate the concept of people-centred health services into health systems²²⁰.

People-centred health care is defined as “an approach to care that consciously adopts individuals’, carers’, families’ and communities’ perspectives as participants in, and beneficiaries of, trusted health systems that are organised around the comprehensive needs of people rather than individual diseases, and respects social preferences”^{220(p2)}, is a relevant concept vis-à-vis RMC. Meeting people’s legitimate right to and expectations for equitable and respectful care is among the priorities of people-centred health care²²¹.

According to the concept of people-centred care, RMC is not only a human rights issue but an issue of equity—gender and infrastructural equity^{163, 222}. The underlying values and guiding principles of people-centred health care are drawn from several international declarations, including the universal declaration of human rights^{223, 224}. Both RMC and people-centred health care share elements of the universal declarations of human rights.

2.5.3 Promotion of respectful maternity care

The shortfall to achieve MDG5 and the endorsement of the universal rights of childbearing women are the main powerhouses for the current focus on RMC globally. The universal rights of

childbearing women—formulated in 2011—is a targeted declaration that was chartered to address the rights of women throughout pregnancy, childbirth, and postpartum periods²⁴. International organisations, professional associations, and ministries of health have endorsed the RMC charter²¹⁴. However, there is evidence gap in the effectiveness of RMC interventions globally⁴. The WHO statement on D&A also underscored the need for research on the effectiveness of RMC interventions⁶. Given the evolving body of research in the area, data from interventional designs that particularly aimed at estimating the effect size of RMC interventions is meagre.

Because RMC is a cross-cutting issue, its advocacy and promotion should engage a range of stakeholders, including health workers, women, communities, and policymakers²²⁵. Women and the community at large should be well-oriented about women's rights in the maternal health continuum as this will play a significant role in the enforcement of the law to protect women's rights. On the other hand, the macro and micro level health system components should articulate the tenets of RMC as part of their core values and work towards the institutionalisation of RMC standards in service delivery outlets^{209, 210}.

The Health Policy Project has developed “A Guide for Advocating for Respectful Maternity Care” that includes the approaches to raising awareness and generating demand for RMC in communities, mobilising communities for accountability for RMC, securing high-level commitment in countries, and engaging media in RMC initiatives (Table 2.6)²⁰⁹. The guide was developed as a first step to provide practical recommendations that could be used by multiple stakeholders, including individual citizens and policymakers, to advocate for the provision of RMC.

Table 2.6 Summary of respectful maternity care advocacy approaches and mechanisms,
209

RMC advocacy approaches	Mechanisms of addressing the approaches
Raising awareness and generating demand from civil society	• Distributing RMC posters and brochures • Establishing an RMC discussion group among friends or concerned citizens • Performing RMC-focused community theatre • Writing a song for a concert or broadcasting on the media • Hosting an RMC film screening and holding a discussion afterwards • Using social media
Mobilising the community to hold local leaders and service providers accountable for RMC	• Holding a Public Hearing to influence service providers, policymakers, the media, and women and their families to support and demand RMC policies and practices • Using community scorecards to analyse issues that underlie D&A and identify ways to address them
Securing commitment at the national level to institutionalise RMC as the standard of care	• Developing a national RMC-focused advocacy strategy • Launching a national campaign to promote RMC • Holding a meeting with members of parliament and local community leaders • Using petitions to inform people about the issue of RMC, demonstrate widespread community support for RMC, encourage change, or peacefully protest a policy related to RMC
Engaging the media in RMC Efforts	• Issuing a media release • Hosting a press conference to disseminate RMC message to multiple members of the media simultaneously and to showcase most influential RMC leaders and spokespeople • Producing a public service announcement • Holding a media sensitisation workshop • Hosting a journalism contest to incentivise and obtain media coverage of RMC issues

Review of success stories of RMC promotions

In 2012, the USAID Maternal and Child Health Integrated Program instituted a study that aimed to identify country experiences of RMC promotion in 25 countries. They conducted a review of literature and interviews with 25 RMC experts. The study categorised RMC interventions into six strategies: advocacy, legal approaches, health facility management, education and training, community-level interventions, and research and monitoring and evaluation¹⁵⁹. Success stories

of RMC advocacy from eight of the countries are summarised in Table 2.7, including measured changes in RMC where relevant.

2.5.4 Respectful maternity care initiatives in sub-Saharan Africa and Ethiopia

Before 2011, there were several initiatives in SSA that prioritised improving the quality of MCH care in the region in order to achieve MDGs 4 and 5. However, particular emphasis was given to RMC following the declaration of the universal rights of childbearing women in 2011²⁴. The “Mamaye” campaigning implemented in six countries (Ethiopia, Ghana, Malawi, Nigeria, Tanzania, and Sierra Leone), visioned to make pregnancy and childbirth safer for mothers and newborns; RMC is one of the main themes advocated by the initiative²²⁶. Furthermore, the Heshima project in Kenya, the RMC improvement project in Tanzania, the Last 10 Kilometers project in Ethiopia, and the White Ribbon Alliance’s campaigning in Nigeria are other RMC initiatives in the region. These approached and their benefits are detailed in Table 2.7.

An implementation study from Ghana indicated that it is possible and rewarding to integrate RMC concepts into other short-term training programmes. In an obstetric simulation training into which they integrated RMC components, they found that the person-centredness of the maternity care women received increased by 43% over six months period of implementation²²⁷. A recent implementation study from Tanzania also reported increased creativity for RMC among midwives who attended RMC workshop that used an intellectual partnership model²²⁸. An intellectual partnership model is a model that helps to co-create knowledge and skills through a partnership between trainers and trainees by transforming the roles of the trainers (often active, authoritative, and powerful) and the trainees (often passive and powerless)²²⁸.

Table 2.7 Success stories from countries promoting respectful maternity care

Country (Author, year)	RMC promotion approaches	Reported benefits (proportions are indicated where available)
Poland ²²⁹ (WHO, 2015)	• Childbirth with dignity campaign was implemented • Women share their childbirth stories with other women and communities • Women rate hospitals online, based on their experiences, and people can see those scores • Women can choose who will be with them in the delivery room	• Brought change in the health system • Developed the first perinatal and postnatal care standards • Partners allowed to access delivery rooms • Babies rooming with their mothers • Online publication of hospitals' data, people choose the hospital they want • Gained international recognition
Equatorial Guinea, Zimbabwe, Paraguay ¹⁵⁹ (Reis et al., 2012)	• Implementation of the Standard Based Management and Recognition approach in maternity care • Comprehensive neonatal care approach was implemented • Midwifery standards were updated • Training of health care workers on • Development of centres of excellence	• Quality of maternity care improved in selected HFs • The humanisation of childbirth services improved • Episiotomy and caesarean section rates declined • Postpartum family planning use coverage improved
Canada ¹⁵⁹ (Reis et al., 2012)	• Adoption of the WHO's baby-friendly hospital initiative • Development of official perinatal policies by the Ministry of Health	• Allowance of birth companions • Most hospitals were regarded the best hospitals to have a baby because of improved humanisation
United Kingdom ²³⁰ (Royal College of Midwives, 2017)	• Campaign for normal birth • Produced ten top tips for promoting a normal and respectful childbirth service	• Several childbirth centres adopted the recommendations of the campaign • Declined rates of unnecessary induction, instrumentation, and caesarean section
Kenya ¹⁶³ (Abuya et al., 2015)	• Training on RMC • Establishment of quality improvement teams at HFs • Established mistreatment reporting mechanisms • Launch of maternity open days when men and women from communities can visit nearby health facilities • Community workshops: RMC sensitisation meetings	• Level of mistreatment reduced by 7%
Tanzania ¹⁵⁷ (Ratcliffe et al., 2016)	• Open birthdays for third-trimester pregnant women • Workshop on RMC for health providers	• Women's knowledge of their rights improved from 30% to 58% • Increased reporting of mistreatment by women from nil to 10% • Increased providers' knowledge of patients' rights • Improved job satisfaction among providers • Improved providers' attitudes on RMC

HF: Health Facility; RMC: Respectful Maternity Care

Respectful maternity care initiatives in Ethiopia

As an emerging component of quality of care and safe motherhood, RMC is in its infancy in Ethiopian health facilities. The Maternal and Child Integrated Program integrated the concept of RMC into a training package designed for midwives²³¹. In addition to this, there has been an RMC improvement project in Northern Ethiopia by the Last 10 Kilometers project which used the Participatory Community Quality Improvement approach in which communities and health workers worked together to identify problems and improve quality of care²³². They have claimed that the approach has improved the relationships between communities and health workers, the uptake of maternal health care services, and quality of maternal health care services in the project sites²³².

In response to the rising expectations of quality and respectful care for all services in public health facilities, the Government of Ethiopia has established a national movement entitled “The Caring, Respectful, and Compassionate Health Workforce”²³³. According to the initiative, ‘caring, respectful, and compassionate’ health workers: consider patients as human beings with complex psychological, social and economic needs and provide person-centred care with empathy; have effective communication with health care teams and demonstrate interactions with patients and other health professionals over time, and across settings; show respect for and facilitation of patients’ and families’ participation in decision and care; and take pride in the health profession they are in and get satisfied by serving the people and the country²³⁴. The implementation status or success of the initiative has not been published to date.

2.6 Summary

Low uptake of maternal health care services, particularly skilled birth attendance, remains a key challenge in reducing maternal mortality in LMICs. Poor quality of care which spans both clinical and non-clinical aspects of care, including the mistreatment of women, is among the key drivers to the low uptake of life-saving maternal health services. Mistreatment not only

jeopardises women's childbirth experience it is also a breach of their right to positive experience during childbirth. There are growing concerns about high levels of mistreatment of women during facility-based childbirth both globally and in Ethiopia. However, there is a research gap on the barriers to the promotion of RMC and the effectiveness of RMC interventions, especially in LMICs. Therefore, investigating barriers to RMC and the effectiveness of RMC intervention is crucial to mitigate the mistreatment of women. Approaching these research gaps using a health system perspective brings an important dimension to this research. In the next chapter, I will review the meaning, scope, and approaches to health system research.

Chapter 3: Overview of health systems

As outlined in Chapter 2, both the contributors to mistreatment and the barriers to the promotion of RMC stem from a diverse set of individual, structural, and political factors that benefit from interrogation using a health systems perspective. In this chapter, I introduce the concepts of health system strengthening (HSS) and health system research to make a base for why I chose the approaches used in my PhD study.

3.1 Introduction

The concept of health systems originated in the early 1960s due to the global optimism for improved health and societal development and with the aim of broadening the scope of health beyond the technical aspect of medical care²³⁵. Eventually, health systems emerged as a crucial dimension of the social fabric encompassing the various social determinants of health²³⁶. The WHO defines the health system as “a system that consists of all organisations, people and actions whose primary intent is to promote, restore or maintain health.”^{237P.2} The definition implies that health systems are multidisciplinary and multistakeholder.

After the 1978 Alma Ata Declaration, there has been growing interest to develop health systems frameworks that aim to understand and describe, analyse, and determine health systems^{235, 238}. As a result, multiple frameworks have been developed by various actors to assist countries to identify context-specific challenges and improve their health systems. However, the multiplicity of health system frameworks also led to confusion at national and international levels to choose appropriate frameworks for improved outcomes²³⁹.

Shakarishvili and colleagues conducted an analytical overview of more than a dozen existing health systems frameworks and underscored that these have areas of complementarity. Accordingly, they proposed for the synthesis of a converged and user-friendly “concepts-to-actions roadmap” that can be used at various levels to assess, analyse, and improve health systems²³⁸. The WHO’s “Building Blocks”, and the World Bank’s “Control Knobs” are among

the frameworks included in their analysis. The areas of complementarity of existing health system frameworks is displayed in Box 3.1 using four dimensions. In this section, I will briefly describe the WHO's health system framework.

Box 3.1 Complementary areas of various health systems frameworks, ^{238(p2)}

Goals

- Better health, financial protection, responsiveness, satisfaction

Overarching principles

- Access, choice, coverage, efficiency, equity, quality, safety, sustainability

Processes/control knobs

- Behaviour, integration, organisation, payment, regulation, resource allocation, resource creation

Building blocks/critical functions

- Demand generation, financing, governance, health information, health workforce, services, technologies and commodities

According to the WHO's classifications, there are six building blocks (service delivery, health financing, leadership and governance, health workforce, medical technologies, and health information) if well-functioning would result in improved access, coverage, quality, and safety of health services (Figure 3.1). As indicated in the definition above, people and communities have a pivotal role in the co-production of health; thus, the building blocks are people-centred. These blocks are not discrete and solitary but possess a set of interacting elements; they operate in an open and dynamic system which makes the health system complex²⁴⁰. Accordingly, intervention in any of the building blocks has an impact on the other blocks, thereby affecting the overall system. Similarly, the broader system also affects any intervention in the health system²⁴¹.

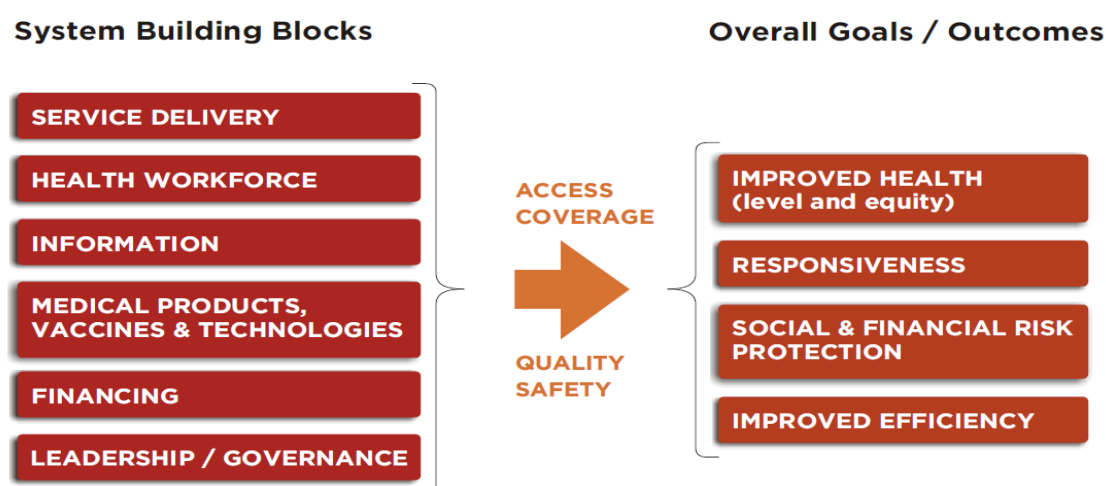


Figure 3.1 The six health system building blocks, ^{237(p3)}

Health systems are featured by openness, unpredictability, counter intuitiveness, and adaptation. Health policymakers and managers are confronted with the ever-dynamic disease trends, climate change, and epidemiological transitions. As such, ensuring the robustness of mitigative approaches requires system thinking across the different levels of health systems.

In advancing the WHO health system framework, scholars have described the components of health systems in various ways. For example, Gilson (2012) classified health systems as comprised of system hardware and system software²³⁶. The hardware components include the general policy, procedure, and structure of health service delivery, whereas the system software encompasses the institutions their norms and values. In that perspective, system software includes the human and social dimensions of the health system. System hardware and software components are intertwined and therefore affect one another in determining the overall system performance^{236, 242}.

Furthermore, Sacks and colleagues expanded the WHO framework to outline the link and dynamism between the building blocks and community health as guidance to substantiate efforts to achieving health for all²⁴³. The expanded framework is believed to enhance the successful implementation of global initiatives such as the Every Woman Every Child for the betterment women's and children's health. Their framework depicts community health

workers as a crucial component of the health workforce block and demonstrates how societal partnerships, community organisations, and social determinants of health in communities interplay with the health workforce and service delivery blocks²⁴³. Generally, adapting existing frameworks for various contexts or strategies helps to have a pragmatic and focused approach to improve health systems.

3.2 Health system strengthening

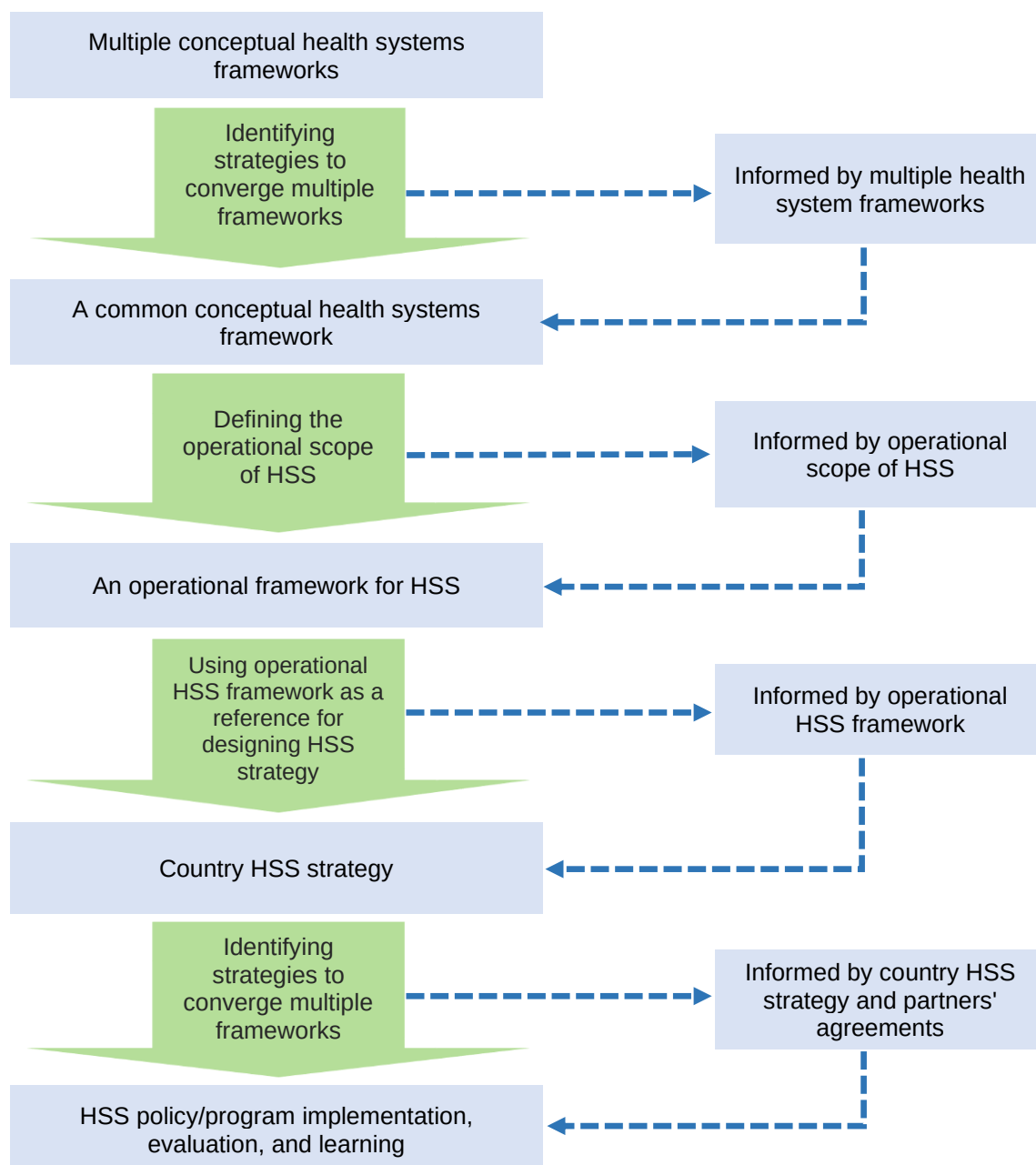
Growing attention to HSS resulted because vertical programs including HIV/AIDS, tuberculosis, and malaria did not yield the expected morbidity and mortality dividends despite massive investment. The conclusion was that these programs did not take into account the system within which these programmes operate^{244, 245}.

WHO defines HSS as “any array of initiatives that improves one or more of the functions of the health systems and that leads to better health through improvements in access, coverage, quality or efficiency”²⁴⁶. There is an inclination of using the term HSS for political gains among governments even while they are sticking to selective and disease-oriented health services delivery model²⁴⁴. Witter and colleagues recommend that a HSS initiative should intervene at least on two of the WHO health system blocks and involve a multisectoral approach to improve access, quality, coverage and efficiency²⁴⁴.

Drawing the difference between HSS and health system support is a critical step in understanding the scope of HSS. While the system support focuses on narrow-focused activities that attempt to achieve short-term results to keep the system running and improve services, HSS aims at producing long-term, comprehensive, and sustainable results that keep the system resilient²⁴⁷. Taking maternal health as an example, activities like a one-of staff training on infection prevention would be system support, whereas institutionalisation of an evidence-informed and actionable infection prevention and control protocol is system strengthening. Yet both system support and system strengthening are important health systems endeavours the former prioritised in conflict and emergency circumstances²⁴⁷.

Shakarishvili’s translation of health systems frameworks—that describe systems, their objectives, blocks, structures, and functions—into HSS frameworks that outline practically

applicable actions for enhancing health systems performance was ground-breaking (Figure 3.2)²³⁸. As a result, the framework was later used by various national and international actors to harmonise and align efforts towards health systems strengthening activities through aligned HSS needs assessment, prioritisation of technical and financial assistance, and health system performance measurement and evaluation^{238, 248}.



*HSS – Health system strengthening

Figure 3.2 Translational frameworks-to-actions roadmap for health system strengthening, ^{238(p14)}

Furthermore, Ergo et al. used a number of health system frameworks to develop a framework that demonstrates how HSS results improve maternal, neonatal, and child health²⁴⁹. Their framework has three main components namely health care sector, community, and households which in turn have their interrelated sub-components that interact with each other to determine the coverage and quality of maternal, neonatal, and child health interventions. According to the authors, financing, organisation, regulation and communication functions help to “break down HSS initiatives and analyse how these initiatives trigger changes in the health system, whether and how these changes affect the coverage and quality of maternal, neonatal, and child health interventions, and what the impact is on maternal, neonatal, and child health morbidity and mortality.”^{249(p4)} However, the framework does not provide specific practical measures that could be taken to enhance HSS.

More recently, the Lancet Global Health Commission on High Quality Health Systems produced a conceptual framework for high-quality health systems that included domains of foundations of health systems, processes of care, and quality impacts (Figure 3.3)²⁵⁰. The framework was informed by various frameworks including the WHO quality of care framework for maternal and newborn health that was discussed in Chapter 2 (Figure 2.4) and demonstrates how strengthening the foundations of health systems contribute to positive user experience and eventually better health outcomes²⁵⁰.

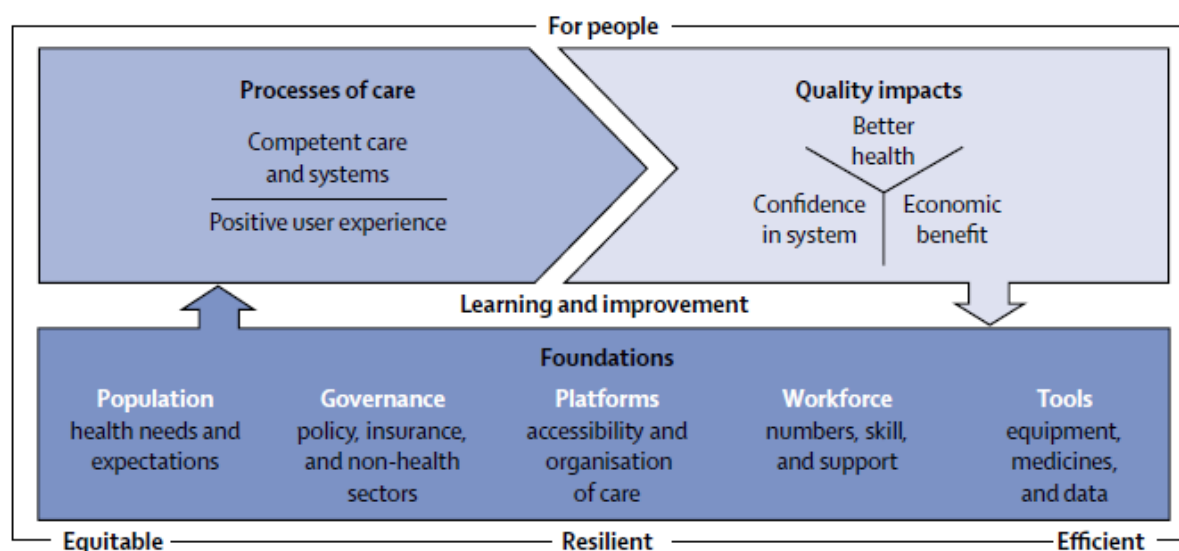


Figure 3.3 High-quality health system framework, ^{250(p1200)}

The health system frameworks and systems thinking tools described so far substantiate the need to apply the concept of dynamism and complexity thinking to conceptualise and understand HSS. Next, I describe the complex adaptive system and its application in health systems research to imagine HSS through the lens of complexity.

3.3 Overview of complex adaptive system

Another important field of inquiry to understand health systems is systems thinking which uses various theories originating from multiple disciplines to understand and continuously engage with a phenomenon or a system²⁵¹. Systems thinking begins from exploring the bigger context to understand what factors operate inside; it is not all about identifying a causal relationship among entities of interest. To date, there are several systems thinking tools that can be used to apply systems thinking in health including the causal loop diagrams, social network analysis, agent-based modelling, and process mapping (Table 3.1).

Table 3.1 System thinking tools, Adapted from^{237(p3-4)}

System thinking tool	Description and purpose
Agent-based modelling	A virtual simulation of a complex system, modelling individual agents with a specified set of characteristics that interact with each other and the environment. Agent-based modelling helps to visualise, analyse, and engage with complex systems.
Causal loop diagram	A system dynamics tool that used a participatory approach to produce qualitative illustrations of mental models, focused on highlighting causality and feedback between system variables or elements. Causal loop diagram helps to display the complex pattern of cause-effect relationships between system elements.
Social network analysis	A graphical method to demonstrate relationships between people, groups, or organizations, demonstrating nodes (individual actors within a network), and ties (the type of relationships) between the actors, and uses a range of tools for displaying the networks and analysing the nature of the relationships.
Process mapping	A set of tools, such as flow charts, to provide a visual representation of a sequence of actions and processes. Their use can be quite flexible, such as to make current processes clear, as a basis for identifying bottlenecks or inefficient steps, or to understand a change or quality improvement process.

Adapted from Peters 2014, Page

Complexity science uses an interdisciplinary approach to understand complex systems and its concepts originated from diverse scientific disciplines like biology, chemistry, physics, sociology, psychology, and others²⁵². The idea of holism is a cornerstone of complexity science that helps to appreciate complex system behaviour which is influenced by interactions between its constituents. Therefore, complexity science opposes the idea of establishing a linear relationship between constituents—reductionism²⁵². Complexity science draws from the contributions of several theoretical areas like the evolutionary theory in biology, self-organisation theory in chemistry, and chaos theory in mathematics. Its application in the social sciences started during the early use of chaos theory to understand organisational change and development^{252, 253}.

A complex adaptive system is a dynamic and open system that consists of a wide variety of interacting elements (complex) and the behaviour of each is responsive to the actions of others within the system (adaptive). The elements within the system have the freedom to

manifest in diverse and often unpredictable ways; thus, the interactions in the system are nonlinear and the resultant responses or changes in the overall system are unpredictable²⁵³⁻

²⁵⁵. Complex adaptive systems theory is explained by various concepts indicated in Table 3.2.

Table 3.2 Complex adaptive system concepts, Adapted from^{253, 254, 256, 257}

Concepts	Description
Agent	A system component (individual or process) capable of responding to other components and adapting its behaviour
Co-evolution	A cyclical process of change and adaptation that results from system alterations that affect agents and the interaction between them
Complex adaptive system	A type of system which comprises diverse agents, and the behaviour of each agent is responsive to the interactions with other agents within the system
Emergence	New system behaviours (larger entities) generated by the interactions of smaller or simpler entities
Feedback loop	Recursive mechanisms as a result of multiple agent interactions over time that create reciprocal behaviour either reinforcing (positive feedback loop) or undermining (negative feedback loop) each other
Nonlinearity	The heterogeneous and multiple levels of interaction between agents which makes agent response unpredictable
Path Dependence	Past experiences influence the responses to new events
Perturbation	An internal or external disruption that alters a patterned established system behaviour
Self-organisation	The way in which agents interact to coordinate their own forms, or patterns of behaviour arising from repeated agent interactions over time

Additionally, because system components (agents) exhibit multiple layers of interaction and adaptation, an agent response to these interactions is unpredictable. Small changes in inputs may lead to enormous changes in outputs and have far-reaching consequences, often described as the butterfly effect. "A difference as seemingly insignificant as a butterfly flapping its wings in Brazil can change the predicted weather in Texas from a sunny day to a

tornado.”^{253P.257} Conversely, enormous changes in inputs may not result in a little change in output²⁵³. Gear and colleagues describe feedback loops as “Recursive mechanisms arising from multiple agent interactions over time that either reinforce (positive) or undermine (negative) each other. Positive feedback loops support a change trajectory while negative feedback loops tend to undermine or negate change”^{254P.2}. Negative response mechanisms function to halt the progression to positive organisational changes and transformations²⁵⁶. When system elements interact, the system displays a new aggregate behaviour, a behaviour that cannot be seen at the individual elements level (changes may happen subtly). This new property is called emergence^{254, 255} and such repeated interactions over time make the system adapt to the behaviour of its elements; this is labelled as self-organisation²⁵³. Self-organisation enables the elements to interact with each other in response to a stimulus or perturbation to adjust their own circumstances and arrange their localised behaviour. Perturbation is any disruption that may occur from inside or outside a system which has the potential to affect organised or patterned behaviour in the system²⁵⁶. Sometimes, past system events or circumstances manifest their desirable or undesirable influence on current system behaviour or event. This property is called path dependence; accordingly, complex adaptive systems are memory or history dependent^{241, 256}.

The concepts of the complex adaptive system, therefore, warrant the embedding of complexity thinking and dynamism into HSS research and implementation that play a paramount role to inform health policies and strategies²⁵⁸.

3.4 Research approaches for health system strengthening

Health services research and health systems research share common attributes in that they use a multidisciplinary approach of investigation. However, though the two concepts do overlap, health systems research is broader in scope that it includes macro-level system conditions such as national policies, leadership, and governance^{236, 259}. Accordingly, health systems research focuses on investigating the overall sphere in which an agent which can be an intervention, or a policy operates. It uses dynamic thinking that necessitates looking

carefully into the nature of various interactions in the system and what possible consequences would result if a change happens in any one of its components.

The Alliance for Health Policy and Systems Research describes health policy and systems research (HPSR) as “an emerging field that seeks to understand and improve how societies organise themselves in achieving collective health goals, and how different actors interact in the policy and implementation processes to contribute to policy outcomes”²⁶⁰. Therefore, the ultimate purpose of HPSR is to inform and influence policies to achieve health goals listed in Box 3.1 (better health, financial protection, responsiveness, and satisfaction) through the overarching principles that underpin a well-functioning health system (access, choice, coverage, efficiency, equity, quality, safety, and sustainability)^{238, 258}. Nevertheless, HPSR is country-specific and uses systems thinking to understand complex social and political phenomena to produce knowledge that improves health systems²⁵⁹.

3.4.1 Implementation research informing health system strengthening

Implementation research plays a role in improving health systems through two mechanisms: (1) the provision of interpretable and applicable solutions or knowledge that can be used in a local context to effectively administer proven interventions and (2) the proposal of efficient and commendable approaches to scaling up effective interventions²⁶¹. That means implementation research works in the real world to understand the various contexts including social, economic, political, cultural, physical, institutional, and legal characteristics in a particular condition or population that interplay with the administration of interventions.

Implementation research is indicated if there is a lack of evidence on what works in a specific context and how scalable an intervention is to ensure sustainability. Hence, implementation research questions about the how, what, and why aspects of interventions in the real world²⁶². The findings from implementation research are often used as an evidence base by HSS initiatives to adapt and learn from proposed implementation models, to mitigate the barriers to the utilisation of services; to inform on high-yielding quality improvement approaches; and to inform on how to maximise the efficiency of services.

Mixed methods studies are suitable methods to address implementation research questions through the understanding of causal pathways, framing outcomes, and assessing feasibility^{261, 263}.

Nowadays, embedding implementation research into HSS actions is becoming a vital practice to understand health system functions better and improve the successfulness of interventions²⁶⁴. For greater relevance in local contexts, embedded implementation research requires a strong collaboration between researchers, policymakers, and implementers; however, the involvement of policymakers and implementers is limited, and the majority of embedded implementation researches are conducted solely by academic researchers²⁶⁵. Hence, building the awareness and research capacity of policymakers and implementers is crucial to bridge existing knowledge and skill gaps among these stakeholders²⁶⁵.

Lessons learned from maternal health quality improvement initiatives in Africa and Asia proved that embedded implementation researches in these initiatives facilitated the understanding of the barriers and enablers to quality improvement interventions, thereby resulting in improved effectiveness²⁶⁶. In 2018, WHO commissioned a special supplement on “Addressing Implementation Challenges for Maternal, Newborn and Child Health Interventions” to promote embedding implementation research in maternal, newborn, and child health interventions²⁶⁴. The supplement included implementation researches from eight LMICs that covered topics on scaling up interventions, improving health systems performance, and engaging communities in health interventions. For example, one of the included studies reported a phased implementation research that was embedded into a labour companionship intervention conducted in Egypt, Lebanon, and Syria; the study developed a feasible scale up model for similar settings²⁶⁷.

3.5 Application of complex adaptive system in the field of maternal health

Complexity thinking has been applied in maternal health care in various settings to learn from health systems of high performing countries, critically examine health system factors affecting maternal health care, revise or change maternal health strategies, and inform

policymakers on HSS actions²⁶⁸⁻²⁷⁰. Comparative case studies—a commonly used method in HPSR that use complexity thinking—provide the opportunity to examine why and how health systems function for better maternal health care in some settings while they fail in other settings^{268, 269}. McPake and Koblinsky used a case study approach to examine how maternal health interventions across the different states of Bangladesh, India, and Pakistan resulted in uneven results and to provide constructive guidance to decision-makers in these countries²⁶⁸.

Additionally, Samuels et al. used a health system framework to understand how multi-level (macro, meso, and micro) and complex health system factors drive HSS that in turn improve maternal and child health (MCH) outcomes in Mozambique, Nepal, and Rwanda²⁶⁹.

Similarly, Parkhurst et al. used systems thinking to explore how maternal health care is affected by complexities in health systems in Bangladesh, Russia, South Africa, and Uganda²⁷⁰. Nevertheless, the application of complexity thinking in maternal health care concentrated at the macro-level of health systems mostly focusing on the effects of financial protection in improving access to and utilisation of services²⁷⁰⁻²⁷³; its use in understanding the quality of maternal health services in general and RMC, in particular, is limited.

Understanding how RMC operates in the broader health system requires unpacking the different relationships that happen in each of the health system components. In actual scenarios, the constraints experienced in one health system domain may not end just there; instead, they produce a spillover effect in other domains. In this regard, multiple health system constraints in maternity care mean that they can create a synergistic challenge to RMC. Understanding these constraints using complex adaptive systems thinking would facilitate an evidence-informed promotion of RMC and testing and scale up of RMC interventions.

Chapter 4: Study aim and methods

As stated in the preceding chapters, the mistreatment of women during facility-based childbirth is an ongoing challenge in Ethiopia. There is a paucity of evidence on both the effectiveness of interventions or innovations to promote RMC, and the factors influencing the success or failure of these interventions. RMC is an under-researched field in Ethiopia and globally despite the WHO listing it as a recommended practice for a positive childbirth experience.

The study described in this thesis aims to improve RMC in Ethiopian hospitals through the piloting and evaluation of an intervention to promote RMC in three health facilities in southern Ethiopia. The specific objectives are:

1. To evaluate the effectiveness of an intervention to promote RMC on the level of mistreatment of women during facility-based childbirth;
2. To assess and explore service providers' perceptions and experiences of the RMC intervention;
3. To explore the challenges service providers experienced in implementing the RMC intervention; and
4. To identify health system constraints to the promotion of RMC in health facilities.

4.1 Conceptual framework

This PhD study was guided by the conceptual framework below that I produced drawing on the literature review of RMC and people-centred health systems to depict how proximal and distal health system factors influence RMC (Figure 4.1). The dashed lines between the different individual facility, program, and sociocultural factors have porous boundaries and the various elements interact dynamically. This study primarily focuses on examining to what level an intervention focused at the service provider level influences RMC and how health system factors in other levels interact and affect the intervention and facilitate or deter the promotion of RMC. Therefore, the scope of the intervention was limited to the domains in red

text in the conceptual diagram (Figure 4.1). However, since the RMC implementation was implemented as a collaborative initiative with the Ministry of Health and SNNPR Health Bureau, it has influenced actions in other domains. For example, based on the action areas identified by a facility-led assessment which was part of the intervention, partition between birthing beds has been installed in one of the hospitals.

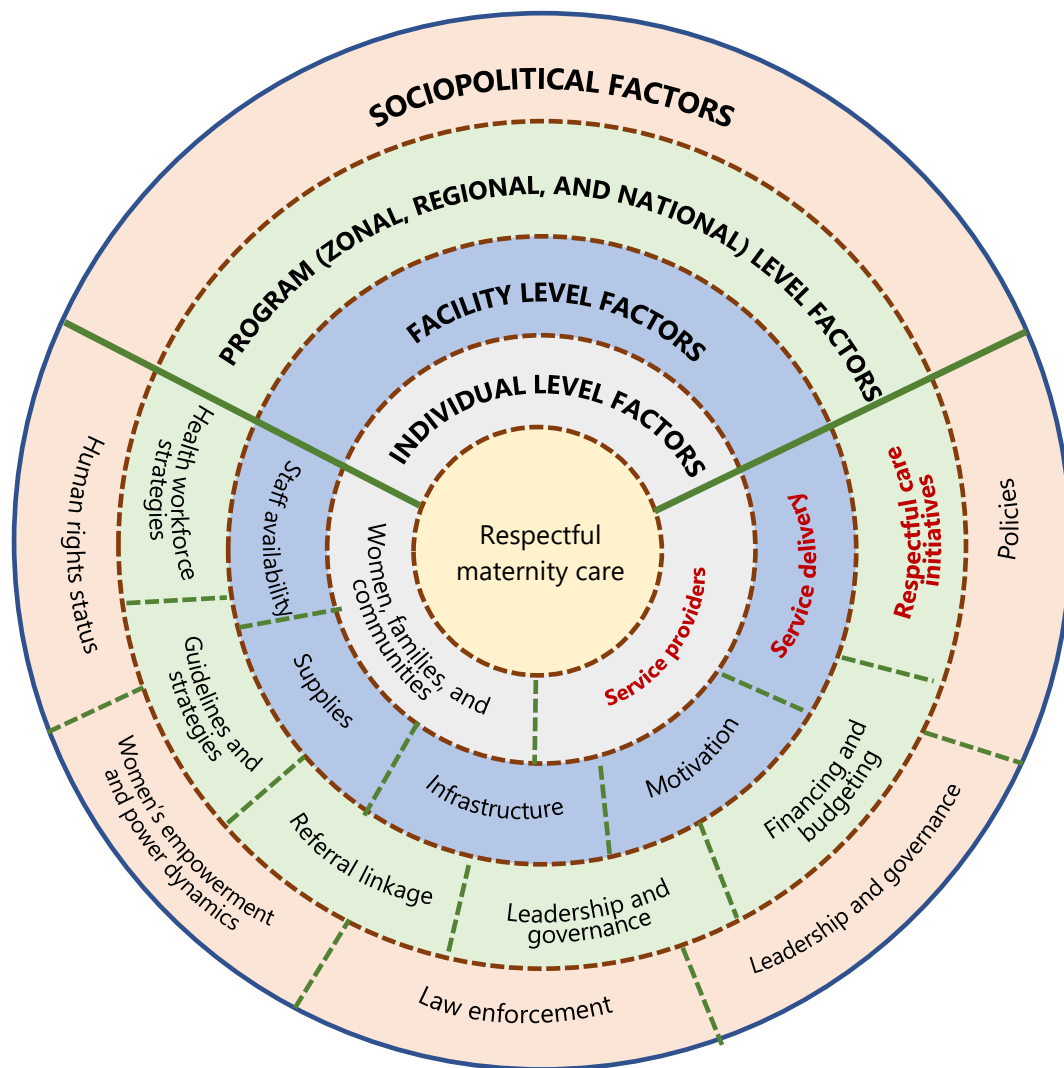


Figure 4.1 The conceptual framework used in the current study (Author derived)
The scope of the intervention of this PhD study focused on the domains highlighted in red text.

4.2 Introduction to the study

I conducted a mixed methods intervention study in southern Ethiopia between 2017 and 2018. The study aimed at identifying health system factors that affect the promotion of RMC and evaluating the effectiveness of an intervention to promote RMC that was designed

specifically for the study. In this study, I posited RMC in the broader maternity care context and looked at the various health system elements that impede the promotion of RMC in hospitals. The intervention to promote RMC focused on the interpersonal aspect of maternity care and it included: a three-day offsite staff training on RMC; placement wall posters in labour wards; and post-training onsite supportive supervision for quality improvement. The study enrolled women who gave birth in hospitals, service providers, MCH coordinators and hospital administrators (chief executive officers and medical directors), and a maternal health program manager. The qualitative study included focus group discussions (FGDs) with service providers and in-depth interviews (IDIs) with MCH coordinators, hospital administrators, and program managers. While FGDs were conducted both before and after the RMC intervention, IDIs were conducted before the intervention. The quantitative wing of the study included two types of surveys—before and after surveys of women and service providers—which will be described in detail in Section 4.6.

4.3 Study setting

The study was conducted in three public hospitals in southern Ethiopia—two general hospitals (Adare General Hospital and Yirgalem General Hospital) and one primary hospital (Leku Primary Hospital). Adare General Hospital is located at the centre of Hawassa City, capital of the SNNPR, and was initially upgraded from a health centre to a primary hospital in 2008 and then to a general hospital in 2012. However, no significant expansion of the maternity unit was done during the processes that managers explained is due to the lack of space in the hospital compound and its vicinity. Currently, a new complex hospital building is under construction that managers and service providers hope will ease the space and infrastructure limitations. Important profiles of the study hospitals are indicated in Table 4.1.

Leku Primary Hospital is situated 23 kilometres to the south of Hawassa city and was upgraded from a health centre in 2013. During the study, the hospital had five beds in its single labour ward and four birthing beds in its only delivery room.

Table 4.1 Characteristics of study hospitals

Facility characteristics		Adare General Hospital	Leku Primary Hospital	Yirgalem General Hospital
Upgraded from a lower-level facility (Yes/No)		Yes	Yes	No
Number of labour ward/s		2	1	1
Total number of beds in the labour ward		10 (5 in each)	5	5
Number of delivery rooms		1	1	1
Number of birthing beds (in the delivery room)		4	4	3
Type of delivery room (Partitioned/Non-partitioned)*		Non-partitioned	Non-partitioned	Non-partitioned
Number of functional showers in the labour ward		0	2	1
Number of functional handwash basins in the labour ward		1	2	1
Designated waiting area for accompanying family members (Yes/No)		Yes	Yes	Yes
Number of health professionals attending women during childbirth (April 2018)	Midwives	22	17	15
	Nurses	2	1	-
	Health officers	-	-	2
	General practitioners	-	1	3
	Integrated emergency surgical officers	2	2	-
	Obstetrician-gynaecologists	-	-	2
Total number of births attended in the last quarter of 2017		1081	433	713
Total number (%) of caesarean deliveries in the last quarter of 2017		164 (14.9)	62 (14.3)	138 (19.4)

**Open plan with multiple beds per room with no curtains/partitions*

Yirgalem General Hospital, which was established in 1968, is located 46 kilometres to the south of Hawassa city and has a longstanding reputation of providing referral services even before the advent of public hospitals in Hawassa city, including Hawassa University Specialized Teaching Hospital. During the study, the hospital had five beds in its single labour ward and one delivery room in which there were three birthing beds.

4.3.1 Referral pathway for maternity care in Ethiopia

According to the Ethiopian health tier system hospitals should provide services for women who come upon referral; however, all study hospitals provide childbirth services to women who arrive upon or without a referral. The three-tiered Ethiopian health service system groups primary hospitals, along with health centres and health posts in the first tier. Primary hospitals serve a catchment population of 60,000 - 100,000 people, while health centres serve a catchment population of 15,000 - 40,000 population. Within a five-kilometre radius of rural health centres there are, on average, five health posts that serve a catchment population of up to 5000 each. Health posts—the lower-level facilities usually staffed with two female health extension workers—provide essential curative, preventive, and promotive health services at the health post, and through home-to-home visits or community outreaches. Females selected from the same community they will be assigned to after graduation, in principle, attend a one-year training in health centres to qualify as “Health Extension Worker”.

General hospitals are included in the second tier and serve a catchment population of one million people and serve as referral centres for primary hospitals. In the top tier are specialised hospitals that serve a population of five million and serve as referral centres for general hospitals (Figure 4.2).

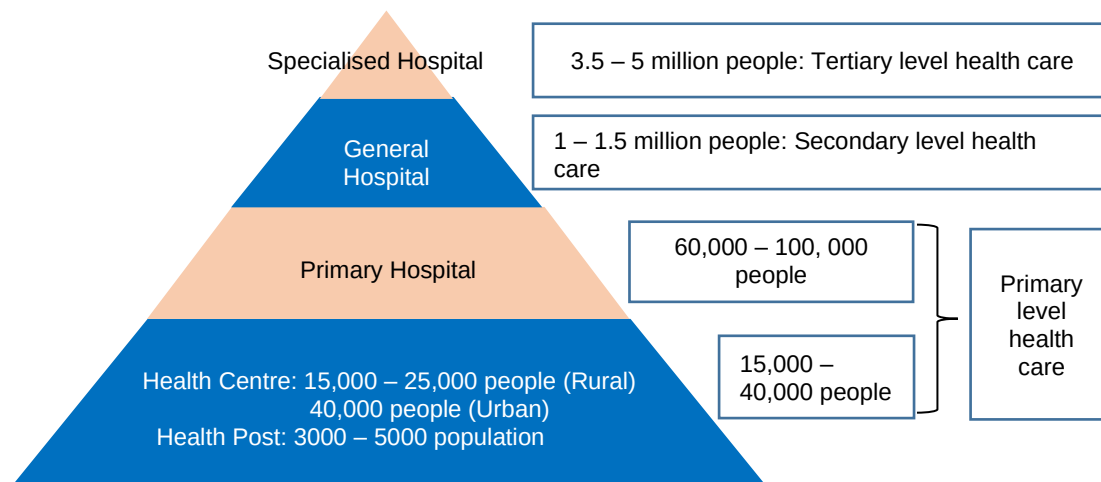


Figure 4.2 Ethiopian health care tier system, ^{39(p142)}

4.4 Study design

Before detailing the study design used in this PhD research, I will describe mixed methods research design, types of mixed methods designs, methods of integration of quantitative and qualitative data, and use of mixed methods designs in health services research.

Overview of mixed methods research

Creswell describes mixed methods research as “an approach to research in the social, behavioural, and health sciences in which the investigator gathers both quantitative (closed-ended) and qualitative (open-ended) data, integrates the two, and then draws interpretations based on the combined strengths of both sets of data to understand research problems”^{274(p2)}. Therefore, only having quantitative and qualitative data in a study cannot make a study mixed methods unless there is a rationale for mixing, systematic analysis, and integration of the two versions of data^{274, 275}. Studies that involve multiple quantitative methods (or multiple qualitative methods) qualify only as multimethod but not mixed method^{274, 275}.

In regards to philosophical views, mixed methods researches dwell in neither of constructivist or postpositivist philosophies; they instead approach a research problem from a pragmatic viewpoint—a view that allows flexibility to choose methods to appreciate the actual problem and devise practical solutions^{276, 277}.

The designs used by mixed methods researchers are grossly classified into basic and advanced designs. Basic mixed methods designs are further classified into exploratory, explanatory, or convergent, depending on the timing of the two methods (quantitative and qualitative). There exists a sequential ordering of the two methods in exploratory and explanatory designs, whereas convergent designs use the two methods in parallel. In explanatory designs, quantitative data are collected and analysed first to inform or plan the qualitative phase of a study. Conversely, in exploratory designs, qualitative data collection and analysis precedes and informs the quantitative phase of a study (Figure 4.3).

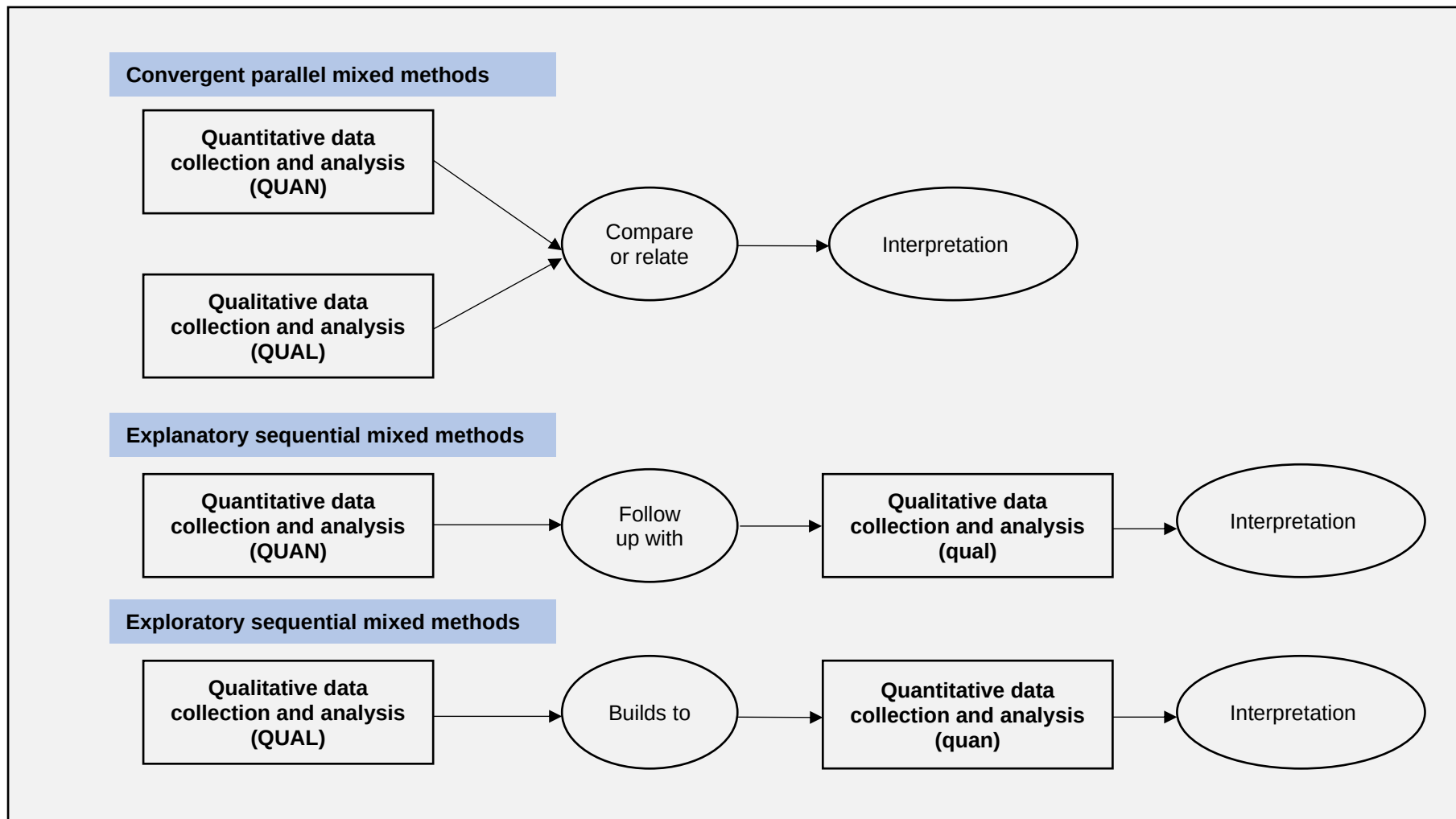


Figure 4.3 Types of basic mixed methods research, ^{276(p220)}

There are three advanced mixed methods designs—multistage, intervention, and social justice—that add further elements to either of the basic designs—explanatory, exploratory, or convergent designs^{274, 276}. Fetters and colleagues name social justice designs as transformative or participatory designs and also recommend a fourth advanced mixed methods framework—a case study²⁷⁸. Next, I provide a further description of interventional mixed methods designs and strategies of integration in mixed methods research.

Interventional design is a widely used advanced mixed methods design in health services research that adds qualitative data into an intervention study before, during, or after the intervention in an applied setting, a process called embedding²⁷⁸. Interventional mixed methods designs help to formulate intervention procedures, study how participants are experiencing the intervention, and follow-up on the outcomes and explain them in more detail²⁷⁴. In simple terms, interventional designs provide the basis to learn from the intervention design and implementation process, what it lacked, what could have been done better, and how it can be modified or scaled-up. Thus, they provide evidence on the contextual features of interventional studies that cannot be grasped by quantitative designs.

The integration of qualitative and quantitative research components in mixed methods research can be done at the design, methods, and interpretation and reporting levels²⁷⁸ (Box 4.1). At the design level, the two methods (quantitative and qualitative) are strategically ordered to inform each other or build on what has been achieved by one of the methods. Integration at the methods level involves strategies to link the data collection and analysis methods used by the two methods which can be through connecting, building, merging, and embedding. Integration at the interpretation and reporting level involves strategies to describe the two methods using reports, convert data from one of the methods to the other, and use visual means to collate findings from the two methods²⁷⁸.

Box 4.1 Levels and approaches of integration in mixed methods research, ^{278(p2136)}

Integration level	Integration approaches	
Design	Basic designs	Advanced designs
	Exploratory sequential	Multistage
	Explanatory sequential	Intervention
	Convergent	Case study
		Participatory
Methods	Connecting	
	Building	
	Merging	
	Embedding	
Interpretation and reporting	Narrative	
	Data transformation	
	Joint display	

This PhD study used an interventional mixed methods design involving pre-and post-intervention qualitative studies (FGDs and IDIs) which were embedded into pre- and post-intervention quantitative studies (women's and service providers' surveys). The quantitative studies aimed at evaluating the effectiveness of the intervention on the level of mistreatment women experience and knowledge and attitude of service providers about RMC.

I used a non-randomised and uncontrolled before-after design taking into consideration the following four justifications. First, there were financial and time constraints to include comparison hospitals because the institutions that financed the intervention could not fund more than what was allotted, and the follow-up time required for randomised and controlled designs would significantly affect the timely completion of this PhD study. Second, it was not feasible to randomise the intervention among participants (healthcare providers) in a given hospital, given that participants work in team and it is difficult to prevent spill over effect of the intervention. Third, given the dearth of evidence on the effectiveness of RMC interventions, a non-randomised and uncontrolled study could generate important evidence related to possible ways of promoting RMC and enabling and constraining health system factors. Finally, the selected design could be hypothesis-generating, with the potential to

generate a field-tested intervention package that could be used by future randomised and controlled studies.

The pre-intervention qualitative studies (FGDs and IDIs) were designed to enrich the contents of the intervention package and identify health system challenges that impede RMC, whereas the post-intervention studies (FGDs) aimed at exploring the challenges experienced during implementation of the RMC intervention. Accordingly, I arranged the qualitative and quantitative studies sequentially, as illustrated in Figure 4.4. Integration of the quantitative and qualitative methods was done at the design, methods, and interpretation and reporting levels. The qualitative and quantitative data were analysed independently. The integration of the two methods at interpretation and reporting level was done using the integration by narrative approach²⁷⁸.

The qualitative methods of exploration were embedded within the larger quantitative design to gain an understanding of the contextual conditions operating in the health system that may constrain the promotion of RMC in the hospitals generally and the intervention to promote RMC specifically. Scholars argue that the measuring effectiveness of an intervention is not the only ultimate purpose of trials; issues of equal importance include examining the acceptability, implementation process, and feasibility of the intervention. The latter necessitates the use of mixed methods evaluation—quantitative and qualitative evaluation²⁷⁹.

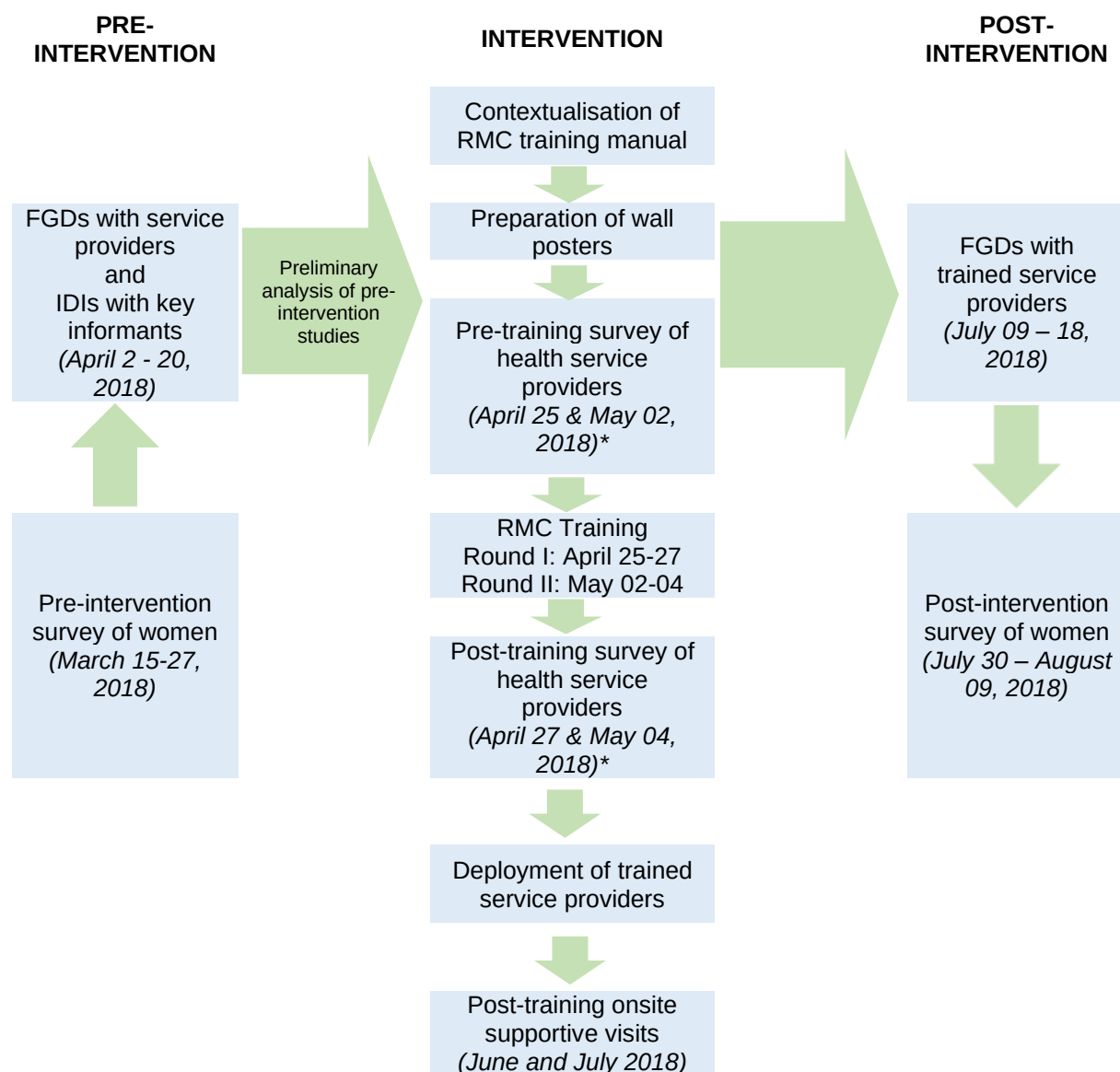


Figure 4.4 Flowchart of studies and the intervention

4.5 The intervention

This study included three interventions: training of service providers, placement of wall posters in labour wards, and post-training onsite supportive visits for quality improvement. The implementation was financed by the Institute for Health Care Improvement, through the Ministry of Health (Ethiopia) and the SNNPR Health Bureau. All interventions were made in close collaboration with the SNNPR Health Bureau. Table 4.2 presents the roles collaborators of this PhD study played.

Table 4.2 Roles of study collaborators

Collaborator	Role in research
1. The University of Melbourne, Australia	Research integrity and ethical standard, provision of travel grant for the PhD candidate
2. Ministry of Health, Ethiopia	Grant acquisition, review of RMC training manual, overall monitoring of intervention to promote RMC
3. SNNPR Health Bureau, Ethiopia	Overall RMC training coordination, ethics review, review of RMC training manual, logistics support, financial contribution to the RMC training
4. Institute for Healthcare Improvement	Financial contribution to the RMC training
5. Hawassa University College of Medicine and Health Sciences	Overall research administration (financial and administrative), logistic support
6. Hawassa City Administration Health Office	Coordination and supervision support
7. Sidama Zone Health Department	Coordination and supervision support
8. Leku Primary Hospital	Coordination support, implementation site
9. Adare General Hospital	Coordination support, implementation site
10. Yirgalem General Hospital	Coordination support, implementation site

4.5.1 Training of service providers

The training of service providers involved a three-day workshop using an RMC training manual developed for this study. The manual passed through three phases before it was implemented in study settings.

Phase I: Preparation of draft manual

I prepared a draft manual after review of previous RMC training manuals used in low-income settings (Kenya²⁰⁸, Tanzania¹⁵³, and Nigeria²⁸⁰), international human rights declarations^{24, 281, 282}, national professional codes of ethics²⁸³⁻²⁸⁵, and national training

manuals on maternity care and quality improvement^{286, 287}. The manual included chapters on an overview of maternal health in Ethiopia, human rights and law in the context of reproductive health, RMC rights and standards, professional ethics, and continuous quality improvement (CQI).

Phase II: In-house manual review

The draft manual was reviewed for content, clarity, and organisation by Alison Morgan and Michelle Kermode (PhD supervisors) who have expertise in maternal health and implementation research in low-income settings, including Ethiopia and Kenya.

Phase III: Manual review by external experts

Three senior maternal health experts at the Federal Ministry of Health and SNNPR Health Bureau reviewed the revised manual for its content and applicability in the Ethiopian context. The main points of improvement suggested by the reviewers were: to rearrange RMC concepts into one section instead of having them in separate sections; to reduce the use of detail data trends on maternal health and maternal mortality indicators—suggesting that it might not be important for the trainees and may confuse them instead; to improve the simplicity of contents under the human rights in sexual and reproductive health chapter; and to include specific learning outcomes at the beginning of each chapter using action verbs. Preliminary findings of the pre-RMC intervention FGDs and the women's survey were also used to improve the training manual and dictate the areas that require emphasis during the training. I used the final version of the training manual (Appendix B-1) to plan the rest of the training activities.

Following preparation of the training manual, I made an inventory of human resources in the maternity units of all study hospitals. The audit aimed to quantify potential training participants—service providers who assist women during childbirth. The SNNPR Health

Bureau and hospital administrations—of the three study hospitals—communicated their expectation that all eligible service providers should attend the training. Eventually, a total of 64 health service providers participated in the RMC training. Fifty-two were midwives, whereas the remaining were: integrated emergency surgical officers (4), general practitioners (3), nurses (3), and health officers (2). Table 4.3 shows the number of potential and actual RMC training participants in each of the study hospitals. In reality, all eligible service providers from Adare and Leku hospitals attended the training sessions. Five of the 22 eligible service providers from Yirgalem hospital did not participate in the training sessions for personal reasons.

Table 4.3 Eligible and actual respectful maternity care training participants by hospital

Profession	Adare General Hospital		Leku Primary Hospital		Yirgalem General Hospital		Total Participants
	Eligible	Actual	Eligible	Actual	Eligible	Actual	
Midwives	22	22	17	17	16	13	52
Nurses	2	2	1	1	1	-	3
Health Officers	-	-	-	-	2	2	2
GPs	-	-	1	1	3	2	3
IESOs	2	2	2	2	-	-	4
Total	26	26	21	21	22	17	64

* GPs: General Practitioners; IESOs: Integrated Emergency Surgical Officers

An interactive RMC training was conducted in two rounds (33 participants in the first round and 31 in the second) of three-day training sessions at Hawassa University Comprehensive Specialized Teaching Hospital. The training site is a regional centre of excellence and an in-service training centre for several short-term training courses. A senior maternal health expert (from the SNNPR Health Bureau), a senior obstetrician-gynaecologist (from Hawassa University Comprehensive Specialized Teaching Hospital), and I facilitated the training sessions. All training facilitators are certified trainers of short-term in-service training manuals by the Ministry of Health, Ethiopia.

The facilitators used various teaching methods, including presentations, role-playing, demonstrations, case studies, individual readings, video shows, and a hospital visit. Training facilitators also used a range of training quality control mechanisms during the RMC training. Recommendations of the “Effective Teaching of Healthcare Providers”²⁸⁸ were used to choose the methods of presentation and draft a structured schedule for the training (Appendix B-2).

At the end of the daily sessions, facilitators administered daily feedback forms to allow participants to reflect on their daily experience of the training sessions and make recommendations for subsequent sessions. Additionally, there were daily post-training meetings chaired by me during which we (training facilitators) reviewed participants’ feedback and took improvement actions accordingly. The next morning, facilitators presented summaries of participants’ feedback to assure participants that facilitators are trying to improve on the delivery and organisation of the training sessions. Facilitators also used a final training course evaluation form to evaluate how the training went overall (Appendix B-3). The second round of the RMC training benefited from the feedback generated by the first round; facilitators made some changes in the sequencing of contents and delivery approaches.

At the end of each training rounds, participants prepared an action plan that they will use to implement recommendations of the RMC training in their hospital. MCH coordinators of the hospitals chaired the action plan preparation. The coordinators participated in the first round training and the last day of the second round training to discuss with their colleagues and to capitalise on the action plan that first-round training participants prepared. The action plan in the second round also benefited from a preliminary report of a facility-led RMC assessment that the coordinators conducted after the first round training. On the last day of the second round training, hospital quality focal persons, hospital medical directors, hospital chief executive officers, and zonal and regional maternal health program experts attended a three-hour consultative meeting with training participants. The meeting aimed to create a

platform for participants to discuss the challenge they experience and the support they require to promote RMC with the managers.

4.5.2 Respectful maternity care wall posters

I distributed five types of wall posters (four in English and one in Amharic languages) to the hospitals following completion of the RMC training. One of the English version wall posters shows the universal rights of childbearing women prepared by the White Ribbon Alliance (Appendix C-1). The remaining three are infographics taken from the intrapartum care for a positive childbirth experience guideline developed by the World Health Organization (Appendix C-2). The Amharic version poster shows the manifestations of “disrespect and abuse” or mistreatment during facility-based childbirth and the universal rights of childbearing women [Appendix C-3]. The contents of this specific poster were adapted by the Federal Ministry of Health, Ethiopia from the WHO statement on “*The prevention and elimination of disrespect and abuse during facility-based childbirth*”⁶. Training facilitators discussed contents of the wall posters during the RMC training; participants positively regarded the importance of having these. Colour-printed and plastic laminated posters were placed in labour (waiting) rooms and delivery rooms.

4.5.3 Post-training onsite supportive visit

A senior maternal health expert from the SNNPR Health Bureau and I conducted two rounds of post-training quality improvement supportive visits in all hospitals at two-week intervals, in June and July of 2018. During the initial visit, RMC-trained service providers, along with their respective coordinators, conducted a facility-led assessment of maternity care settings using a structured checklist that was part of the RMC training [Appendix B-1]. The maternal health expert and I were only there to provide support. Action plans were developed—using a template that was part of the training—by service providers to address actionable gaps identified by the assessment [Appendix B-1]. Maternity unit coordinators passed the gaps that they believed could not be addressed at their scope to hospital administrations for further actions. During the second visit, the hospital teams reviewed the performance of their

plan and identified core barriers to implementing the plan. Similar steps of action plan preparation were undertaken in the move to improve RMC and promote CQI as a routine process.

4.6 Quantitative methods

4.6.1 Women's survey

A cross-sectional survey of women was conducted before and after the RMC intervention. The survey primarily aimed at measuring the level of mistreatment of women during facility-based childbirth in the study hospitals and to quantify the difference in the level of mistreatment before and after the RMC intervention. Women's survey was done to address the first study objective.

4.6.1.1 Participants

Participants were pregnant women who gave birth in the study hospitals during the survey period. Women who had either vaginal or caesarean (emergency or elective) birth and who consented to participate were included regardless of their birth outcome. Including women who underwent caesarean section allowed to account for the variation in the duration women stayed in health facilities and thereby the degree of contact with service providers (especially for vaginal examination). Data collectors invited women to participate in the study after they have completed their discharge requirements and procedures.

4.6.1.2 Sample size and sampling

The sample size for this study was estimated using the assumptions for calculating the difference between two sample means considering a statistical power of 90%, an allocation ratio of 1:1 between the pre- and post-intervention groups, and 0.05 level of significance. I assumed an anticipated mean count of mistreatment experiences women face in the study hospitals (before the intervention) of 4.91, taken from a previous study conducted in Ethiopia by me¹² and an anticipated mean count of mistreatment experiences women face in the study hospitals (after the intervention) of 3.96 (mean difference of 0.95). With these

assumptions, the minimum required sample size was 172 (86 in the pre-intervention group and 86 in the post-intervention group). The above sample size was adjusted for a clustering effect of 2 to account for clustering. I hypothesised that women receiving care in the same hospital are more likely to receive comparable care during childbirth, hence adding a clustering effect. Additionally, to accommodate for non-response, a 10% non-response rate was considered making the final sample size 378 (189 in each of the pre- and post-intervention groups).

I used birth volumes in the last quarter of 2017 to proportionately allocate samples to the three hospitals for the pre-intervention survey; I used birth volumes of the second quarter of 2018 to allocate samples for the post-intervention survey. Accordingly, I surveyed 172 (87 pre-intervention, 85 post-intervention) women from Adare hospital, whereas 86 (46 pre-intervention, 40 post-intervention) and 130 (65 pre-intervention, 65 post-intervention) of the women were from Leku and Yirgalem hospitals, respectively.

Women were invited to participate in the study and were consecutively enrolled until the required sample size was achieved for each study hospital. Using a consecutive sampling of women for exit survey in the study setting did not introduce a biased sample because women stayed in the hospitals for a minimum of six hours after childbirth and thus it was feasible to access them regardless of the amount of time they spent in active labour.

Additionally, consecutive sampling was operationally efficient. However, in exit surveys of clients visiting outpatient clinics, consecutive sampling on their exit may pose a bias because clients who spent longer consultation time will be overrepresented; clients with shorter consultation time will leave before being approached by data collectors while their counterparts are being exit-surveyed²⁸⁹.

4.6.1.3 Tool development and outcome measures

I developed a 57-item questionnaire which is organised in four sections—sociodemographic characteristics, obstetrics and service-related characteristics, current birth-related characteristics, and mistreatment characteristics (Appendix D-1). The section tailored to the

assessment of mistreatment included 25 questions—with six additional skip logic questions—about women’s experiences of childbirth in the study hospitals. The questions pertained to six categories namely: verbal abuse (4 questions); physical abuse (3 questions); non-consented care (5 questions); lack of information, privacy and confidentiality (4 questions); neglect and discrimination (4 questions); and refusal of preference (5 questions) (Table 4.4). The responses consisted of dichotomised mutually exclusive options set as “yes” or “no”.

These mistreatment assessment questions were developed as per the recommendations of a methodological review I co-authored; we reviewed five prevalence studies of mistreatment conducted in four sub-Saharan Africa countries, including Ethiopia¹⁰. The majority of the mistreatment assessment items have been validated in Ethiopia¹⁹⁹. Additionally, the recommendations of Bohren and colleagues⁵ was used with some modifications to develop the six categories of mistreatment used in this study (Table 4.4). The outcome variable was the number of mistreatment components women experienced (a count variable) computed from the 25 variables, ranging from zero to 25. This was done to capture the difference in the number of mistreatment components women experienced that could not be captured by a simple prevalence measure that reports whether women were mistreated or not. For example, both a woman who experienced four types of mistreatment and a woman who experienced one type of mistreatment are mistreated, but the intensity of mistreatment is different between the two.

Table 4.4 Mistreatment assessment questions and their categories

Mistreatment category	Mistreatment questions
Verbal abuse	Did the health workers use harsh or rude language? Did the health workers make judgmental or accusatory comments about you? Did the health workers make threats of withholding treatment? Did the health workers blame you for any feature of your birth outcomes?
Physical abuse	Were you beaten, slapped, kicked, or pinched during childbirth? Were you gagged during childbirth? Were you physically restrained during childbirth?
Non-consented care	Did the health workers obtain your consent for all procedures? Did the health workers ever separate you from your baby without explaining the reason? Did the health workers ask your permission before conducting a vaginal examination? Did the health workers ask your permission before performing surgery (episiotomy or caesarean section)? Did the health workers make you stay in the hospital against your will?
Lack of information, privacy and confidentiality	Did the health workers keep information about you confidential? Did the health workers conduct vaginal examination without maintaining your privacy? Did the health workers give you periodic updates on your labour? Did the health workers speak to you in a language you do not understand?
Neglect and discrimination	Did the health workers always come following your call? Were you ever left for a prolonged period of time without attention during your labour? Was a health provider present for the actual birth of your baby? Did the health workers discriminate against you based on your religion /ethnicity/age/socioeconomic status/medical condition?
Refusal of preference	Did the health workers allow you to have your birth companion present? Did the health workers allow you to move around during your labour? Did the health workers allow you to have food or fluids? Did the health workers allow you to deliver in your preferred position? Did the health workers allow you to have a cultural practice in labour?

The independent variables of this study were: whether the woman belongs to pre- or post-intervention group; sociodemographic characteristics (place of residence, age, age at first marriage, marital status, educational status, occupation, religion, ethnicity, monthly income, number of children); obstetric characteristics (complication/s during pregnancy and delivery,

type of birth, intervention/s for vaginal birth); service utilisation history (antenatal visits, history of facility-based birth); and service-related characteristics (referral status, time of admission, hours of stay, gender of service provider)

The survey questionnaire was initially prepared in English and later translated into two local languages (Amharic and Sidamu Afo) and back-translated to check for consistency. I translated the questionnaire into Amharic language and an experienced linguist from Hawassa University conducted back translation of the Amharic version into English. The back-translated version was compared with the original English version to check for inconsistencies and revise the translated version to ensure equivalence of meaning. For the Sidamu Afo language version, a public health expert who is a native Sidamu Afo speaker translated the English version into Sidamu Afo language and compared it with the Amharic language version for inconsistencies.

Subsequently, I prepared an electronic data collection template using the KoBoToolbox tool, and data were collected using the KoBoCollect application for android devices. Initially, I designed the English version questionnaire on the web version followed by the design of the Amharic and Sidamu Afo language versions. The translators and I had checked for consistency between the three versions before I imported the templates into the Android tablets that were used for data collection. The KoBoCollect platform allows for easy navigation between the different language versions when required and can be used in an offline version. Data collectors were not entitled to make changes on the content of the questionnaire; their access to the forms was limited and protected by an admin password held by me. The consent sheet that will be discussed in detail later was prepared in a paper format and was not included in the electronic platform as it has to be signed off by participants. A sample snapshot of the electronic data collection interface is shown below (Figure 4.5).

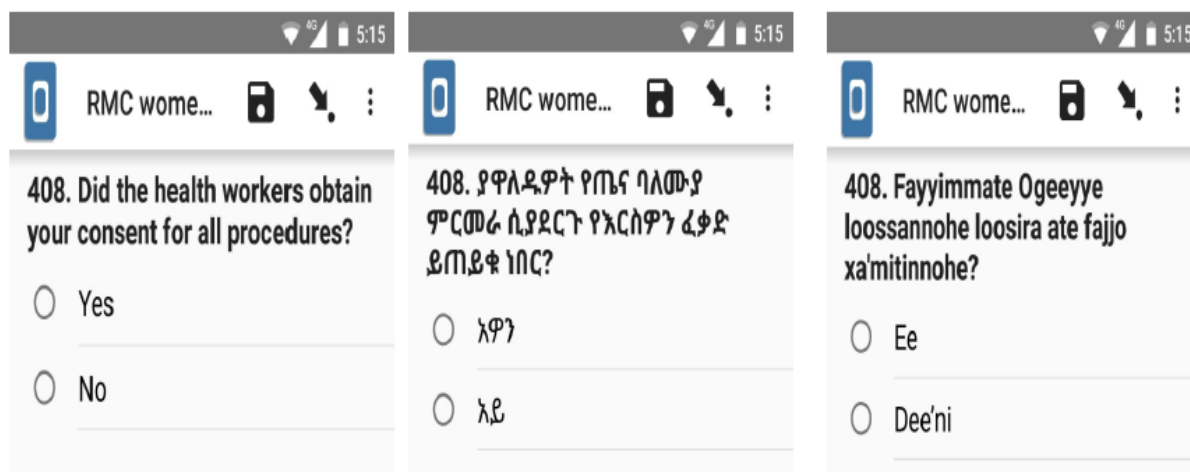


Figure 4.5 Snapshot of the KoBoCollect application

4.6.1.4 Data collection

Data were collected and supervised by trained nurses and midwives who were fluent speakers of both Amharic and Sidamu Afo languages, recruited from Hawassa University Comprehensive Specialized Hospital. Three data collectors and one supervisor received a detailed three-day training on the purpose of the study, contents of the questionnaire, effective survey administration, and ethical procedures in research. The questionnaire was pre-tested on 15 women who gave birth in Hawassa University Comprehensive Specialized Hospital, which resulted in minor modifications to the questionnaire. The pre-intervention survey of women was conducted between 15 - 27 March 2018 and the post-intervention survey was conducted between July 30 and August 09, 2018. Before conducting the post-intervention survey, data collectors received a one-day refresher training. For quality purpose, the supervisor reviewed completed questionnaires for key contents before data collectors uploaded these to the server. I controlled the quality of uploaded questionnaires on a case-by-case basis before they were approved.

4.6.1.5 Participants enrolment process

Maternity ward heads were instructed to pass on information to onsite data collectors about the bed numbers of women who are about to be discharged whenever that happens. Women were then approached by the data collectors who provided information regarding

the purpose of the study and the data collection procedures. However, data collection took place after participant women have received their hospital discharge notes to minimise the chance of courtesy bias—clients may be reluctant to report negative childbirth experiences due to the fear of getting jeopardised care in response²⁹⁰. Women who agreed to participate in the study were surveyed in a private room dedicated to this purpose during the data collection period.

4.6.1.6 Data processing and analysis

Data were exported from the koBoToolbox platform to SPSS V.24 software for cleaning and later to Stata software (StataCorp, version 15, College Station, TX, USA) for analysis.

Descriptive analyses, including frequency distributions, means, and medians, were done to summarise key variables of the study. Additionally, cross-tabulations were performed to check whether selected independent variables of interest vary between the pre- and post-intervention groups.

The outcome variable, number of mistreatment components women experienced, was generated using the “generate variable” option on Stata software by counting values within cases, the 25 mistreatment measurement variables. I used the one sample independent Kolmogorov-Smirnov test to check whether the generated outcome variable follows the Poisson distribution. Additionally, I compared the mean and the variance of the outcome variable to identify whether the outcome variable is convenient for Poisson modelling. For a count variable to be suitable for Poisson regression, the mean and the variance should be close to each other. A count data that exhibit overdispersion, a scenario when the variance is higher than the mean, warrant the use of advanced analysis to reduce the overdispersion and make it suitable for Poisson regression²⁹¹.

Three models were constructed in this study to decide on the model that best assesses the changes in the number of mistreatment components experienced by participants of the two groups.

Model I: A null or an intercept-only model with the intercept as fixed effect and random effects for hospitals

Model II: A model containing the intervention as fixed effect and random effects for hospitals, and

Model III: A model containing the intervention, sociodemographic, obstetric, and health service-related factors as fixed effects and random effects for hospitals

In all models, I set “hospital” as a random-effects variable to take into account the likely absence of independence among women who received care from the same hospital—cluster-level effects. I conducted a multilevel mixed effects Poisson regression analysis to identify the association between the independent and outcome variables while adjusting for possible confounders. I used adjusted exponentiated regression coefficients (β) with their corresponding 95% confidence intervals (CIs) to estimate the level of association between independent variables and the outcome variable. To check for correlation between the independent variables included in the Model III, I run a multicollinearity test using the variance inflation factor (VIF). The outputs of the mentioned-above statistical analyses are reported in Chapter 5.

4.6.2 Service providers’ survey

I conducted a cross-sectional survey of health service providers before and after the RMC training at the training venue. This survey primarily aimed at assessing service providers’ knowledge of RMC and mistreatment, perceptions towards RMC, and experience of mistreatment of women in their respective hospitals—the second study objective. The findings of this specific survey are reported in Chapter 6.

4.6.2.1 Participants’ recruitment

Participants of this survey were service providers from the three study hospitals who attended the RMC training. I informed potential participants about the aim of the survey at the beginning of the first day of the training sessions (in both rounds) after registration of

participants—for administration purpose—was completed. Additionally, I informed training participants that their decision to participate in the survey (or not) would not affect their participation in the training.

Because more than half of the training participants were those who participated in the pre-intervention FGDs or IDIs, the research idea was not new for them, and the process was straightforward. Following the information session, all participants were invited face to face to take part in the survey before the training commenced at the training venue. Finally, all (64) service providers who attended the RMC training from the three study hospitals agreed to participate in the survey. Details about service providers who participated in the RMC training was discussed earlier in Section 4.5.1.

4.6.2.2 Instruments and measurement

I developed a 31-item paper-based self-administered questionnaire organised in four sections gathering data on the following: participants' sociodemographic, professional, and work-related characteristics; their observed experiences of mistreatment of women in the 30 days preceding the survey date; and their perceptions of RMC and mistreatment. (Appendix D-2). Eight questions representing different categories of mistreatment refined from the women's survey questionnaire by me (non-consented care; lack of information, privacy and confidentiality; physical abuse; verbal abuse; the refusal of preference; neglect and discrimination) were used to assess whether participants had witnessed the mistreatment of women in their hospital.

During the pre-RMC training survey, I used the full version of the questionnaire; the post-RMC training survey questionnaire only included the section on perceptions of RMC and mistreatment. Following participants' consent, questionnaires with anonymous codes were put in unsealed envelopes and distributed; participants noted their unique codes, which were subsequently used for the post-intervention survey. I also provided instructions on how to complete the questionnaire page by page. Completed questionnaires were returned in

sealed envelopes to maintain anonymity. The pre- and post-RMC training surveys were matched using the anonymous codes.

4.6.2.3 Data analysis

I entered into and analysed the survey data using Stata software (StataCorp, version 15, College Station, TX, USA). Descriptive statistics were computed, and an exact McNemar's test was performed to analyse pre-post differences in participants' perceptions of RMC and mistreatment. McNemar's test is an appropriate statistical procedure for the pretest-post-test analysis of dichotomous variables collected from paired samples; in this case, pre- and post-RMC training participants²⁹². As opposed to the chi-square test that tells whether two categorical variables are associated or not, the McNemar's test intends at the showing whether the outputs of a dichotomous variable in a paired sample vary significantly or not. Hence, it makes it a perfect test for the pretest-posttest comparison of a dichotomous variable collected from the same participants before and after an intervention.

4.7 Qualitative methods

4.7.1 Data collection methods and participants

FGDs were conducted with service providers both before and after the RMC interventions. I conducted the pre-intervention FGDS to explore on the knowledge of service providers on quality childbirth care, RMC, and the mistreatment of women; health system challenges service providers experience in the provision of RMC; the contributors to the mistreatment of women in health facilities; de/motivators of RMC provision; and seek for their recommendations of what needs to be done to improve RMC in their hospital. The preliminary analysis of the FGDs was used to improve the RMC training manual in terms of both its scope to address the knowledge gap providers had and the contextual factors in the study hospitals. I conducted the post-intervention FGDs to explore service providers' perceptions and experiences of the RMC training and its implementation process and the

challenges they experienced during the implementation (Table 4.5). The post-RMC intervention FGDs were conducted two months after the RMC training.

Participants of the FGDs were service providers who provide care during labour, childbirth, and immediate postpartum periods in the maternity care unit of the study hospitals. The post-intervention FGD included only those providers who have attended the RMC training.

In addition to the FGDs, IDIs were conducted to explore the barriers to the promotion of RMC from the perspectives of program managers and administrators who look after the programming and operation of maternal health services in the hospitals, districts, zones, and thereafter (Table 4.5). All IDIs were conducted before the RMC intervention. Participants of the IDIs were key informants at the hospital and program levels. At the hospital level, I interviewed MCH coordinators, institutional quality focal persons, medical directors, and chief executive officers. The program level IDI was conducted with a senior maternal health expert at the SNNPR Health Bureau (Table 4.5).

Table 4.5 Summary of focus group discussions and in-depth interviews

Category	Facility	No. of FGDs/IDIs	No. of participants	Topic areas explored
Pre-intervention FGDs	Hospital I	2	16 (14 midwives, 2 nurses)	Features of quality maternity care; Knowledge and perception of mistreatment; Knowledge and perception of respectful care; contributors to mistreatment; challenges experienced in labour wards; motivators and demotivators to provide respectful care; actions required to promote respectful care
	Hospital II	1	8 (7 midwives, 1 integrated emergency surgical officer)	
	Hospital III	1	8 (7 midwives, 1 health officer)	
Post-intervention FGDs	Hospital I	1	7 (6 midwives, 1 nurse)	Perceived behavioural influences of the training; challenges encountered, and new behaviours emerged in implementing the training; additional actions required to implement the training; partakers of RMC
	Hospital II	1	8 (8 midwives)	
	Hospital III	1	6 (5 midwives, 1 general practitioner)	
IDIs	Hospital I	4	4 (MCH* coordinator, quality focal person, medical director, and chief executive officer)	Features of quality maternity care; Knowledge and perception of mistreatment; Knowledge and perception of respectful care; contributors to mistreatment; perceived status of respectful care; respectful care initiatives; challenges in advancing respectful care
	Hospital II	4	4 (MCH coordinator, quality focal person, medical director, and chief executive officer)	
	Hospital III	3	3 (MCH coordinator, quality focal person, and medical director)	
	Regional Health Bureau	1	1 (senior maternal health expert)	

4.7.2 Sample size and sampling

I conducted seven FGDs; four pre-RMC intervention and three post-RMC intervention FGDs. Two of the pre-intervention FGDs were done in Adare General Hospital because of its high client volume and number of practising staff, while one FGD was conducted in each of the remaining two hospitals (Leku Primary Hospital and Yirgalem General Hospital) (Table 4.5). A total of 32 participants took part in the pre-RMC intervention FGDs (6 -10 participants in each FGDs); 24 of the participants were females, while the remaining 8 were males. One post-RMC intervention FGD was conducted in each study hospitals. A total of 21 participants took part in the post-RMC intervention FGDs (6-8 participants in each FGDs); 15 of the participants were females while the remaining 6 were males.

Participant selection for the pre-intervention FGDs was based on the availability of service providers depending on their duty assignment. Maternity care unit coordinators invited service providers who were not on day-time duty. For the post-RMC intervention FGDs, candidate participants (those who attended the RMC training and who were not on day-time duty) were invited to participate in the FGD (Table 4.5).

I conducted one IDI in SNNPR Health Bureau, three IDIs in Yirgalem General Hospital, four IDIs in Leku Primary Hospital, and four IDIs in Adare General Hospital—totalling 12 IDIs. I selected participants of the IDIs conveniently depending on their organisational responsibility. Key informants at the hospital level were MCH coordinators, institutional quality focal persons, medical directors, and chief executive officers. The program level IDI was conducted with a senior maternal health expert at the SNNPR Health Bureau (Table 4.5).

4.7.3 Data collection

Pre-intervention FGDs and IDIs were conducted from March 2018 to April 2018, whereas post-intervention FGDs were conducted in July 2018. Initially, I developed semi-structured interview guides in English after a thorough literature review vis-à-vis the aim of the study

and the plan for integration of the two methods—quantitative and qualitative. Evidence from published and grey literature on the mistreatment of women in health facilities; providers' behaviour and responses to organisational change; health system barriers to maternal health services; and quality improvement in maternity settings were the main elements included in the guides (Appendix E).

The guides were then reviewed for content and clarity by two of the PhD supervisors. I then translated the final version interview guides for both the FGDs and IDIs into Amharic language and used these versions to collect data in Amharic. The topic areas covered by the interview guides are displayed in Table 4.5. I collected and digitally audio-recorded the interviews. All FGDs and IDIs with MCH coordinators and quality focal persons were conducted in private meeting rooms at the study hospitals. IDIs with the remaining category of key informants were conducted in the respective participants' private office rooms. Participants were provided with compensation for local transportation.

4.7.4 Data management and analysis

I did the simultaneous translation (from Amharic language to English) and transcription of the audio recordings of both the FGDs and IDIs. The transcribed data were then imported into NVivo software (QSR International, Version 12 Plus) for analysis. I used the software to digitally code the imported data after reading and rereading of the transcripts. Qualitative data were analysed in two different rounds—the first analysing only the post-RMC intervention FGDs and the second analysing all FGDs and IDIs together. The method of qualitative data analysis was chosen depending on the study objectives and plan for integration of the qualitative and quantitative methods.

A) Analysis of the post-RMC intervention FGDs alone

I decided to analyse the post-RMC FGDs alone aiming at mixing the findings with findings of the pre- and post-RMC training survey of service providers. This was done to address the third objective of this PhD study. Details about the method of mixing, analysis, and the

findings are available in Chapter 6. I used both inductive and deductive thematic analysis approaches and later compared the themes that emerged for consistency. The deductive analysis used the semi-structured interview guide as a basis to organise themes and responses, whereas the inductive analysis identified themes emerging from the transcripts. I reviewed the major themes and sub-themes vis-à-vis the transcripts and the interview guides and final themes were agreed upon. Using a hybrid thematic analysis—both inductive and deductive coding—approach helps in maintaining the rigour of thematic analysis and building on already identified themes in a particular field of study²⁹³. I followed the consolidated criteria for reporting qualitative research (COREQ) to ensure that important components of the pre-intervention FGDs are reported²⁹⁴.

B) Analysis of FGDs and IDIs together

I chose this method of analysis to address the fourth objective of this PhD study. Data from the pre-and post-intervention FGDs and IDIs were brought together and analysed thematically according to Braun and Clarke's approach²⁹⁵. Believing that the quality of care women receive during childbirth is positioned within a complex adaptive health system, the thematic analysis adhered to the tenets of complexity theory to identify and discuss health system constraints to the promotion of RMC²⁵⁴. The theory was used as a framework to explore and map the complex interactions within and between health system elements—which were grouped under system hardware and system software categories—and their resultant effects in the promotion of RMC generally and the implementation of the RMC training specifically. A causal loop diagram was used to display the interaction between qualitative data and the identified themes. A detailed description of the method of data analysis is included in the publication within Chapter 7.

4.7.5 Measures taken to ensure rigour and quality

Ensuring rigour in qualitative research methods involves examining both the chosen research methods (methodological rigour) and the analyses undertaken (analytical rigour)^{295, 296}. Addressing these critical parameters improves the degree of trustworthiness

of the study²⁹⁷. In this section, I describe the methodological and analytical strategies that were used to ensure rigour and robustness in the qualitative methods used in this PhD study. A noteworthy recap here is that the study involved an intervention in public hospitals collaborating with various stakeholders, including the Ministry of Health, SNNPR Health Bureau, and the study hospitals. In Table 4.6, I summarise the actions taken to ensure that essential criteria of rigour in qualitative research were met.

Table 4.6 Measures taken to ensure rigour in qualitative methods

Criteria*	Measure/s taken in this study
Substantive contribution	Detailed descriptions of how the study contributes to the body of knowledge in the field of RMC in light of existing evidence and known gaps were done.
Method appropriateness/ informed methods choices	As service providers were the primary recipients of the RMC intervention that aimed to mitigate the mistreatment of women, the FGDs and IDIs were strategically sequenced and methodologically sound to enrich the contents of the RMC training manual and to allow service providers to reflect on their experience in implementing the training. That has also contributed embedding the qualitative methods into the quantitative methods to adhere to the requirements of interventional mixed method studies.
Data richness	The question guides used to facilitate the FGDs and IDIs were prepared after a thorough literature review in the field of maternal health and RMC that included grey and published literature. My prior experience as a co-investigator in an implementation research for scaling up a newborn health intervention (kangaroo mother care) that involved all three hospitals was an asset in understanding the real context and in refining the question guides accordingly. Additionally, preliminary findings of the quantitative findings from the providers' survey were also used to refine the question guides for the post-RMC intervention FGDs.
Sampling	A significant proportion of service providers who were involved in the RMC intervention participated in the FGDs and IDIs which allows a robust reflection on the intervention, the challenges in implementing it, and health system constraints overall.
Saturation/data adequacy	The methodological approach used in the study was capable of achieving a methodological saturation as a result of the following (1) the FGD participants were from the same unit of the study facilities, meaning that they have shared experiences of the challenges in implementing RMC (2) two-third (65%) of those who participated in the RMC intervention have participated in the FGDs and I believed that is methodologically sound to discover

Criteria*	Measure/s taken in this study
	adequate data, and (3) the key informants (MCH coordinator, quality focal person, medical director, chief executive officer, and regional maternal health expert) who participated in the IDIs represent the whole range of administrative and operations positions with significance to RMC.
Credibility	<u>Prolonged engagement</u> There was a prolonged engagement with the various participants of the study. During the planning phase of the study, I collaborated with the Ministry of Health and SNNPR Health Bureau to select study hospitals for implementation, review the intervention package, and oversee its implementation. Next, there was a strong collaboration with the study hospitals. Hospital administrators and service coordinators participated in the IDIs and were also part of the operational plan to cascade the RMC training sessions and post-training onsite activities. All service providers from the hospitals who participated in the pre-RMC intervention FGDs also took part in the RMC training and a portion of these service providers again participated in the post-RMC intervention FGDs allowing for the continuity of ideas and reflections during the course of the study. <u>Member checking</u> Preliminary findings of the pre-RMC intervention FGDs were presented to participants on the first day of the RMC training sessions for their reflection. Overall findings of the IDIs and FGDs were discussed with selected participants (regional maternal health expert, all hospital chief executive officers, and MCH coordinators) after the completion of the onsite interventions.
Dependability	The entire research activities and processes are described in detail for potential replication; a flow chart (Figure 4.4) and a table (Table 4.5) are also used to improve clarity.

Criteria*	Measure/s taken in this study
Confirmability	I checked and rechecked the coding of data by reading and rereading the transcripts. Additionally, PhD supervisors reviewed and confirmed the final codes and we agreed on the final themes.
Transferability	Broad descriptions of the study settings, contexts, the intervention, and participants are made to allow the transferability of the findings of this study to other settings. Additionally, qualitative data were analysed using two different approaches to respond to the corresponding study objectives.
Theory and rich interpretations	The study used the complex adaptive systems theory to explain and map the complex interaction between the themes and sub-themes that were identified using both deductive and inductive approaches (hybrid technique). Additionally, I constructed a causal loop diagram to display the pattern of interactions between the themes and subthemes to ease understanding and pinpoint potential considerations in future interventions in similar contexts.
Reflexivity	Before I enrolled in my PhD study, I worked as an academician, researcher, and technical consultant in the field of maternal, sexual, and reproductive health in Ethiopia for over ten years. I am a lead trainer of a short course for the prevention of mother-to-child transmission of HIV training modules for nurses, midwives, doctors, and other program staff. That, along with other technical support endeavours, offered me the chance to remain engaged in clinical activities and to bear witness to how women get mistreated in health facilities. I became interested to examine the reasons for the differences between the proportion of women who seek ANC compared to those who give birth at health institutions and conducted a region-wide study in SNNPR to further explore these differences. The study revealed a huge missed opportunity: two-thirds of women who sought at least one ANC delivered at home, partly due to the perceived mistreatment and poor quality of care ⁴² . Better understanding these important – but often neglected – barriers to care in the Ethiopian context prompted me to conduct a study that aimed to assess the mistreatment of women during my Maternal Health Young Champions Fellowship with the Maternal Health Task Force at the Harvard School of Public Health. Two of my papers

Criteria*	Measure/s taken in this study
	published from the study, along with other reported studies thereafter, helped me to understand the level of mistreatment of women¹² and service providers' perceptions and awareness of mistreatment⁴¹. One year before I started my PhD, I collaborated with the Ministry of Health and the Center for International Reproductive Health Training to conduct an implementation research that aimed to improve informed consent in obstetric and gynaecologic surgeries in a teaching hospital²⁹⁸ and to independently assess the client-centredness of sexual and reproductive health services in one of the model clinics in Ethiopia. All these research endeavours concretised my expertise in the field and the need for action to raise service providers' awareness of RMC. Following that, drawing from my academic expertise (teaching specialist in health services management), I recognised the need for evidence-informed implementation and health systems strengthening to improve RMC and prevent mistreatment and that led to the genesis of my PhD study. I position myself as an insider and having a collegial relationship with most of the study participants, due to a previous working relationship. I coordinated several MCH projects that were implemented in the hospitals, including co-coordinating a two-year implementation research project to develop kangaroo mother care scale-up model (all hospitals are affiliated to my home university—Hawassa University). Additionally, the current RMC intervention was participatory as it was planned and implemented in coordination with the hospital administrators and coordinators; I co-facilitated the RMC training and the post-training onsite support. Participants knew that the intervention was commissioned by the Ministry of Health and SNNPR Health Bureau and my role there is to study how the intervention goes; that enabled me to have an open and friendly relationship with the training and research participants. Accordingly, I believe that there was no significant power differential between the participants and me, which was demonstrated by the participants' openness to express their discomfort and frustrations with the RMC intervention whenever they felt so.

**The rigour criteria were compiled from four methodological papers* ^{293, 296, 299, 300}

4.8 Ethical considerations

The Health Sciences Human Ethics Sub-Committee at the University of Melbourne (HESC 1750054) granted an ethics clearance for this PhD study. The study also received local ethics approval from the ethical review board at the SNNPR Health Bureau, Ethiopia (Appendix F). Additionally, I have presented support letters sought from the Federal Ministry of Health and the SNNPR Health Bureau to the hospitals' administrations.

A plain language statement that provides information about the study was provided to all potential participants by data collectors (for women's survey) and the PhD student (for service providers' survey, FGDs, and IDIs). The plain language statement was prepared in two languages (Amharic and Sidamu Afo) for women's survey and in English for the service providers survey, FGDs, and IDIs (Appendix F). Participants were given a chance to ask questions and seek clarifications about the study. All participants have provided their written consent to participate in the study upon understanding the plain language statement (Appendix F).

Individuals who did not indicate interest in participating in the study were free to decline the invitation to participate. For illiterate women, data collectors read out the plain language statement and then completed a pre-prepared checklist that asked women to confirm their understanding of the essential elements of the study. Once this confirmation of understanding was completed, the data collectors signed the consent form on the women's behalf. As mentioned earlier, the plain language statement and the consent form for the women's survey were not attached to the electronic data collection system. The signed consent forms are stored in a secure location.

Data collectors were instructed to pause the interview and provide comfort if a woman who has experienced mistreatment should become distressed. Additionally, if a woman disclosed a serious event of abuse such as physical assault, data collectors were informed to refer the woman—upon her approval—to the hospital's complaint reporting centre that is

staffed by social workers. The interview would not be resumed unless the woman provided consent for it to do so. However, data collectors experienced no such event during the entire survey.

Data collectors conducted hospital-based surveys with women in private rooms to ensure women's privacy. I collected no personal identifiers from women, and thus the women's survey was anonymous. The service provider's questionnaire was also anonymous, and participants placed their questionnaire in a sealed envelope and put it in a box prepared for this purpose. I conducted FGDs and IDIs in rooms where no one except participants and myself was present. Data collected from all participants is stored in a password-protected place. All audio recordings of the FGDs and IDIs were transferred to secure digital storage on the date they were recorded, and removed from the digital audio recorders. At the completion of the women's survey data collection, I collected back the data collection tablets; data collectors were not given access to download completed forms.

4.9 Dissemination of the findings

A) Conference presentations

The quantitative finding from the women's survey of this study was presented through an oral presentation at the 11th European Congress on Tropical Medicine and International Health that was held in September 2019 in Liverpool, United Kingdom. Additionally, selected findings of the FGDs and IDIs were presented at the COPASAH Global Symposium that was held in October 2019 in New Delhi, India. A total of four abstracts have been accepted for presentation at the forthcoming Sixth Global Symposium on Health Systems Research (November 2020) and the 2020 Global Women's conference (September 2020).

B) Policy brief

I have prepared a policy brief for local use by the Federal Ministry of Health, Ethiopia and other stakeholders (Appendix G). The policy brief development passed through a series of reviews. Initially, experts at the Population Reference Bureau (USA) and the African Institute

for Development Policy (Kenya) reviewed the policy brief for its content and rigour, clarity, and outline. I am a recipient of the Policy Communications Fellows Program-2019 that was organised by the Population Reference Bureau (PRB) in collaboration with the African Institute for Development Policy (AFIDEP). The fellowship aims at building capacity of PhD students who conduct researches that have potential policy implications to be equipped with the necessary skills of communicating research to policy audiences.

Following the draft policy brief development, experts at the Ministry reviewed the brief and I made changes to accommodate their comments before the brief was approved for use. Additionally, in July 2020, I made an online presentation of the findings for senior maternal experts at the Ministry of Health, Ethiopia and other partner organisations working with the Ministry. The Ministry is also arranging for a wider dissemination platform in which audiences from regional health bureaus, partner non-governmental organisations, professional associations, and teaching hospitals participate.

C) Publications

Two papers have been published, and a manuscript and a commentary have been submitted to and are under review with peer-reviewed, international journals for broader dissemination to target audiences. Additionally, I have published a blog post in *International Health Policies* that highlights the gains that could be achieved through promoting respectful maternity care (Appendix H). I also use social media platforms such as Twitter, Facebook, and LinkedIn to share published articles.

Chapter 5: Results Part I – Evaluation of respectful maternity care intervention in Ethiopian hospitals

5.1 Preface

In this chapter, I report findings from the survey of women that was conducted before and after the RMC intervention. The survey addresses the first study objective (to evaluate the effectiveness of an RMC intervention on the level of mistreatment of women during facility-based childbirth) and compares the mistreatment experiences of women who gave birth in the hospitals before the intervention with those who gave birth two months after the intervention.

I used a multilevel mixed-effects modelling to quantify the changes in the mistreatment score (comprising 25 components) between women surveyed before and after the intervention. Designing the outcome variable as a score (count variable) enabled me to look closely into which changes resulted after the intervention, according to the different categories of mistreatment. In addition, I identified individual, facility, or service-related factors that were associated with mistreatment during childbirth. The findings indicated that the level of mistreatment during facility-based childbirth was lower by 18% after the RMC intervention compared to the level before the intervention.

I report the results using a peer reviewed journal article published in BMJ Open.

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Mitigating the mistreatment of women during facility-based childbirth: Evaluation of respectful maternity care intervention in Ethiopian hospitals. BMJ Open.
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BMJ Open Mitigating the mistreatment of childbearing women: evaluation of respectful maternity care intervention in Ethiopian hospitals

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ABSTRACT

Objectives There is a lack of evidence on approaches to mitigating mistreatment during facility-based childbirth. This study compares the experiences of mistreatment reported by childbearing women before and after implementation of a respectful maternity care intervention.

Design A pre-post study design was undertaken to quantify changes in women's experiences of mistreatment during facility-based childbirth before and after the respectful maternity care intervention.

Intervention A respectful maternity care intervention was implemented in three hospitals in southern Ethiopia between December 2017 and September 2018 and it included training of service providers, placement of wall posters in labour rooms and post-training supportive visits for quality improvement.

Outcome measures A 25-item questionnaire asking women about mistreatment experiences was administered to 388 women (198 in the pre-intervention, 190 in the post-intervention). The outcome variable was the number of mistreatment components experienced by women, expressed as a score out of 25. Multilevel mixed-effects Poisson modelling was used to assess the change in mistreatment score from pre-intervention to post-intervention periods.

Results The number of mistreatment components experienced by women was reduced by 18% when the post-intervention group was compared with the pre-intervention group (adjusted regression coefficient (Aβ)=0.82, 95% CI 0.74 to 0.91). Women who had a complication during pregnancy (Aβ=1.17, 95% CI 1.01 to 1.34) and childbirth (Aβ=1.16, 95% CI 1.03 to 1.32) experienced a greater number of mistreatment components. On the other hand, women who gave birth by caesarean birth after trial of vaginal birth (Aβ=0.76, 95% CI 0.63 to 0.92) and caesarean birth without trial of vaginal birth (Aβ=0.68, 95% CI 0.47 to 0.98) experienced a lesser number of mistreatment components compared with those who had vaginal birth.

Conclusions Women reported significantly fewer mistreatment experiences during childbirth following implementation of the intervention. Given the variety of factors that lead to mistreatment in health facilities, interventions designed to mitigate mistreatment need to involve structural changes.

Strengths and limitations of this study

- This is the first study to test the effectiveness of a respectful maternity care intervention in Ethiopia.
- Comparing the counts of mistreatment components captures the diversity of mistreatment that would not have been possible by simple prevalence measures.
- Treating hospitals as random-effects controls for the impact of other interventions that may have happened around the same time in those facilities.
- Mistreatment components experienced by women were assessed using binary options (yes/no) questions which ignore multiple incidents of a mistreatment component.
- An exit survey of women is prone to recall bias in acquiring data on multiple incidents of mistreatment that would have been minimised by labour observation.

INTRODUCTION

Despite the remarkable decline in maternal mortality worldwide, around 800 women die each day due to preventable conditions that emerge in the course of pregnancy and childbirth.¹ According to the World Health Organization's (WHO's) estimates, 295 000 maternal deaths occurred in 2017, of which 4.7% occurred in Ethiopia.¹ Low utilisation of maternal healthcare services, especially care during childbirth, is a key challenge to reducing maternal mortality.²⁻³ In 2019, only 47.5% of women gave birth in health facilities in Ethiopia.⁴

Women's negative experiences and/or other women's negative experiences of facility-based childbirth are commonly reported reasons for not attending a health facility at the time of childbirth.⁵⁻⁸ These experiences include hostile or insensitive staff,⁷ disallowance of birth companions,^{6 7} disrespectful care,⁹⁻¹¹ women's lack of autonomy,⁸ poor reception at health facilities,⁶ lack of

privacy,^{6 7} unfriendly staff,¹² abusive care¹² and poor readiness of health facilities.¹² The attitudes, actions and system barriers that contribute to such negative experiences are nowadays labelled as mistreatment or disrespect and abuse. However, an internationally agreed definition of mistreatment or disrespect and abuse still lacks as behaviours that are acceptable to women in some contexts may be unacceptable to women in different contexts.

There is compelling evidence from many countries on the negative impact of mistreatment on the uptake of facility-based childbirth. An evidence synthesis of studies from 16 low-income and middle-income countries and China revealed that mistreatment during childbirth is a powerful deterrent to facility-based childbirth.¹³ Additionally, studies from Afghanistan,¹⁴ Bolivia,¹⁵ Ghana,¹⁶ Kenya,^{17 18} Tanzania,¹⁹ Malawi²⁰ and India²¹ have clearly reported disrespectful care at birth as a key deterrent to facility-based childbirth.

The body of knowledge on mistreatment is still emerging and evolving, hence methodological approaches to estimate levels of mistreatment differ across settings, thereby making comparison challenging.^{22 23} Prevalence studies conducted in different parts of Ethiopia between 2013 and 2017 report many examples of mistreatment ranging from non-consented care, non-confidential care, discriminatory care, abandonment of care, non-dignified care, to physical abuse during facility-based childbirth.^{24–28}

The 2014 WHO statement, which condemns all forms of mistreatment during facility-based childbirth, identifies five actions to prevent and eliminate mistreatment globally. The statement calls for: evidence synthesis on the effectiveness of interventions that aim to improve respectful maternity care and thereby mitigate mistreatment, defining and measuring mistreatment, and inculcating service providers with the culture of respectful care at the time of birth.²⁹ Following this, various studies, including a multi-country study led by WHO, have been conducted to review and synthesise methodological frameworks for research on mistreatment.^{13 22 23 30–32} However, implementation research to assess the effectiveness of interventions to halt mistreatment have not been reported in Ethiopia.

In the move towards mitigating mistreatment, a focus on respectful maternity care is growing globally, and the 'Universal Rights of Childbearing Women' has been endorsed in several countries.³³ WHO defines respectful maternity care as 'the care organized for and provided to all women in a manner that maintains their dignity, privacy and confidentiality, ensures freedom from harm and mistreatment, and enables informed choice and continuous support during labour and childbirth'.³⁴

With the aim of meeting the maternal mortality targets of the sustainable development goals, strategies for ending preventable maternal mortality were introduced in 2015. The strategy calls for health systems not to neglect respectful maternity care while endeavouring to deliver effective clinical interventions.³⁵ WHO's framework for quality maternal and newborn healthcare reinforces the

important role of respectful maternity care, and identifies respect and preservation of dignity as one of the eight domains of quality of care.³⁶ Additionally, in 2018, WHO released guidelines for a positive childbirth experience which recommend respectful maternity care throughout labour and birth for all women.³⁴ A recent WHO paper published in *The Lancet* that found high levels of mistreatment in four countries also highlighted the need for an urgent action to promote the provision of respectful maternity care worldwide.³⁷

The government of Ethiopia launched a national movement entitled 'the caring, respectful and compassionate health workforce' in 2016. The initiative is one of the four health sector transformation agendas aiming to achieve health targets set for the 5 years between 2015/2016 and 2020/2021.³⁸ However, respectful maternity care initiatives are in early-stage development and currently limited to a few pilot health facilities and technically supported by international partner organisations. Consequently, there is an evidence gap regarding implementation of effective respectful maternity care interventions in the country.

This study was undertaken to assess women's experiences of mistreatment during facility-based childbirth before and after implementation of an intervention that was designed to improve the quality of care women receive during childbirth in hospitals. Previous respectful maternity care intervention studies from Kenya³⁹ and Tanzania^{40 41} revealed a significant reduction in the level of mistreatment and an improved attitude of service providers towards women, as a consequence of the interventions. This study is part of a broader interventional mixed methods study that aimed to identify health system challenges to the implementation of respectful maternity care and potential solutions to address these challenges. Lessons drawn from the respectful maternity care training and its implementation⁴² and health system constraints to the promotion of respectful maternity care in Ethiopian hospitals are reported elsewhere. To our knowledge, this study is the first to report on the effectiveness of a respectful maternity care intervention in Ethiopia. The study findings add weight to the emerging evidence base on respectful maternity care, and will be used to inform planning and decision making concerning maternal health and other related services in Ethiopia.

MATERIALS AND METHODS

Study setting

This study was undertaken in three hospitals located in the Southern Nations Nationalities and Peoples Region (SNNPR), Ethiopia. Health services in Ethiopia are organised in three tiers: health posts, health centres and primary hospitals are in the first tier; the second tier consists of general hospitals; and the third tier, specialised hospitals.³⁸ In principle, general hospitals are designed to serve a catchment population of 1–1.5 million people whereas primary hospitals are expected to serve 60 000–100 000 people. One of the study hospitals, Leku, is a primary

hospital reported to be serving a catchment population of 261 271 including an estimated 8000 women who give birth each year. The other two hospitals, Adare and Yirgalem, are general hospitals serving a catchment population of 359 358 and 267 589, respectively. An estimated 10 000 and 9000 pregnant women give birth each year in the catchments of Adare and Yirgalem hospitals, respectively. The hospitals were selected purposively taking into consideration their geographical proximity and their varying level in the tiers of the Ethiopian health system. The intervention involved only these three hospitals. None of hospitals have a private labour ward or birthing room which means that several women labour in the same room and give birth in one birthing room.

Study design

This study is part of a mixed methods implementation research study that was conducted to identify health system constraints to the promotion of respectful maternity care and to develop and assess mitigation approaches. A pre-post study that involved no comparison group was undertaken between December 2017 and September 2018 to quantify changes in women's experiences of mistreatment during facility-based childbirth. Women who gave birth in the study hospitals were surveyed at the time of discharge; the pre-intervention surveys were conducted in March 2018, whereas the post-intervention surveys were conducted in July and August 2018.

Description of the intervention

The intervention included: training of service providers, placement of wall posters in labour rooms and post-training supportive visits for quality improvement. Each of these are described later.

The training of service providers involved a 3-day workshop using a respectful maternity care training manual developed for this intervention. The manual was drafted by maternal health researchers from Ethiopia and Australia after review of previous respectful maternity care training manuals designed for low-income settings (Kenya,⁴³ Tanzania⁴⁴ and Nigeria⁴⁵), international human rights declarations,^{33 46 47} national professional codes of ethics and national training manuals on maternity care and quality improvement. The manual includes an overview of maternal health in Ethiopia. It covers topics such as human rights and law in the context of reproductive health, respectful maternity care rights and standards, professional ethics, and continuous quality improvement. The draft manual was reviewed by three senior maternal health experts at the Federal Ministry of Health and SNNPR Health Bureau for its content and applicability in the Ethiopian context. Two rounds of 3-day respectful maternity care training sessions were conducted at Hawassa University Comprehensive Specialized Teaching Hospital. The training was interactive and deployed various teaching methods including presentations, role plays, demonstrations, case studies, individual readings, video shows and a hospital visit. Training sessions were

facilitated by the principal investigator, a senior maternal health expert from the SNNPR Health Bureau and a senior obstetrician-gynaecologist. A total of 64 health service providers participated in the training, 33 in the first round and 31 in the second round (all were staff from the participating hospitals). Fifty-two were midwives, whereas the remaining were integrated emergency surgical officers (4), general practitioners (3), nurses (3) and health officers (2). The SNNPR Health Bureau and hospital administrations communicated their expectation that all service providers at the participating hospitals who assist women during childbirth should attend the training. In reality, all eligible service providers from Adare (26) and Leku (21) hospitals attended the training sessions. Five among the 22 eligible service providers from Yirgalem hospital did not attend the training sessions for personal reasons.

Five types of wall posters (four in English and one in Amharic) were distributed to the hospitals following completion of the service provider training. The posters were displayed in labour wards and waiting rooms to serve as job aids for service providers who are trained in English to become health professionals and who generally use service guidelines and reporting formats prepared in English. One of the English version wall posters lists the universal rights of childbearing women prepared by the White Ribbon Alliance.³³ The remaining three are infographics taken from the intrapartum care for a positive childbirth experience guideline prepared by the WHO.³⁴ The Amharic version poster described the manifestations of mistreatment during facility-based childbirth and the universal rights of childbearing women endorsed by the Federal Ministry of Health, Ethiopia.

Two rounds of post-training quality improvement supportive supervision visits were conducted by the principal investigator and a senior maternal health expert in all hospitals at 2-week intervals, in June and July of 2018. During the initial visit, a facility-led assessment of maternity care settings was conducted using a structured checklist that was part of the health providers' training (online supplementary file 1). The checklist included 32 respectful maternity care standards that were assessed using observation, interview, and review of documents; the standards were grouped into five categories. Action plans were developed by service providers to address actionable gaps identified by the respectful maternity care standards assessment. The gaps that could not be addressed at the labour ward level were passed to hospital administrators for further actions (online supplemental file 1). During the second visit, similar steps were undertaken to see changes as a result of the initial action plan and promote continuous quality improvement as a routine process. Detailed information on the sequencing of the interventions and the timing of data collection for the broader study, including the current study, is appended (online supplemental file 2).

Participants and procedures

Pregnant women who gave birth in the study hospitals were eligible for inclusion in the study regardless of their mode of birth (natural or operative) or birth outcome. Once women had completed their discharge requirements and procedures, they were invited to participate in the study and were consecutively enrolled until the required sample size was achieved for each study hospital.

Sample size and sampling

Stata V.14 software was used to calculate the sample size for this study using the menu option for determining the difference between two sample means with the assumption of: an anticipated mean count of mistreatment experiences women face in facility-based childbirth (pre-intervention) of 4.91, taken from a study conducted in Addis Ababa²⁶; an anticipated mean count of mistreatment experiences women face in facility-based childbirth (post-intervention) of 3.96 (mean difference of 0.95); statistical power of 90%; an allocation ratio of 1:1 between the pre-intervention and post-intervention groups; 0.05 level of significance; and 10% non-response rate. Additionally, women receiving care in the same hospital are more likely to receive comparable care during childbirth, so the sample size was adjusted for clustering by assuming a clustering effect of 2. With these assumptions, the minimum required sample size was calculated to be 378 (189 in the pre-intervention group and 189 in the post-intervention group). Eventually, 392 women were invited and 388 women were surveyed (190 in the pre-intervention and 198 in the post-intervention) making the response rate 98.9%; rushing to go home and lack of interest to participate were the reasons for non-participation. Allocation of samples to the three hospitals was made proportionately depending on the number of women who gave birth in the hospitals in the last quarter of 2017 for the pre-intervention survey, and the second quarter of 2018 for the post-intervention survey. Accordingly, 172 (87 pre-intervention, 85 post-intervention) women were surveyed from Adare hospital, whereas 86 (46 pre-intervention, 40 post-intervention) and 130 (65 pre-intervention, 65 post-intervention) were from Leku and Yirgalem hospitals, respectively. Eligible women were enrolled into the study consecutively until the required sample size was met.

Variables and outcome measures

The survey included 25 questions about women's experiences of childbirth in the study hospitals (table 1). The questions pertained to six categories: verbal abuse; physical abuse; non-consented care; lack of information, privacy and confidentiality; neglect and discrimination; and refusal of preference. The responses consisted of dichotomised mutually exclusive options set as 'yes' or 'no'. The outcome variable was a count variable computed from the 25 variables clustered into the categories mentioned earlier; the number of mistreatment components women

experienced were counted as a score out of 25; maximum possible score being 25 and minimum 0.

The main independent variable of the study was whether the woman belongs to the pre-intervention group or the post-intervention group, that is, whether she was hospitalised before or after the intervention. The other independent variables, that is, potential confounders that were considered for adjustment were: sociodemographic (place of residence, age, age at first marriage, marital status, educational status, occupation, religion, ethnicity, monthly income, number of children); obstetric characteristics (complication/s during pregnancy and childbirth, type of birth, intervention/s for vaginal birth); service utilisation history (antenatal visits, history of facility-based childbirth); service-related (referral status, time of admission, hours of stay, gender of service provider).

Questionnaire development

The survey questionnaire was developed as per the recommendations of a comparative analysis of five prevalence studies of mistreatment that were conducted in sub-Saharan Africa countries, including Ethiopia.²² Additionally, the typology suggested by a mixed methods systematic review on mistreatment during facility-based childbirth²³ was used to refine and group the 25 questions with some modifications. The questionnaire was originally prepared in English and later translated into both Amharic and Sidamu Afo languages and back-translated to check for consistency (online supplemental file 3). Subsequently, an electronic data collection template was prepared using the KoBoToolbox tool, and data collection was made using the KoBoCollect app for android devices.

Data collection

Data were collected by trained nurses and midwives who were fluent speakers of both Amharic and Sidamu Afo languages, recruited from Hawassa University Comprehensive Specialized Hospital. Data collectors received detailed 3-day training on the purpose of the study, contents of the questionnaire and effective and ethical survey administration. The questionnaire was pretested on 15 women who gave birth in Hawassa University Comprehensive Specialized Hospital which resulted in minor modifications to the questionnaire. Before conducting the post-intervention survey, data collectors received a 1 day refresher training. To ensure data quality, the supervisor reviewed completed questionnaires for key contents before they were uploaded from the tablets to the server; the principal investigator cross-checked all uploaded questionnaires for consistency and completeness.

Data management and analysis

Data were exported to SPSS V.24 software for cleaning and later to StataSE V.15 software for analysis. The outcome variable, number of mistreatment components women experienced, was confirmed to follow the

Table 1 Women's experience of mistreatment during childbirth

Types of mistreatment experienced	Pre-intervention n (%)	Pos-tintervention n (%)	P value for χ^2
Verbal abuse	17 (8.6)	11 (5.8)	0.29
Health workers used harsh or rude language	8 (4.0)	6 (3.2)	0.64
Health workers made judgmental or accusatory comments about woman	8 (4.1)	2 (1.1)	0.06
Health workers made threats of withholding treatment	1 (0.5)	2 (1.1)	0.54
Health workers blamed woman for any features of birth outcome	4 (2.0)	4 (2.1)	0.95
Physical abuse	33 (16.7)	17 (8.9)	0.02*
Woman was beaten, slapped, kicked or pinched	7 (3.5)	5 (2.6)	0.61
Woman was gagged	19 (9.6)	11 (5.8)	0.16
Woman was restrained	19 (9.6)	9 (4.74)	0.06
Non-consented care	165 (83.3)	124 (65.3)	<0.001*
Health workers did not obtain consent for procedure/s	138 (69.7)	84 (44.2)	<0.001*
Health workers ever separated woman from her baby without explaining	14 (7.1)	7 (3.7)	0.14
Health workers did not ask woman's permission before conducting vaginal examination	128 (64.7)	91 (47.9)	0.001*
Health workers did not ask woman's permission before performing surgery (episiotomy or caesarean section) (n=220)	69 (65.1)	44 (38.6)	<0.001*
Health workers made woman stay in the hospital against her will	4 (2.0)	2 (1.1)	0.44
Lack of information, privacy and confidentiality	189 (95.5)	182 (95.8)	0.88
Health workers did not keep woman's information confidential	18 (9.1)	7 (3.7)	0.03*
Health workers conducted vaginal examination without maintaining woman's privacy	162 (81.8)	147 (77.4)	0.28
Health workers did not give periodic updates on woman's labour	104 (52.5)	129 (67.9)	0.002*
Health workers spoke to woman in a language she could not understand	5 (2.5)	9 (4.7)	0.24
Neglect and discrimination	24 (12.1)	17 (8.9)	0.31
Health workers did not always come following woman's call	8 (4.0)	7 (3.7)	0.86
Woman was ever left for a prolonged period of time without attention	19 (9.6)	12 (6.3)	0.23
Health worker was not present for the actual birth of woman's baby	5 (2.5)	3 (1.6)	0.51
Health workers discriminated woman based on her attribute	–	2 (1.1)	–
Refusal of preference	134 (67.7)	104 (54.7)	0.01*
Health workers did not allow woman to have a birth companion present	64 (86.5)	18 (69.2)	0.04*
Health workers did not allow woman to move around during labour	43 (76.7)	63 (94.3)	0.002*
Health workers did not allow woman to have foods or fluids	66 (94.3)	62 (98.4)	0.21
Health workers did not allow woman to give birth in her preferred position	43 (66.2)	12 (33.3)	0.001*
Health workers did not allow woman to have cultural practice in labour	16 (76.2)	0 (–)	–

Poisson distribution by using a one sample independent Kolmogorov-Smirnov test ($p=0.97$). Additionally, the mean (4.40) and variance (4.14) of the outcome variable were found to be close and thus suitable for Poisson modelling. Three models were constructed in this study: a null (intercept-only) model with the intercept as a fixed effect and random effects for hospitals (model I); a model containing the intervention as a fixed effect and random effects for hospitals (model II); and a model containing the intervention, sociodemographic, obstetric and health

service-related factors as fixed effects and random effects for hospitals (model III). The independent variables were checked for multicollinearity using the variance inflation factor. Hospital was set as a random-effects variable in all models to take into account the likely absence of independence among women who received care from the same hospital. Analysis results from model III are reported in this study. A multilevel mixed effects Poisson regression analysis was conducted to identify the association between the independent and outcome variables while adjusting

for possible confounders. The fixed effects (association measures) and random effects (variation measures) for the number of mistreatment components experienced are reported. Adjusted exponentiated regression coefficients (β) with their corresponding 95% CIs were used to estimate the level of association between independent variables and the outcome variable. For comparison purpose, we also ran a fixed effects model with robust standard errors which included hospitals along with other variables of model III as fixed effects.

Patient involvement

Women who gave birth in the study hospitals during the survey periods were involved in the study. These women

were not involved in research design, tool development, data analysis and reporting.

RESULTS

Demographics

Among the 388 women who participated in the study (198 pre-intervention, 190 post-intervention), there was no difference in the distribution of place of residence, age, age at first marriage, educational level, marital status, religion and ethnicity between the two groups (table 2). Illiteracy and having a regular monthly income were higher in the post-intervention group. More than two-thirds

Table 2 Women's sociodemographic characteristics

Variables		Pre-intervention n (%)	Post-intervention n (%)	P value for χ^2
Place of residence	Urban	125 (63.1)	119 (62.6)	0.92
	Rural	73 (36.9)	71 (37.4)	
Age in completed year	15–24	98 (49.5)	96 (50.5)	0.93
	25–34	89 (45.0)	85 (44.8)	
	35–44	11 (5.5)	9 (4.7)	
	Median (IQR)	25 (7)	24 (8)	
Age at first pregnancy	Median (IQR)	20 (4)	20 (4)	0.72
Educational level	No formal education	29 (14.7)	38 (20.0)	0.13
	Primary education	81 (40.9)	74 (39.0)	
	Secondary education	48 (24.2)	54 (28.4)	
	College and above	40 (20.2)	24 (12.6)	
Marital status	Single	2 (1.0)	1 (0.5)	0.86
	Married	195 (98.5)	188 (99.0)	
	Separated	1 (0.5)	1 (0.5)	
Religion	Christian Protestant	140 (70.7)	141 (74.2)	0.29
	Christian Orthodox	27 (13.6)	27 (14.2)	
	Christian Catholic	7 (3.5)	2 (1.0)	
	Muslim	17 (8.6)	10 (5.3)	
	Others	7 (3.6)	10 (5.3)	
Ethnicity	Sidama	139 (70.2)	128 (67.4)	0.20
	Oromo	7 (3.5)	15 (7.9)	
	Amhara	13 (6.6)	17 (9.0)	
	Wolayita	17 (8.6)	17 (9.0)	
	Others	22 (11.)	13 (6.8)	
Occupation	Housewife	101 (51.0)	134 (70.5)	<0.001
	Private employee	8 (4.0)	8 (4.21)	
	Government employee	36 (18.2)	29 (15.3)	
	Private business	41 (20.7)	13 (6.8)	
	Others	12 (6.1)	6 (3.2)	
Respondent has regular monthly income*	Yes	89 (45.0)	69 (36.3)	0.08
	<1552 Br	34 (38.2)	25 (36.2)	
	≥1552 Br	55 (61.8)	44 (63.8)	
	Median (IQR)	2000 (2015)	2000 (1900)	
	No	109 (55.0)	121 (63.7)	

*US\$1=27.23 Br (average between March and August 2018).

(70.5%) of women in the post-intervention group were housewives compared with 51% in the pre-intervention group, $p<0.001$ (table 2).

Obstetric characteristics

More than half of the participants in the pre-intervention (55.6%) and post-intervention (51.6%) groups were multiparous (table 3). The majority of women gave birth to their previous child at a health institution, 75.2% in the pre-intervention and 70.1% in the post-intervention group. Comparable levels of women in both groups had antenatal visits during their index pregnancy; however, having three or more antenatal visits was higher among women in the pre-intervention survey (82.4% vs 71.2%; $p=0.04$). Complications during the index pregnancy were reported by 17.2% of women in the pre-intervention group and 10% in the post-intervention group ($p=0.04$). Compared with women in the pre-intervention group, women in the post-intervention group were less likely to have had a vaginal birth (77.4% vs 87.9%, $p=0.01$) or an intervened vaginal birth (39.5% vs 46.4%, $p=0.15$) (table 3).

Service characteristics

There was no difference between the pre-intervention and post-intervention groups with respect to referral status and time of admission (table 3). On the other hand, a higher proportion (52.5%) of women in the pre-intervention group gave birth during the night-time than their counterparts (42.6%), $p=0.05$. More than three-fifths (61.1%) of women in the pre-intervention group were assisted mainly by female service providers (51.6% in post-intervention group, $p=0.06$) (table 3).

Preference during childbirth

There were 86 (43.7%) women in the pre-intervention group who wanted to have a birth companion in the labour ward, while the proportion was only 17.9% in the post-intervention group ($p<0.001$). Among those women who wanted to have a birth companion in the pre-intervention group, 14% were afraid to ask service providers to have one (23.5% in the post-intervention group). A higher proportion of women in the pre-intervention group wanted to adopt a preferred birthing position (34.9% vs 19.1%, $p<0.001$) and cultural practice in the labour ward (21.7% vs 8.9%, $p=0.001$). Additionally, more than half (51.2%) of women who wanted to have cultural practice in the pre-intervention group were afraid to ask service providers to have the practice (47.1% in the post-intervention group). The proportion of women who wanted to move around during birth and who wanted to have food or fluids during birth did not vary significantly between the two groups (table 3).

Experiences of mistreatment

Almost all women (99.5% pre-intervention vs 99% post-intervention group) reported experiencing at least one type of mistreatment. The number of mistreatment types experienced ranged from 1 to 12 in the

pre-intervention group (median=5), and 1 to 11 in the post-intervention group (median=3.5).

When the pre-intervention and post-intervention groups are compared, a number of improvements are evident. Vaginal examination was performed without permission for 47.9% of the women in post-intervention group; 64.7% in pre-intervention group ($p=0.001$) (table 1). Additionally, seeking women's consent before procedures, and the practice of allowing birth companions improved post-intervention. On the other hand, some aspects of mistreatment such as the use of harsh or rude language against women, gagging women and leaving women for a prolonged period of time without attention did not improve significantly following the staff training. Additionally, more than two-thirds (67.9%) of women in the post-intervention group claimed that service providers did not give periodic updates on their labour (52.5% in the pre-intervention survey; $p=0.002$) (table 1).

We also compared the proportion of women who had encountered mistreatment grouped by six categories (verbal abuse; physical abuse; non-consented care; lack of information, privacy and confidentiality; neglect and discrimination; and refusal of preference). Women who reported having experienced at least one type of mistreatment in a given category were regarded as mistreated in that category. The level of non-consented care measured after the intervention (65.3%) is lower than before the intervention (83.3%), $p<0.001$ (table 1). Similarly, experiences of physical abuse and refusal of preference showed improvement after the intervention. No significant difference was detected in the level of the remaining three categories of mistreatment (table 1).

Factors associated with the number of mistreatment components experienced

In the bivariate analysis, the number of mistreatment components experienced was higher among women who had a complication during the index childbirth ($C\beta=1.16$, 95% CI 1.05 to 1.30) and an intervention for vaginal birth ($C\beta=1.31$, 95% CI 1.20 to 1.44) (table 4). Women who gave birth in Yirgalem hospital also experienced a higher number of mistreatment components ($C\beta=1.36$, 95% CI 1.22 to 1.51) compared with those who gave birth in Adare hospital. In contrast, the number of mistreatment components experienced was lower among women who had two or more births and women who had a caesarean birth (table 4).

Multilevel analysis of changes in reported components of mistreatment

Outputs of the intercept-only model (model I) showed that there was significant variation between hospitals in the number of components of mistreatment experienced by women (table 4). The intraclass correlation coefficient (ICC) of model I also revealed that 12.3% of the variation in the number of components of mistreatment experienced by women is attributable

Table 3 Women's obstetric and maternal healthcare characteristics and preferences during childbirth

Variables		Pre-intervention n (%)	Post-intervention n (%)	P value for χ^2
Total number of births	One	88 (44.4)	92 (48.4)	0.43
	Two or more	110 (55.6)	98 (51.6)	
	Median (IQR)	2 (1)	2 (2)	
Place of birth of previous child (n=206)	Health facility	82 (75.2)	68 (70.1)	0.41
	Outside health facility	27 (24.8)	29 (29.9)	
Number of previous facility-based childbirths	None	22 (20.2)	22 (22.5)	
	One	69 (63.3)	53 (54.0)	
	Two and more	18 (16.5)	23 (23.5)	
	Median (IQR)	1 (0)	1 (0)	
Antenatal visit during index pregnancy	Yes	188 (94.9)	184 (96.8)	0.35
	One	5 (2.7)	9 (4.9)	0.04
	Two	28 (14.9)	44 (23.9)	
	Three or more	155 (82.4)	131 (71.2)	
	No	10 (5.1)	6 (3.2)	
Experienced complication during index pregnancy	Yes	34 (17.2)	19 (10.0)	0.04
	No	164 (82.8)	171 (90.0)	
Experienced complication during index childbirth	Yes	67 (34.0)	70 (36.8)	0.56
	No	130 (66.0)	120 (63.2)	
Referral status on admission	Referred	81 (40.9)	86 (45.3)	0.39
	Non-referred	117 (59.1)	104 (54.4)	
Time of admission*	Day time	106 (53.5)	99 (52.1)	0.78
	Night-time	92 (46.5)	91 (47.9)	
Time of birth*	Day time	94 (47.5)	109 (57.4)	0.05
	Night-time	104 (52.5)	81 (42.6)	
Type of birth	Vaginal birth	174 (87.9)	147 (77.4)	0.01
	Caesarean after trial of vaginal birth	18 (9.1)	38 (20.0)	
	Caesarean without trial of vaginal birth	6 (3.0)	5 (2.6)	
Had intervention/s for vaginal birth (n=377)†	Yes	89 (46.4)	73 (39.5)	0.15
	No	101 (53.6)	111 (60.5)	
Types of assisted vaginal birth (n=162)‡	Vacuum extraction	12 (13.5)	9 (12.3)	0.83
	Forceps delivery	8 (9.0)	2 (2.7)	0.10
	Episiotomy	82 (92.1)	71 (97.3)	0.16
Gender of main service provider	Female	121 (61.1)	98 (51.6)	0.06
	Male	77 (38.9)	92 (48.4)	
Woman wanted to have birth companion in the labour ward	Yes	86 (43.7)	34 (17.9)	<0.001
	No	111 (56.5)	156 (82.1)	
Woman wanted to move around during birth	Yes	57 (28.8)	67 (35.5)	0.16
	No	141 (71.1)	122 (64.5)	
Woman wanted to have food or fluids during birth	Yes	70 (35.4)	63 (33.2)	0.65
	No	128 (64.6)	127 (66.8)	
Woman had a preferred birthing position	Yes	69 (34.9)	36 (19.1)	<0.001
	No	129 (65.1)	153 (80.9)	

Continued

Table 3 Continued

Variables	Pre-intervention n (%)	Post-intervention n (%)	P value for χ^2
Woman wanted to have cultural practice in labour			
Yes	43 (21.7)	17 (8.9)	0.001
No	155 (78.3)	173 (91.1)	

*A woman can have more than one procedure.

†Stayed in hospital for at least two hours between 20:00 and 08:00 immediately before childbirth.

‡Includes: episiotomy, vacuum extractor or forceps.

to differences across hospitals. Model II, a model with the main independent variable (intervention group), was different and fit as compared with model I (p for likelihood ratio (LR) test <0.001). Furthermore, model III (a model that includes all the independent variables and the intervention group) was different and fit as compared with model II (p for LR test <0.001). The ICC of model III shows a lower variation (9%) between the hospitals than models I and II. Model III displays the changes in the number of components of mistreatment experienced by participants of the two groups (pre-intervention and post-intervention) after adjusting for potential confounders.

As displayed in table 4, the number of components of mistreatment experienced by women in the post-intervention group is lower by 18% than those in the pre-intervention group; adjusted regression coefficient ($A\beta$)=0.82, 95% CI 0.74 to 0.91. The fixed effects model with hospitals as predictors yielded the same effect size with a narrower CI ($A\beta$ =0.82, 95% CI 0.76 to 0.89).

The number of components of mistreatment experienced by women was higher among women with complications during pregnancy ($A\beta$ =1.17, 95% CI 1.01 to 1.34) or childbirth ($A\beta$ =1.16, 95% CI 1.03 to 1.32). Women who gave birth by caesarean section after trial of vaginal birth ($A\beta$ =0.76, 95% CI 0.63 to 0.92) and by caesarean section without trial of vaginal birth ($A\beta$ =0.68, 95% CI 0.47 to 0.98) experienced fewer number of mistreatment components. The number of mistreatment components experienced by women did not significantly vary by women's demographic, service-related or other obstetric characteristics not already mentioned earlier (table 4).

DISCUSSION

This study was conducted as part of a mixed methods implementation research that aims to identify health system barriers to respectful maternity care and to propose and test mitigation approaches. To our knowledge, this study is the first to report on the effectiveness of a respectful maternity care intervention (facility-level) in Ethiopia. The study found that the number of mistreatment components experienced by women after the respectful maternity care intervention was reduced by 18% compared with the number experienced by women before the intervention. This is a

notable improvement given the small-scale intervention we implemented and the known limitations of interventions focused primarily on training health workers.⁴⁸ Training of service providers alone cannot be a solution to address mistreatment unless other system elements that significantly influence the behaviour of service providers are also addressed.

Similar implementation studies have been conducted in response to the growing attention to mistreatment and the need to identify recommendations to eliminate mistreatment. The *Heshima* study (Kenya)³⁹ and the *Staha* study (Tanzania)⁴¹ were conducted to assess the impact of respectful maternity care interventions on the level of mistreatment. The *Heshima* study involved a multi-component respectful maternity care intervention (policy, facility and community level); 7% reduction in the prevalence of mistreatment was reported following the intervention.³⁹ The *Staha* study involved community level (client service charter) and facility-level (quality improvement inventory and intervention in maternity wards) interventions, and reported a 66% reduction in the odds of women reporting mistreatment after the intervention.⁴¹ Both *Heshima* and *Staha* studies used a prevalence measure of mistreatment; women who faced at least one form of mistreatment were labelled as mistreated. Considering women who encountered at least one form of mistreatment as mistreated in these studies may have resulted in the underestimation of the magnitude of change.

In this study, the proportion of women who experienced non-consented care, physical abuse and refusal of preference was significantly lower in the post-intervention group. No significant difference was observed in the proportion of women who experienced mistreatment in the remaining three categories of mistreatment (verbal abuse; lack of information, privacy and confidentiality; and neglect and discrimination). The very high proportion of women who reported 'non-consented care' suggests that the issue of obtaining consent is not well understood by the staff (and probably by the hospital administration also). Similarly, the very high proportion of women who reported 'lack of information, privacy and confidentiality' and 'refusal of preferences' suggests a poor understanding of these concepts and rights among providers. These are areas that need to be integrated and foregrounded into professional development/quality

Table 4 Multilevel mixed-effects regression of counts of mistreatment experienced by women

Variables	Bivariate model C β (95% CI)	Model I A β (95% CI)	Model II A β (95% CI)	Model III A β (95% CI)
(A) Fixed effects				
(Intercept)		4.32 (3.60 to 5.12)	4.82 (3.98 to 5.84)*	7.18 (3.34 to 15.44)
Intervention group				
Pre-intervention	Ref.		Ref.	Ref.
Post-intervention	0.79 (0.72 to 0.87)		0.79 (0.72 to 0.87)*	0.82 (0.74 to 0.91)*
Place of residence				
Urban	Ref.			Ref.
Rural	1.11 (1.00 to 1.22)			1.05 (0.93 to 1.19)
Age in completed year				
15–24	Ref.			Ref.
25–34	0.85 (0.77 to 0.94)*			0.95 (0.82 to 1.09)
35–44	0.74 (0.58 to 0.94)*			0.81 (0.61 to 1.08)
Age at first pregnancy	1.03 (1.01 to 1.04)*			1.01 (0.99 to 1.03)
Marital status				
Single	Ref.			Ref.
Married	0.77 (0.48 to 1.25)			0.79 (0.45 to 1.39)
Separated	1.24 (0.61 to 2.51)			1.06 (0.49 to 2.31)
Religion				
Christian Protestant	Ref.			Ref.
Christian Orthodox	0.91 (0.78 to 1.04)			0.93 (0.76 to 1.12)
Christian Catholic	1.01 (0.74 to 1.38)			1.01 (0.73 to 1.40)
Muslim	1.04 (0.87 to 1.25)			1.07 (0.88 to 1.31)
Others	0.70 (0.54 to 0.93)*			0.80 (0.60 to 1.07)
Ethnicity				
Sidama	Ref.			Ref.
Oromo	0.90 (0.73 to 1.12)			0.93 (0.72 to 1.19)
Amhara	0.87 (0.72 to 1.05)			0.98 (0.77 to 1.25)
Wolayita	0.96 (0.81 to 1.14)			1.13 (0.92 to 1.40)
Others	1.02 (0.86 to 1.20)			1.00 (0.81 to 1.24)
Educational level				
No formal education	Ref.			Ref.
Primary education	1.11 (0.96 to 1.27)			0.99 (0.84 to 1.15)
Secondary education	1.05 (0.90 to 1.22)			0.98 (0.81 to 1.18)
College and above	1.18 (1.00 to 1.39)			1.07 (0.84 to 1.38)
Occupation				
Housewife	Ref.			Ref.
Private employee	1.06 (0.84 to 1.35)			1.06 (0.77 to 1.47)
Government employee	1.01 (0.89 to 1.16)			0.95 (0.72 to 1.25)
Private business	1.00 (0.87 to 1.16)			1.01 (0.80 to 1.27)
Others	1.14 (0.91 to 1.41)			0.90 (0.69 to 1.16)
Has regular monthly income*				
No	Ref.			Ref.
Yes	0.95 (0.86 to 1.04)			0.92 (0.75 to 1.13)
Total number of births				
One	Ref.			Ref.
Two or more	0.76 (0.69 to 0.84)*			0.86 (0.74 to 1.02)
Antenatal visit during index pregnancy				

Continued

Table 4 Continued

Variables	Bivariate model C β (95% CI)	Model I A β (95% CI)	Model II A β (95% CI)	Model III A β (95% CI)
No	Ref.			Ref.
Yes	0.82 (0.66 to 1.02)			0.95 (0.74 to 1.22)
Experienced complication during index pregnancy				
No	Ref.			Ref.
Yes	1.35 (1.19 to 1.53)*			1.17 (1.01 to 1.34)
Experienced complication during index birth				
No	Ref.			Ref.
Yes	1.16 (1.05 to 1.30)*			1.16 (1.03 to 1.32)*
Referral status on admission				
Referred	Ref.			Ref.
Non-referred	0.93 (0.85 to 1.02)			1.07 (0.94 to 1.21)
Total hours of stay	1.00 (0.99 to 1.00)			1.00 (0.99 to 1.00)
Gender of main service provider				
Female	Ref.			Ref.
Male	1.05 (0.95 to 1.16)			1.03 (0.93 to 1.16)
Type of birth				
Vaginal birth	Ref.			Ref.
Caesarean after trial of vaginal birth	0.78 (0.67 to 0.90)*			0.76 (0.63 to 0.92)*
Caesarean without trial of vaginal birth	0.67 (0.48 to 0.95)*			0.68 (0.47 to 0.98)*
Had intervention for vaginal birth				
No	Ref.			Ref.
Yes	1.31 (1.20 to 1.44)*			1.04 (0.91 to 1.19)
(B) Random effects				
Hospital				
Variance		0.02 (0.01 to 0.14)*	0.03 (0.001 to 0.14)*	–
ICC (%)		12.3	13.6	9.0
(C) Model fitness				
AIC		1600	1577	1570
Log likelihood		–798	–786	–750
P value		–	<0.001	<0.001

*Bold values are significant at $p < 0.05$.

β , exponentiated regression coefficient; A β , adjusted exponentiated regression coefficient; AIC, Akaike's information criterion; C β , crude exponentiated regression coefficient; ICC, intraclass correlation coefficient.

improvement programmes for all levels of staff and the preservice training of health professionals. Additionally, the high level of mistreatment among women who had complications during childbirth, and assisted vaginal birth might be explained by the fact that several cadres attend women during such events.

According to the *Health Workers for Change* study conducted in four African countries, structural issues such as shortage/lack of manpower and supplies, and poor working conditions inhibit implementation of change interventions.⁴⁹ According to the Bowser and Hill framework,⁵⁰ structural constraints not only impede change initiatives, they also independently contribute to mistreatment. Thus, the categories of mistreatment that

were likely to have been a product of these structural issues were not influenced by the intervention because it lacked a structural dimension.

The fact that there is no private labour room combined with the increased presence of birth companions after the intervention may explain the relative lack of improvement in women's privacy. Adequate preparation and adaptation of labour wards is recommended before operationalising birth companionship in resource-limited contexts.^{34 51} Lunze and colleagues reviewed 259 (83 sub-Saharan Africa based) studies and reports of innovative approaches for improving maternal and newborn health, using the lens of WHO's health system building blocks. The review revealed that interventions in one

health system building block affected other building blocks; the review recommends a system-wide intervention to maximise the effectiveness and sustainability of interventions.⁵² Similarly, WHO also recommends that respectful maternity care should be viewed through the lens of systems thinking when prioritising action areas to improve quality of care.³⁶

What makes the *Staha* study similar to our study is that, no changes in the level of verbal abuse and neglect and discrimination were observed after the intervention.⁴¹ This might be explained by the fact that ingrained negative and normalised behaviours require time to change and are highly associated with age and experience of service providers, younger and less experienced providers being less supportive during labour.⁵³ On the contrary, if a proactive focus on respectful care is provided during preservice training to younger graduates, who are usually motivated for change, it may nurture respectful behaviour.⁵⁴ Additionally, other factors such as uncomfortable working circumstances, overcrowded facilities, space constraints and poorly motivated staff are not only barriers to the implementation of new guidelines⁵⁵ but also contributors to mistreatment.⁵⁰ These factors may have contributed to the steady level of the mistreatment components that did not improve in the current study.

Evidence suggests that women's chosen birth companionship contributes to positive birth outcomes for both the mother and the newborn⁵⁶ and is recommended by the WHO.³⁴ In this study, among 120 women who wanted to have a birth companion, only 18 (15%) were allowed to have their chosen companion (11.6% in pre-intervention vs 23.5% in post-intervention group). Additionally, 16.7% (14% in pre-intervention vs 23.5% in post-intervention group) of those who would have wanted to have a companion were afraid to ask service providers about this. These unexpressed preferences highlight that facilities and service providers should promote companionship rather than wait for the request to come from women.^{34 56} And this should be supported by political commitment, high-level advocacy and operating guidelines.⁵⁷ The proportion of women who reported to have their preference during childbirth in the post-intervention survey was lower than that of pre-intervention survey participants; this may be due to the high proportion of women who had a caesarean birth in the post-intervention survey.

In this study, comparing the number (counts) of mistreatment components women experienced helped to identify the changes in the extent or diversity of mistreatment that would not have been possible to identify by simple prevalence measures. Additionally, treating hospitals as random-effects in the statistical model controls for the impact of other interventions that may have happened around the same time in those facilities. The absence of difference in demographic and obstetric characteristics between women of the two groups (pre-intervention and post-intervention) also adds to the soundness of the statistical analysis used to detect changes in mistreatment. Additionally, where women are admitted in a shared ward,

comparing the proportion of women mistreated rather than comparing the counts of mistreatment fails to detect changes that might have resulted after an intervention. This is because, there are components of mistreatment that cannot be totally prevented without major structural changes, for example, provision of adequate space to ensure privacy and confidentiality.⁴⁰

One of the limitations of this study is that the mistreatment components experienced by women repeatedly were counted only once as binary response options (yes/no) questions were used. This approach fails to capture multiple incidents of mistreatment components experienced by women, for example, how many times a woman was verbally abused. Additionally, it might have also led to the underestimation of the intervention effect size. To overcome such problems, using questions with frequency response options is recommended. A survey of women at their exit, as in this study, is prone to recall bias in acquiring data on multiple incidents; instead, independent observation in the labour room would be more appropriate.⁵⁸ However, observation also has inherent limitations, for example, the Hawthorne effect—service providers modify their behaviour and become less disrespectful because they know they are being observed. Pertaining to the generalisability of findings, because the study was conducted only in three hospitals located in the SNNPR, the findings may not be generalisable to other types of hospitals, health centres and clinics that provide childbirth services in Ethiopia. Additionally, the short washout period and the lack of a control group in this study is a key limitation as it is not possible to attribute with certainty the changes observed to the respectful maternity care intervention.

Finally, we believe that this study being the first to test the effectiveness of a respectful maternity care intervention in Ethiopia, contributes to evidence for further endeavours to improve respectful maternity care specifically, and the quality of childbirth services generally. Thorough implementation studies that are designed to capture macro and micro level contributors to mistreatment need to be conducted to inform evidence-driven actions to eliminate mistreatment during facility-based childbirth in Ethiopia.

CONCLUSIONS

This study revealed that the childbirth services women received in the study hospitals were characterised by a wide range of mistreatment behaviours and/or health facility conditions. The respectful maternity care intervention tested in this study was accompanied by a reduction in women's experience of mistreatment during facility-based childbirth. Given the variety of factors that lead to mistreatment in health facilities, interventions designed to mitigate mistreatment need to be multidimensional—including demand-side (community level), supply-side (health system level) and policy-level interventions. We believe that this study adds to existing

knowledge on innovations that can be used to mitigate mistreatment. Further research is needed to investigate the impact and sustainability of health system-level interventions on women's experiences of mistreatment during facility-based childbirth.

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Contributors AA conceived the study; AA, AM and MK designed the study, developed data collection tools; AA trained data collectors, coordinated the fieldwork; AA, SA, HM, ETL and SG conducted the intervention; AA, AM and MK analysed the data; AA, AM and MK drafted the manuscript; SA, HM, ETL and SG revised the manuscript for intellectual content. All authors have read and approved the manuscript.

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Competing interests None declared.

Patient consent for publication Not required.

Ethics approval Ethics approval was obtained from the Institutional Review Board (Ethics ID: 3-12/12926) located in SNNPR Health Bureau, Ethiopia and the Human Ethics Sub-Committee (Ethics ID: HESC 1750054) at the University of Melbourne, Australia. Permission letter to conduct this study was also granted from the Federal Ministry of Health and SNNPR Health Bureau. A printout of information about the study (plain language statement) prepared in local languages was given to literate study participants, and their written consent was recorded on a separate consent form. For illiterate participants, data collectors read contents of both the plain language statement script and the consent form, sought their verbal consent, and signed the consent form on their behalf in the presence of a witness. All forms used were approved by the ethics committees.

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Chapter 6: Results Part II – Service providers’ experiences of respectful maternity care training and its implementation

6.1 Preface

Chapter 6 reports findings from the survey of service providers conducted before and after the RMC training (at the training venue) and FGDs with trained service providers conducted two months after the training (at participants’ hospitals). The results in this chapter respond to the second and third study objectives (to assess and explore service providers’ perceptions and experiences of the RMC intervention; and to explore the challenges service providers experienced in implementing the RMC intervention) and report participants’ perceptions and experiences of the training and the bottlenecks to implementing the RMC training in the hospitals.

I followed Fetters and colleagues^{278, 301} recommendations of mixed methods research design, analysis, integration and writeup to organise this chapter. I used a hybrid thematic analysis approach to analyse the FGDs, and the pretest-posttest comparisons of service providers’ perceptions and attitudes were assessed using McNemar’s test²⁹².

A peer reviewed journal article published in Reproductive Health is used to present the results.

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. Reproductive Health. 2020;17:103.

RESEARCH

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Lessons learned through respectful maternity care training and its implementation in Ethiopia: an interventional mixed methods study

Anteneh Asefa^{1,2*} , Alison Morgan², Meghan A. Bohren³ and Michelle Kermode²

Abstract

Background: Improving respectful maternity care (RMC) is a recommended practice during childbirth as a strategy to eliminate the mistreatment of women and improve maternal health. There is limited evidence on the effectiveness of RMC interventions and implementation challenges, especially in low-resource settings. This study describes lessons learned in RMC training and its implementation from the perspectives of service providers' perceptions and experiences.

Methods: Our mixed methods study employed a pre- and post-intervention quantitative survey of training participants to assess their perceptions of RMC and focus group discussions, two months following the intervention, investigated the experiences of implementing RMC within birthing facilities. The intervention was a three-day RMC training offered to 64 service providers from three hospitals in southern Ethiopia. We performed McNemar's test to analyse differences in participants' perceptions of RMC before and after the training. The qualitative data were analysed using hybrid thematic analysis. Integration of the quantitative and qualitative methods was done throughout the design, analysis and reporting of the study.

Results: Mistreatment of women during childbirth was widely reported by participants, including witnessing examinations without privacy (39.1%), and use of physical force (21.9%) within the previous 30 days. Additionally, 29.7% of participants reported they had mistreated a woman. The training improved the participants' awareness of the rights of women during childbirth and their perceptions and attitudes about RMC were positively influenced. However, participants believed that the RMC training did not address providers' rights. Structural and systemic issues were the main challenges providers reported when trying to implement RMC in their contexts.

Conclusion: Training alone is insufficient to improve the provision of RMC unless RMC is addressed through a lens of health systems strengthening that addresses the bottlenecks, including the rights of providers of childbirth care.

Keywords: Respectful maternity care, Training, Participants, Mistreatment, Childbirth

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Plain English summary

Improving respectful maternity care and eliminating the mistreatment of women during childbirth is a key strategy to improve maternal health. However, there is limited evidence on the effectiveness of respectful maternity care interventions and implementation challenges, especially in low-resource settings. This study examines service providers' reaction to and experiences of respectful maternity care training and its implementation. Both qualitative and quantitative approaches were used to appreciate how training participants perceived and experienced the training and its implementation in public hospitals. Identification of the challenges service providers experience in implementing respectful maternity care training will help make system-wide and evidence-based preparations, in addition to the training, in order to promote respectful maternity care in health facilities. The training improved the participants' awareness of the rights of women during childbirth. Participants' perceptions and attitudes about respectful maternity care were also positively influenced by the training. However, participants believed that the training did not address providers' rights. Structural issues were the main challenges providers reported when trying to implement respectful maternity care in their contexts. Further health system strengthening actions are required to address structural issues if respectful maternity care is to be improved.

Introduction

In 2017, almost all (99%) of the 295,000 global maternal deaths occurred in developing regions, 66.3% in sub-Saharan Africa [1]. Evidence shows that improving access to quality and woman-centred care during pregnancy and childbirth substantially reduces preventable maternal and newborn deaths [2, 3]. Respect and dignity, effective communication, and emotional support are key domains of the World Health Organization's (WHO) vision for quality of care for pregnant women and newborns [4]. These domains are also integral parts of respectful maternity care (RMC) and make a sizable contribution to positive childbirth experience [5]. Furthermore, RMC has been flagged as a potential strategy for reducing preventable maternal mortality and morbidity to accelerate progress towards meeting the SDG targets for improving maternal health [6].

RMC is defined as "the care organized for and provided to all women in a manner that maintains their dignity, privacy and confidentiality, ensures freedom from harm and mistreatment, and enables informed choice and continuous support during labour and childbirth" [7]. Mistreatment during facility-based childbirth may discourage women from giving birth in health facilities [8], and is a violation of their right to health [5]. Although a standardized approach to measuring

mistreatment is still evolving, studies from Ethiopia [9–13] and other sub-Saharan Africa countries [14–18] report high levels of mistreatment, including physical abuse. The growing account of the mistreatment of women throughout labour and childbirth globally led the WHO to publish a statement entitled "The Prevention and Elimination of Disrespect and Abuse During Facility-Based Childbirth" [19]. The statement calls for heightened actions and research on RMC and mistreatment to improve women's access to respectful and quality maternity care services.

Interventions that promote RMC may be multi-dimensional and include components such as RMC training, quality improvement initiatives, maternity open days, community workshops, client service charter, and dispute resolution. In Kenya and Tanzania, a combination of these interventions demonstrated fewer incidents of mistreatment following the interventions [20–22]. However, information on service providers' experiences of and reactions to RMC interventions, and related factors affecting implementation is limited. Addressing this information gap not only contributes to the promotion of RMC through evidence-based planning but also serves to identify barriers to RMC within the wider health system.

In 2018, an RMC intervention was implemented in three hospitals located in the Southern Nations Nationalities and Peoples Region (SNNPR), Ethiopia as part of a broader study that aimed to identify health system challenges to the implementation of RMC and potential solutions to address these challenges. The broader intervention included: training of service providers, the introduction of wall posters and pamphlets, and post-training facility-based quality improvement sessions. This paper draws lessons from RMC training and its implementation in these three hospitals. We believe that the findings of this study will add to the existing body of evidence that can be used to design and implement RMC initiatives in low-income settings. The effect of the broader intervention on the mistreatment of women during facility-based childbirth is reported elsewhere (Asefa A, Morgan A, Gebremedhin S, Tekle E, Abebe S, Magge H, Kermode M: Mitigating disrespect and abuse during facility-based childbirth: evaluation of respectful maternity care intervention in Ethiopian hospitals, unpublished).

Materials and methods

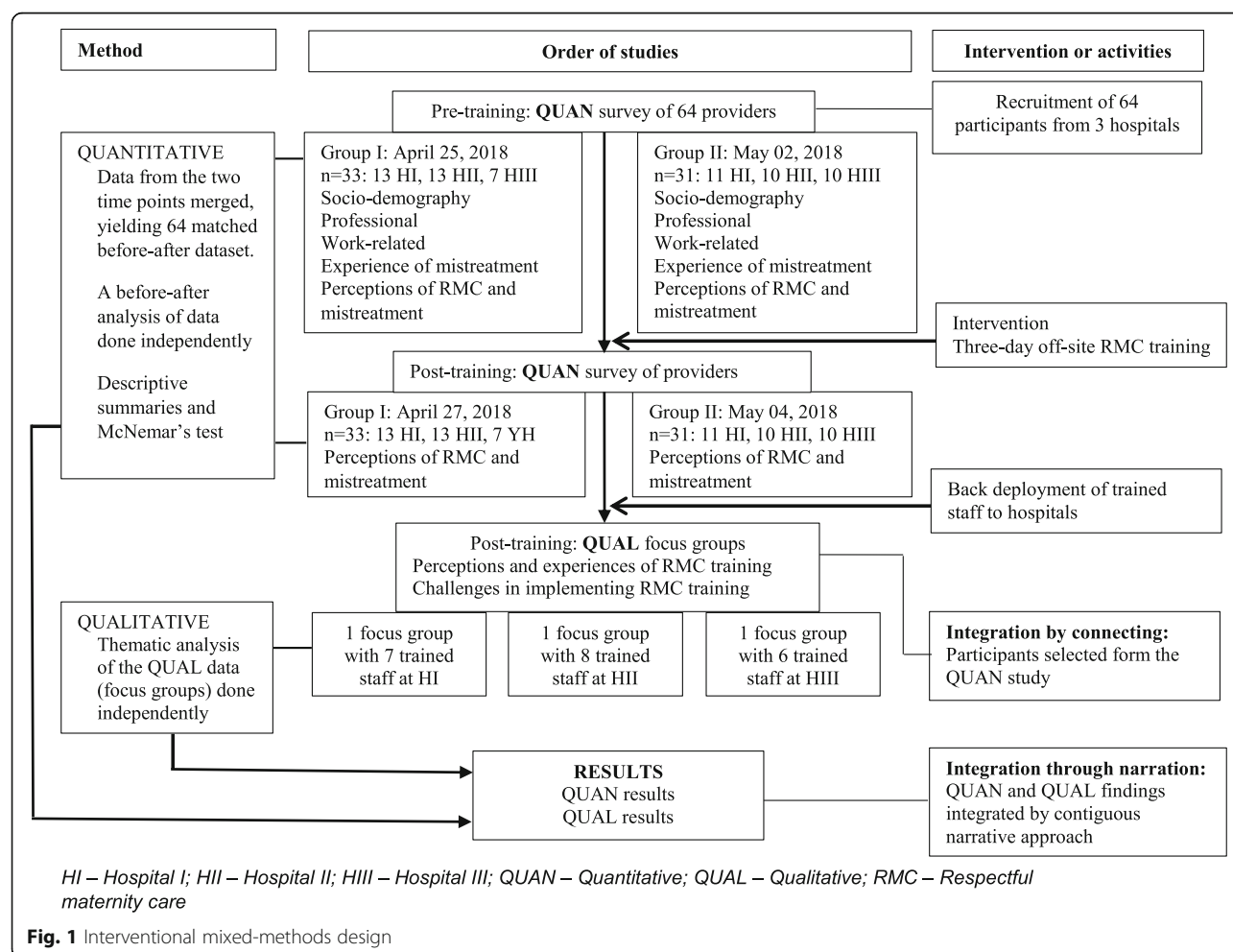
Description of the RMC intervention

The intervention consisted of a three-day off-site training workshop for participants (midwives, integrated emergency surgical officers, nurses, general practitioners, and health officers) recruited from three public hospitals. Development of the training manual happened in three stages: (1) review of the literature on previous RMC training manuals designed for low-income settings [23–25] and preparation

of the draft manual by the primary author; (2) review of the draft manual by senior health system and maternal health experts; and (3) final review for content, applicability and contextualization by three local senior maternal health experts. Topics included in the manual are: an overview of maternal health in Ethiopia, human rights and law in the context of reproductive health, RMC rights and standards, professional ethics, and continuous quality improvement. The RMC training used participatory adult learning principles and was delivered through presentations, role play, demonstrations, case studies, individual readings, videos, and a hospital visit. On the last day of the training, a consultative meeting was held with hospital managers, medical directors, and program managers from health departments. The purpose of this meeting was to generate buy-in for the implementation of RMC in the study hospitals. The trainings were held at a University Comprehensive Specialized Teaching Hospital and facilitated by a local multidisciplinary team consisting of the primary author, a senior maternal health expert, and a senior obstetrician-gynaecologist.

Study design

This study used an interventional mixed methods design involving a post-intervention qualitative study (focus groups) which was embedded in a pre- and post-intervention quantitative study (participant survey). Interventional mixed methods supplement an experimental design with a qualitative investigation to: help design intervention procedures, study how participants are experiencing the intervention, and follow up on the outcomes and explain them in more detail [26]. The integration of qualitative and quantitative data can occur before, during, or after the intervention [27]. A pre-intervention survey was conducted first, followed by a similar post-intervention survey with the same participants. Two months after the post-intervention survey, focus group discussions (FGDs) were held with a sub-set of intervention participants (Fig. 1). The quantitative study assessed participants' experience of mistreatment of women in their facilities and compared participants' perceptions of RMC before and after the intervention. The qualitative study explored participants' perceptions of



RMC and the challenges encountered when implementing RMC during the 2 months following the training. This article adheres to the guidelines for writing articles of mixed methods recommended by Fetters and colleagues [28]. In this study, the quantitative findings are reported first.

Quantitative methods

Setting

Pre- and post-intervention quantitative surveys were conducted between April and May 2018 immediately before and after the RMC training. The training site is a regional centre of excellence and serves as an in-service training centre for several short-course trainings.

Participant recruitment

All health service providers who attend labour and child-birth at the three hospitals were invited to attend the training. All invited service providers from two of the hospitals (26 from Hospital I and 21 from Hospital II) attended the training, in two cohorts to ensure service coverage in the respective institutions. At Hospital III, 5/22 invited service providers did not attend the training due to personal reasons. Service providers participating in the training were invited to take part in the survey. The potential participants were informed about the aim of the survey before the training commenced and were informed that their decision to participate in the survey (or not) would not affect their participation in the training. All (64) service providers agreed to participate (Fig. 1).

Instruments and data collection

A self-administered paper-based questionnaire administered in English was used to collect data on the participants' sociodemographic, professional, and work-related characteristics; observed experiences of mistreatment of women in the 30 days preceding the survey date; and perceptions of RMC and mistreatment. Eight questions representing different categories of mistreatment (non-consented care; lack of information, privacy and confidentiality; physical abuse; verbal abuse; refusal of preference; neglect and discrimination) were used to assess whether participants had witnessed mistreatment of women in their hospital. During the pre-intervention survey, the full version of the questionnaire was used; the post-intervention survey questionnaire only included the section on perceptions of RMC and mistreatment. Following participants' consent, questionnaires with anonymous codes were put in unsealed envelopes and distributed; participants noted their unique codes, which were subsequently used for the post-intervention survey. The primary author also provided instructions on how to complete the questionnaire page by page. Completed questionnaires were returned in sealed envelopes to maintain anonymity.

Data analysis

Survey data were entered into and analysed using Stata (StataCorp, version 15, College Station, TX, USA). Descriptive statistics were computed, and an exact McNemar's test was performed to analyse pre-post differences in participants' perceptions of RMC and mistreatment. McNemar's test is an appropriate statistical procedure for the pretest-post-test analysis of dichotomous variables collected from paired samples; it is used to assess differences on a dichotomous dependent variable between two correlated groups [29].

Qualitative methods

Setting

FGDs were conducted in July 2018 in private meeting rooms at the study hospitals. One of the hospitals (Hospital II) is a primary hospital, whereas the remaining two are general hospitals. All hospitals are comprehensive emergency obstetric care hospitals; based on a review of delivery registers of the hospitals, 12–17% of the total deliveries in 2017 were caesarean deliveries.

Sample size and sampling

One FGD was conducted in each of the three hospitals. The criteria for inclusion in the FGD was attending the RMC training. Convenience sampling was used to recruit FGD participants – all training participants who were off-duty and available on the date of the FGD were invited to participate (Fig. 1).

Instruments and data collection

A semi-structured interview guide was used during the FGDs, the design of which was based on a review of the literature, the study objectives, and the plan for data integration. The guide was originally prepared in English and translated into Amharic language by the primary author. FGDs were conducted in Amharic by the primary author and were digitally audio-recorded. Participants were provided with compensation for transportation.

Data management and analysis

Audio recordings of the FGDs were translated and transcribed from Amharic to English simultaneously by the primary author. The transcripts were imported into NVivo software (QSR International, Version 12 Plus) for management and initial analysis by the primary author. Thematic analysis using hybrid (both deductive and inductive) approach was used and later compared for consistency. The deductive analysis used the semi-structured interview guide as a basis to organize themes and responses whereas the inductive analysis identified themes emerging from the transcripts. The major themes and sub-themes were reviewed vis-à-vis the transcripts and the interview guides by two of the authors,

and final themes were agreed upon. The consolidated criteria for reporting qualitative research (COREQ) was used to ensure that important components are reported (Additional file 1) [30].

Results

Quantitative findings

Table 1 reports the sociodemographic characteristics of participants. Most of the survey participants were female (68.8%), married (62.5%), 22–29 years old (73.3%), Orthodox Christians (51.5%), and lived in the same town where their hospital was situated (80.0%). Most participants were midwives (79.7%), and 50% had served for more than 5 years as a health professional; 39.1% had served in their current hospital for less than 2 years. On average, 62.5% of participants reported that they worked three or more weekend or night shifts per week.

Providers' experiences of the mistreatment of women before the training

Participants were asked about their observations of mistreatment of women during childbirth in their facilities within the 30 days preceding the survey date (Table 2). Accordingly, 39.1% of participants reported witnessing fellow health workers conducting vaginal examination for women without maintaining physical privacy. Almost one-third reported witnessing the use of insults, intimidation, threats or coercion directed at a woman or her companions (31.3%). Many observed a healthy newborn kept in a different room from his/her mother (28.1%); and a woman left alone during labour for a long period of time (25.0%). The use of physical force with woman in labour, including forcefully parting a woman's leg or physically restraining her was also witnessed by 21.9% of participants. More than one-quarter (29.7%) of participants reported that they themselves may have mistreated a woman during childbirth in the previous 30 days; and 29.7% of participants reported that they had felt disrespected or mistreated in their workplace by a patient or other staff member at least once during the same period.

Providers' perceptions of RMC before and after the training

We assessed the extent to which participants' perceptions of RMC and mistreatment changed after attending the RMC training. Eight relevant dichotomous dependent variables were collected pre and post the training (paired data) (Table 3). Although not statistically significant, the proportion of participants with positive perceptions of RMC increased after the training in six of the eight domains. Positive perceptions about the belief that it is possible to change how care is structured and provided, and ensuring privacy screens are used did not change (Table 3). The proportion of participants

Table 1 Participants' sociodemographic, professional and work-related characteristics (Survey finding)

Variables		n (%)
Affiliation (hospital)	Hospital I	24 (37.5)
	Hospital II	23 (35.9)
	Hospital III	17 (26.6)
Gender	Female	44 (68.8)
	Male	20 (31.2)
Age (years)	22–29	44 (73.3)
	30–38	16 (26.7)
	Median (IQR)	27 (5)
Place of residence	Same town where hospital is located	53 (82.8)
	Different town	11 (17.2)
Monthly income (in birr) ^a	2700–4200	25 (41.7)
	4201–5500	23 (38.3)
	> 5500	12 (20.0)
	Median (IQR)	4600 (1642.5)
Marital status	Single	24 (37.5)
	Married	40 (62.5)
Religion	Christian Orthodox	33 (51.5)
	Christian Protestant	24 (37.5)
	Muslim	3 (4.7)
	Other	4 (6.3)
Ethnicity	Sidama	139 (70.2)
	Wolayita	17 (8.6)
	Amhara	13 (6.6)
	Oromo	7 (3.5)
	Other	22 (11.1)
Current profession	Midwife	51 (79.7)
	General practitioner	4 (6.3)
	Integrated emergency surgical officer	4 (6.3)
	Nurse	3 (4.7)
	Health officer	2 (3.1)
Service duration as health professional (in years)	< 2	14 (21.9)
	2–5	18 (28.1)
	> 5	32 (50)
Service duration in current hospital (in years)	< 2	25 (39.1)
	2–5	26 (40.6)
	> 5	13 (20.3)
Usual number of night duties per week	≤ 2	24 (37.5)
	3	23 (35.9)
	≥ 4	17 (26.6)

^a1USD ~ 27 Br (Average between March and April 2018)

Table 2 Participants' experiences of mistreatment in the past 30 days preceding the training (Survey finding)

Types of mistreatment experienced	Yes, n (%)
Have you seen birth attendants ignore the concerns of a labouring woman?	17 (26.6)
Have you seen a labouring woman left alone for a long period of time?	16 (25.0)
Have you seen a healthy newborn kept in a different room from his/her mother?	18 (28.1)
Have you seen health workers conduct a vaginal examination on a labouring woman without maintaining physical privacy?	25 (39.1)
Have you seen a labouring woman denied foods or fluids when she wanted to have some?	16 (25.0)
Have you heard health workers use insults, intimidation, threats or coercion with a labouring woman or her companions?	20 (31.3)
Have you seen health workers discriminate against a labouring woman based on a specific attribute (age/marital status/ethnicity/education/HIV status)?	14 (21.9)
Have you seen health workers use physical force with a labouring woman (for example slapping, hitting, or tying on a bed)?	14 (21.9)
In your own personal capacity have you done anything that may have disrespected a woman in childbirth?	19 (29.7)
Have you ever felt disrespected or abused in your workplace by a patient or other staff member?	19 (29.7)

perceiving all eight RMC domains positively before the training was 21.9%, which increased to 35.9% after the training ($p = 0.08$). Beliefs that it is sometimes necessary for service providers to yell at a woman during labour did not show much improvement (21.9% pre-test; 20.3% post-test, $p = 1.00$) (Table 3). The belief that it is not necessary to seek verbal consent from a woman prior to conducting a vaginal examination was 10.9% during post-test (15.6% pre-test, $p = 0.61$). The perception that it is not possible for nurses and doctors to change the way things are done in the labour room got worse (17.2% pre-test; 18.7% post-test; $p = 0.61$).

Qualitative findings

Three FGDs were conducted with 6–8 participants per group. Most FGD participants were midwives (81.0%). We identified four major themes in the data analysis: impact of the RMC training; perception of the RMC training; challenges in implementing RMC guidelines; and support required to improve RMC. Corresponding sub-themes that emerged from the second and third major themes are also presented along with illustrative quotations.

How were providers impacted by the training?

Service providers reported that they had gained new knowledge about the rights of women during childbirth,

Table 3 Participants' perceptions of RMC and mistreatment before and after the training (survey finding)

Providers' perception of RMC and mistreatment	Pre-training	Post-training		<i>p</i> -value for Exact McNemar's test
		Disagree	Agree	
It is not possible for nurses and doctors to change the way things are done in the labour room unless directed by managers	Disagree	47	6	1.00
	Agree	5	6	
It is sometimes necessary for health service providers to yell at a woman during labour	Disagree	42	8	1.00
	Agree	9	5	
Ethiopian women understand that health service providers sometimes have to be harsh for the woman's own good	Disagree	36	10	0.54
	Agree	14	4	
Husbands should not be allowed in the labour room during the birth of their children	Disagree	34	11	0.84
	Agree	13	6	
It is sometimes necessary for health service providers to slap a woman during labour	Disagree	54	3	0.73
	Agree	5	2	
It is not necessary to ask for verbal consent from a labouring woman before conducting a vaginal examination	Disagree	48	6	0.61
	Agree	9	1	
It is not always possible to screen women to ensure privacy when they are giving birth	Disagree	55	3	1.00
	Agree	3	3	
Ethiopian women do not want to have a companion of their choice with them when they give birth	Disagree	35	8	0.51
	Agree	12	9	

which included assuming the position of choice, birth companionship, not being yelled at during labour, being provided with information about care, consenting to examination/treatment, and receiving respectful and dignified care.

Previously, we used to apply force to examine women; sometimes, we also get angry with and shout at them. We have now understood that we must treat women very politely; counsel them on the importance of examination and get their consent before an examination. [FGD, Hospital III].

Participants discussed that the training influenced their attitudes toward mistreatment. Behaviours that were not perceived as mistreatment before the training were less accepted after the training. This was expressed by the participants in two different ways: as a description of attitudinal change and as self-reported acts of mistreatment. Some of the mistreatment behaviours considered by participants to be “normal” before the training, but not after the training were: denying food during labour, denying birth companionship, denying pain relief measures, not involving women in decision making, and conducting examinations without privacy screens.

... those things that were considered minor and ignored in routine care, like informing clients about what is being done, are very important. Women should get information about the procedure that they are having, including its advantages and disadvantages. We have now improved our service accordingly. [FGD, Hospital II].

Participants stated that providers sometimes intimidated or forced women to have a vaginal examination, justifying this because it was considered necessary to avoid negative birth outcomes which could subsequently reflect on their performance evaluations and potentially result in administrative actions. Some women were abandoned because they were perceived to be uncooperative with providers' requests. This was mentioned as justification for negligence and was used when staff already felt overburdened and burnt out with their job, as a strategy for reducing their workload. Participants mentioned that the training helped them to better understand that these acts were a form of mistreatment, and that they should be avoided.

... there were clients who refuse an examination and there were some providers who reply 'if I am not undertaking the examination for you, no one will come and help you' in response. This is frightening

and unprofessional and it is not a usual practice after the training. [FGD, Hospital III].

Participants described how the RMC training influenced their perceptions of intentional and unintentional actions used while assisting women. Participants previously believed that whatever they did during childbirth was for the benefit of the women.

There was an attitude that even if I shout at or insult a woman, it is just for her benefit; to encourage her to labour strongly and get the baby out. I used to think I am clean [correct]. [FGD, Hospital I].

The concepts of RMC and mistreatment introduced during the training helped participants to reflect on their own behaviours and take corrective actions where necessary. Participants explained that informal hierarchies between service providers, and between providers and women, were challenged by the training. One participant said that *'the provider-patient hierarchy that existed before the training is changed and we [providers] are treating women as our clients, not as patients'* (FGD, Hospital III). Participants also described how they were *'trying to treat women how they [providers] want to be treated'* (FGD, Hospital I). Additionally, participants reiterated that the training helped them to recognize that they must be tolerant when women are perceived to be restless or uncooperative.

Although a woman speaks something that is very harsh to me, I must be patient, I must swallow [absorb] unacceptable behaviours and be tolerant while caring for her, instead of responding to her negatively. [FGD, Hospital I].

Participants reported that this misconception that women with previous childbirth experiences do not experience labour pain, which can result in poor quality care for multiparous women, was changed by the training. Female participants who had multiple children knew from personal experience that this was a misconception.

I used to presume that multipara women do not have strong labour pain. I used to get angry at them and say 'what is wrong with you? This is not your first labour experience'. But, after the training, my attitude has been changed and I am treating multipara women as I treat primiparas; I do not get angry at them. [FGD, Hospital III].

Majority of participants reported that their motivation for work was positively influenced by the training. One participant mentioned that the feedback she gets from

women in response to the good care she provides is motivating for her, 'if you show good behaviour to women, eventually they do not show you a bad one. Thus, I will be very positive and welcoming to them'.

How did providers perceive the training?

Three sub-themes were identified during exploration of participants' perceptions of the RMC training: design and content; training methods; and concern for providers.

Design and content

Participants reported that the RMC training manual was well-organized, and the contents were precise and easy to understand. The concepts of RMC and universal rights of childbearing women were reported to have been very new and relevant to the majority of participants.

I liked the training manual. It is very precise and clear. The training was also delivered in an understandable and clear approach; it was not redundant. In addition, the ideas discussed were what we are working on, practical. [FGD, Hospital II].

One participant mentioned that it was inappropriate to include issues about sexual abuse in the training manual as such incidents are very rare. Furthermore, some participants were not comfortable with the extent of women's rights in childbirth, especially the right to refuse procedures. They were concerned that women in the study areas do not have the level of health literacy required to make informed decisions about their care.

... what was presented as sexual abuse in the case scenarios is a bit annoying. I do not think such events happen in Ethiopia. [FGD, Hospital III].

Training methods

Participants positively endorsed the engaging and participatory approach used by the training, especially the role play, case scenarios, and video shows. Participants valued the professional mix of the training facilitators and appreciated the presence of administrative managers (hospital chief executive officers and medical directors, and program coordinators at zonal levels), which strengthened buy-in to maximize the training's impact.

I am happy that senior managers and supervisors were invited to the training. Involving such personnel is a wonderful opportunity to forward our requests and invite their actions. [FGD, Hospital II].

Concern for providers

Participants were concerned that the training did not give adequate attention to the rights of service providers,

while it emphasized the rights of women. Accordingly, they suggested that their rights as service providers should also be considered and communicated to service users.

Providers' rights should be included, and women's rights should be revised and context-based. I do not think we can entertain such broad rights of women in our country's context. [FGD, Hospital III].

Participants explained that they wanted women and their companions to be made aware of their responsibilities in health facilities when seeking care for childbirth. One participant reported that some clients and companions behave very negatively and abuse providers in a way to claim their rights.

... where I was working before, there is a community forum and communities were oriented that 'professionals that dress white gown are meant to serve you [communities]; you can use their service for free'. The people are very innocent; when they come to health facilities and they consider you as their housemaid. Such acts create further friction. [FGD, Hospital I].

Participants stressed that various training manuals, guidelines, and standard operating protocols, including the current RMC training, predominantly focus on what providers should do for clients. On the other hand, participants reported that there is nothing about what should be done for providers (such as a rise in pay scale, adequate compensation for night shift, and recognition by managers) in response to implementing these multiple instructions.

Challenges in implementing RMC guidelines

Participants described a range of challenges encountered when implementing the RMC guidelines in practice, including lack of or inadequate infrastructure and supplies, high workload, and women's and companions' poor understanding of appropriate behaviour in a hospital setting.

Lack of or inadequate infrastructures and supplies

All participants agreed that severe space constraints in the wards made it hard to ensure women's privacy and allow birth companions. In all three hospitals, multiple women are together in one labour ward (4–6 women) and one delivery ward (3–4 women); all hospitals have only one delivery room. Participants from one hospital mentioned that it is not convenient to walk around the delivery beds if privacy screens are placed in between the beds. Thus, participants believed that it is not

feasible to allow a companion for every woman to stay in the wards.

Shortage of supplies like privacy screens, medicines, bed linens, towels, and detergents were the structural drivers preventing the provision of RMC mentioned by participants. Some participants from two of the hospitals described lack of water in the bathrooms as a source of discomfort for women, even if they receive respectful interpersonal care.

Participants from one hospital reported that the hospital does not provide any meal service for women, and as a result, women from rural villages who cannot afford the cost of food for themselves and their companions suffer.

There was a woman who came having fetal distress and then scheduled for emergency surgery; she stayed here for five days. She did not have money to buy foods. What is the fate of this woman? [FGD, Hospital II].

High workload

Work overload, especially during night shifts, makes it challenging to provide the desired level of respectful care. Night shifts are perceived as long compared to morning and late shifts, and only a small number of providers are available to care for women. Participants said that at times security personnel responsible for controlling overcrowding due to many companions are not available, so nurses and midwives have to assume this role as well.

Women's and companions' poor understanding of appropriate behaviour in hospital settings

. According to the participants, some women refuse to have procedures like episiotomy and pelvic examination despite having complications such as active bleeding; women who come from rural catchments and lack the knowledge and understanding to make an informed consent. Participants also reported companions', especially male partners', lack of consideration for providers to be a problem.

... there was a nice midwife who was attending a woman. The provider wanted to go to a washroom, but a woman's companion refused to let him go holding on his neck and saying, 'you are employed to follow women and you cannot leave my wife for a minute'. This is a huge disrespect of the provider. [FGD, Hospital I].

Providers demanded further actions and support to promote RMC

Participants solicited for existent actions in addition to the training to improve RMC in their respective hospitals.

These are summarised under three sub-themes: improving infrastructure and supplies; training, capacity building, and motivation; and engaging key stakeholders.

Improving infrastructure and supplies

Participants believed that facility managers and zonal and regional health authorities should take proactive action to ensure that all required services and supplies for childbirth are regularly available. Participants emphasized the role hospital managers are supposed to play in this regard, mentioning that the managers should pay close attention to the routine activities of maternity wards rather than only monitoring monthly reports and providing written feedback on these. It was reportedly easier to get a donation from an outside organization than place a supply order via the very long government procurement processes. Participants recommended short-term (partitioning delivery rooms, and renovation) remedies be taken to improve the privacy of women.

We have informed our managers. The response we get is 'it is in the process'. You get an item purchased after a long time and the purchased items are very low quality and get dysfunctional in a very short period, even in days. [FGD, Hospital III].

Training, capacity building, and motivation

Participants maintained that training only those in the maternity units is inadequate to improve RMC unless other staff and students in practicum whom women encounter as part of their care, including security officers and cleaners, are trained in RMC. Additionally, it was strongly suggested that nurse, midwife, and medical interns receive a pre-service orientation or training before assuming the responsibility of assisting women at the time of childbirth.

Respectful maternity care should be everyone's concern including health professionals, cleaners, security officers, students, and managers. During high case-load periods, there are women who get treated by students only and get discharged. Thus, students should be actively involved. [FGD, Hospital III].

Participants recommended the recruitment of manpower to balance the existing client load with the number of service providers. Participants also demanded improvement of the pay scale, compensation and benefits, recognition, and visits by managers to be motivated to provide RMC.

It is after providers get satisfied that they will provide respectful maternity care and make women happier. Thus, we would be grateful if there will be

benefit package improvements and adequate motivations by our managers. [FGD, Hospital III].

Engaging key stakeholders

Participants indicated their concern that RMC cannot be achieved by health professionals alone. They said support staff, hospital and higher-level administrators, partner organizations such as teaching hospitals and universities, women, and communities should work together to improve RMC.

We should be the first actors to improve respectful maternity care. Next, our hierarchical managers and supervisors should ensure the continuity of respectful maternity care service provision. They must come and support us. As said, their support should be in place to make the hospital the best place for women to deliver in receiving respectful maternity care. Everything that needs improvement starting from the gate to the hospital manager should be improved. [FGD, Hospital I].

Discussion

This paper presents the analysis of one component (RMC training) of a multi-component intervention (training of service providers, the introduction of wall posters and pamphlets, and post-training facility-based quality improvement). The study complements a growing interest in the promotion of RMC globally and revealed that training of service providers alone is limited in promoting RMC unless it is approached from a health system strengthening perspective. Although the RMC training has positively influenced the perception and understanding of service providers towards RMC, implementations of the RMC recommendations stalled due to diverse barriers. Participants witnessed that the mistreatment of women during childbirth is common in their facilities but cannot be eliminated in their capacities and therefore demanded additional system-wide support by facility managers and beyond.

Participants' attributed the reasons that women are mistreated during childbirth to one or more of the following domains: lack of knowledge and misunderstanding; normalization of mistreatment; punitive action against uncooperative and emotional women; to gain compliance with required examinations in order to achieve good birth outcomes; and structural issues (inadequate infrastructures and supplies, high workload, and inadequate staff incentive mechanisms). However, the RMC training fell short of addressing the last domain; these structural issues are main drivers of mistreatment and must be intervened to foster the culture of RMC [31].

The 'health workers for change' study conducted in four African countries reported that improving knowledge of provider-client relationship was important to instil a positive attitude among providers [32]. That study argued that achieving attitudinal change by trainings alone is futile in the long run, and improving structural issues is also required to achieve sustained change. Another study from Benin reported on reluctance among midwives to institute humanization of childbirth. However, gradual adoption of the new behaviours resulted in increased professional self-esteem and sense of motivation for better care—mainly due to the appreciation from women and family members [33]. In the medium term, we hope that service providers who received the RMC training in the current study may also undergo a similar change process.

Sometimes, the qualitative and quantitative results were incongruent in our study. The survey revealed that participants' perceptions of individual RMC components did not show significant improvement. However, participants of the FGDs stated that the training positively influenced their perceptions of RMC. This might be due to a social desirability bias because the training facilitator conducted the FGDs; participants might have reported in a way to please the facilitator. Additionally, the survey questions were somewhat limited so could not give a full picture of the changes in perceptions that might have occurred. In contrast, the FGDs allowed participants to describe their perceptions in a more nuanced way. Moreover, the lack of statistical significance in the quantitative assessment might be because providers were perceiving the difficulties they were likely to encounter when trying to improve RMC given their facility's long-standing structural limitations.

Similar Kenyan and Tanzanian studies found that providers' ability and willingness to provide RMC was strongly related to how they perceived their work environment including the availability of adequate staff and supplies, career opportunities, support services, and pay [34, 35]. A recent global meta-review indicated that shortage of manpower and lack of drugs and equipment were major bottlenecks to improving the quality of maternal and newborn health care [36]. According to the WHO's framework for the quality of maternal and newborn health care, using a health system approach to promoting RMC is indicated if real change is to happen because RMC spans all health system building blocks—a deficit in one block eventually affects the remaining blocks thereby subsequently affecting RMC [2].

Birth companionship is an integral part of RMC and a recommended practice throughout labour and childbirth [7]. Birth companions play an important role by providing continuous labour support for women contributing to positive birth outcomes and women's satisfaction [37, 38]. Participants described that space constraints in the

hospitals and birth companions jeopardizing other women's privacy were deterrents to the inclusion of birth companions in the shared labour wards. Other studies from Ethiopia [9], Kenya [14, 34], Tanzania [21], Guinea [39], and Japan [40] have also reported that the presence of a birth companion is not allowed due to physical structures.

The violation of service providers' rights reported in this study may not only be a precursor to the mistreatment of women but also demotivating for service providers, which in turn contributes to the provision of disrespectful care [41]. Human rights should apply to both clients and service providers. Therefore, the health system should be organized in a way that enables service providers to enjoy their rights to decent working conditions including adequate wages and staffing, availability of required supplies and equipment, and protection against violent clients [42, 43]. However, participants critiqued the RMC training as lacking a focus on the rights of the service providers. Future RMC initiatives would benefit from inclusive designs that also promote the rights of service providers.

This study benefited from the use of mixed methods design, which helped to identify the range of bottlenecks impeding the implementation of RMC recommendations. Additionally, the use of hybrid technique for the thematic analysis of the FDGs added rigour to the themes identified. We believe that future RMC interventions in similar settings should focus on the identified structural gaps and approach RMC from health system strengthening perspectives to maximize the return of RMC training. However, the study is limited in generating evidence of the challenges service providers might face in implementing RMC recommendations in health centres and tertiary and specialized hospitals as the settings vary in terms of administration and level of service. Additionally, the small sample size, the short implementation period, and the lack of a control group for the quantitative study make attribution of perception changes to the training difficult.

Conclusions

This study has revealed that RMC training was positively regarded by participants. However, training of service providers alone is limited in promoting RMC because of related system constraints such as trained manpower deployment; essential material and supplies; physical infrastructure (building and space); health professionals' motivation; and community awareness. Therefore, addressing RMC through a lens of health systems strengthening that promotes a rights-based approach to maternal health services for both women and staff is most likely to successfully mitigate the mistreatment of women during facility-based childbirth.

Supplementary information

Supplementary information accompanies this paper at <https://doi.org/10.1186/s12978-020-00953-4>.

Additional file 1. Consolidated criteria for reporting qualitative studies (COREQ): 32-item checklist.

Abbreviations

COREQ: Consolidated criteria for reporting qualitative research; FGD: Focus group discussions; SNNPR: Southern nations nationalities and peoples region; WHO: World health organization

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Authors' contributions

AA conceived the study; AA, AM and MK designed the study, developed data collection tools; AA coordinated the fieldwork; AA and MK analysed the data; AA drafted the manuscript; AM, MB and MK revised the manuscript for intellectual content. All authors have read and approved the manuscript.

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Availability of data and materials

Reasonable requests can be made to access the data analysed in this study from the corresponding author.

Ethics approval and consent to participate

Ethics approval was obtained from the Institutional Review Board located in SNNPR Health Bureau (Ethiopia) and the Human Research Ethics Committee (HREC) at the University of Melbourne (Australia). Permission letter to conduct this study was also granted from the Federal Ministry of Health and SNNPR Health Bureau. Information about the study was delivered to all study participants and written consent was obtained.

Consent for publication

Not applicable.

Competing interests

The authors declare that they have no competing interests.

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Chapter 7: Results Part III – Health system constraints to the promotion of respectful maternity care

7.1 Preface

The third results chapter reports the findings from FGDs and IDIs conducted before the RMC intervention and additional set of FGDs that were conducted after the RMC intervention. The results respond to the fourth study objective (to identify health system constraints to the promotion of RMC in health facilities) and describe health system factors that affect the promotion of RMC in the study hospitals.

I used a complex adaptive system theory to depict how system hardware and software elements function in the broader context and affect RMC, even in the presence of the RMC intervention implemented as part of the larger study.

This study is the first of its kind to explore RMC from the perspectives of health systems research using complex adaptive systems theory. The causal loop diagram included in the chapter summarises the interactions between various system elements that were identified by the study.

Results are presented using a peer reviewed journal article published in Sexual and Reproductive Health Matters.

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Imagining maternity care as a complex adaptive system: understanding health system constraints to the promotion of respectful maternity care

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Abstract: *Evidence of the health system challenges to promoting respectful maternity care (RMC) is limited in Ethiopia and globally. This study investigated the health system constraints to RMC in three Southern Ethiopian hospitals. We conducted a qualitative study (7 focus group discussions (FGDs) with providers of RMC and 12 in-depth interviews with focal persons and managers) before and after the implementation of an RMC intervention. We positioned childbirth services within the health system and applied complex adaptive system theory to analyse the opportunities and constraints to the promotion of RMC. Both system "hardware" and "software" factors influencing the promotion of RMC were identified, and their interaction was complex. The "hardware" factors included bed availability, infrastructure and supplies, financing, and health workforce. "Software" factors encompassed service providers' mindset, staff motivation, and awareness of RMC. Interactions between these factors included privacy breaches for women when birth companions were admitted in labour rooms. Delayed reimbursement following the introduction of fee-exemption for maternity services resulted in depleted revenues, supply shortages, and ultimately disrespectful behaviour among providers. Other financial constraints, including the insufficient and delayed release of funds, also led to complex interactions with the motivation of staff and the availability of workforce and supplies, resulting in poor adherence to RMC guidance. Interventions aimed at improving only behavioural components fall short of mitigating the mistreatment of women. System-wide interventions are required to address the complex interactions that constraint RMC. DOI: 10.1080/26410397.2020.1854153*

Keywords: respectful maternity care, health system, complex adaptive system, system hardware, system software

Introduction

Despite the implementation of a range of maternal health interventions, maternal mortality remains high in many low- and middle-income countries (LMICs), including those of sub-Saharan

Africa.¹ Key to achieving the sustainable development goal target of reducing the global maternal mortality ratio to 70 per 100,000 live births by 2030² is improving the quality of both clinical and non-clinical care women receive during the

time of pregnancy, childbirth, and in the immediate postpartum period.³

The World Health Organization (WHO) defines the quality of care as “the extent to which health care services provided to individuals and patient populations improve desired health outcomes” and outlines that safety, effectiveness, timeliness, efficiency, equity, and people-centredness of health services are integral to achieving quality.⁴ Applying this definition to maternal and newborn health services helps to view quality from two standpoints: quality from the perspective of the provision of care (clinical care) and quality from the perspective of how women and their families experienced the care (interpersonal care).⁵ Historically, however, most quality improvement interventions have focused on the clinical dimensions of maternity care while overlooking the interpersonal and social aspects of care.⁶

The mistreatment of women during facility-based childbirth has been reported as both a violation of women’s human rights and a significant deterrent to the utilisation of skilled birth services.^{7–9} Several studies from sub-Saharan Africa, including WHO-led studies, reported high levels^{10,11} and diverse manifestations^{7,12} of the mistreatment of women. Similarly, the worryingly high level of mistreatment of women in Ethiopia^{13–16} highlights the need for a focused strategy if the country is to improve maternal health and reduce maternal mortality. In 2019, only 47.5% of pregnant women gave birth in health facilities in Ethiopia although 74% of pregnant women received at least one antenatal care visit from a skilled provider.¹⁷ A portion of this missed opportunity may be addressed by preventing the mistreatment of women.^{7,18}

Respectful maternity care (RMC) is one of the eight domains of WHO’s framework for quality of maternal and newborn health care and refers to care that includes the right to dignity; respect; privacy; confidentiality; equality; informed consent; autonomy; and timeliness.^{5,19} Additionally, within the 2018 WHO *Intrapartum Care for Positive Childbirth Experience* recommendations, RMC is recommended to improve the quality and woman-centredness of care during childbirth.⁸ In addition to framing these recommendations, there should be a mechanism for fostering accountability to achieve sustainable change.²⁰ These efforts need to happen in the context of comprehensive quality of care improvements, including the technical dimension.²¹

Given the diverse contributors to the mistreatment of women during childbirth,²² system complexity-informed strategies need to be designed to advance context-specific and evidence-based maternal health interventions.³ Although RMC, as a non-clinical aspect of quality care,⁵ relies on the practice of service providers, it is open to the interactions between other system components such as infrastructure, information and referral systems, financing, and motivation, among others.^{23,24}

Positioning RMC in a complex system helps to explore the constraints and patterns of interaction between system elements that directly or indirectly affect the delivery of RMC in health facilities.²⁵ In this study, the maternity care system is regarded as a complex adaptive system. Accordingly, the concepts of complex adaptive systems were used to guide data analysis and interpretation of the findings of this study.²⁶

The concepts of complexity science are rooted in disciplines including biology, chemistry, physics, and sociology, among others. Consequently, several theories including evolutionary theory in biology, self-organisation theory in chemistry, and chaos theory in mathematics contributed to the complexity science construct, the latter resulting in a heightened interest in complexity science among social scientists to study change, evolution, adaptive, and emergent behaviours in social and organisational phenomena such as health-care.^{27–29} Complexity science resulted in the paradigm shift from the linear cause and effect inquiry underlying traditional formal approaches, to synthetic reasoning and modelling of complex systems.²⁷

A complex adaptive system is a dynamic system that consists of a wide variety of elements, and in which the behaviour of each is responsive to the actions of others within the system (adaptive); interactions are nonlinear; and responses or changes are unpredictable (complex).^{23,26,28} Table 1 shows a brief description of selected complex adaptive system concepts. Nonlinearity refers to the heterogeneous and multiple levels of interaction between system agents which makes system behaviour unpredictable.^{26,30} Small changes in inputs may lead to large changes in outputs. Conversely, large changes in inputs may result in small changes in output.²⁸ Gear and colleagues describe feedback loops as “recursive mechanisms arising from multiple agent interactions over time that either reinforce (positive) or undermine

Table 1. Description of important concepts

Concepts	Description*
Complex adaptive system	A type of system which comprises diverse agents (complex), and where the behaviour of each agent is responsive to the interactions with other agents within the system (adaptive)
Self-organisation	The way in which agents interact to coordinate their own forms, or patterns of behaviour arising from repeated agent interactions over time
Nonlinearity	The heterogeneous and multiple levels of interaction between agents which makes agent response unpredictable
Feedback loop	Recursive mechanisms as a result of multiple agent interactions over time that create reciprocal behaviour either reinforcing (positive feedback loop) or undermining (negative feedback loop) each other
Emergence	New system behaviours (larger entities) generated by the interactions of smaller or simpler entities
Path Dependence	Past experiences influence the responses to new events
System hardware	Constituent of health system that includes human resources, financing, technology, service delivery, infrastructure, and supplies
System software	Constituent of health system that includes tangible (leadership, management, and governance knowledge and skills, rules and procedures) and intangible (values and norms, power relationships, and information communication) elements that interplay with system hardware elements to influence the system
*Source: Modified from Braithwaite et al. ³² ; Gear et al. ²⁶ ; Gomersall et al. ²³ ; and Sheikh et al. ³³ .	

(negative) each other. Positive feedback loops support a change trajectory while negative feedback loops tend to undermine or negate change”.²⁶ When system elements interact, the system displays a new aggregate behaviour that cannot be seen at the individual element level. This property is called emergence^{23,26} and such repeated interactions over time make the system adapt to the behaviour of its elements; this is labelled as self-organisation.²⁸ Sometimes, past system events or circumstances manifest their desirable or undesirable influence on current system behaviours or events – path dependence.^{30,31}

Despite the recent attention, evidence on the effectiveness of RMC interventions is meagre both in Ethiopia and globally.⁸ Identifying the health system constraints to the promotion of RMC would contribute to the development of evidence-based approaches. Our qualitative study was undertaken to provide a better understanding of health system constraints to the promotion of RMC in Ethiopian hospitals. We aim to contribute to the body of evidence that can be used in the design and implementation of RMC programs in Ethiopia and other similar settings.

Methods

This study is part of a broader mixed-methods intervention study which was conducted between March 2018 and August 2018 to explore health system factors influencing RMC and to develop and assess mitigation approaches in southern Ethiopia. The study was conducted in collaboration with the Federal Ministry of Health and the Southern Nations Nationalities and Peoples Region (SNNPR) Health Bureau, Ethiopia. This paper reports on the qualitative component of the study exploring the health system constraints to implementing RMC. We used the WHO's health system building blocks (service delivery, health financing, leadership and governance, health workforce, medical technologies, and health information) to identify the constraints.³⁴

Study setting

According to the three-tiered Ethiopian health service system, primary hospitals, along with their catchment health centres and health posts, constitute the first tier. Primary hospitals are designed to provide primary level services with a minimum capacity of 35 beds and 24-h

emergency services, including comprehensive emergency obstetric care. In the second tier, there are general hospitals which provide the same services as primary hospitals, but have over 50 beds, and are designed to provide a range of specialist services including gynaecology and obstetrics, paediatrics, internal medicine, surgery, psychiatry and emergency services, and include diagnostic facilities and therapeutic interventions. Specialised hospitals form the third tier and serve as referral centres for general hospitals.³⁵

The study was conducted in three public hospitals (two general and one primary hospital) and their corresponding programme administrative units. The hospitals were selected based on the primary author's familiarity with the settings and intention to have an appropriate mix of

primary and referral facilities. The hospitals admit women with or without a referral for both normal and caesarean delivery services and share similar characteristics with other hospitals of their levels in the country. See Table 2 for profiles of the study hospitals.

The intervention

The rationale for this intervention arises from the lack of (1) a stand-alone RMC promotion package in Ethiopia and (2) evidence on the effectiveness and implementation challenges of RMC interventions in Ethiopia and globally. There were three components to the RMC intervention: a three-day offsite staff training on RMC; placement of wall posters in labour wards; and onsite supportive supervision. The intervention focused on the interpersonal aspect of care, including the

Table 2. Profiles of study hospitals

Characteristics	Hospital I	Hospital II	Hospital III
Geographical and population profile (2017)			
Location (urban/rural)	Urban	Semi-urban	Semi-urban
Catchment population	359,358	261,271	267,589
Expected pregnancies in the catchment	12,434	9,040	9,259
Number of public hospitals in the catchment (including current one)	03	01	01
Number of health centres in the catchment	05	09	11
Facility profile			
Total number of births attended in the last quarter of 2017	1081	433	713
Total number (%) of caesarean births in the last quarter of 2017	164 (14.9)	62 (14.3)	138 (19.4)
Upgraded from a lower-level facility (Yes/No)	Yes	Yes	No
Number of labour wards	02	01	01
Total number of beds in the labour ward	10 (5 in each)	05	05
Number of delivery rooms	01	01	01
Total number of birthing beds in the delivery room	04	04	3
Type of delivery room (Partitioned/Non-partitioned)*	Non-partitioned	Non-partitioned	Non-partitioned
Number of functional showers in the labour ward	0	02	01
Number of functional handwash basins in the labour ward	01	02	01
Designated waiting area for accompanying family members (Yes/No)	Yes	Yes	Yes
*Open plan with multiple beds per room with no curtains/partitions.			

recommendation for the admission of birth companions, but did not involve structural or hardware components. Further detail about the evaluation of the intervention from women's and service providers' perspectives is available in other studies published elsewhere.^{36,37} Implementation of the whole set of components of the intervention lasted for three months. All service providers who assist women in the study hospitals ($n = 69$) were invited to participate in the intervention. Eventually, 64 service providers received all the intervention components including the training; five service providers did not attend the training for personal reasons. The participants comprised 51 midwives (79.7%), 4 general practitioners (6.3%), 4 integrated emergency surgical officers (6.3%), 3 nurses (4.7%), and 2 health officers (3.1%); 44 (68.8%) were female and a similar percentage were aged between 22 and 29 years. Table 3 shows details of the components and participants of the intervention.

The RMC intervention goes in line with the core themes of the caring, respectful, and compassionate (CRC) health workforce initiative, one of the four transformation agendas of Ethiopia's Health Sector Transformation Plan (2015–2020).³⁵ A 2019 government review indicated that lack of ownership and engagement of stakeholders at all levels, lack of system-wide implementation, lack of finance, weak monitoring and evaluation systems, lack of research and evidence in the field, and resistance among providers were among the key challenges in implementing the initiative.³⁸ While the CRC initiative is generic and designed for the entire health service in the country, it lacks depth and focus to address the core themes of RMC. In contrast, the study intervention dealt with promoting all components of the RMC charter¹⁹ and involved the mechanisms to track progress and take improvement actions.

Sampling and recruitment

We conducted 7 focus group discussions (FGDs) with service providers (4 FGDs before the RMC intervention and 3 FGDs after the RMC intervention) and 12 in-depth interviews (IDIs) with key informants. As the IDIs aimed to explore the status of respectful care in the hospitals and existing challenges to providing RMC from the perspectives of key informants who hold a managerial position, all were conducted before the RMC intervention.

Focus group discussions

Participants of the FGDs were service providers who provide care during labour, childbirth, and immediate postpartum periods in the maternity care unit of the study hospitals. The pre-RMC intervention FGDs were conducted in three public hospitals; two FGDs were conducted in one of the hospitals, while one FGD was conducted in each of the other hospitals. A total of 32 participants took part in the pre-RMC intervention FGDs (6–10 participants in each FGD); 24 of the participants were female, while the remaining 8 were male (Table 4). A total of 21 participants took part in the post-RMC intervention FGDs (6–8 participants in each FGD; 1 in each intervention hospital) that were conducted two months after the intervention; 15 of the participants were female, while the remaining 6 were male. Participant selection for the pre-intervention FGDs was conducted based on the availability of service providers and depending on their duty assignment. The maternity care unit coordinators invited all service providers who were not on day-time duty and those who turned up were included. All participants (32) of the pre-RMC intervention FGDs received the RMC training, making 50% of the RMC training participants. For the post-RMC intervention FGDs, candidate participants (those who attended the RMC training and who were not on day-time duty) were invited to participate in an FGD (Table 4). The pre-intervention FGDs were conducted to explore the knowledge of service providers on quality maternity care, RMC, and the mistreatment of women; health system challenges; service providers' experience in the provision of RMC; the contributors to the mistreatment of women in health facilities; de/motivators of RMC provision; and seek for their recommendations of what needs to be done to improve RMC. The post-intervention FGDs explored the challenges service providers experienced during implementation of the RMC training and further actions required to promote RMC.

The preliminary analysis of the formative data set – 4 pre-intervention FGDs and 12 pre-intervention IDIs – helped us to contextualise the RMC training, notably the addition of a consultative discussion with training participants, hospital administrators, and programme managers on the last day of the training sessions.

Table 3. Description of the RMC intervention			
Component	Description	Participants	Intervention period
RMC training	The RMC training manual included contents on an overview of maternal health in Ethiopia; human rights and law in the context of reproductive health; RMC rights and standards; professional ethics; and continuous quality improvement. The manual was designed after a thorough review of RMC implementation programmes in Kenya, Tanzania, and Nigeria; and WHO's recommendations of Intrapartum Care for Positive Childbirth Experience; and national guidelines and professional ethics codes.	64 service providers at the participating hospitals who assist women during childbirth (in two rounds)	First round: 25–27 April 2018 Second round: 2–4 May 2018
Wall posters	Four wall posters • The universal rights of childbearing women prepared by the White Ribbon Alliance (one poster) • Infographics taken from the intrapartum care for a positive childbirth experience guideline prepared by the WHO (three posters)	All (64) training participants The wall posters were included in the RMC training manual and all participants were briefed on these.	25 April–4 May 2018 Posters were handed over to the hospitals' MCH coordinators at the end of the second round training session.
Onsite supportive supervision	Two rounds of post-training quality improvement supportive supervision were conducted to appraise the action plan implementation, and to set actions for the next cycle with the long-term aim of developing a culture of continuous quality improvement actions. Guidance on a facility-led assessment of RMC using a structured checklist that was part of the RMC training manual. Guidance on action plan development to address actionable gaps identified by the assessment checklist.	All (64) service providers who attended the RMC training. (There were service providers who attended both rounds of the supervision.)	First round: June 2018 Second round: July 2018

In-depth interviews

All IDIs were conducted before the RMC intervention with key informants at hospital and

programme levels. Key informants at the hospital level were maternal and child health coordinators, institutional quality focal persons, medical

Table 4. Summary of participants and topic areas investigated during FGDs and IDIs

Category	Facility	No. of FGDs/ IDIs	Total no. of participants*	Topic areas explored
Pre-intervention FGDs	Hospital I	2	16 (14 midwives, 2 nurses)	Features of quality maternity care; twice and perception of mistreatment; twice and perception of respectful care; contributors to mistreatment; challenges experienced in labour wards; motivators and demotivators to provide respectful care; actions required to promote respectful care
	Hospital II	1	8 (7 midwives, 1 integrated emergency surgical officer)	
	Hospital III	1	8 (7 midwives, 1 health officer)	
Post-intervention FGDs	Hospital I	1	7 (6 midwives, 1 nurse)	Perceived behavioural influences of the training; challenges encountered, and new behaviours emerged in implementing the training; additional actions required to implement the training; partakers of RMC
	Hospital II	1	8 (8 midwives)	
	Hospital III	1	6 (5 midwives, 1 general practitioner)	
Pre-intervention IDIs	Hospital I	4	4 (MCH** coordinator, quality focal person, medical director, and chief executive officer)	Features of quality maternity care; twice and perception of mistreatment; twice and perception of respectful care; contributors to mistreatment; perceived status of respectful care; respectful care initiatives; challenges in advancing respectful care
	Hospital II	4	4 (MCH coordinator, quality focal person, medical director, and chief executive officer)	
	Hospital III	3	3 (MCH coordinator, quality focal person, and medical director)	
	Regional health bureau	1	1 (senior maternal health expert)	

*Most FGD participants were midwives because 80% of service providers who assist women during childbirth in the study hospitals were midwives.
 **MCH: Maternal and child health.

directors, and chief executive directors of the three intervention hospitals. The programme level IDI was conducted with a senior maternal health expert at the SNNPR Health Bureau (Table 4). The key informants were selected aiming at obtaining rich information from both hospital and programme levels that could enable us to meet the study objective. The IDIs explored the constraints to the promotion of RMC from the perspectives of programme managers and administrators who look after the programming and operation of maternal health services at hospital, zonal, and regional levels.

Data collection

Pre-intervention FGDs and IDIs were conducted from March 2018 to April 2018, and post-intervention FGDs were conducted in July 2018. Initially, semi-structured interview guides were developed in English after a thorough literature review. The key topic areas explored during the FGDs and IDIs are presented in Table 4. The FGDs lasted 45 minutes to one hour while the IDIs lasted 20–30 min.

The guides were then reviewed for content and clarity by two of the co-authors. The primary author translated the final version interview

guides for both the FGDs and IDIs into Amharic language and used these versions to collect data in Amharic. Data were collected and digitally audio recorded by the primary author, who is familiar with the local context. Participants were provided with compensation for local transportation.

Data analysis

The primary author did the simultaneous translation (from Amharic to English) and transcription of the audio recordings. The transcribed data were then imported into NVivo software (QSR International, Version 12 Plus) for analysis. Data from the pre-and post-intervention FGDs and IDIs were analysed concurrently. Data were coded inductively and deductively using standard qualitative methodology,³⁹ and analysed in two steps, first inductively to identify themes emerging from the transcripts and then deductively using the complex adaptive systems theory.²⁶ Additionally, complexity theory helps to synthesise the constraints to RMC through the lens of inherent organisational complexities in hospitals; evidence from such synthesis can later be translated to tackle implementation problems.³¹ Coding of data was undertaken by the primary author after reading and rereading the transcripts to identify themes that impede RMC; the themes were then reviewed by one of the researchers (AM). The agreed-upon themes were then grouped into either system hardware or system software categories, according to Elloker et al.⁴⁰ In this context, system hardware refers to supply, health workforce, facilities, and financing, whereas system software refers to knowledge and mindset, referral system, support and motivation, and service delivery guidelines. Following the thematic analysis, we used complex adaptive system theory as a framework to explore and map the complex interactions within and between the system hardware and system software elements.²⁶ This approach of data- and theory-driven analysis is suggested by scholars to improve rigour in thematic analysis.⁴¹ The primary author developed a causal loop model using Vensim software to visualise the interactions between different system elements in the maternity care system that affect the delivery of RMC. The developed model was then reviewed by all authors. We used the consolidated criteria for reporting qualitative research to report important aspects of this study.⁴²

Ethical considerations

Ethical approval for this study was obtained from the University of Melbourne (Australia) and the SNNPR Health Bureau (Ethiopia). Participants were given a plain language statement about the study that they read before consenting to participate; all participants gave written consent before participating in the study.

Findings and interpretations

We identified seven health system factors influencing the promotion of RMC belonging to the categories of system hardware (bed availability; infrastructure and supplies; financing; and health workforce) and system software (staff motivation; service providers' mindset; and awareness of RMC). These elements exhibited complex interactions with each other, amplifying the challenges of implementing RMC. Limited responsiveness within the maternity care system constrained implementation of the RMC recommendations. In the following sections, we report on the system interactions by identifying where complex adaptive system processes were at play, which are depicted in Figure 1. Consistent with complex systems, some of the themes have shared causal factors and intersect with each other.

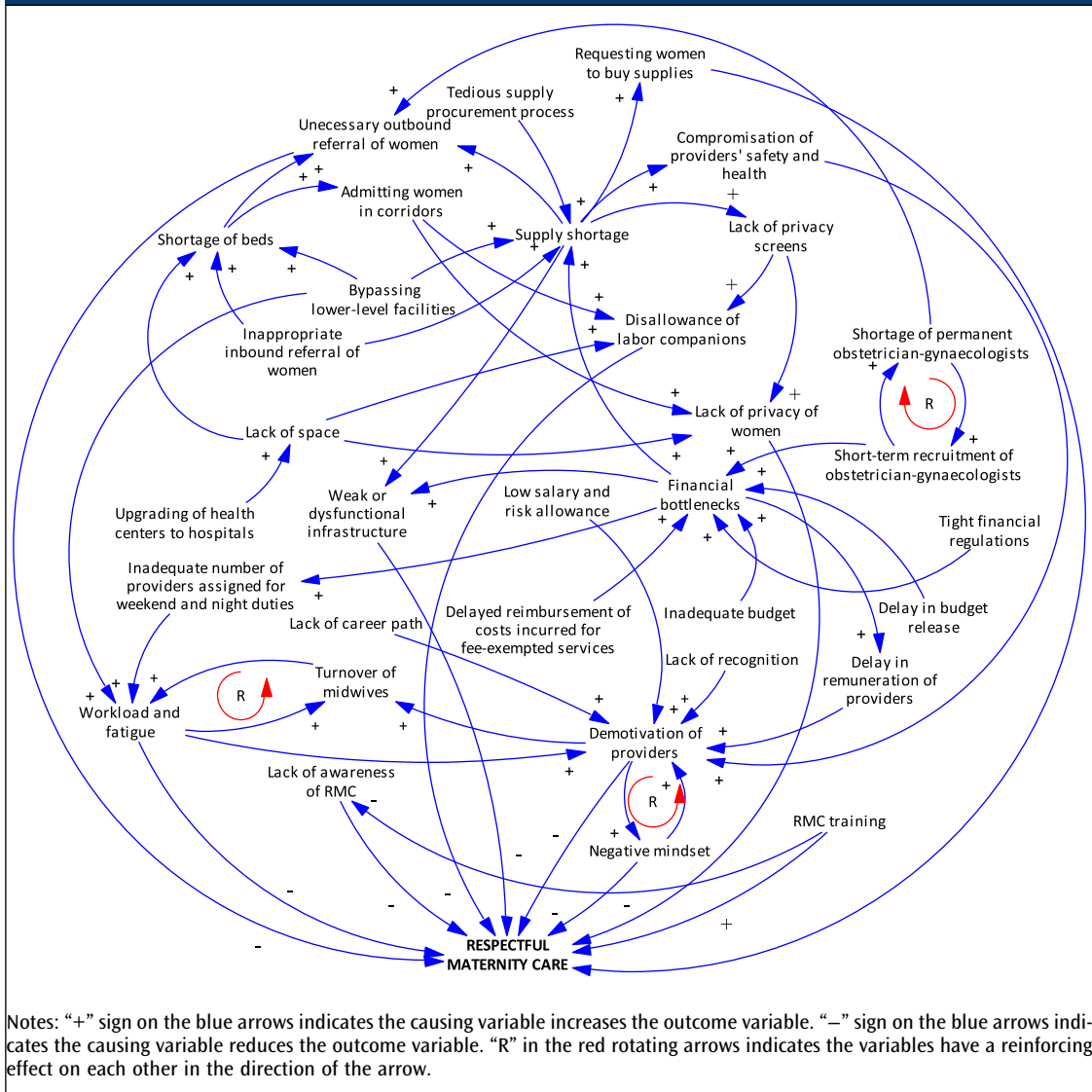
Bed availability

All study hospitals have only one labour ward and one delivery ward (separate from the labour ward) where women stay together; there are four to six hospital beds in each labour ward and three to four birthing beds in each delivery room (Table 2). In response to the rising client flow, one of the hospitals had previously built a new maternal and child health unit which helped to separate obstetrics and gynaecology wards while the remaining two have renovated their labour wards to accommodate more beds.

"We are restructuring the wards using partition boards to add two more beds. As a long-term solution, we are constructing a new hospital building that will take about two years to be available for service." (Coordinator, Hospital I)

Despite these facility-level remedies to increase bed capacities, all study hospitals experienced patient numbers that exceeded bed capacity:

"... the main challenge is the shortage of beds, especially during the night-time; there is a huge

Figure 1. Causal loop diagram of factors influencing respectful maternity care in hospitals*

complaint from staff and the community in this regard. Sometimes, it is the gatekeepers who tell women coming by ambulance to turn around and look for other hospitals in the city.” (Coordinator, Hospital I)

Although women can give birth in lower-level health facilities, participants reported that most women who come to hospitals for childbirth

bypass health centres, assuming that they will receive better service in hospitals, an important factor explaining the shortage of beds and overcrowding in hospitals. Participants also said that many women are referred from lower-level facilities without any clinical indications requiring referral and could have given birth safely at primary level health services and that bypassing these facilities increases pressure on the hospitals.

“More than half of the women who give birth in our hospital can give birth at health centre levels. Women bypass these facilities, and there is also an inappropriate referral of women from these facilities. Last month, 59 women who were referred from ‘health centre A’ gave birth in our hospital without any particular procedure for an assisted delivery (vacuum or forceps).” (Coordinator, Hospital III)

In response to the overcrowding, health workers are faced with the following choices to manage excess client flow: admitting women who are in labour to wait in corridors until someone gets discharged, or referring women to other facilities, including those who have already been referred to them from other facilities.

Infrastructure and supplies

In all hospitals, in addition to the overcrowding described above, there were both space constraints and supply shortages. The absence of privacy screens was a key constraint to the provision of respectful care, especially maintaining women’s privacy during vaginal examinations. In the two upgraded hospitals, there was only limited expansion of the labour wards, delivery rooms, and waiting areas for families, meaning that the renovations have not equipped the hospitals with adequate space given the expansion of services.

“This hospital was a clinic 57 years ago; it was then upgraded to a health centre and later to a primary hospital and then general hospital without significant expansions. That is why the buildings/rooms are not conducive to provide services to the level that a general hospital should do.” (Manager, Hospital I)

Following the RMC training, all hospitals allowed labour companions to accompany women in labour wards, which meant there were several companions in one labour ward. The willingness among staff indicates that there is a real opportunity to promote labour companionship in the long run. However, participants said that it was challenging to maintain women’s privacy during vaginal examinations because there are several “strangers” in the labour wards which are already considered small, given the number of beds they accommodate, as indicated in Table 2. Thus, while the admission of labour companions likely benefited women during labour, it simultaneously had an undesirable effect on the privacy of other

women. As a result, service providers faced a dilemma of which aspect of RMC to prioritise – privacy or labour companionship. Eventually, labour companions were denied admission in labour wards, especially in two of the hospitals, because of the privacy concerns.

“Because we do not have adequate [privacy] screens, we are asking all labour companions to go out of the ward whenever a woman is to have an examination...” (Service provider, post-RMC intervention FGD, Hospital III)

The interaction between the lack of privacy and the admission of labour companions in labour wards proved to be competing forces, a manifestation of non-linear inter-relationships. Service providers’ understanding of privacy seemed to extend only to the companions of other women in the ward, not to the other women (residing) in the ward, who are also strangers. This implies privacy is still lacking, although the degree may be less than when companions are in the room. In a different context, there might be a positive relationship between the presence of labour companions and RMC, but in a context in which available supplies, especially privacy screens, were often lacking, the expected relationship is modified and effectively reversed. In effect, this particular hardware issue is among the key system elements jeopardising RMC.

Other supply issues identified were the shortage of bed linen; infection prevention supplies including aprons, gloves, soap and chlorine solutions; blood packs; essential medicines including ergometrine; and foetal monitoring equipment. Furthermore, lengthy procurement procedures and the supply of low-quality medical equipment were additional challenges to the continuous availability of supplies:

“...a respectful midwife cannot address all requirements of respectful care alone. He/she must be provided with required supplies...” (Coordinator, Hospital II)

In the case of acute stockouts of recurrent supplies, hospitals adapted to these situations by commissioning special purchase of supplies using their internal revenue, asking for support from non-governmental partner organisations, and borrowing from nearby health facilities. To initiate an independent purchase of missing supplies mentioned above, hospitals require an

out-of-stock clearance from the Ethiopian Pharmaceutical Supply Agency. Once hospitals are granted permission, meeting the requirements of government procurement guidelines⁴³ was reported to be very challenging.

“We have allocated a budget for the purchase of supplies. However, it is tough to get these in the market. How could I admit a woman for labour when I do not have a glove to use? A mother will get referred without her will and consent ...” (Manager, Hospital I)

Additionally, participants described several facility constraints including dysfunctional or complete absence of utilities like shower and sinks, shortage of water supply, no waiting area for companions, and poorly ventilated wards. These challenges were also the reason why service providers did not allow women and their families to perform cultural ceremonies/practices that they would do if the woman had birthed at home. Hospital administrators have indicated that they have budget limitations for regular maintenance and renovation works. Accordingly, the supply and facility constraints in the hospitals were influenced by complex interactions between various agents such as leadership, governance, and financing, which are complex systems themselves.

These supply, space, and facility constraints have direct (denying women the required level of services and resulting in unnecessary referrals) and indirect (damaging providers’ commitment to provide care due to health and safety concerns) negative effects on RMC.

Healthcare financing

All hospitals were implementing a financing recommendation set forward by the Ethiopian government to make antenatal, delivery, and postnatal care services available free of charge in public health facilities although there were some inconsistencies before the CRC initiative.⁴⁴ As part of the government’s initiative to promote CRC, the hospitals waived the fee for investigations conducted during pregnancy and childbirth, including obstetric ultrasound.

“Investigations, including ultrasonography, for women are provided free of charge with a special consideration not only to make them happy and encourage them to give birth in health facilities but also to provide the services that they are

entitled to get from hospitals.” (Coordinator, Hospital III)

The fee-exemption was introduced first in health centres and then in hospitals between 2005 and 2010. In principle, hospitals apply to the Ministry of Health at the end of every quarter for reimbursement for the costs incurred to deliver fee-exempted services. While the fee-exemptions were regarded as positive in promoting equity, challenges arose to meet the expectations for services. For example, delays in reimbursement were reported in all hospitals and contributed to supply shortages because hospitals were not able to accumulate funds that they could use for procurement. We identified an emergent behaviour in response to the implementation gap of the fee-exemption policy for maternal health services – requesting women to buy supplies:

“... now, we are in the second quarter of the current budget year. However, we did not yet get reimbursed by the Ministry for our expenses of the second quarter of the previous budget year. We are in a big challenge currently.” (Manager, Hospital II)

Insufficient and delayed release of budgeted funds were the two other key challenges affecting the management and delivery of childbirth services in the hospitals. The beginning of a fiscal year is the most challenging period when hospitals encounter difficulties in paying compensation for services such as night and weekend duties, as the new fiscal year’s budget is not usually released for use on time. Consequently, service providers wait for months to get paid for their weekend and night duties, and this has resulted in demotivation of service providers and a negative relationship between service providers and administrators.

Financial bottlenecks also resulted in the assignment of a substandard number of midwives for night and weekend duties to minimise expenses. As such, the assigned service providers bear a higher workload than they are supposed to; this often leaves them frustrated and eventually results in the mistreatment of women.

“... in some hospitals and most health centres, an adequate number of midwives are not assigned for night duties; this practice is totally against the standard, and it happens because health facilities do not want to pay for night duty. There are

occasions five or more labouring women come in a single night, and the workload makes us ‘health providers’ to behave disrespectfully.” (Service provider, pre-RMC intervention FGD, Hospital I)

These complex interactions between different agents in the financing system left hospitals in financial bottlenecks which in turn added to the complexity in the maternity care system (affecting the availability of supplies, deployment of adequate staff, timely payment of remuneration, etc.), making it difficult to practice RMC. The delay in providers’ night and weekend duty payments made providers feel disrespected, further compounding the complexity of RMC delivery.

Staff motivation

As part of the CRC initiative, all hospitals have introduced staff appraisal and recognition ceremonies which occur every six months to give awards to the best performing staff from each unit of the hospitals, including maternity units. The coordinator of one of the hospitals reported that they also have a fortnightly coffee ceremony in which women and their families are involved and best practices and gaps identified are discussed. This recognition was important to improve staff morale.

“... there are CRC focal persons in each unit who appraise respectful care, deal with breach of professional ethics, and hold group meetings with their team. The best performer professional is selected every six months from each unit, and a certificate of appreciation is awarded to motivate them.” (Coordinator, Hospital I)

However, there were simultaneously weak staff incentives and a lack of motivation schemes in hospitals, which had a negative effect on RMC by damaging providers’ enthusiasm to provide respectful care. These included: low salaries; risk allowance gaps among professions; lack of support and recognition by managers; lack of career opportunities; undefined career path (especially for midwives and integrated emergency surgical officers); low and delayed remuneration for night and weekend duties; and lack of a positive work environment.

“Sometimes, you keep on doing and discharging your responsibilities appropriately, but no one from the senior managers comes to you and sees what you do and gives you recognition.” (Service provider, post-RMC intervention FGD, Hospital I)

Hospital administrators reported that they use the national pay scale, and they do not have the authority to adjust salaries and other payments however they share providers’ complaints.

“Because what is being paid here is low, service providers look for part-time jobs elsewhere. That, in turn, compromises the quality of service in our hospital as service providers get fatigued ... I know this is a national problem and cannot help it ... ” (Coordinator, Hospital I)

Midwives reported that there is an unfair gap of risk allowance among different professions; midwives report receiving 470 birr (~17 USD) per month while health officers and emergency nurses receive a higher risk allowance, 1250 birr (~46 USD) and 1200 birr (~44 USD), respectively. Managers have also expressed the gap as inappropriate and creating dismay among midwives. Midwives claimed that they are exposed to a higher level of professional risk, such as infections, compared to health officers and emergency nurses. Because of these dissatisfactions, the lack of career opportunities, and the relatively better pay that other non-health professional graduates (such as accountants) of the same years of employment receive, participants said that fellow midwives are leaving the profession.

“Practicing midwifery is difficult in Ethiopian facilities; as a midwife, you are supposed to work for 24 hours if you have night duty, the workload is exceptionally high, you take care of several women at a time. Disproportionately, your salary is very low, as is your risk payment.” (Service provider, pre-RMC intervention FGD, Hospital II)

The interaction between high workload and attrition of midwives exhibited a positive feedback loop: the more midwives resign, the higher the workload becomes, which in turn leads the remaining midwives to resign. This emergence of behaviour (resignation) among midwives due to the longstanding problem of staff motivation, including a lack of career path, further makes the delivery of RMC complex. Given the shortage of midwives in the country, such preventable attrition would again add to the complexity of health workforce availability and quality and is a barrier to promoting RMC.

Health workforce

Both program coordinators and administrators emphasised that the shortage of staff, especially

midwives and obstetrician-gynaecologists, needs to be resolved if respectful care is to improve. Hospitals recruit obstetrician-gynaecologists on a short-term and often expensive contract basis to fill the acute shortages of these specialists, and that is draining their revenues.

A manager of one of the hospitals reported that obstetrician-gynaecologists do not want to work on a permanent basis in order to take advantage of the higher salary, sometimes more than three times the regular salary that hospitals offer on a contract basis. The more the hospitals pay for contract-based recruitment, the less likely specialists are to take full-time positions.

The shortage of professionals has created an increased workload, fatigue and negligence, unnecessary referrals, and failure to respond to women's preference of service providers. Dissatisfaction with the work climate and dysfunctional professional hierarchy, in addition to the low pay, were also identified as the key reasons for the high turnover of service providers in the hospitals.

"... It is the standard to have two providers for a labouring woman; one for the mother and one for the newborn. However, we do not practice that always since there is a shortage of workforce... this makes providers nervous at the end." (Coordinator, Hospital III)

Service providers' mindset

Service providers who participated in the intervention showed a willingness to implement practices to support RMC. These included allowing support by labour companions, allowing women to birth in their preferred position, and seeking women's consent before procedures, and reflected a level of agency amongst the staff and a commitment to quality improvement initiatives.

"... we used to provide care with force if women refused to have a procedure or an examination. After the training, there is no such practice; we provide services with consent and respect." (Service provider, post-RMC intervention FGD, Hospital II)

Yet health workers also faced entrenched interpersonal hierarchies of care that constrained RMC. Because of an intergenerational trend of hierarchical patient-provider and provider-provider relationships and the lack of awareness of the constituents of RMC, participants said they

were mistreating women intentionally and unintentionally.

"Junior professionals adopt behaviour of their seniors. The trend so far was distancing and hierarchy between different professionals and between professionals and patients; that finally leads to the designation of providers as 'bosses' who order patients what to do." (Coordinator, Hospital III)

"... there is a wrong tradition of regarding health professionals as kings among service users; 'no one can talk to them' type of thought. That resulted in some providers feeling proud of their professional status and undermining others ..." (Manager, Hospital II)

The post-intervention FGDs revealed that some providers have reservations about the feasibility of fully respecting the universal rights childbearing women should have in health facilities. Providers reported that the rights of women could not be entertained given the existing multidimensional constraints reported in this study. Additionally, providers required their rights also be defined and guaranteed.

"... in 99% of the cases, health facility management attend only to the rights of clients; they do not emphasise the rights of professionals ..." (Service provider, pre-RMC intervention FGD, Hospital I)

After the RMC training, some providers opposed the distribution of a pamphlet on The Universal Rights of Childbearing Women (Amharic version)¹⁹ that had been endorsed by the Ministry of Health. Eventually, none of these pamphlets were distributed. Participants said that women and their companions demand to exercise the rights included in the pamphlet and that providers are not able to address these due to system hardware constraints despite most rights on the declaration being related to interpersonal care.

"... for example, I had a long night assisting women, but I am not paid fairly. Is it fair to accuse me of violating women's rights? I do not think ... a lot must be done from top to bottom in responding to providers right before trying to maintain women's right." (Service provider, post-RMC intervention FGD, Hospital III)

Even after receiving the RMC training, some service providers continued to express the idea that it is acceptable to disrespect women when providers are not also respected.

Awareness of RMC

Before the RMC training, RMC was a new terminology to participants of the FGDs and IDIs; similar were “mistreatment” and “disrespect and abuse”. Participants had an awareness of what respectful care means, mostly in its interpersonal aspect, while they lacked awareness of its systemic aspects. As supported by participants of the post-intervention FGDs, short-term RMC trainings like the one implemented in this study play a key role in improving service providers’ awareness of RMC and the rights of childbearing women in health care settings.

“I am now aware that I may disrespect women in various ways. On the other hand, I have also understood that I can serve women very nicely and make them satisfied with little efforts. I have also learned what makes women displeased.” (Service provider, post-RMC intervention FGD, Hospital II)

Participants recommended that support staff who have a direct or indirect role in maternity care, including the reception at the hospital entrance gate, should also receive the training, with the justification that RMC cannot only be achieved by the care in maternity wards. A programme coordinator at the regional level outlined that there is a gap in knowledge of RMC because the existing service delivery guidelines lack content on RMC.

Discussion

Service providers’ lack of knowledge of RMC and an unconscious normalisation of disrespectful care highlights the need for tailored RMC education. Nonetheless, it is important to emphasise the non-behavioural challenges that also need to be addressed to ensure that knowledge is translated into practice. We conducted this study to outline the system constraints to the promotion of RMC in public hospitals from the perspectives of service providers and managers. The pre- and post-RMC intervention qualitative enquiries benefited this study in identifying the complex interactions between various system elements in the absence of and with the intervention. Notably, the post-RMC intervention FGDs helped to demonstrate how the interaction between various system constraints could mark the implementation of RMC recommendations.

In two other studies, we have reported on the evaluation of the RMC intervention (survey of women before and after the intervention)³⁷ and

the lessons learned through its implementation, including the enablers of RMC (mixed-methods study among service providers who participated in the intervention).³⁶ The survey of women revealed that the number of mistreatment components women experienced during childbirth in the study hospitals was reduced by 18% after the RMC intervention.³⁷ The mixed-methods study revealed that service providers’ awareness of the rights of childbearing women, perceptions and attitudes about RMC, and motivation to provide respectful care improved after the RMC intervention.³⁶

To our knowledge, this is the first study to explore the status of RMC through the theoretical lens of complex adaptive systems, which allowed us to focus both on structures and functions (processes) of the maternity care system and the interplay between these. We have synthesised the findings of this study using a causal loop diagram that shows the complex relationships between different system elements in the RMC system (Figure 1).

The interaction between system hardware and software constraints in maternity settings was complex and warrants a systems approach to improve RMC. A system constraint can affect both clinical and non-clinical maternity care components at the same time or may have spill-over from one of these components to another due to the existence of interactions between the components.⁴⁵ Similarly, an intervention component that aims at improving a system component may have a positive or negative consequence on other components. For example, weak implementation of the fee exemption for maternity care services resulted in a lack of revenue and supply shortages in the hospitals; in response, women were asked to buy supplies in direct contradiction to the policy.²⁸ Not only is this disrespectful, but it may also offset the intended aim of the fee removal, which is to improve service utilisation.^{46,47}

System hardware and software constraints challenged the implementation of RMC recommendations. For example, financial limitations in the study hospitals led to a complex relationship affecting recruitment and motivation of staff, availability of supplies, and maintenance of facilities. A study from Kenya also demonstrated that financial limitations negatively impacted service providers’ and hospital administrators’ motivation to implement hospital initiatives.⁴⁸ According to Clark, such complex problems necessitate

complex interventions (interventions that encompass different parts such as financing, supply, workforce, infrastructure, and others) but cannot be solved by behavioural interventions alone.⁴⁹ Therefore, as outlined by the WHO, implementing context-based complex interventions to improve the quality of services is instrumental in promoting RMC.⁵

Evidence reviews report that having a labour companion during labour and childbirth helps women to have a positive childbirth experience.^{50,51} In this study, service providers encountered the problem of sustaining practices of admitting labour companions and allowing cultural practices in labour wards, due to space and privacy constraints, and because an admission of companions inadvertently fed back negatively on the privacy of women. Such constraints are also critical challenges in promoting the culture of labour companionship in health facilities globally.⁵¹ These constraints also indicate that women's privacy is already in jeopardy in the absence of adequate infrastructure. Addressing these barriers plays a crucial role in promoting RMC and quality of care⁵² and contributes to the improved uptake of maternity care services.^{53,54} Furthermore, taking a contextualised and proactive approach to planning for health systems infrastructure improvement is required to improve the quality of care, mitigate the consequential and unintended impacts of innovations, and respond to the evolving needs in LMICs, including Ethiopia.^{3,49}

Women bypass lower-level health facilities, as indicated in this study, due to lack of confidence in lower facility providers, perceived low-quality of service, and fear of referral processes in case of a birth complication in lower-level facilities.⁵⁵ When this is coupled with the lack of bed capacity in hospitals, it predisposes women to mistreatment by denying them the timely and quality care they deserve. It also results in a second referral and hospitals have to deal with client overflow. A study conducted in three regions in Ethiopia reported that 86.4% of patients visited hospitals without referral, and bypassing was common among maternal and child health care seekers.⁵⁶ Similarly, a Tanzanian study also found that 44% of women bypassed primary health facilities for childbirth mainly due to concern about the quality of care at health centres.⁵⁷ It is, therefore, essential to improve the quality of maternity care services in lower-level primary health

facilities and to build communities' confidence in these facilities.⁵⁵ Without these actions, improving RMC only in hospitals means more women keep on bypassing primary facilities because of preferences for hospital-level care in the community, generating factors which impede improvement of quality of care in hospitals.

While it is appropriate that regulatory and financial control mechanisms aim at ensuring governance and reducing corruption in the health system,⁴³ they may also result in lengthy bureaucratic processes if poorly designed and/or implemented, which can lead to disrespectful behaviours among service providers.^{35,58} Nothing justifies disrespectful or abusive treatment of women, but these working conditions make it more likely. A review by Reader and Gillespie reported that such institutional causes result in normalisation of patient neglect and abuse among providers and should therefore be addressed from both behavioural and organisational interventions.⁵⁹

A noteworthy finding of this study is the importance of involving health managers in any health worker behaviour intervention. Service providers reported being demotivated as they were improving services as per the RMC training guideline. Yet, no one from the facility management recognised these efforts – a missed opportunity to keep up the enthusiasm for change. A study from Benin reported that management support and recognition of midwives and other staff was vital in sustaining positive changes gained from a humanised childbirth intervention.⁶⁰

Strengths and limitations

Exploring service providers' perspectives of applying new knowledge into practice is of paramount importance to plan for future interventions that can be applied in the real world.⁶¹ In this regard, the conduct of FGDs both before and after the RMC intervention is the main strength of this study as it profoundly helped us to have a richer understanding of how multiple interactions between various system constraints could offset the implementation of RMC recommendations and other similar quality improvement initiatives in maternity settings. Additionally, the use of complexity theory in the data analysis surpassed the depth of evidence that would be obtained by the traditional approaches of exploring single cause and effect relationships; it brought the wider picture of how various entities interact

with each other and directly or indirectly affect RMC in the real-world setting. However, this study only reflects scenarios at primary and general hospitals and may, therefore, lack the breadth to cover system constraints in referral and teaching hospitals and health centres in Ethiopia. Additionally, since the post-intervention FGDs were conducted two months following the intervention, our study is unable to explore how systems adapted further after that point. In the current study, complexity theory was applied post hoc for data analysis but did not guide the development of data collection tools; this might have limited the completeness of the data collected and the opportunity to explore alternative frames of analysis. Furthermore, participants of the post-intervention FGDs might have reported their experiences of the RMC training in a way that would please the investigator who moderated the FGDs, from social desirability bias.

Conclusions

This study identified complex health system constraints that hinder the promotion of RMC in hospitals. Although quality of maternity care embodies both clinical and interpersonal aspects of care, this study highlights that interventions aimed at improving only interpersonal or behavioural components fall short of mitigating the mistreatment of women unless they also address the system-wide constraints. As indicated in the study, there is scope for real improvement if the health system components are part of the solution to promote RMC and end the mistreatment of women. To enhance the status of maternal health in Ethiopia, we recommend the

implementation of RMC from a health system strengthening viewpoint. We also recommend future implementation research in the field of RMC to bridge the discourse between theory and practice in the local context. Finally, we believe that the findings of this study inform policies and strategies to promote RMC in Ethiopia and other LMICs.

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Résumé

Les données sur les difficultés rencontrées par le système de santé pour promouvoir des soins de maternité respectueux sont restreintes en Éthiopie et dans le monde. Cette étude a enquêté sur les obstacles du système de santé qui contrarient des soins de maternité respectueux dans trois hôpitaux du sud de l'Éthiopie. Nous avons mené une étude qualitative (sept discussions par groupe d'intérêt avec des prestataires de soins et 12 entretiens approfondis avec des agents de liaison et des gestionnaires) avant et après la mise en œuvre d'une intervention de soins de maternité respectueux. Nous avons positionné les services d'obstétrique dans le système de santé et appliqué une théorie de systèmes complexes adaptatifs pour analyser les possibilités et les limitations de la promotion de soins de maternité respectueux. Des facteurs aussi bien matériels qu'immatériels influençant la promotion de soins de maternité respectueux ont été identifiés et leur interaction était complexe. Les facteurs «matériels» comprenaient la disponibilité de lits, les infrastructures et les fournitures, le financement et le personnel de santé. Les facteurs «immatériels» englobaient l'état d'esprit des prestataires de services, la motivation du personnel et la connaissance des soins de maternité respectueux. Parmi les interactions entre ces facteurs figuraient des violations de l'intimité des femmes lors de l'admission d'accompagnants dans les salles d'accouchement. Les délais dans les remboursements après l'introduction de l'exonération des frais pour les services de maternité ont provoqué une baisse des revenus, des pénuries de fournitures et, en fin de compte, un comportement irrespectueux des prestataires. D'autres obstacles financiers, notamment le décaissement tardif de fonds insuffisants, ont aussi provoqué des interactions complexes avec la motivation du personnel et la disponibilité du personnel de santé et des fournitures, ce qui a abouti à une piètre observance des conseils sur des soins de maternité respectueux. Les interventions visant à améliorer uniquement les composantes comportementales ne suffisent pas pour atténuer les mauvais traitements subis par les femmes. Des mesures englobant l'ensemble du système sont nécessaires pour s'attaquer aux interactions complexes qui limitent les soins de maternité respectueux.

Resumen

En Etiopía y mundialmente existe evidencia limitada de los retos que enfrenta el sistema de salud para promover atención respetuosa de la maternidad (ARM). Este estudio investigó las limitaciones del sistema de salud con relación a la ARM en tres hospitales de Etiopía meridional. Realizamos un estudio cualitativo (siete discusiones en grupos focales con prestadores de servicios de ARM y 12 entrevistas a profundidad con personas focales y administradores) antes y después de la ejecución de la intervención de ARM. Posicionamos los servicios de atención durante el parto dentro del sistema de salud y aplicamos la teoría del sistema adaptativo complejo para analizar las oportunidades y limitaciones para promover ARM. Se identificaron los factores de “hardware” y “software” del sistema que influyen en la promoción de ARM, y su interacción era compleja. Los factores de “hardware” eran: disponibilidad de camas, infraestructura y suministros, financiamiento y fuerza laboral de salud. Los factores de “software” abarcaban la mentalidad de los prestadores de servicios, la motivación del personal y la conciencia de ARM. Un ejemplo de las interacciones entre estos factores era el incumplimiento de privacidad de las mujeres al admitir acompañantes del parto en las salas de parto. El reembolso retrasado después de la introducción de exención de tarifas por servicios de atención de la maternidad causó agotamiento de ingresos, escasez de suministros y comportamiento irrespetuoso entre prestadores de servicios. Otras limitaciones financieras, entre ellas la insuficiente y retrasada liberación de fondos, también propiciaron complejas interacciones con la motivación del personal y la disponibilidad de fuerza laboral y suministros, lo cual produjo incumplimiento de la orientación sobre ARM. Las intervenciones destinadas a mejorar solo los componentes conductuales no llegan a mitigar el maltrato de las mujeres. Para abordar las complejas interacciones que limitan la ARM, es necesario ejecutar intervenciones en todo el sistema.

Chapter 8: Discussion

The overarching aim of my PhD study was to identify health system factors that influence the promotion of RMC in Ethiopian public hospitals and to recommend mitigative approaches.

As part of the wider RMC intervention, I developed and implemented an RMC training manual which was the first to be implemented in the country; the manual also included a CQI component. I conducted an interventional study, employing an advanced mixed methods design to: 1) compare the changes in the level of mistreatment of women before and after the RMC intervention; 2) understand how service providers perceived the RMC training; 3) identify the challenges service providers experienced in trying to implement the RMC training manual in their hospital; and 4) explore health system constraints to the promotion of RMC.

In this chapter, I provide a summary of the key research findings, implications of the findings for future research and implementation in the field of RMC in Ethiopia and other similar settings, strengths and limitations of the study, and concluding remarks.

8.1 Summary of key findings

As described in Chapter 4, this study used an embedded mixed methods design; the two methods (quantitative and qualitative) were integrated at the design, methods, and interpretation and reporting levels. In this section, I focus on integration at the interpretation and reporting level using a narrative technique²⁷⁸ to interpret and discuss key findings of the three papers indicated in Chapters 5 - 7. Chapter 5 reported findings from the women's survey (quantitative); Chapter 6 reported findings from service providers' survey and post-RMC intervention FGDs with service providers (mixed methods); and Chapter 7 reported findings from all FGDs and IDIs with service providers, coordinators and managers (qualitative).

8.1.1 Complex constraints to respectful maternity care

The causal loop diagram developed based on the findings of this study depicts (Figure 8.1) that multiple system elements manifest complex interactions with each other to either drive or restrain RMC. Those elements may belong to system hardware or software categories and act at macro, meso, or micro levels of the health system²³⁶. The system hardware constraints to RMC were insufficient supplies, shortage of professionals, weak infrastructure, and financing limitations. The system software constraints included service providers' attitudes, inadequate support and motivation, and low awareness of RMC.

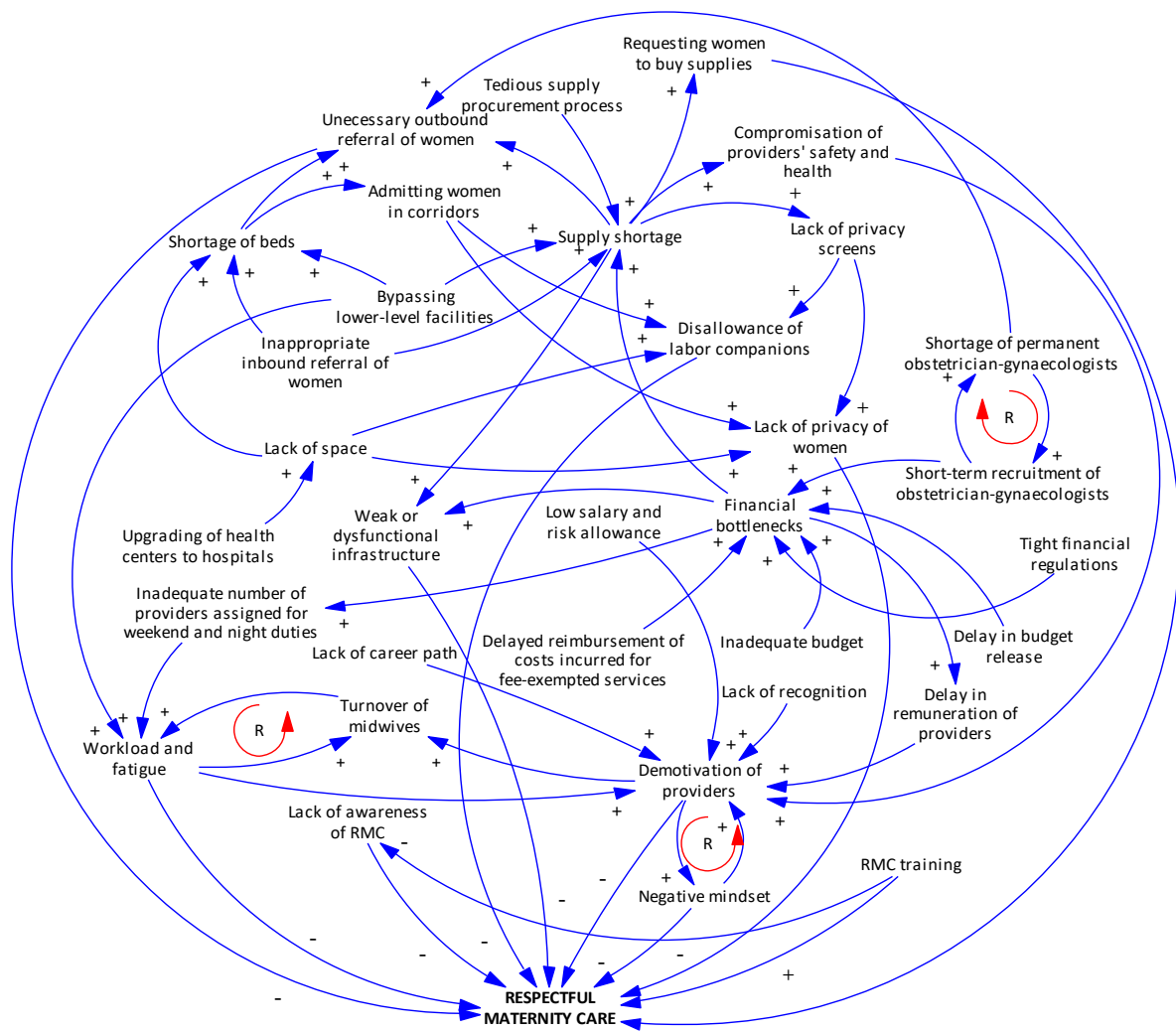


Figure 8.1 Factors influencing respectful maternity care

“+” sign on the blue arrows indicate the causing variable increases the outcome variable

“-” sign on the blue arrows indicate the causing variable reduces the outcome variable

“R” in the rotating arrows (red-coloured) indicate the variables have reinforcing effect on each other in the direction of the arrow

The study demonstrated that interventions on the interpersonal component of RMC could be hindered by dynamic and complex interactions among different system elements. Hence, addressing certain constraints would yield a short-term result—and often in a limited system boundary—but not a lasting legacy because of the continuous causality dynamics in the system^{240, 302}. In this study, several health system factors affecting the promotion of RMC exhibited complex interactions. Part of these system factors might have stemmed from entrenched adaptations to negative health system behaviours or functions (mal-adaptation) that drive resistance to change and transformation^{257, 303}.

The relative improvement in some categories of mistreatment of women after the RMC intervention while other categories remained unchanged also indicate that some components of RMC require a multidimensional health system intervention in addition to interventions solely aimed at improving the interpersonal aspect of care. For example, the proportion of women who lacked privacy during vaginal examinations remained steady despite service providers being trained about the importance of privacy. Multiple women staying in one labour or delivery room, the unfavourable consequence of allowing birth companions, and the lack of privacy screens made it cumbersome to maintain privacy.

A review of 118 strategies that were implemented in LMICs to improve service providers' practices also substantiated that combining training and supervision had a better result than training alone; a combination of strategies that targeted infrastructure in addition to training and supervision resulted in increased service providers' performance³⁰⁴. Another review that examined staff training and supervision initiatives in SSA identified that these initiatives lacked effectiveness study and that in turn has affected their potential of improving the quality of care for pregnant women and their newborns³⁰⁵. The current study addressed that limitation—lack of effectiveness study—and identified the need for system-oriented and multifaceted interventions to sustain results of the RMC interventions.

This study is the first to use a causal loop analysis to identify the pattern of interactions between various system factors that constrain the promotion of RMC in health facilities. Various contributors to the mistreatment of women during facility-based childbirth may be cautiously interpreted as barriers to the promotion of RMC; however, these lack rigour to cover the diverse set of the constraints to RMC promotion. In this regard, previous reviews by Bowser and Hill and Bradley and colleagues that identified the contributors to mistreatment fall short of depicting the pattern of relationships between the contributors and the inherent complexities that may have existed^{8, 11}. Linear thinking overlooks how different elements gear each other along the pathway to the outcome of interest—which is often unpredictable—thereby limiting the vigour of innovative ideas or interventions designed to affect the outcome^{302, 306}.

In this study, although providers claimed that the RMC training has positively influenced their attitude, findings of the post-training survey did not reveal significant difference from the baseline. Service providers required other structural issues such as availability of essential supplies and sufficient human resources, adequate pay and motivation, and clear career pathways in order to promote RMC. Current evidence³⁰⁷ and other multi-component intervention studies from Kenya¹⁶³ and Tanzania^{157, 308, 309} also suggest that non-behavioural and system-oriented interventions are required alongside staff training to bring a sustained change in RMC behaviour.

A recent behavioural study from Zambia reported that there was an ingrained behavioural resistance among service providers to provide RMC³¹⁰. Service providers believed that: they are doing what they are supposed to do; there is no mistreatment or it is normalised; if women reject emergency procedures, there would be severe complications that may result in maternal or infant deaths; and entertaining women's rights harms service providers' reputation and their power in clinical decision making. The authors believed that these behavioural barriers could be mitigated by improving the way providers provide care through onsite training, feedback and supervision³¹⁰. This PhD study challenges the authors'

perspectives and pinpoints that there are diverse health system constituents in the maternity care system which may offset the impacts of these recommendations. For example, financial constraints, supply and infrastructure challenges, and inadequate facility-level management support were some of the factors that affected adoption of positive behaviour among staff.

However, the behavioural resistance exhibited in the Zambia's study might have also been the case in the current study. Four of the eight perception assessment questions (it is sometimes necessary for health service providers to yell at a woman during labour; it is sometimes necessary for health service providers to slap a woman during labour; it is not necessary to ask for verbal consent from a labouring woman before conducting a vaginal examination; and Ethiopian women do not want to have a companion of their choice with them when they give birth) were directly related to attitudes and did not require immediate intervenable actions after the training. Such behavioural resistance originates from complex demotivators that closely interact with the mindset of individuals (Figure 8.1). An intervention study from Nepal that aimed to improve the attitude of midwives also indicated that training did not result in required behaviour change as several health system factors were at play; the authors reported that behaviour change required a continuum of interpersonal and structural interventions in their context³¹¹. Two systematic reviews have also identified that normalised organisational cultures and unequal power dynamics in health systems as a source of resistance to behaviour change initiatives^{172, 312}

Another key finding of this study is that just 15% of women who wanted to have a birth companion were able to exercise that choice (11.6% in pre-intervention vs 23.5% in post-intervention group). Additionally, 16.7% (14% in pre-intervention vs 23.5% in post-intervention group) of women who would have wanted to have a companion were too afraid to ask service providers to have one. This suggests that women do not know their rights in health facilities or service providers do not encourage women to express their preferences and concerns or ask questions. After the RMC training, service providers resisted the plan to provide a pamphlet on the universal declaration of childbearing women, including the right to

companionship, to all women attending ANC and childbirth services. Service providers stated that the rights included in the pamphlet overpromise what they (service providers) or their facilities cannot provide in light of the reality on the ground. Accordingly, service providers recommended adequate preparation before distributing the pamphlets.

As depicted in Figure 8.1, conditions that resulted in the disallowance of birth companions stem from various system elements which have complex relationships. Therefore, the introduction of birth companions would benefit from adequate preparation and system-oriented decisions that foster political commitment, high-level advocacy, and institutionalisation of guidelines³¹³. Mitigating these constraints would promote the practice of birth companionship which contributes enormously to women's positive childbirth experience^{314, 315}, and improved uptake^{312, 316} and quality of facility-based childbirth services³¹⁷. Moreover, addressing these constraints not only promotes respect, it also addresses the third delay, 'delay in receiving adequate care at the facility' and makes a measurable contribution to reducing preventable maternal deaths³¹⁸.

Generally, positioning service providers central to the promotion of RMC, it appears that there are a multitude of factors that affect their potential role in promoting RMC. Accordingly, a pragmatic approach to HSS would lead to a resultant improvement of system-wide components, thereby creating a fertile ground for service providers to promote RMC.

8.1.2 High level of mistreatment during childbirth

Given the diverse health system constraints to the promotion of RMC discussed in Section 8.1.1, it was not surprising to find a high level of mistreatment of women during childbirth in the study hospitals. Almost all women of both pre- and post-intervention groups experienced at least one type of mistreatment, the most common being lack of information, privacy and confidentiality (pre-intervention = 95.5%, post-intervention = 95.8%). One-sixth (16.7%) of women were beaten, slapped, kicked, pinched, gagged, or restrained during childbirth in hospitals before the intervention (8.9% after the intervention; $p=0.02$). More than one-fifth

(21.9%) of service providers have also witnessed fellow providers committing either of these practices in their hospitals in the month preceding the survey.

As detailed in Section 2.4.5, comparison of the prevalence measures of mistreatment across different settings is challenging due to the lack of standard measurement approaches both in terms of content and process. However, it is possible to conclude that the level of mistreatment reported in this study is higher than two comparable studies from other parts of Ethiopia which reported a mistreatment level of 74% and 78%^{12, 14}. The measurement approach used in this study—counting the number of mistreatment components a woman experienced—and the breadth of the 25 mistreatment components might have led to such high prevalence. Along with the growing research and implementation on RMC globally, I believe the measurement approach used in this study will contribute towards a standardised measurement approach that can be contextualised for local settings.

In multi-ethnic and multi-cultural countries like Ethiopia, identifying what constitutes mistreatment and what women need requires mapping of existing evidence and engaging the community and local experts to contextualise mistreatment measurement approaches^{193, 319}. Failure to identify what women value in a given context may lead to mistreatment of women and cast a shadow on the robustness of person-centred maternity care, the cornerstone of RMC^{319, 320}. For example, in this study, 26.6% of service providers perceived that Ethiopian women do not want to have a birth companion during labour in health facilities. However, 31.1% of women participants reported that they wanted to have a birth companion of their choice. When this misperception compounds the other identified health system constraints, service providers are highly likely to overlook favourable opportunities to allow birth companions.

Another striking finding of this study was women who had a complication during childbirth had 16% higher levels of mistreatment compared to their counterparts. In further analysis of the mistreatment categories, I identified that the major difference exists in the verbal abuse

category; 11% of those who had childbirth complication were verbally abused, 5.2% among those who did not have childbirth complication ($p=0.04$). Service providers explained that they commit verbal abuse in order to get women's compliance with instructed procedures or examinations and save the baby; a study from rural Kenya noted similar intent of verbal abuse, especially against first-time mothers³²¹.

An Indian study also revealed that the level of mistreatment during childbirth was higher among women who had complications during childbirth, especially obstructed labour³²². The stress service providers experience when they are faced with complications that they may not be able to manage may result in a higher likelihood of yelling³²³. Verbal abuse of women with complications—often due to poor progress of labour—is not only the violation of women's rights, it also contradicts the tenets of clinical equity that rationalise women with complications deserve increased attention and care³²⁴. Additionally, verbal abuse is a deleterious behaviour that operates synergistically with the complication women experience, increasing the likelihood of postpartum depression⁷.

8.1.3 Potential efficacy of the respectful maternity care intervention

The multilevel mixed-effects analysis revealed that the counts of mistreatment components (a score from 25) women experienced during childbirth reduced by 18% after the RMC intervention (95%CI: 9% - 26%). This indicates that there are RMC components that improved after the intervention, especially consented care. Favourable changes were also observed in regard to physical abuse and attending to women's preferences. The proportion of women who experienced non-consented care decreased from 83.3% to 65.3% ($p<0.001$). Similarly, a before and after study from a teaching hospital in Hawassa which involved a two-day training on surgical informed consent reported that the number of informed consent components received by women who underwent caesarean section increased by 16%²⁹⁸. It implies that it is possible to enhance consented care with little or no involvement of system hardware actions.

Studies that implemented multicomponent RMC interventions in Kenya and Tanzania also reported lower levels of mistreatment of women after RMC interventions, 7% and 66% respectively^{163, 308}. However, it is methodologically inappropriate to compare the effect size with the current study because of the scope and ownership of the interventions, mistreatment measurement approaches, and model of analysis, from many others. As outlined in Section 2.4.5, substantial differences in the measurement approaches of mistreatment pose a drawback in comparison of prevalence measures and effect size mainly due to the inherent limitations of the methods used¹⁰. That is why now is the time to develop and agree on a standard measurement approach that can be contextualised across settings to lay the ground for future meta-analyses of the effectiveness of RMC interventions; better late than too late.

Table 8.1 summarises the key differences between the current study and the Kenyan and Tanzanian studies. The method used in the Kenyan study might be prone to the normalisation of mistreatment because women were just asked whether they were mistreated or not instead of objectively identifying mistreatment using verifiable indicators. This in turn might have limited the capacity to identify mistreatment components that have changed after the intervention but were not recognised by women; see Figure 2.9. With regards to the Tanzanian study, the questions included in the mistreatment measurement lacked breadth to include issues including access to birth companions and privacy during vaginal examination in labour rooms. These two issues are less likely to change after an intervention that lacks significant structural and process-related modifications. Excluding these issues from the measurement questionnaire would lead to an overestimation of the effect size which may have been very low otherwise.

Table 8.1 The effects of respectful maternity care interventions in three sub-Saharan countries

Country (Evaluation year)	Intervention component	Duration of intervention	Mistreatment measurement approach	Follow-up period	Change in mistreatment
Kenya ¹⁶³ (Abuya et al., 2014)	• Policy dialogue • RMC workshop • Community dialogue • Maternity open days • Quality improvement support	14 - 34 months	Exit survey of women in health facilities • Self-reported feeling of humiliation • Women who reported except “5” to a Likert scale question (Were you treated in a way that made you feel humiliated or disrespected?) with scores 1-5 were considered as disrespected and abused Outcome variable: dichotomous (Yes or No) Method of ascertainment analysis: Generalized linear mixed model	Two months	7% absolute reduction
Tanzania ³⁰⁸ (Kujawski et al., 2015)	• Introduction of client service charter • Facility-based quality improvement process	11 months (Intervention was being managed independently by facility managers and regional focal persons, which means the project was still operating)	Exit survey of women in health facilities • Self-reported experience of D&A • Women who responded “yes” to any of 14 questions designed to assess D&A Outcome variable: dichotomous (Yes or No) Method of ascertainment analysis: Multivariate logistic regression	Ten months	66% reduction in the likelihood of mistreatment
Ethiopia (Current study, 2018)	• RMC workshop • Placement of wall posters • Facility-based quality improvement support	Five months	Exit survey of women in health facilities • Counts of mistreatment experiences was done. Women were asked if they have experienced any of 25 mistreatment components Outcome variable: count (a score from 25) Method of ascertainment analysis: Multilevel mixed-effects Poisson regression	Two months	18% reduction in the counts of mistreatment types women experienced

Applying conservative mistreatment measurement indicators and approaches contributes to giving equal weights to the different facets of the mistreatment of women in health facilities. In this study, comparing the counts of mistreatment components women experienced helped to identify not only the magnitude but also the severity of mistreatment. In other words, having an equal proportion of women who experienced at least one form of mistreatment before and after an intervention does not necessarily mean the intervention did not work. One should also investigate the number of mistreatment components women experience and how that changed after an intervention. Thus, the extent or diversity of mistreatment that would not have been possible to identify by simple prevalence measures was picked up by the method used in the current study. For example, in this study, almost all women have experienced at least one form of mistreatment both in the pre- and post-intervention groups (99.5% vs 99%, respectively). However, the mean count of mistreatment experienced by women reduced from 4.9 in the pre-intervention to 3.9 in the post-intervention groups. Likewise, the proportion of women who reported to have been physically restrained reduced from 9.6% to 4.7% ($p=0.06$).

Generally, in comparison with the Kenyan and Tanzanian studies, the intervention used in this study is associated with a commendable change in the level of mistreatment given the relatively lower intensity of intervention. However, there is also a chance that the shorter follow-up period might have contributed to an increased effect size as compared to the Kenyan study. In the Tanzanian study, the authors claimed that the follow-up period was ten months; however, it was highly likely that the health facilities performed to please the funders because they knew the project lifetime was still active until the endline survey. The commonly shared limitation of all studies is that they lacked control groups and the pre- and post-intervention measurements were not matched, which are major drawbacks to approximate estimates of effect sizes of the interventions.

8.2 Implications of the findings for improving respectful maternity care in Ethiopia and other LMICs

8.2.1 Mitigating respectful maternity care challenges from the perspectives of health system strengthening

From the findings of this PhD study, instilling the culture of RMC into the maternity care system and beyond depends on several health system components that exhibit complex interactions. Therefore, addressing both the health system bottlenecks that drive disrespectful behaviour among service providers, and the health system constraints that limit RMC require evidence-driven actions. Based on my experience of the intervention to promote RMC used in this study and the multilayered and complex health systems factors identified, I recognised that the conceptual framework used in this study (Figure 4.1) cannot fully demonstrate the level and types of system-oriented actions that are needed to promote RMC. The health system constraints identified in this study can be categorised into micro-, meso-, and macro-level challenges and these have been conceptualised in Figure 8.2.

Figure 8.2 also presents the synthesis of the health system constraints to the promotion of RMC identified by the current study along with other RMC interventions reported from Ethiopia²³¹, Kenya¹⁶³, and Tanzania^{157, 308} and evidence from other quality of midwifery care research and implementation. Given the interpersonal and system-level nature of RMC and the wide array of drivers of mistreatment⁸, it is commendable to implement bottom-up and top-down HSS.

In this study, more than 81% of the RMC intervention recipients were midwives given the maternity setting of the intervention. Thus, midwife-focused targeted interventions in the move to promoting RMC would be critical. A Lancet Midwifery series paper (Renfrew et al.,) identified that midwifery contributes substantially to improve the quality of maternal and newborn care, including respectful care³²⁵. Strengthening the education, licensing, and regulation of midwifery practice along with health system-level actions were identified as

core drivers to success in that regard³²⁵. Therefore, leveraging endeavours aimed at integrating respectful care standards from the perspectives of high-quality care in midwifery education, licensure, and regulation in Ethiopia and other low-income settings would be an excellent opportunity to promote RMC and quality of care, improve maternal health, and meet the maternal health targets of the SDGs³²⁶⁻³²⁸.

Establishing a functioning system that attends to midwives' voices—what midwives want and the challenges they experience in providing quality maternal and newborn care—is of critical importance to timely intervene actions that would positively influence midwives behaviour³²⁷.

COM-B behaviour change wheel model, a model that was developed upon review of other behaviour change frameworks, helps to understand what components interact and affect the adoption of new behaviour among intervention recipients. According to the model, a behavioural intervention may change behaviour of its recipients by focusing on one or a combination of following three dimensions—capability, opportunity, and motivation.

However, the intervention implemented in this study lacked breadth to span all these components to bring a profound respectful behaviour change. Although, the COM-B model was not applied in this study to exhaustively identify what affected service providers' adoption of respectful care behaviour, the various system hardware and software constraints that were identified in this study affected the capability and motivation of service providers and the existence of physical opportunity to promote RMC³²⁹. Therefore, future research on RMC interventions could consider how to ensure theoretical coverage across the three dimensions of the COM-B model.

Provided the important role of respect and preservation of dignity domain in the WHO's quality of care framework²⁶ and its interrelationships with the other seven domains, promoting RMC using a broader quality of care approach is believed to address the various dimensions of the COM-B behaviour change framework. According to a systematic review that was conducted to map barriers to the provision of quality midwifery care in LMICs, meso- and macro-level intervention designs aimed at improving the quality of midwifery care

should take into account sociocultural (gender roles, feminisation of midwifery profession, and ascribing care at birth as women's work), economic (wages, accommodation, and investment in healthcare), and professional (investment in education, regulation, and professional autonomy) factors to bring a sustainable behaviour change (Figure 8.2) ³³⁰.

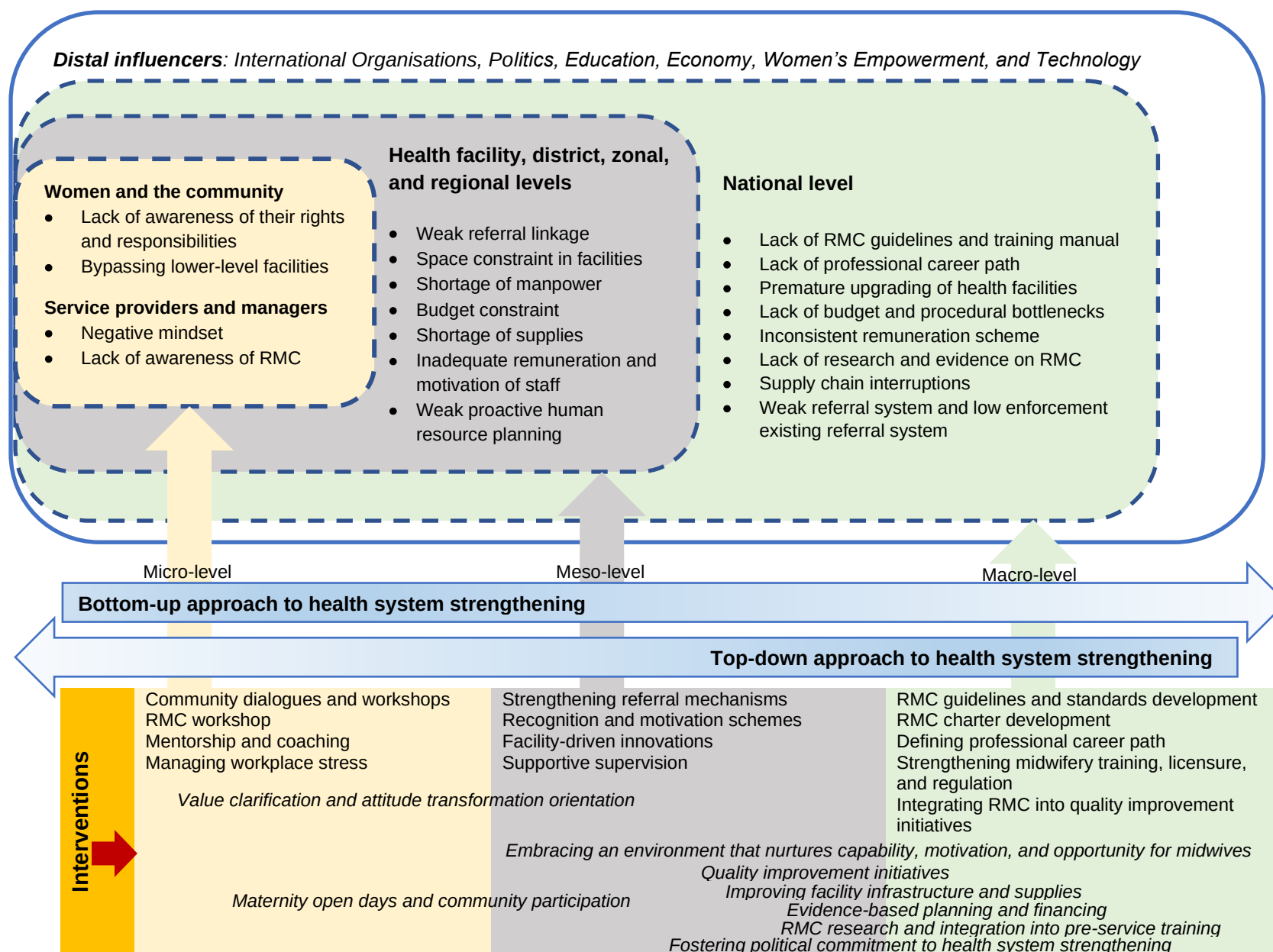


Figure 8.2 Health system strengthening approaches to the promotion of respectful maternity care (Author derived)

8.2.2 Implications for future research on respectful maternity care

Given the sparse evidence on health system constraints to RMC and the effectiveness of RMC interventions in Ethiopia and globally⁴, this study has contributed to the knowledge base to promote RMC, especially in LMICs. The findings from the study suggest that there are complex dynamics in the broader health system that influence the respectfulness of childbirth services in health facilities. In that regard, understanding the health system challenges that span beyond health facilities and affect the courteous and respectfulness of care specifically, and the quality of childbirth services generally is crucial. Drawing from the lessons learned and evidence generated in this study, the following research priorities should be considered to establish a solid foundation in RMC research and implementation.

8.2.2.1 Implementation research on respectful maternity care and embedding research into quality improvement initiatives

The complexities of the health system constraints to the promotion of RMC identified by this PhD study indicate that these constraints extend to the broader health system in Ethiopia warranting a more rigorous and comprehensive health system analysis. As the current study included only primary and general hospitals, it is limited in revealing the contexts at lower-level (health centres) and higher-level (referral and specialised hospitals) health facilities and their corresponding administration system. Therefore, conducting implementation research involving a medium-scale prototype RMC intervention that spans all levels of health facilities is instrumental in yielding empirical evidence to scale-up RMC interventions nationally. As such, from the angle of HPSR, conducting implementation research that include multidimensional system hardware and software interventions is imperative to the formulation of evidence-based programs, strategies, and policy decisions to nurture respectful health system²⁴². Including private health facilities that provide childbirth services also helps to examine whether the level of RMC in these facilities is optimal, better than or so compared with public health facilities.

Additionally, embedding research into various quality improvement initiatives¹²⁹ in maternity care settings in the country would be an excellent opportunity to contribute to knowledge production that can be applied in the local context³³¹. Embedded implementation research has dual benefits both for researchers and implementers because it allows the free flow of knowledge in two directions—from researchers to implementers and from implementers to researchers—improving the robustness of knowledge produced³³².

Moreover, examining how the national Compassionate, Respectful and Caring Health Workforce initiative is being implemented using the lens of health system is integral in two facets; it allows to draw lessons from how interventions only aimed at instilling the culture of respect among healthcare workers is regarded by frontline healthcare workers. Secondly, it helps to identify the gaps in the implementation of the initiative that may span the scope of policymakers, decision-makers, and frontline healthcare workers. Accordingly, lessons drawn can be contextualised for maternity care settings and used in future RMC promotion endeavours.

Implementation research helps to understand how to successfully deliver health interventions, including interventions for which there is adequate proven efficacy²⁶². To improve the robustness of implementation research in the field of RMC specifically, and quality of maternity care generally, scholars should consider and exhaustively incorporate the ten domains of successful implementation research suggested by the ImpRes framework namely: implementation research characteristics, implementation theories, frameworks and models, determinants of implementation, implementation strategies, service and patient outcomes, implementation outcomes, economic evaluation, stakeholder involvement and engagement, patient and public involvement and engagement, and unintended consequences²⁶³. Thus, future implementation research on RMC could consider addressing the various domains of implementation research to strengthen existing knowledge base in the field of RMC.

8.2.2.2 Expanding research on respectful care to the continuum of maternal and newborn care

As depicted throughout this thesis, although sparse, current development of implementations of RMC are entirely limited to the care around the time of childbirth. However, existing evidence shows that mistreatment against women and their newborns, and families also happens during antepartum and postpartum care in health facilities^{333, 334}. Women's experiences of mistreatment during facility-based antepartum care casts a dark shadow on the probability of these women remaining in the ANC continuum and having their childbirth in health facilities³³⁵. Similarly, the mistreatment of women and newborns during the postpartum period also poses far-reaching adverse consequences on the uptake of other newborn, maternal, sexual and reproductive health services³³³.

Exploring the nature of mistreatment that happens in antepartum and postpartum care settings would help to devise a pragmatic mitigation strategy which can be aligned with RMC initiatives in intrapartum settings. Likewise, examining the effect of RMC interventions in intrapartum settings to the uptake of future antepartum, newborn, and postpartum services may give a clue to its long-term return and the opportunity for expanding the scope of RMC that could span the MCH continuum of care.

Another significant action would be examining health system constraints to the provision of ANC for a positive pregnancy experience at all levels of health facilities in Ethiopia. In light with the huge drop out of women from maternal care continuum^{31, 42}, exploring on how to improving women's positive experiences of ANC throughout their pregnancy would contribute to the evidence base in the field to retain women throughout the care in the time of pregnancy, childbirth, and thereafter.

8.2.2.3 Building local research capacity on respectful maternity care

RMC includes respecting women's non-harmful cultural preferences and practices. Researchers equipped with local and cultural understanding are well-posed to delve into

the cultural fabrics of their community to explore and address cultural barriers to the utilisation of maternal health services³¹⁶. However, as it is with other health and health-related research, research on maternal health services—including RMC—is largely led by international researchers who often lack in-depth knowledge and understanding of local cultures; local researchers often play ancillary roles when involved^{336, 337}. Therefore, working towards narrowing such inequity not only builds local research capacity, it also contributes towards building strong evidence which can be translated into practice. In accordance with Abimbola's (2019) "gaze-pose matrix", leveraging the ideal matrix (a local pose for a local gaze) would accelerate knowledge translation for the betterment of RMC at local levels³³⁸. With such a mindset, improving local and international funding and collaboration for implementation research on RMC would be commendable to design, test, and scale-up high-yield interventions.

Furthermore, the diverse culture and practice of multiculturalism, especially in the SNNPR, implies that there is a long path ahead to explore what women want during childbirth and what matters to them in order to generate evidence for the design of culturally-appropriate maternity care³¹². This again affirms the need for building equitable research capacity in the country to fill the existential evidence gap to promote culturally sensitive childbirth services. Therefore, future collaborative studies that delve into the culture, values, and norms of women and their communities are warranted, and it is preferable if these studies involve researchers sharing the same culture with that of the communities under study.

8.2.3 Implications for integrating respectful maternity care into pre-service training curriculum

This study revealed that knowledge of RMC and the rights of childbearing women was suboptimal among service providers who claimed that they have never been oriented or taught about respectful care in their pre-service academic curricula. Additionally, the intergenerational trend of power dynamics between providers and clients and between providers themselves in clinical teaching environments has contributed to a negative

mindset among graduates. To mitigate this, finding innovative ways to integrate the core concepts of RMC and the rights of childbearing women into the formal training curricula of healthcare professions education immensely contributes to positively influencing the behaviour of students and their mentors as well³³⁹.

Cognizant of the wide array of health workforce production in Ethiopia, steering the integration of RMC into pre-service education requires mapping public and private healthcare professional education institutions and their regulatory system. As such, an intersectoral collaboration between the education and the health sectors would hasten the process. Furthermore, making RMC one of the accreditation requirements of healthcare professionals would also contribute to promoting the culture of respect in maternity care settings and beyond³⁴⁰. Engaging professional associations and student representatives in the process would also help in strengthening ethical practice, respectfulness, and accountability in the pre-service training system and thereafter²⁵⁰.

8.3 Limitations of the study

This study benefited from the use of mixed methods design that involved: an intervention package; women, service providers, service coordinators and administrators, and program managers as participants; ordered approaches of quantitative and qualitative studies before and after the intervention; and the application of complex adaptive systems theory to understand health system constraints to RMC and lessons learned during the trajectory of the small-scale RMC intervention. However, the study has several limitations, as described below.

8.3.1 Robustness to identify complexities of respectful maternity care constraints

The qualitative methods that explored health system constraints to the promotion of RMC in the study hospitals did not involve participants from the Ministry of Health and other non-governmental partner organisations providing technical support across the health system. This might have failed to exhaustively identify and map the complexities of health system

constraints to RMC promotion, especially those related to strategic and policy level issues. For example, including participants from the Ministry would have provided a better understanding of the complexities in why hospitals do not get a timely release of funds for maternal health services fee waiver. Additionally, the application of complexity theory post hoc for analysis of the qualitative data means that the theory did not guide the data collection tools (question guides) development, thereby limiting the richness of the tools to reveal complexities.

Embedding gender frameworks to examine power dynamics helps to improve the robustness of health system research design, implementation, and analysis which would later be applied for sound strategies³⁴¹. However, in this study, although I have explored the interrelationship between power dynamics and RMC and disaggregated quantitative data by sex, I did not apply a gender framework during the design and analysis of the qualitative methods. In all study hospitals, male managers assumed all chief executive officer and medical director positions. In light of that, the application of a gender framework would have generated more relevant information on how gender dynamics might have affected RMC in the complexity model than the gender-based power dynamics and hierarchical relationships identified in the study.

8.3.2 Limited span, early engagement, and duration of the intervention

Dynamic properties in response to system-wide interventions are likely to tell the system's readiness to adopt a new behaviour or change in the immediate post intervention period with the complexities being revealed later. With this regard, the RMC intervention's lack of breadth to cover the various health system building blocks poses a limitation in understanding how the maternity care system responds to multidimensional approaches. Additionally, the RMC intervention was an externally driven initiative for the hospitals because they were not involved from its very inception. This might have led to poor ownership among facility managers which in turn affects the degree of support provided for service providers during implementation, masking the real potential of the intervention.

Lastly, the short period of the intervention might not have been sufficient for the maternity care system to self-organise in response to the intervention again limiting the study's potential to depict dynamic system behaviour after the RMC training.

8.3.3 Lack of comparison group

Close to reality estimation of the attribution of the level of the mistreatment of women and attitude of service providers to the RMC intervention could not be achieved because of the lack of comparison groups (hospitals which did not receive the intervention) and randomisation of participants. Additionally, the before and after survey of women was limited in estimating the difference of mistreatment before and after the RMC intervention because it surveyed a different set of women before and after the intervention. Although I used multilevel mixed-effects Poisson regression to account for random and fixed variables, this analysis method cannot fully account for inherent limitations of having a different set of participants before and after the intervention.

8.3.4 Generalisability

The three study hospitals and their corresponding administration system may not be representative to other health facilities, including health centres, in SNNPR particularly and in Ethiopia generally. Referral hospitals and comprehensive specialised hospitals, often teaching hospitals receiving funds from and are under the mandate of the Ministry of Higher Education, have different management and governance structure. Accordingly, the system hardware and software entities that interplay in the RMC system of these higher-level hospitals are believed to be more complex and dynamic. Additionally, the current study only included public hospitals and does not show the real status of RMC and its constraints in private or for non-profit hospitals that provide childbirth services. Therefore, the health system constraints revealed in this study may not be generalisable to health centres, other public hospitals of different levels, private hospitals, and for non-profit hospitals in Ethiopia.

8.3.5 Follow-up period

The period between the intervention of this study and the post-intervention studies (three months) is short and that has limited the study's capacity to adequately address issues related to: how the maternity care system adapts or self-organises to the intervention; new system behaviour which might manifest afterwards; and whether the changes observed with the mistreatment of women last longer or not or whether or not the RMC promotion initiatives continue or not.

8.3.6 Desirability bias

As indicated in Section 4.7.5, this PhD study required my prolonged engagement with both managers and service providers to coordinate the RMC intervention and facilitate the FGDs and IDIs, contributing to rigour of the study and credibility of the findings. It also contributed to maintaining collaborative and open relationships with managers and service providers to understand the reality on the ground and adapt the RMC intervention accordingly. However, my role in facilitating the post-intervention FGDs might have led to service providers reporting their experiences of the RMC training differently in a way that would please me—social desirability bias.

Despite all these limitations, this study significantly contributes to the emerging knowledge base on RMC in Ethiopia and globally. Most importantly, it provides relevant evidence on how RMC should be approached from a health system perspective provided the fact that training of service providers is not adequate or is the panacea for the elimination of the mistreatment of women during facility-based childbirth. Lastly, the current study highlights on actions to be taken into consideration during the design and implementation of similar implementation studies.

8.4 Conclusion

Globally, despite the lack of standardised measurement approach, there is a growing recognition of the high-level of mistreatment of women during facility-based childbirth,

especially in low-income settings. The mistreatment of women not only discourages women from having facility-based childbirth, it also denies their right to positive childbirth experience. However, evidence on health system constraints to RMC and the effectiveness of RMC interventions in mitigating the mistreatment of women is limited. This PhD study is ground-breaking research to investigate RMC from the standpoint of health systems research using the lens of complex adaptive systems theory.

The dynamics of health system constraints to the promotion of RMC this study has identified contribute to the body of knowledge that could be used for evidence-informed strategies and implementations to improve the quality of maternity care generally and RMC specifically.

The findings substantiate the evidence that maternity care should be approached from a system-oriented perspective to bring a sustainable and lasting contribution. Additionally, the lessons learned through the implementation of the piloted RMC intervention, mainly the RMC training, are believed to play a significant role in future implementation studies aimed at scaling up a standalone or integrated pre-service or in-service RMC training in Ethiopia.

The diverse manifestations and high prevalence of the mistreatment of women revealed by this study are not surprising given the lack of awareness among service providers, the normalisation of mistreatment behaviours, and complex system hardware and system software constraints in the study setting. RMC training has proven to be useful in improving the interpersonal aspect of respectful care while falling short of addressing the structural dimensions of care. The complex interactions between the various system elements in the maternity care system, which resulted in the poor status of RMC translates into the need for a broad spectrum and system-oriented RMC promotion approaches. There is a long journey ahead if the mistreatment of women in health facilities is to be eliminated in Ethiopia.

Improving maternal health from a rights-based and a HSS approach is exercising leadership up to the expectations of women's rights to live and enjoy quality, culturally sensitive, and respectful health services. To hasten the ever-prevailing maternal health inequities globally

and nationally, acting on the missing link—RMC—is not too late to meet the SDG target of reducing maternal mortality and promote UHC. Moreover, promoting respect at interpersonal and health system levels attract more women to health facilities, improves their childbirth experiences, and mitigate preventable deaths. RMC is not only about dealing with “women’s issues”; it is also about creating healthier families, communities, and nations.

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Appendices

Appendix A: Commentary - Unveiling respectful maternity care as a way to address global inequities in maternal health

Unveiling respectful maternity care as a way to address global inequities in maternal health

Anteneh Asefa ^{1,2}

The WHO describes respectful maternity care (RMC) as “the care organised for and provided to all women in a manner that maintains their dignity, privacy and confidentiality, ensures freedom from harm and mistreatment, and enables informed choice and continuous support during labour and childbirth”.¹

The components of respectful care mentioned in the definition above focus on the interpersonal relationships in the woman–provider dyad. Nonetheless, they have their foundations on a robust health system, and respectful care cannot be realised in the absence of a well-functioning health system.

In this commentary, I will focus on the potential of promoting RMC—from the perspectives of health system strengthening—in bridging the gap in maternal health inequity. I use evidence from Ethiopia to elaborate the cases where necessary and share my thoughts on the way forward to promote RMC, especially in low-income settings.

Maternal mortality has declined worldwide, with an impressive 45.2% reduction between 1990 and 2017.² However, there is a staggering divide between low- and middle-income countries (LMICs) and high-income countries, the former accounting for 99% of global maternal deaths in 2017. Sub-Saharan Africa is home to 66% of the global maternal deaths in the same year.² Additionally, the majority of maternal deaths occur in countries whose health systems are inadequately financed, leading to poor availability, accessibility, quality, and thereby low utilisation of life-saving maternal health services.² In the positive side, in low-income countries, increase in maternal health investment significantly contributes to the reduction of maternal mortality;³ this warrants the existence of a window of opportunity to improve maternal health if there is a strong political commitment.

Summary box

- ▶ Promoting respect at interpersonal and health system levels attract more women to health facilities, improves their childbirth experiences and mitigate preventable deaths, thereby bridging maternal health inequities.
- ▶ Addressing maternal mortality from a rights-based approach is exercising leadership up to the expectations of women's rights to live and enjoy quality, culturally sensitive and respectful health services.
- ▶ The scale of respectful maternity care extends beyond the interpersonal facets of care in health facilities and spans meso-level and macro-level health system elements.
- ▶ Respectful maternity care has its foundations on a robust health system, and you cannot have respectful care in the absence of a well-functioning health system.

The high maternal mortality in LMICs also indicates the existential gap in meeting women's right to freedom of choice and access to a well-functioning health system.⁴ In sub-Saharan Africa, constellations of rights-related individual and systems-level factors, including the mistreatment of women, act as powerful barriers to the utilisation of life-saving maternal health services.^{5 6} Despite being a growing body of scholarship, studies from Ethiopia and globally have shown a worrisome occurrence and manifestations of the mistreatment of childbearing women in health facilities.^{7–10}

Scholars suggest framing maternal mortality from the perspective of fundamental human rights to foster accountability in the move to ending preventable maternal deaths.^{11 12} Eventually, the human rights approach to maternal health marked the juncture of RMC as the Universal Rights of Childbearing Women which evolved under the leadership of the White Ribbon Alliance.¹³ WHO's Strategies Toward Ending Preventable Maternal Mortality that were introduced

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in 2015 calls for health systems not to neglect RMC while endeavouring to deliver effective clinical interventions.¹⁴

RMC FROM THE PERSPECTIVES OF PEOPLE-CENTRED HEALTHCARE

Meeting people's legitimate right to and expectations for equitable and respectful care, including respecting social preferences, is the cornerstone of people-centred healthcare.^{15 16} Through the lens of people-centred care, RMC is not only a human rights issue, it is also an issue of gender equity.¹⁷ On the 69th World Health Assembly, the executive board passed a resolution to integrate the concept of people-centred health services into health systems, which has amplified the focus given to RMC.¹⁶ In a panorama, the scale of RMC extends beyond the interpersonal facets of care in health facilities and spans meso-level and macro-level health system elements. Likewise, mistreatment or the failure to provide RMC do not predominantly originate from health professionals' behaviour but from health system constraints, where actions need to be concerted.^{7 18}

HOW CAN RMC BE PROMOTED?

Globally, there is a dearth of evidence on the efficacy of RMC interventions and innovative approaches that can mitigate these constraints and thereby lessen the mistreatment of childbearing women in health facilities.

Here, I am largely drawing from an implementation research from Ethiopia that explored health system

constraints to the promotion of RMC in public hospitals and tested a multicomponent intervention (staff training, placement of wall posters and post-training onsite support for quality improvement) that was designed to promote RMC.^{18–20} The study used an interventional mixed methods design that included surveys of both women and service providers before and after the intervention, focus group discussions with service providers before and after the intervention and in-depth interviews with key informants before the intervention. Based on the findings of the study and other implementation studies from Kenya, Nigeria and Tanzania,^{21–23} I have synthesised approaches to the promotion of RMC (figure 1). In the figure 1, identified barriers to the promotion of RMC in Ethiopian hospitals are organised across micro-level, meso-level and macro-levels of the health system.

Likewise, interventions that were tested to promote RMC in various settings globally are also categorised under their respective health system level, some having the potential to operate in more than one level. Interventions at the individual (women, communities and service providers) level largely focus on behavioural interventions while meso-level interventions target filling gaps at lower and middle-level facilities; macro-level actions concentrate on policies, strategies and guidelines to improve the operation of health systems.

Given the complex relationships between different elements described in figure 1,¹⁸ RMC interventions targeting a specific component cannot have a lasting effect. In lieu, system-oriented and multidimensional

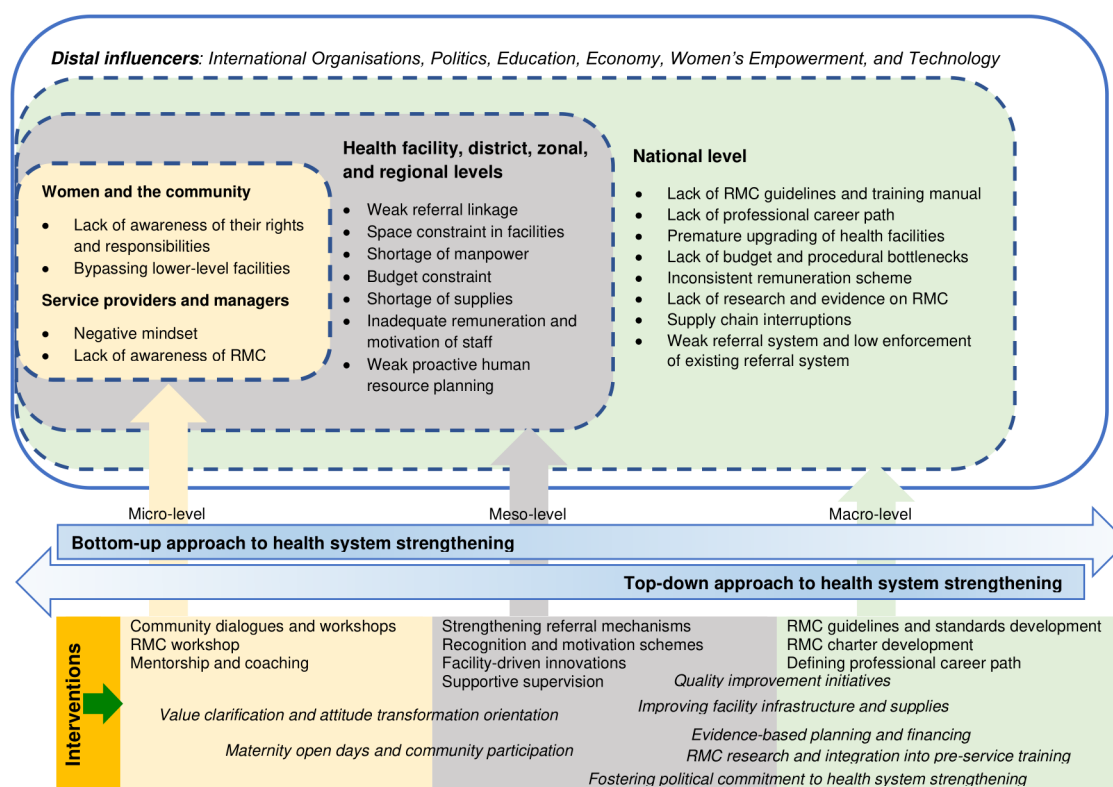


Figure 1 Health system strengthening approaches to the promotion of RMC. RMC, respectful maternity care.

interventions are warranted to improve the accessibility and uptake of maternity care and march towards a rights-based approach to ending maternal mortality. Taking into account the interpersonal and system-level nature of RMC and the wide array drivers of mistreatment,²⁴ it is commendable to implement bottom-up and top-down health system strengthening to promote RMC (figure 1).

COVID-19 AND RMC

The impacts of the COVID-19 pandemic are exacerbating maternal health inequities globally; in low-income settings, the impacts are higher due to pre-existing weak health systems. The pandemic is adversely affecting maternal health services in various aspects through disrupting the supply chain of essential supplies and logistics, diverting attention away from maternal health, interrupting the availability of antenatal and childbirth services, reducing maternal healthcare seeking among women due to the fear of getting infected, inappropriate separation of mothers and newborns and reduced interpersonal care to minimise contact between clients and service providers.^{25 26}

Evidence generated during and after the pandemic significantly contribute to actions to be taken to ensuring health system resilience in the long run and making the health system ready for the next crisis.²⁷ As such, future health system strengthening initiatives should amalgamate strategies to absorb shocks and maintain the quality and respectfulness of maternity care. In the absence of resilience, struggling and fragile health systems further deteriorate and would lead to devastatingly increased levels of maternal and child mortalities from preventable causes, let alone maintaining RMC specifically and quality of care generally.^{25 28}

THE WAY FORWARD

Because RMC is a cross-cutting issue, its advocacy and promotion should engage a range of stakeholders, including health workers, women, communities, policymakers and implementing institutions.²⁹ Women and the community at large should be well-oriented about women's rights in the maternal health continuum as this will play a significant role in the enforcement of the law to protect women's rights. On the other hand, in addition to designing evidence-oriented strategies to strengthen the various health system functions, the meso-level and macro-level health system actors should articulate the tenets of RMC as part of their core values and work towards the institutionalisation of RMC standards and strengthening accountability mechanisms in service delivery outlets.^{30 31}

Rights-based approach to respectful care

Governments along with their allies should design and/or enforce system-wide policies and strategies that foster the inalienable rights of childbearing women to the access to high quality and respectful care; this includes

financial accountability to ensure that no woman is left behind. Furthermore, nurturing a culture of accountability and respect in healthcare plays paramount importance to curb the intentional mistreatment and humiliation of women in health facilities.³²

Decolonising research on RMC and building local capacity

RMC includes respecting women's unharmed cultural preferences. I believe that researchers endowed with local and cultural understandings are well-posed to delve into the cultural fabrics in their community to explore and address cultural barriers to the utilisation of maternal health services. However, as it is with other health research, research on maternal health services—including RMC—is meagre and largely masterminded by international researchers, local researchers often playing ancillary roles when involved. Therefore, working towards investing in implementation research and building local research capacity yields strong evidence which can be translated into practice. In accordance with Abimbola's 'gaze-pose matrix', bulging the ideal matrix would accelerate knowledge translation for the betterment of RMC at local levels.³³ With such a mindset, improving local and international funding for implementation research on RMC would be commendable to design, test and scale-up high-yield interventions.

CONCLUSION

Addressing maternal mortality from a rights-based approach is exercising leadership up to the expectations of women's rights to live and enjoy quality, culturally sensitive and respectful health services. To hasten the ever-prevailing maternal health inequities globally and nationally, acting on the missing link—RMC—from the perspectives of health system strengthening helps not only to improve maternal health services and meet the maternal mortality target of the sustainable development goals, it also augments the progress to achieving universal health coverage.

Moreover, promoting respect at interpersonal and health system levels attract more women to health facilities, improves their childbirth experiences and mitigate preventable deaths. RMC is not only about dealing with 'women's issues'; it is also about creating healthier families, communities and nations.

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Appendix B: Respectful maternity care training package

Appendix B-1: Respectful maternity care training manual

Respectful Maternity Care (RMC) Training Manual For Health Service Providers



April 2018

Acronyms

ANC	Antenatal Care
CRC	Compassionate and Respectful Care
CQI	Continuous Quality Improvement
D&A	Disrespect and Abuse
MDG	Millennium Development Goals
M&E	Monitoring and Evaluation
MDT	Multidisciplinary Team
MMR	Maternal Mortality Rate
RMC	Respectful Maternity Care
SNNPR	Southern Nations Nationalities and Peoples Region
TBA	Traditional Birth Attendant
WHO	World Health Organization

Overview of the training manual

This training manual is designed to improve healthcare providers' knowledge and attitude on respectful maternity care (RMC) in order to help them provide women-friendly maternity care and prevent disrespect and abuse (D&A) during facility-based childbirth.

This training manual is developed/adapted from documents in-country and other countries: RMC guide developed by the population council, RMC workshop guide developed by MCHP; compassionate respectful and caring (CRC), continuous quality improvement (CQI), PMTCT, and BEmONC training manuals developed by the Federal Ministry of Health, Ethiopia. During developing this training manual focus was given to reflect the Ethiopian context and the specific needs of health care workers at the health facility level in the country. It also covers the concepts of continuous quality improvement (CQI) which is designed for Ethiopian health care workers by the Federal Ministry of Health, Ethiopia. Various RMC training manuals used in Kenya, Tanzania, Nigeria, and Benin have been proved to improve the provision of RMC in health facilities.

Overall training objectives

By the end of this training, participants will be able to

- Outline the current status of maternal health in relation to respectful care
- Describe key RMC concepts, terminology, and legal and rights-based approaches related to respect in childbirth
- Apply the principles of CQI in maternity care settings
- Explain health professionals' role in promoting RMC
- Practice possible approaches that reduce D&A in hospital settings
- Describe the interplay between RMC and professional code of ethics
- Develop personalised action plans to support the implementation of RMC interventions in health facilities

To achieve the objectives listed above, the training manual is organized into six sections

Section I: Describes the current status of maternal morbidity and mortality at global, regional (sub-Saharan Africa), and national level. Besides, it deals with levels of maternal health service utilization in Ethiopia and factors which are associated with non-use of these services.

Section II: Defines disrespect and abuse in childbirth and highlights on the categories of D&A. It will also provide information on the main contributors to D&A during facility-based childbirth.

Section III: Elaborates on the intersection between health and human rights with special attention to reproductive health rights. International and national human rights charters and declarations and their relationship with RMC will also be an added value of this section.

Section IV: Deals with the basic principles and components of RMC. Case scenarios and videos will be used to enhance participants understanding of RMC.

Section V: The relationship between RMC and professional code of ethics will be discussed. Nursing, midwifery, and medical code of ethics currently in use in Ethiopia will be discussed.

Section VI: Focuses on continuous quality improvement (CQI) approach which aims to enable participants to improve the provision of RMC in their health facilities.

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I. Introduction

Irrespective of health service expansion in Ethiopia, service utilization, especially maternal health services, is low though there is gradual improvement. According to the 2016 Ethiopian demographic and health survey report, the proportion of births attended by a skilled birth attendant is 28%. Besides, the proportion of women who had at least one antenatal care visit was 62%; four antenatal visits 32%. Different factors hinder service utilization, including disrespect and abuse.

Role play by facilitators

As one facilitator finishes reviewing knowledge pre-tests with participants, the other facilitator should lie on table or desk, covered with blanket/sheet/drape. This facilitator will act as a woman in labour. The standing facilitator will act as the midwife caring for her. A man or woman can play the role of the woman in labour or the midwife.

The dialogue should follow this pattern of interaction. You do not have to read this verbatim but should communicate these behaviors.

Midwife: “What’s wrong with you? The midwife who admitted you says that you were in labour since this early this morning.”

Woman in Labour: screams out in pain as if having a contraction.

Midwife: “Don’t be so loud. You’re going to frighten that woman in the bed next to you. Just breath and you’ll be fine.”

Woman in Labour: starts to sit up.

Midwife: shouts and pushes woman back onto bed/table: “Lie down. You can’t get up now.” You are too young to let yourself get pregnant anyway. And as long as you’re in this hospital, you’re going to lie down until you have the baby!”

Woman in Labour: “My mother and sister are outside. Can they come in?”

Midwife: “Of course not. This is a hospital. We need to keep things clean.”

Midwife: “I’ve got to examine you.” Midwife tries to pull sheet/blanket back from the woman in order to examine her.

Woman in Labour: holds sheet tightly and doesn’t allow the midwife to pull back sheet.

Midwife: speaks harshly and impatiently: “You don’t mind if these other women see you, do you? They’re all just like you. Anyway, you should have thought to keep the sheet up and keep your legs together when your boyfriend was crawling in bed with you.”

Woman in Labour: is crying: “Can’t you give me something for pain?”

Midwife: harshly: “You don’t need anything for pain. And if you’re not going to let me examine you, then I’m going to leave you alone and let you deliver this baby by yourself.

Midwife: exits room, leaving woman crying.

Following the demonstration, ask participants to turn to the participant beside them and briefly discuss in pair:

- What examples of disrespect and abuse did you note during this demonstration?
- Have you ever experienced this type of care?
- Have you ever seen this type of care in the workplace?
- What positive behaviours could the midwife have taken to make the care more respectful?

After 10-15 minutes ask the group to conclude their paired discussion and turn their attention to the larger group.

Lead the participants in a discussion by asking the following questions:

- What are some of the examples of disrespect and abuse you noted or discussed within your paired conversation? Allow 10 minutes for responses.
- What positive behaviours could the midwife have taken to make the care more respectful? Allow 10 minutes for responses.

Summarize the discussion, telling them that throughout the day, they will learn more and will be able to share more examples of disrespect and abuse and how to promote respectful maternity care.

Section I: Maternal health and maternal mortality: national and global estimates

Section objectives

At the end of this section, participants will be able to:

- Describe the current status of maternal mortality
- Describe the major barriers to maternal health services utilization in Ethiopia

1.1 Maternal mortality at a glance

Pregnancy, childbirth, and their consequences remain the leading causes of death, disease, and disability among women of reproductive age in developing countries. Nearly 303,000 maternal deaths have occurred globally in 2015 according to estimates of the World Health Organization (WHO). Almost all (99%) of these deaths happened in developing nations. Maternal mortality is highest in sub-Saharan Africa, where the maternal mortality ratio (MMR) was estimated to be 546 per 100,000 live births in 2015; MMR in most developed regions of the world was 12 per 100,000 in 2015. Ethiopia is the second country in sub-Saharan African countries where a large number of maternal deaths occur; next to Nigeria and preceding the Democratic Republic of the Congo. An estimated 12000 -13,000 maternal deaths occurring annually in Ethiopia in 2016.

What are the major causes of maternal mortality?

- **Hemorrhage:** This can occur anytime during pregnancy, delivery and post-natal period. It has multiple causes and is thus difficult to predict. Anemia can aggravate the effects of bleeding.
- **Pre-eclampsia/eclampsia:** If blood pressure is measured routinely in the four antenatal visits and women are educated on the symptoms of pre-eclampsia/eclampsia, it is easier to identify and prevent complications.
- **Obstructed labour:** It is difficult to predict. However, women who have had obstructed labour in previous deliveries or who have a baby not in a vertex position by 36 weeks gestation have a higher chance of having obstructed labour.
- **Puerperal sepsis:** This may result from unclean delivery practices, prolonged rupture of membranes, and reproductive tract infections.
- **Complications of unsafe abortion:** such as hemorrhage, infection and injury because of misuse of surgical instruments.

1.2 Maternal health services utilization in Ethiopia

Irrespective of health service expansion in Ethiopia, service utilization, especially maternal health services, is low though there is gradual improvement. According to the 2016 Ethiopian demographic and health survey report, the proportion of births attended by a skilled birth attendant is 28%. Besides, the proportion of women who had at least one antenatal care visit is 62%; four antenatal visits 32%. There are different factors that hinder the service utilization which includes disrespect and abuse.

Although there has been a remarkable improvement in maternal mortality reduction in Ethiopia, the MDG 5 target of reducing maternal mortality by 75% (between 1990 and 2015) was not met. That is partly due to health systems barriers in the utilization of maternal health services, especially skilled care at birth which arise mostly from the poor perceived quality of care in maternity units. During the past fifteen years, it was not possible to see a comparable increment of health facility-based deliveries as to that of antenatal care utilization in Ethiopia. This indicates, there is bid missed opportunity; mothers who actually seek antenatal care service do not show up for health facility delivery. Figure 1 displays trends in the utilization of maternal health services over the fifteen years period between 2000 and 2015.

Ethiopia has reduced maternal mortality by 69% percent since 1990 with a 5 percent annual rate of reduction. Despite significant progress in the reduction of mortality, there are unacceptably high numbers of maternal and newborn deaths in Ethiopia. The Ethiopia Demographic and Health Survey (EDHS) of 2016 reported MMR of 412 per 100,000 live births and neonatal mortality at 29 deaths per 1000 live births. The major causes of maternal death in Ethiopia are haemorrhage, hypertension in pregnancy, obstructed labour, sepsis, and anaemia.

The health sector transformation plan (HSTP), maternal and newborns health are priorities for the strategic period. This plan set a target of reducing the maternal mortality ratio to 199 maternal deaths per 100,000 live births and the neonatal mortality rate to 10 per 1,000 live births by 2020. The vast majority of maternal and neonatal deaths could be prevented if women and her newborn had access to quality basic and emergency care.

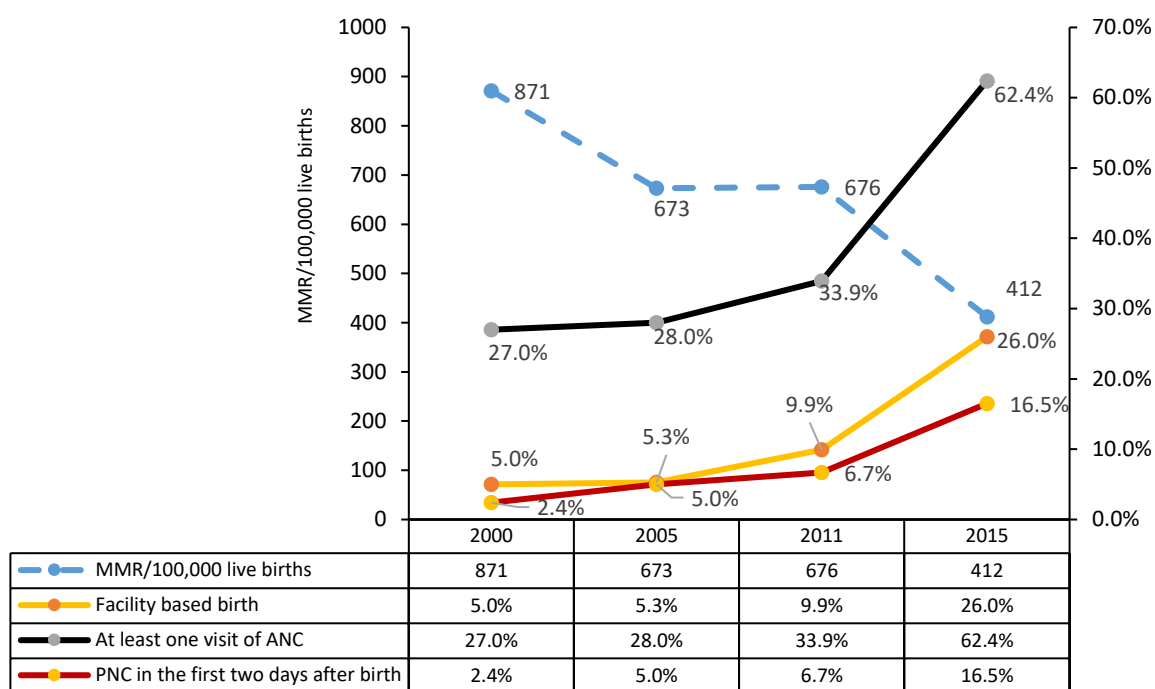


Figure 1: Trends of maternal health care utilization and maternal mortality rate in Ethiopia: 2000-2015

Why do Ethiopian women do not deliver in health facilities?

There are multiple reasons why Ethiopian women prefer not to give birth in health facilities. Below are the main ones:

- Perceived and experienced poor quality of services in health facilities
- Lack of respectfulness of services during childbirth: disrespect and abuse
- Poor facility infrastructure, including water, electricity, equipment, drugs, and supplies
- Fear of facing male health service provider
- Poor access to health facilities: transportation problems, communication networks with health institutions
- Fear of direct or indirect costs
- Influence of male partners and elderlies (mothers and grandmothers)
- Nighttime labour

Table 1 below summarizes the findings of several studies on reported reasons for non-facility delivery in various regions of Ethiopia

Table 1: Barriers to institutional delivery in Ethiopia

Study area (Author/s, year)	Barriers to institutional delivery; Issues which relate to disrespect and abuse are listed in bold type	
All administrative regions(Sipsma et al., 2013) (<i>Rural</i>); (Sipsma et al., 2013)	- Resource constraint at HFs: staff, logistics Hostile or insensitive staff Being ashamed of showing body to strangers - Cost of facility-based services: indirect costs	Uncomfortable delivery couches Disallowance of family members in labour wards - Environmental barriers: topography, weather
Northwest Ethiopia: Gagusa district (Alemayehu and Mekonnen, 2015) (<i>Rural</i>) (Alemayehu et al., 2015)	- Long distance to arrive at health facility - Facility-based birth not customary - Parental influence	- Non-regular service at HFs Previous bad experience
North Ethiopia: Tsegede and Adwa(Hailu and Berhe, 2014, Jackson et al., 2016) (<i>Rural</i>) (Hailu et al., 2014 & Jackson et al., 2016)	- Women's low educational status - Long distance	- Women's low decision-making power Disrespectful care at HFs
All administrative regions (Tarekegn et al., 2014, Yebyo et al., 2016) (<i>Urban and rural</i>) (Tarekegn et al., 2014 & Yebyo et al., 2015)	- Women's and male partners low educational status - Women's non-use of ANC Women's poor autonomy	- Being rural resident - Women's low economic position - High parity
Central Ethiopia: southwest Shoa(Wilunda et al., 2015) (<i>Urban and semi-urban</i>) (Wilunda et al., 2015)	Perceived poor quality of care - Women's low decision-making scope - High parity	- Long distance from health facilities - Being rural resident
Addis Ababa(Mirkuzie, 2014, Tebekaw et al., 2015) (<i>Urban</i>) (Mirkuzie et al., 2014 & Tebekaw et al., 2015)	- Social influences - Physical access to health facility	Perceived poor quality of care Disrespect in health facilities
Northwest Ethiopia: Sekela and Chilga(Kebede et al., 2013, Teferra et al., 2012) (<i>Rural</i>) (Teferra et al., 2012 & Kebede et al., 2013)	- Poor economic status - Long distance	Poor approach of service providers - Poor attitude on delivery care
South-central Ethiopia: Butajira(Roro et al., 2014) (<i>Rural</i>) (Roro et al., 2014)	- Women's low decision-making power - Reliance on TBA's care - Misconception of services provided at health facility Disallowance of birth companions Traditional and/or spiritual factors - Economic factors	- Accessibility to health care facilities Poor reception of women at HFs Lack of privacy - Poor competence of health care providers - Low perceived susceptibility Inadequate resources at HFs
North-east Ethiopia: Afar(King et al., 2015) (<i>Rural</i>) (King et al., 2015)	- Women's limited decision-making opportunities Perception of poor quality of SBA care Poor structural readiness of HFs Unfriendly or even abusive service	- Long distances and no access to roads - Costs of travel and medicines - Domestic workloads - Women's non-use of ANC
South Ethiopia: Hadiya(Asseffa et al., 2016) (<i>Rural</i>) (Asseffa et al., 2016)	Previous history of uncomplicated birth at home	Poor economic status

Dear participants the following quotes are taken from various studies which show how women describe their reason for not delivering in health facilities or their experience of facility-based childbirth. Please read them individually.

"I have heard that she has pinched a mother [that was delivering with a forceps]. How can you do that and expect mothers to come? There are nurses that yell at mothers and slap them; we hear about some nurses who do that, and I have also heard that there were incidents like that even at this health centre", a woman from Tsegedie woreda, Tigray, 2016

Nearly 4% of women who had home birth mentioned the reason for home delivery to be a previous bad experience of facility-based childbirth, Guagusa woreda, Amhara, 2015

".....some mothers are not comfortable when we tell relatives who came with them to wait outside", health centre head, Tigray, 2016

"I still suggest other women to give birth at a health facility even though I did not have good experience in the hospitals where I gave birth. The providers at the hospital treated me badly especially the ladies...yet, I feel that my life was saved because I gave birth in the hospitals" Mother of three who gave birth in a hospital, Addis Ababa, 2014

"...I see a baby...she is giving birth!' But none of the nurses showed up for help. The woman gave birth with the help of the mothers around her.....they do not properly manage or handle a woman suffering in labour. So we become angry and think it is better to get the service of traditional Birth Attendants", male participant, rural Butajira, SNNPR, 2014

"For a woman, there will be eight to ten professionals to come around and attend her which is troubling for a labouring woman to expose her genitalia", a female participant from rural, SNNPR, 2014

".....when women deliver at health facility many health workers touch them, and cultural foods are not allowed during labour, this is not good; I heard this from other women who delivered at health facility a woman also told me that health professionals laywomen on delivery bed without any clothes, so I don't want to be in such condition at health facility ', woman, Tembaro woreda, SNNPR, 2017

I am afraid of delivering in a health facility. They [health professionals] don't allow my family members (who are the main source of psychological support and comfort) to accompany me in the labour ward. They leave us alone on the delivery couch and everybody who comes in and out of the delivery room watches our naked body which is quite embarrassing. We also

get little respect from health workers. I won't have these problems if I go to a traditional birth attendant. I seek help from a health facility only as a last resort (.i.e., if I encounter difficulty to deliver in my home).

Section II: Disrespect and abuse during childbirth

“Disrespect and abuse of women during maternity care are problems that have been obscured by a “veil of silence,” and they can significantly impact women’s willingness to seek life-saving maternity care.

Learning objectives

At the end of this section, participants will be able to:

- Outline the core themes of the definition of disrespect and abuse
- Mention the basic features of disrespect and abuse during childbirth
- Describe the contributors to disrespect and abuse during childbirth

2.1 Disrespect and abuse during childbirth: meaning and scope

Disrespect and abuse: “interactions or facility conditions that local consensus deems to be humiliating or undignified, and those interactions or conditions that are experienced as or intended to be humiliating or undignified” (Freedman et al., 2014) (Figure 2). D&A is also interchangeably used with the term “mistreatment” to convey a similar message.

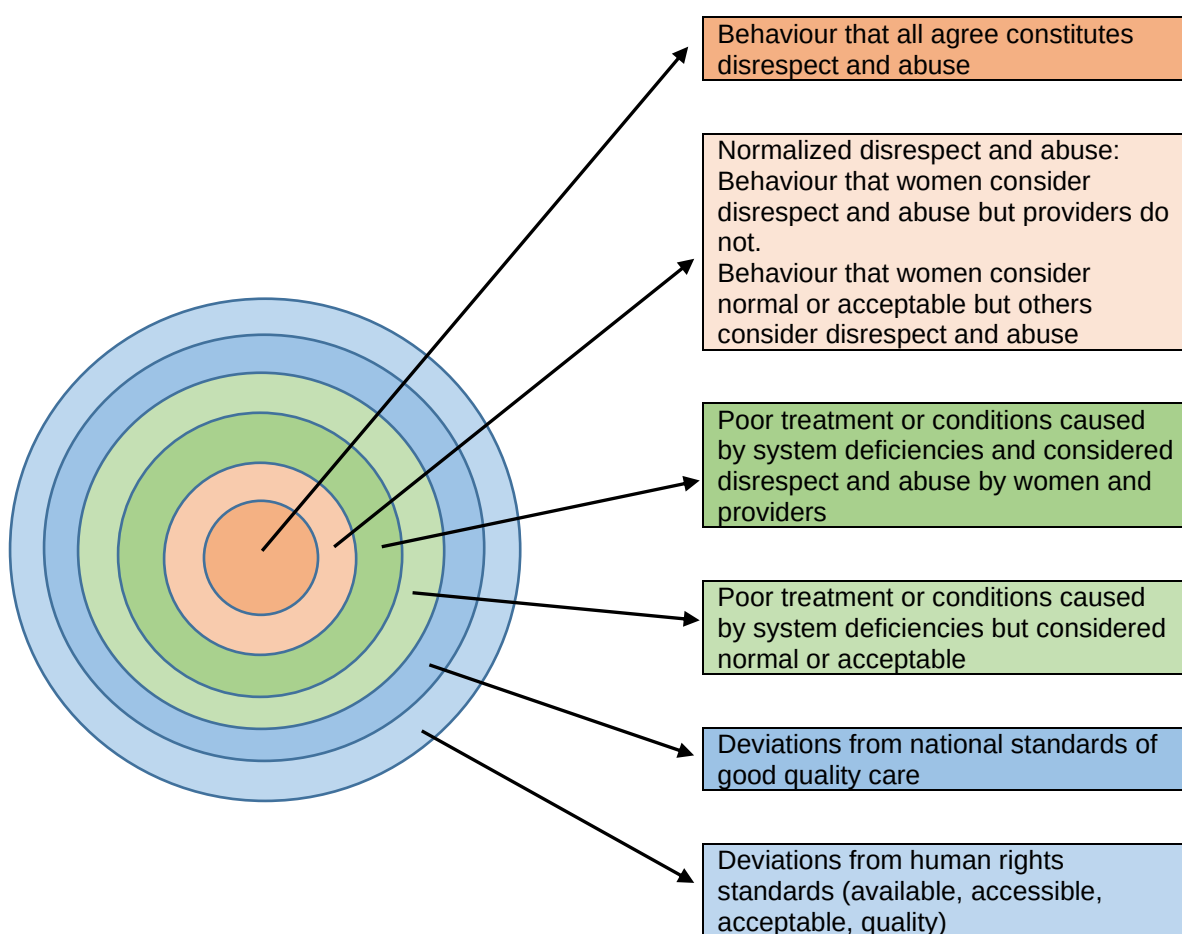


Figure 2: Scopes of the definition of disrespect and abuse

A little-understood component of the poor quality of care experienced by women during facility-based childbirth is the disrespectful and abusive (D&A) behaviour of healthcare providers and other facility staff. Acknowledgement of these behaviours by policymakers, programme staff, civil society groups, and community members indicates the problem is widespread. A few Ethiopian studies also showed that D&A is widely experienced by childbearing women in Ethiopian health facilities (Asefa and Bekele, 2015, Shiferaw et al., 2013).

According to a landscape analysis conducted in 2010 and other systematic investigation on disrespect and abuse, disrespectful and abusive behaviours can be categorized into seven categories. However, the categories are not intended to be mutually exclusive; rather, they should be seen as overlapping along a continuum.

- Physical abuse,
 - Eg: Beatings by healthcare workers were normalised and justified as being “for the good of the baby.”
- Sexual abuse,
- Verbal abuse,
 - Eg: “Am I the one that impregnated you?”
- Stigma and discrimination,
 - Eg: You don’t even have good clothes, how do I serve you?
- Failure to meet professional standards of care,
 - Eg: “My baby was almost out before anyone helped me—I may as well stay at home.”
- Poor rapport between women and providers, and
 - Eg: All labour is painful, don’t exaggerate
- Health systems conditions and constraints (Bohren et al., 2015, Bowser and Hill, 2010).
 - Eg: More than one delivery bed (without partition) in labour wards

2.2 Contributors to disrespect and abuse

Numerous factors contribute to disrespect and abuse; see the following figure for the details.



Figure 3: Contributors to disrespect and abuse

2.3 Prevention and elimination of disrespect and abuse during facility-based childbirth

In 2014, the World Health Organization released a statement that aimed at preventing and eliminating the disrespect and abuse of women during facility-based childbirth. The statement reads as:

“Every woman has the right to the highest attainable standard of health, which includes the right to dignified, respectful health care”.

Furthermore, the statement describes that many women experience disrespectful and abusive treatment during childbirth in facilities worldwide. Such treatment not only violates the rights of women to respectful care, but can also threaten their rights to life, health, bodily integrity, and freedom from discrimination. This statement calls for greater action, dialogue, research and advocacy on this important public health and human rights issue. The

statement is prepared in more than 15 languages including Amharic and is endorsed by several governmental and non-governmental organizations across the globe.

The following five actions are recommended by the statement to prevent and eliminate disrespect and abuse during facility-based childbirth globally

1. Greater support from governments and development partners for research and action on disrespect and abuse
2. Initiate, support and sustain programs designed to improve the quality of maternal health care, with a strong focus on respectful care as an essential component of quality care
3. Emphasizing the rights of women to dignified, respectful health care throughout pregnancy and childbirth
4. Generating data related to respectful and disrespectful care practices, systems of accountability and meaningful professional support are required
5. Involve all stakeholders, including women, in efforts to improve quality of care and eliminate disrespectful and abusive practices

See annex I for the full details of the statement.

Section III: Human rights and law in the context of health and reproductive health

Learning Objectives

By the end of the session, participants will be able to

- Define 'human rights'
- State the origin and characteristics of human rights
- Discuss a human rights-based approach to reproductive health
- Discuss human rights instruments for RMC

Facilitator Instructions

1. Ask participants to brainstorm meanings for 'human rights.' Allow several responses and provide the correct definition as needed.
2. Discuss the origin and characteristics of human rights.
3. Interactively discuss the legal background of a human rights-based approach to reproductive health.
4. Facilitate a brainstorming session on the definition of 'reproductive health' and 'reproductive rights.' Write participants' responses on a flipchart and discuss each one. Use a PowerPoint presentation to provide the correct definitions of these terms.
5. Discuss examples of human rights and limitations to human rights-based approaches to reproductive health

3.1 Introduction to human rights

Definition of 'human rights': Human rights are those rights that every human being possesses and is entitled to enjoy simply by virtue of being a human being (*United Nations General Assembly, 1948*).

Origin and characteristics of human rights: Human rights are founded on religious, philosophical, and legal principles. Most religions promote the concept of equal and fair treatment of all human beings. The principle of equality, dignity, and non-discrimination form the philosophical basis of human rights (*United Nations General Assembly, 1948*).

The following are characteristics of human rights:

- Internationally guaranteed
- Legally protected
- Focused on the dignity of human beings
- Protective of individuals and groups
- Obligatory for both state and non-state actors
- Cannot be waived or taken away
- Equal and interdependent
- Universal

Box 1: international human rights declarations and charters

Legal Background of Human Rights *(Adapted from definitions of SRHR in the ICPD and Beijing Platforms of Actions 2005)*

United Nations Charter, 1945

- Act as the foundation of human rights legal instruments
- Reaffirm faith in fundamental human rights, worthy of the human person and their dignity
- Encourage and promote respect for human rights
- Based on principles of equality and non-discrimination

Universal Declaration of Human Rights (UDHR), 1948

- An international bill of human rights, adopted by the UN General Assembly
- Based on the philosophy of equality, dignity, and non-discrimination
- Sets the direction for subsequent work in human rights
- Serves as a yardstick to measure respect and compliance for human rights

International human rights instruments

- Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)
- International Covenant on Economic, Social and Cultural Rights (ICESCR)
- Convention on the Elimination of All Forms of Racial Discrimination (CERD)
- International Covenant on Civil and Political Rights (ICCPR)
- Convention Against Torture and Other Inhuman, Cruel and Degrading Treatment (CAT)
- Convention on the Rights of the Child (CRC)

Examples of African regional human rights instruments

- African Charter on Human and Peoples' Rights (African Charter)
- Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol)
- African Charter on the Rights and Welfare of the Child (Children's Charter)

Examples of Human Rights

The concepts of human rights and rights of law are dynamic. Although a range of fundamental human rights has already been legally recognised, nothing precludes existing rights from being interpreted more broadly or additional rights being accepted. As a result, human rights are a powerful tool for promoting social justice and dignity. Some of the human rights guaranteed in the main international human rights treaties include:

• Non-discrimination	• The choice to marry and have a family
• Life	• Enjoyment of the highest standard of physical and mental health
• Bodily integrity	• The choice of whether, when, and how many children to have
• Privacy	• Prohibition of arbitrary arrest, detention, and exile
• Freedom of thought	
• Liberty and security	
• Freedom of expression	

- Due process in criminal trials
- Self-determination
- Education
- Information

Limitations of Human Rights

Rights are not absolute. Under certain conditions, limitations can be imposed by the state on the exercise and realisation of certain rights. This ensures respect for the rights of others and the maintenance of public order, health, morals, and national security.

3.2 Human Rights-based Approach to Reproductive Health

Definition of reproductive health: Complete physical, mental, and social well-being in all matters related to the reproductive system, including a satisfying and safe sex life, the capacity to have children, and the freedom to decide if, when, and how often to do so.

Reproductive rights: The rights of couples and individuals to decide freely, and to responsibly number and space their children; to have the information, education, and means to do so; and to attain the highest standards of sexual and reproductive health and make decisions about reproduction free of discrimination, coercion, and violence.

Rights-based Approach to Reproductive Health

In general, a human rights-based approach includes accountability, participation, transparency, empowerment, and non-discrimination, and identifies entitlements as the core of human rights.

- A human rights-based approach (HRBA) is founded on the principles of peace, justice, freedom, development, and sustainability.
- HRBA also focuses on accountability and identifying those responsible for human rights realisation (duty bearers), as well as those whose capacities to meet their responsibilities must be strengthened (claim holders).
- HRBA empowers beneficiaries to develop a self-sustaining process of change, eliminating the dependency on foreign agents for reform or development

3.3 Health as human rights in the Ethiopian context

In accordance with international charters and declarations, the constitution of the federal democratic republic of Ethiopia also entitles everyone to use basic services without any preconditions and prejudices. In addition to this, the health policy also depicts high concern for a high standard and acceptable level of health care

Box 2: Basic components of the Ethiopian Health Policy (1993)

Box 2: Basic components of the Ethiopian Health Policy (1993)

1. Democratization and decentralization of the health service system
2. Development of the preventive and promotive components of health care
3. Development of an equitable and acceptable standard of health service system that will reach all segments of the population within the limits of resources
4. Promoting and strengthening of intersectoral activities
5. Promotion of attitudes and practices conducive to the strengthening of national self-reliance in health development by mobilizing and maximally utilizing internal and external resources.
6. Assurance of accessibility of health care for all segments of the population
7. Working closely with neighbouring countries, regional and international organizations to share information and strengthen collaboration in all activities contributory to health development including the control of factors detrimental to health
8. Development of appropriate capacity building based on assessed needs
9. Provision of health care for the population on a scheme of payment according to ability with special assistance mechanisms for those who cannot afford to pay
10. Promotion of the participation of the private sector and nongovernmental organizations in health care

Section IV: Respectful maternity care (RMC)

Learning Objectives

By the end of this session, participants will be able to

- Explain the meanings of 'respectful maternity care', 'respect', and 'disrespect,'
- Discuss the components of the universal rights of childbearing women
- Mention mechanisms of promoting respect during childbirth

4.1 What is respectful maternity care?

RMC concept: RMC encompasses respect for women's basic human rights and includes respect for their autonomy, dignity, feelings, choices, and preferences, including companionship during maternity care (White Ribbon Alliance, 2015).

Why is respect during childbirth important?

Respect in childbirth is a global issue due to its strong link not only with service utilization but also with human rights. 'Respect' is a specific feeling of regard for the actual qualities of the one respected (e.g., "I have great respect for her judgment"). Specific ethics of respect are of fundamental importance in different cultures, beliefs, and professions. On the other hand, 'Disrespect' means rude conduct and is usually considered to indicate a lack of respect. Promoting respect during childbirth thus contribute enormously to maternal mortality reduction by preventing disrespect and abuse during childbirth, which leads to the underutilization of skilled birth care (Figure 4).

4.2 Respectful maternity care from the perspective of the compassionate and respectful health workforce initiative in Ethiopia

Introduction to Compassionate, Respectful and Caring (CRC) (The Federal Democratic Republic of Ethiopia Ministry of Health, 2017)

Compassion (ፋህሩህ)

Is a feeling of deep sympathy and sorrow for the suffering of others accompanied by a strong desire to alleviate the suffering? Therefore, we can say it is being sensitive to the pain or suffering of others and a deep desire to alleviate the suffering. To be optimally effective in clinical medicine, every health professional without exception should be technically excellent and practice with compassionate care. However, many technical advances in medicine are beneficial to patients, no person who is ill should have to suffer the indignity of a technically competent but uncaring doctor, nurse, or other staff members. Good medical practice has been perennially captured in the phrase "the art of medicine," which combines scientific-

technical knowledge with humanism, defined as the physician's interest in and respect for the patient as a person experiencing illness.

Too many clients experience de-humanizing and impersonal treatment, so that this is now a crisis within healthcare systems, proving destructive not only for patients, but for professionals, families and the systems themselves.

Compassion (ሩህሩህ): lies at the intersection of empathy (in this case, understanding patients' concerns) and sympathy (feeling patients' emotions). A health professional's care without compassion cannot be truly patient-centered. Compassionate care addresses the patient's innate need for connection and relationships and is based on attentive listening and a desire to understand the patient's context and perspective.

Respectful (ተገልጋይን የሚያከብር)

Is the kind of care, in any setting, which supports and promotes, and does not undermine a person's self-respect, regardless of any differences?

- Pay attention to
- Honouring
- Avoiding damage e.g. insulting, injuring
- Not interfering with or interrupting
- Treating with consideration
- Not offending

Caring (ተንከባካቢ)

Caring is an intensification of the affective dimension of empathy in the context of significant suffering. It is coupled with effective interventions to alleviate that suffering.

Compassionate, respectful and caring (CRC) - means serving patients, being ethical, living the professional oath, and being a model for young professionals and students. It's a movement that requires champions who identify with their profession and take pride by helping people.

Historical Background of CRC

Compatin is a Latin word meaning to 'suffer with', and as a word it has been with us a long time. Having said that as a word it is not easy to conceptualize and to say whether it is always good, or whether it is sometimes bad. The term compassion has a long association with most major religions and philosophies and taught to include a number of virtues, such as empathy, sympathy, kindness, respect, and perhaps most importantly, actually taking some kind of 'action'. Compassionate Care within the healthcare setting has received much attention globally; following concerns that healthcare often fails at a fundamental level. Work is in place at a multi-disciplinary level to utilize and integrate this concept. The role and importance of a compassionate approach was brought to the forefront in the United Kingdom, with the release of the Francis Report. This report, which gained international

attention, was based on an inquiry into devastating events at Mid-Staffordshire Hospital and finding that for many patients the most basic elements of care were neglected.

Looking into the Ethiopian context there are many professionals who are compassionate, respectful and caring with the required skills needed. However, a significant proportion of health professionals see patients as just 'cases' and do not show compassion, lack of respect to patients and their families was the common complaint among the community at large and patients in particular.

The health sector transformation plan, in line with our country's second growth and transformation plan (GTPII), has set ambitious goals to improve equity, coverage and utilization of essential health services, improve quality of health care, and enhance the implementation capacity of the health sector at all levels of the system. A focus in quality and equity requires a shift in the status quo to drive improvement at national scale over the next five years.

Four transformation agenda: equity and quality health service, woreda transformation, information revolution and compassionate, respectful and caring workforce.

The National CRC Technical Working Group has developed training packages based on a Rapid Training Needs Assessment (TNA) which shows the awareness of health care providers on compassionate and respectful care was found to be high; however, the results of the assessment also demonstrate the poor translation of this knowledge into practice. In effect, this discovery has brought to light the need for a tailored training aimed at improving the attitudes and skills of health care providers in relation to CRC.

Characteristics of CRC Health Professionals

CRC health professionals have the following four essential characteristics:

1. Consider patients as human beings with complex psychological, social and economic needs and provide person-centered care with empathy;
2. Effective communication with health care teams, interactions with patients and other health professionals over time and across settings;
3. Respect for and facilitation of patients' and families,' participation in decisions and care
4. Take pride in the health profession they are in and get satisfaction by serving the people and the country.

The Benefits of CRC

Beneficiaries	Who	How
First	Clients	• When health professionals are compassionate, patients are less anxious • Adherence to medical advice and treatment plans • Compassionate care correlates positively with both prevention and disease management. Diabetic patients, for example, demonstrate higher self-management skills when they self-report positive relationships with their providers • Hostile emotional states in patients delay the healing processes • Quality of health professionals –patient communication with increased physical functioning, emotional health and decreased physical symptoms of pain in patients
Second	Health professionals	• Health care Professionals satisfaction with their relationships with patients can protect against professional stress, burnout, substance abuse and even suicide attempts • Burnout is strongly associated with poorer quality of care, patient dissatisfaction, increased medical errors, lawsuits and decreased expressions of compassion • Participation in a mindful communication associated with short-term and sustained improvement in well-being and attitudes associated with patient care • A major predictor of patient loyalty • When health professionals are compassionate, they achieve earlier and more accurate diagnoses because the patient is better able to reveal information when he or she feels emotionally relaxed and safe • Respect from the client/patients • Health professionals will find their work more meaningful and gratifying
Third	Students	• Good role modeling is essential for students • Increased motivation to be CRC health professionals
Fourth	Health care facilities	• Patient satisfaction will rise • Quality of health care will be improved • Lower malpractice suits • Staff will be more loyal to their hospital or health care system • Patient adherence to treatment will rise • Resources can be conserved • Greater employee satisfaction and reduced employee turnover.

4.3 Safe motherhood and respectful maternity care

The notion of safe motherhood must expand beyond the prevention of morbidity or mortality to encompass respect for women's fundamental human rights, including their autonomy, dignity, feelings, choices, and preferences (inclusive of companionship during maternity care). During childbirth, providers should be caring, empathetic, supportive, and trustworthy, and should contribute to confidence and empowerment. They should also be gentle and respectful, and communicate effectively to enable informed decision making. However, this may not be the case for most women.

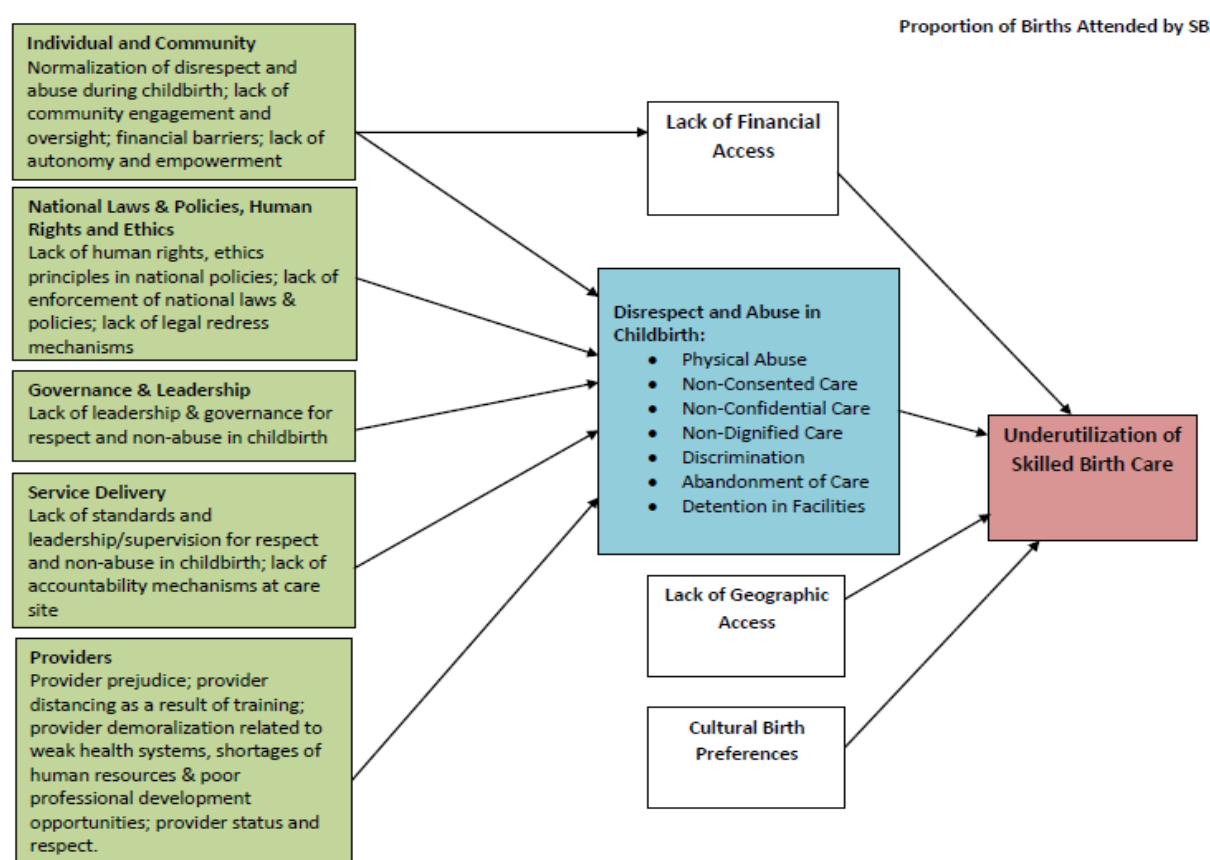


Figure 4: Relationship between disrespect and abuse and utilization of maternal health care services

4.4 The Universal Rights of Childbearing Women

The WHO and other international organizations have endorsed the universal rights of childbearing women which was prepared by the White Ribbon Alliance in 2011.

Respectful maternity care: the universal rights of childbearing women

1. Every woman has the right to be free from harm and ill-treatment

2. Every woman has the right to information, informed consent and refusal, and respect for her choices and preferences, including the right to her choice of companionship during maternity care, whenever possible
3. Every woman has the right to privacy and confidentiality
4. Every woman has the right to be treated with dignity and respect
5. Every woman has the right to equality, freedom from discrimination, and equitable care
6. Every woman has the right to healthcare and the highest attainable level of health
7. Every woman has the right to liberty, autonomy, self-determination, and freedom from coercion

The charter aims to address disrespect and abuse of women seeking maternity care and to provide a platform for improving RMC through:

- Raising awareness for including childbearing women in the guarantees of human rights recognised in internationally adopted United Nations and other multinational declarations, conventions, and covenants
- Highlighting the connection between human rights and implementation activities relevant to maternity care
- Increasing the capacity of maternal health advocates to participate in human rights processes and champion RMC
- Aligning a sense of entitlement to high-quality maternity care among childbearing women with international human rights standards
- Providing a basis of accountability for communities and the maternal care system
- Demonstrating the legitimate place of maternal health rights within the broader context of human right

4.5 Promoting respectful and dignified care during childbirth

Role play

Communicating a Woman's Right to Dignified Childbirth

Directions

The group will self-select one participant to take a few minutes to read the background information provided below and prepare. The observers should read the same information so they can participate in the large group discussions that follow.

The purpose of the role play is to provide an opportunity for participants to appreciate the importance of good communication when talking to women about available healthcare and their sexual and reproductive rights.

Participant roles

Provider: The provider is an experienced healthcare worker at a primary healthcare centre, who also has good communication skills.

Antenatal care clinic: ALL others

Situation: The women are at an antenatal care clinic. Some are interested in learning more about the care available at the health centre because a relative or neighbour delivered there. Everyone present knows someone who has died as a result of childbirth. One of the providers working in the facility has a reputation in the community for 'shouting at women all the time.' Many are nervous about health facility delivery because the majority of women in the community deliver at home.

Focus of the role play: The focus should be on the interaction between the midwife and the women. The midwife should

- Be friendly and reassuring
- Describe the role of the midwife
- Briefly explain the range of services available for women, and how families can be involved in decisions about care
- Encourage the women to ask questions and take time to address them
- Discuss a woman's right to a companion for facility-based visits during her pregnancy
- Discuss safe motherhood and women's right to safe, respectful healthcare

The mothers at the clinic should ask questions and express their concerns until the midwife has provided them with adequate information about the midwife's role, their rights as women, and the care available at the health centre.

Discussion questions: The trainer/facilitator should use the following questions to facilitate discussion after the role play:

1. How did the midwife approach the clinic teaching/caring?
2. Did the midwife give enough information about her role? About the health centre? About a woman's right to safe motherhood? About her right to have a birth companion?
3. How did the women respond to the midwife?
4. What did the midwife do to demonstrate emotional support and reassurance during the group's interaction?
5. Were the midwife's explanations and reassurance effective? Why or why not?

Video: Display WHO's RMC video and let the participants have 3 minutes paired discussion after the video

RMC scenario 1

You are a midwife who arrives for duty in the district hospital where you work. As you take over duty from the previous midwife you are told that one of the women in labour, Abeba, is 17 years old, gravida 1 para 0, full term, reportedly in labour for 8 hours, admitted to the hospital four hours ago. You are told that she is uncooperative and difficult to examine because she holds her legs together and cries.

You observe Abeba lying on a bed in the labour room with only a sheet covering her. You know that the labour area does not have curtains between beds and you know that the midwife who is reporting to you usually takes the sheet off when examining someone and has been seen to force a woman's legs apart when she decides to do an exam. She usually communicates little with women in labour except to tell them to "be quiet" or "shut up." The other midwife leaves and you take over the care of Abeba. Fortunately, you see that you have only two women in labour at this time.

What may be some of the underlying factors that account for the disrespectful behaviour of the other midwife?

- Imitated other healthcare workers who abused and disrespected patients
- Is abused at home
- Has physical or emotional problems
- Is stressed because of family or other situation

What might you do to provide respectful maternity care to Abeba?

- Approach Abeba with a smile and introduce self
- Ask her how she is, and listen attentively to her response
- Patiently recognize that her resistance to a vaginal exam may have many causes: fear, shyness, socio-cultural beliefs, experience of gender-based violence
- Gently touch her or wipe her forehead with a cool cloth
- Spend some time with her providing comfort measures
- Since there is only one other woman in labour, allow Mrs. M's (and the other woman) to have one companion
- When it is time to examine her:
 - Explain what you are going to do and why you are going to do it
 - Be sure she is properly draped with the sheet or other covering while doing the exam
 - Gently approach her and ask for her help by separating her legs so that you can examine her to help both of them know how she and the baby are doing
 - Explain the findings of the exam and their significance/meaning

- Reassure Abeba that she only needs to call you and you will come to her bedside
- Come quickly when she or her companion calls
- Reassure Abeba that you will not leave her, even if her companion has to step outside
- Treat Abeba as an individual and consider her companion/family as you care for her
- Instruct companion how best to assist and keep the companion informed and involved
- Provide pain relief as appropriate

RMC scenario 2

You are a midwife who began work in the labour and delivery room of the referral hospital in your city about six months ago. You have become concerned because you hear from your neighbours and others that they do not want to go to the hospital in labour because they are treated so poorly. You also observe that:

- On arrival, women are given a bed number and are referred to by that number rather than their name
- The other midwives make fun of the women, especially those who are from lower socio-economic groups
- The women are given no privacy. Although curtains exist, they are not used. There is no attempt to drape a woman during an examination
- Women are forced to stay in bed and lie on their back during labour and birth
- Women are frequently pushed and shoved if they attempt to sit up or turn over during the birth
- Women are left alone when their midwife goes for tea or lunch

You are quite concerned about the abuse and disrespect that the women receive.

What are some possible reasons for this abusive and disrespectful care?

Among the answers might be:

- The management or administration may not have a respectful attitude towards women in labour or may not have stopped to think about the experience of the women in labour
- The payment may not be satisfactory for the long working hours and duty
- The schools in which the other midwives were trained may not have taught respectful maternity care in classroom and/or clinical practice
- The physicians and other high-level people may show disrespect and abuse of the women and therefore it is viewed as “normal.”

How might you help promote respectful maternity care in your setting?

Among the answers might be:

- Treat each woman respectfully, referring to each by name, pulling the curtain and draping when examining the women, smiling, comforting, reassuring.
- You might mention some of the things that your neighbours and friends say about the care they receive—not in an accusatory way, but in a way that makes them think about the implications of their care
- You might mention—not in an accusatory way, but in the way a friend might inform a friend about something they learned—that you have learned of a study that says that women in labour do better with a companion and are not left alone. You might also mention that fear and anxiety can cause women to be “uncooperative,” and to actually feel more pain
- You might mention that for the poorer women, this might be the only place where they can receive care and attention. Call upon their emotions and minds to help them understand the difficult situation from which they come
- When possible, use an example of yourself or your relative who experienced either good care, which was positive, or abusive, disrespectful care, which left a negative effect on you
- In casual conversation with staff or administration, ask if they would feel comfortable with their sister to receive care here. Never be accusatory, but only thought-provoking.

Video on respectful maternity care

Basic components of respectful care during childbirth:

Box 3: tips for promoting respect and make a woman happy during childbirth

1. Introduce yourself to a woman when you first meet her
2. Serve all women respectfully regardless of their religion/race/ethnicity/age/socioeconomic status/medical condition, avoid discrimination
3. Do not beat, slap, kick, or pinch a woman
4. Allow a woman to cry or scream during labour, do not gag her
5. A woman needs to move her body part during labour, do not physically restrain her
6. Use polite language, avoid use of harsh or rude language
7. Do not make judgmental or accusatory comments
8. Do not make threats to withhold treatment
9. A woman should not be blamed for any feature of her birth outcome/s
10. Seek for woman's consent prior to performing any procedure
11. Never shout loudly when communicating woman's information to other staff
12. Keep woman's personal information secure
13. Perform vaginal examination very gently to minimize pain
14. Give a woman pain relief when she needs it and it is appropriate
15. Obtain woman's consent always before preparing her for surgery
16. Respond to a woman immediately following her call
17. Never leave a woman without attention during labour
18. Keep a baby with his mom unless there is justifiable reason to keep the baby away
19. Maintain woman's privacy while you perform vaginal examination
20. Do not ignore woman's concern/s while she is in labour
21. Try to speak to a woman in a language or at a language level she understands
22. Serve a woman in a polite manner
23. Give a woman periodic updates on her labour
24. Allow woman's birth companions for companionship: conditions apply
25. Give credit to every effort a woman makes in labour
26. Allow a woman to move around during labour unless there is medical indication to deny her
27. Allow a woman to take food or fluids if there is no other indication to deny her
28. Allow a woman to assume position of her choice during labour
29. Allow a woman any cultural practice which are not harmful she wants to practice in labour
30. Do not objectify a woman in labour
31. Do not make a woman stay in the hospital without her will

Section V: Professional ethics and RMC

Learning Objectives

At the end of this section participants will be able to:

- Define 'healthcare ethics,' 'code of conduct,' 'etiquette,' 'scope of practice,' and 'professional associations'
- Discuss the principles of ethics
- Explain the common themes in the set of ethics that promote dignified care and respect
- Describe the role and responsibilities of regulatory bodies and professional associations in promoting dignified and respectful care
- Discuss ethical issues surrounding childbirth

5.1 Definition of terms

Ethics: involve a systematic examination of moral life and seek to provide sound justification for the moral decisions and actions of people. The word ethics can also refer to philosophical inquiry in examining 'right from wrong' and 'good from bad'.

Codes of ethics: makes public the professional values of healthcare providers, as well as the values of professional education and practice. Each provider has a personal value system influenced by his or her upbringing, culture, religious and political beliefs, education, and life experiences. Ethical decision making considers values that are important to other individuals, as well as the reasons for their importance.

Scope of practice: defines the responsibilities of the provider as well as the legal boundaries of practice. It defines what health professionals can be held accountable for in the course of practice. The scope differs from one profession to another and stipulates the practice boundaries and the linkages between professions.

Etiquette: the customary code of polite behaviour in society or among members of a particular profession or group (Wikipedia). Thus etiquette is the rules which guide on the proper or polite way of acting in a profession.

Ethical principles

Ethical principles guide moral decision making and action, and assist in the formation of moral judgment in professional practice. Ethical principles important to medical practice include

- **Beneficence (obligation to do good) and non-maleficence (obligation to avoid doing harm):** Applying these principles to medical practice can pose problems for providers. Avoidance of deliberate harm and injury to others, however, is something

within an individual's capacity and resources. Failure to uphold this principle can be interpreted as grossly unethical, regardless of context.

- **Justice:** The principle of formal justice states that equals should be treated equally and that those who are unequal should be treated differently according to their needs. Clients with greater healthcare needs (such as maternal complications and chronic illness) require more attention.
- **Autonomy:** The ethical principle of autonomy claims that individuals should be permitted personal liberty to determine their own actions, according to plans that they have chosen. During labour, women must be informed of the services available to them, at which point they can choose to opt-in or out. Birthing preferences are the woman's choice, and the provider must respect individuals as self-determined choosers. To respect a mother's choices is to acknowledge autonomy stemming from personal values and beliefs, as well as preferred cultural practices.

5.2 Approaches to ensuring ethical practices

- Regulatory mechanisms
 - Accreditation and licensure
 - External quality assurance
 - Community rating
- Enactment of professional codes of ethics
 - Eg: medical code of ethics, midwifery codes of ethics, nursing codes of ethics
- Legal entities
- Establishing administrative structures in health systems
- Engagement with professional associations
 - Eg: Ethiopian Midwives Association, Ethiopian Nurses Association, Ethiopian Medical Association

5.3 Overview of professional codes of ethics in Ethiopia

Selected articles from professional codes of ethics in Ethiopia, which most relate to RMC, are presented below. Participants are advised to read the full codes of ethics of their respective profession. Dear participants, while reading these ethical codes, relate each code with the category of RMC it best fits with.

1. Professional Code of Ethics and Conduct for Midwives (Ethiopian Midwives Association, 2011)

Midwives shall:

- Assist clients to express their individual needs and values and take these into consideration when determining the optimal plan of care
- Actively involve their clients in the planning and delivery of care
- Provide care regardless of clients' gender, ethnicity, religion, age, health, and socioeconomic status.
- Accept the right of each woman to control her pregnancy and birthing experience
- Accept that the woman is responsible for decisions that affect herself, her baby, and her family
- Uphold each woman's right to free, informed choice and consent throughout her childbirth experience
- Clearly inform and educate clients and the public as to the role, function, standards and philosophy of midwifery practice
- Assist clients in obtaining the necessary information from appropriate sources, when what is required is beyond the midwife's scope
- Respect the informed decision of a client having the necessary ability to accept or refuse care
- Obtain consent for midwifery interventions where necessary and collaborate with other members of the health care team to obtain consent for medical treatment. When clients are incapable of making informed choices, consent should be sought from family members or significant others
- Provide appropriate care until alternative arrangements are made, if the midwife is unable to comply with the client's requests because they run contrary to the law or midwife's moral beliefs
- Safeguard the confidentiality of all client-related information in order to protect the woman's right to privacy
- Disclose confidential information only as authorized by the client, or when there is a legal obligation to disclose the information. Midwives shall maintain the anonymity of clients when disclosing confidential information in other circumstances which are not stated here
- Provide midwifery care in a manner that preserves the clients' privacy and dignity
- Prevent or resolve any situation in which clients are not accorded privacy or dignity
- Render appropriate care to support a dignified and peaceful death in case where life can no longer be sustained

- Practise midwifery in accordance with the health professions code of conduct, the health regulation, the bylaws and policies of the FMoH
- Promote the normal process of birth within the context of safe practice
- Accept full responsibility for the care they provide to women, their newborn infants, families and communities.
- Ensure that the safety of their clients is not jeopardised by the Omission or Commission of any midwifery activity
- Not abandon care or deprive women of essential health services
- Never practice midwifery while their ability to perform any professional service is impaired by alcohol or a drug
- Safeguard the health and safety of their clients against incompetent, unethical or illegal practices
- Alert the appropriate authority of any situations which endanger the health or safety of clients or colleagues
- Provide accurate and relevant information when speaking on midwifery or health-related matters in public

2. Medical ethics for doctors in Ethiopia (Ethiopian Medical Association, 2010)

Doctor shall:

- Attend her/his patient with maximum possible care, devotion and conscientiousness. She/he shall respect the dignity of her/his patient and her/his attitudes shall be sympathetic, friendly and helpful
- Practice her/his profession without discrimination
- Maintain her/his professional secrecy in respect for all matters which have come to her/his knowledge in the course of her/his duties to the patients except in those situations clearly stipulated by the law or when the patient gives written consent for the release of information
- Not disclose the identification of her/his patient in her/his scientific publications or lectures unless there is a written consent of the patient
- Inform the patient about the treatment (Including surgical procedures), she/he intends to carry out
- Help the patient make choices from among the therapeutic alternatives consistent with good medical practice
- Shall not do anything without justification for the health of the Individual or the community

3. Code of ethics for nurses, The International Council of Nurses

Nurses and people

- In providing care, the nurse promotes an environment in which the human rights, values, customs and spiritual beliefs of the individual, family and community are respected
- The nurse ensures that the individual receives accurate, sufficient and timely information in a culturally appropriate manner on which to base consent for care and related treatment
- The nurse holds in confidence personal information and uses judgement in sharing this information
- The nurse shares with society the responsibility for initiating and supporting action to meet the health and social needs of the public, in particular, those of vulnerable populations
- The nurse advocates for equity and social justice in resource allocation, access to health care and other social and economic services
- The nurse demonstrates professional values such as respectfulness, responsiveness, compassion, trustworthiness and integrity
- The nurse sustains a collaborative and respectful relationship with co-workers in nursing and other fields

Section VI: Continuous Quality Improvement (CQI)

Learning Objectives

At the end of this section participants will be able to:

- Describe the key principles of CQI
- Outline the main steps of CQI process
- Demonstrate use of facility-led RMC assessment tool for quality improvement

6.1 Introduction to CQI

Quality Improvement (QI) is an approach to improvement of service systems and processes through the routine use of health and programme data to meet patient and program needs. M&E data provides valuable information that can be used as part of efforts in continuous quality improvement (CQI). CQI represents one form of using data generated by M&E system among others to improve the quality of services.

Key Principles of CQI in the Context of MNCH

Integrated MNCH care systems that are planned in a systematic manner will result in care that better meets patient needs and follows national guidelines. Therefore, it is sometimes necessary to update or change current systems in order to improve care and obtain the desired results. The key principles for improving MNCH care include:

- 1. Client satisfaction:** Focusing on the needs of patients
- 2. Scientific approach:** implementing an improvement model that includes measuring-testing change - re-measuring, and applying change;
- 3. Team approach:** providing leadership support to improve the system of care; and identifying and including knowledgeable staff who will participate in improvement activities. People from different units/work process might be on the same team to complement each other to achieve the same objectives and goals. It is also possible to involve the community in the team.

Quality improvement activities to improve the work undertaken at health centres and hospitals can be integrated into the routine flow of existing work. When this is not the case, improvement work may be seen as separate and additional to everyday work. Also, it may be a concern that one cannot take extra time to work on quality, be it to track data or discuss the care system in a team. However, simple and practical methods can be adapted to help get started. Once improvements begin, systems may function more efficiently and effectively, actually simplifying work.

6.2 CQI Process – How does CQI work?

Quality Assurance is a process centred approach ensuring that an organisation is providing the best possible service. It is related to quality control, which focuses on the end results, after processing. Quality Improvement (QI) is one of the three aspects of quality assurance. In the first two aspects of quality assurance, one needs to define quality and then set priorities to identify specific areas for improvement. The second aspect of quality assurance is the setting up of a system to measure quality and define performance measurement methods for improvement and use existing data, or collect data that will be used to monitor successes. The third aspect is the quality improvement process that involves establishing a Quality Improvement Team that identifies the gap between the current and expected level of quality and uses appropriate methods to close the gaps.

In order to do this, a team can use quality management tools and principles, to understand system deficiencies and improve or redesign processes.

The following are recommended steps a quality team can do to facilitate quality improvement initiatives:

Step 1: Understand the process. This step includes studying the *services* being provided in the clinic, clearly articulating the process, and stating their *outputs* and *outcomes*. By doing so, the QI team can understand and state/record the wants and needs of the clients and other stakeholders involved in consensus. Figure 5 gives an overview of how understanding current state (process) is important to plan for the future.

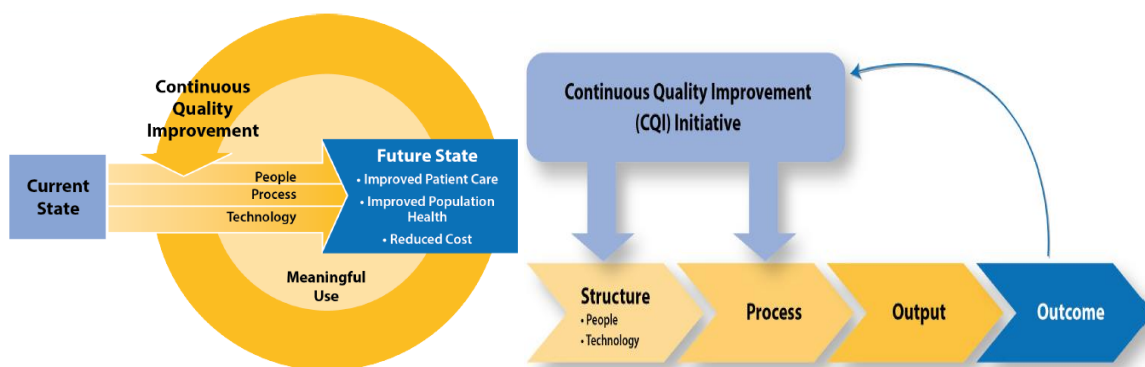


Figure 5: CQI frameworks

“Process mapping”

Implementation steps

- 1) Develop a flowchart (process mapping) of the existing processes;
- 2) Exchange ideas about potential barriers to QI

A process map (work flow chart) is one of the many tools that help us in visualizing the steps of any process in sequential order and can be used to illustrate a sequence of events, activities or tasks for processes ranging from simple to complex. The level of detail to use in process mapping is up to the person(s) sketching the map.

Step 2: Measure quality standards. This step requires development of performance measures (or selected indicators) for the quality standard. Once these quality indicators are selected, the QI team will need to collect, *investigate* and present the results of their analysis during Multi-Disciplinary Team (MDT) meetings.

Performance measurement tells you what is really happening, as opposed to what you think is happening. It tells you what is being documented in the clinic records and is available to help with the decision-making of providers who see the patient. It tells you whether tasks that are supposed to be done are being done, and done well. Refer back to the RMC standards in Box 3.

Step 3: Develop a problem statement: Once opportunities for improvement are recognized, the QI team will work on prioritization using a set of criteria. Some of these criteria can be feasibility, resource availability, and the control QI team has in solving the problem. For addressing each of the problems selected, a *clear* and *concise* statement that the QI team has *discussed* and *agreed* upon should be used to state the problem in reference.

While it is not always necessary to begin with a problem statement, the practice of creating and stating a problem statement helps the QI team to have a shared vision of the opportunity at hand. Note that a good problem statement does not discuss potential causes or solutions. It also does not include statements of blame or discusses potential causes or solutions to the problem.

To demonstrate this, note how the initial statement below is re-written as an articulate and blame-free statement that does not discuss solutions:

Statement of the Problem:

“Women’s privacy is not protected in labour ward because of several women delivering in the labour room. This has been stated as one of disrespectful care during childbirth which influences women’s decision of place of delivery”

To clearly identify the problem at hand, consider answering the following questions as a team:

- What is the problem at hand?
- How do you know that it is a problem?
- How frequently does it occur, or how long has it existed?
- What are the effects of this problem?

- How will you know when it is resolved?

Step 4: Analyze. This step involves conducting a root cause analysis of the problem stated, and brainstorming on improvement strategies to test. Root cause analysis can be done in many ways, including:

- Fishbone analysis
- The Five Whys
- Key Driver Diagram

“Fishbone Analysis”

Fishbone Diagram (“Cause & Effect Diagram”) is used to brainstorm and map out possible causes of a quality problem. This process is started by drawing a central line (a spine) next to the problem we are working on, and drawing diagonal lines that represent categories/groups of possible causes that the QI team will brainstorm about. When categorizing causes, one of the standard branches (“bones”) you can use are **the five Ps** (patients/clients, providers, policies, processes and procedures, and place/equipment) as shown in figure 6. However, it is possible to use different types of groupings that are applicable to your facility.

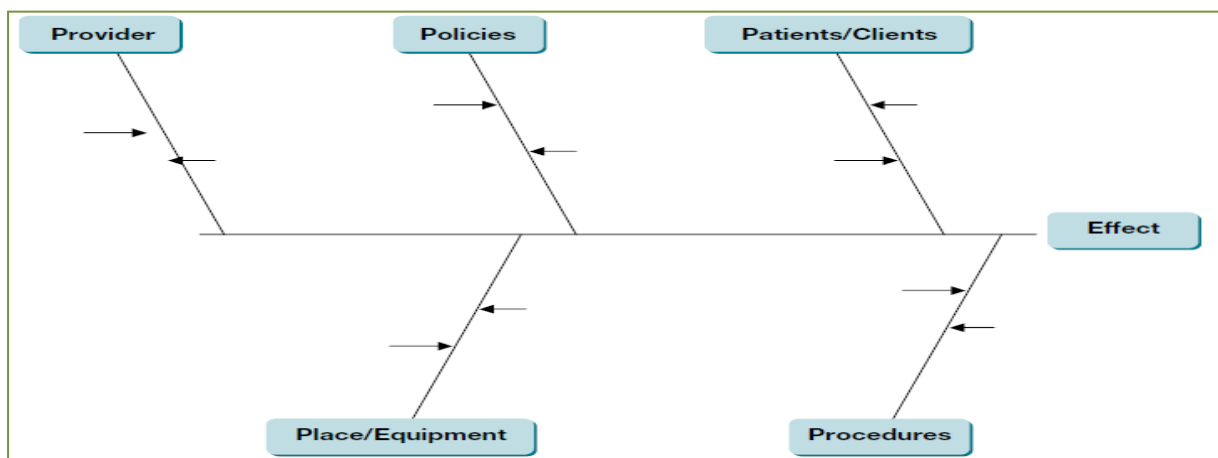


Figure 6: A template of a sample Fishbone Diagram

“The Five Whys”

This process starts by stating the problem you are trying to work on first, and asking a series of whys related to the problem. Although the method is known as “Five Whys”, ask as many whys as you need in order to get the level of insight you are looking for. The Five Whys can be used along Fishbone Diagrams to brainstorm on root causes of a problem. You can ask the reason why the stated problem exists at the spine of a fishbone diagram, and list the reasons the team will come up within their respective categories.

“Key Driver Diagram”

A key driver diagram is used to help organize our test ideas in an improvement effort. It lays out the initial contributors (primary driver or root causes) of a given statement, and then additional contributors to the contributory itself (secondary drivers or immediate causes). A descriptive test idea can then be listed with the purpose of testing. The tree-like structure of the diagram assists in enhancing the development of a predictive thought process.

Once the tree is constructed, the QI team or multidisciplinary team can decide to work on (1) one test idea towards one set aim, (2) multiple test ideas towards different respective aims, or (3) multiple test ideas working towards one aim. The driver diagram should be updated throughout an improvement effort and used to track progress in theory building. Figure 7 provides a template of key driver diagram.

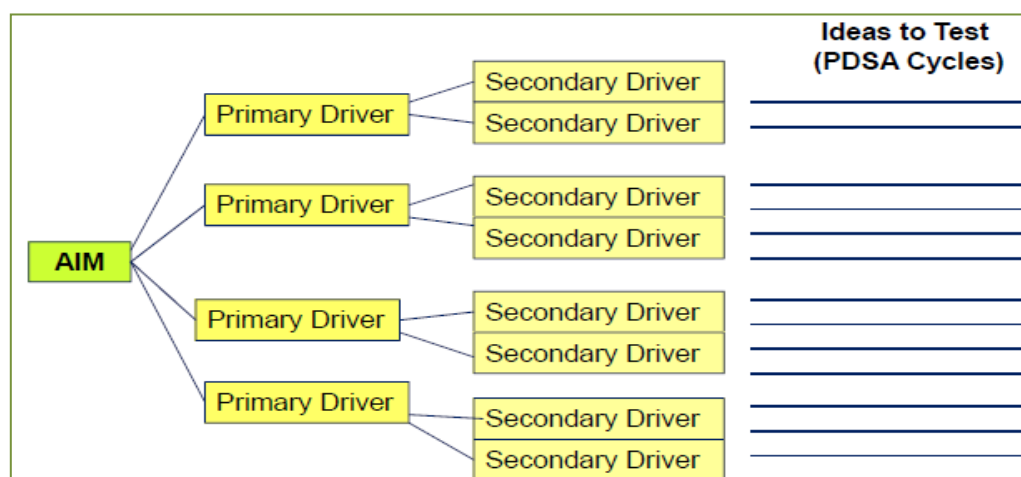


Figure 7: A template for key driver diagram

Step 5: Develop an aim statement. After declaring the problem and analyzing the root causes of the stated problem, develop an aim statement articulating the area for improvement, its current status, and its intended achievements. Aim statements should be *Specific, Measurable, Actionable, Realistic, and Time bound* (SMART). An example of a simple SMART aim statement is:

By the end of February 2018, this project aims to increase the proportion of women whose privacy is maintained during labour 45% to 87%.

The following template can be used to frame a SMART aim statement.

By ____ (date), we will improve ____ from ____ (baseline) to ____ (new level).

Step 6: Test and implement. This step focuses on testing and implementation of a test-idea (proposed intervention). The test(s) can be several small tests or one large test of all proposed

solutions. Continuous cycles of PDSA (Plan-Do-Study-Act) are one of the tools used to test and implement newly proposed interventions. This is done by turning ideas into action and connecting actions taken to learning. Figure 8 and the descriptions below it spell out the details included in each phase of PDSA.

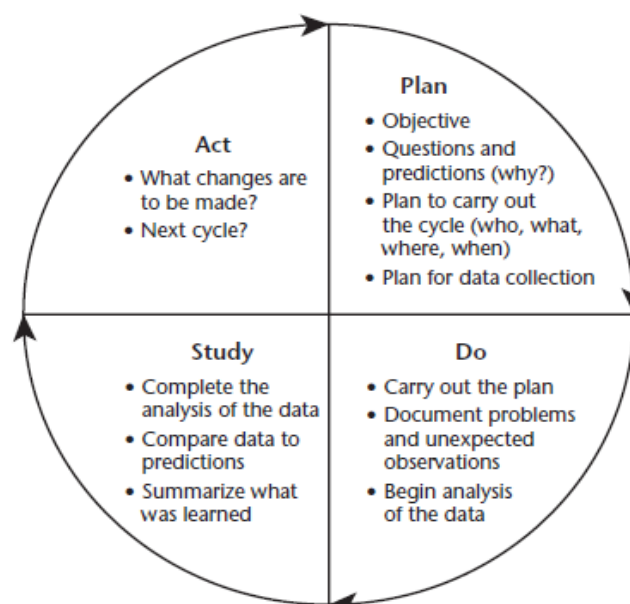


Figure 8: Items to consider when conducting a PDSA cycle (Langley et al., 2009)

6.3 Implementation of CQI

All health workers are expected to adhere to the standard operating procedures (SOPs) including professional ethics and standard protocols to treat clients/patients respectfully and professionally. For example, a nurse/midwife assisting a labouring mother should demonstrate her/his respect to his/her client by supporting, being compassionate and closely following her throughout the process.

6.4 Multi-Disciplinary-Team (MDT) or QI team

In most health facilities in Ethiopia, MDTs are already in place and functional. Seizing this opportunity, this team could play an important role in continuous improvement of RMC, which further contributes to the increased uptake of maternal health services. The minimum quality performance can be assessed using the facility led assessment checklist (*Annex II*) to identify areas for improvement and initiation of the CQI process by MDT who are knowledgeable on the respective service delivery area. (Please note that this checklist is subject for modification according to the facility setting).

The use of available data helps identify current gaps that need to be addressed through:

- Asking staff and patients for ideas about what needs to be improved;
- Prioritizing key opportunities for improvement;
- Selecting one specific improvement at a time on which to focus your work.

How to use the CQI tools

Facility led assessment checklist

This CQI tool enables minimum RMC standards expected to be implemented at labour wards and can be used as a starting point to identify problems in the provision of RMC.

This checklist should be used both by health workers, by the MDT (CQI team) and by the external quality assessment team to monitor the status of RMC in the health facilities. For example, (1) a midwife working in the labour ward can check her/himself how much s/he is complying with the minimum standards of RMC and strive to improve his/her performance accordingly; (2) The MDT/CQI team can use this tool to enable them to conduct a baseline assessment, and to start to monitor the changes/improvements every two weeks or as per the terms of each facility; (3) The Woreda/Zonal/sub-City/Regional team can also use this tool to get an external view of the quality of services in the health facilities in their respective catchment areas.

The tool has five RMC result statements with 32 corresponding checking points/actions.

Check all the boxes for the “Checking points”. Put a tick“✓” mark in the box if the performance complies with the standard. Otherwise, leave the box blank. You can decide to mark-up on the checking points/questions after Observation “O”, Interview “I”, or Review of Documents “RD”. You can follow the letters in parenthesis next to each checking point to assist you to identify which approach is better to use for answering the questions. If you find some important findings for the question, you can write them under the remark column of the table. If a specific standard indicator is not applicable for a woman at a specific scenario, put a tick“✓” in the “Not Applicable (NA)” column.

For scoring, there is a “Score” row to put the score for each of the RMC result statements. When scoring, count the boxes with tick mark only (“✓”) and plot the number of ticks as a numerator and the total checkpoints as denominator (ticked and none); remember to minus the NA standards from the denominator. Once you finish scoring all the RMC components, go to the last row of the tool to do the aggregate score; add all numerators and denominators separately then calculate the proportion by multiplying the result by 100 to get the percentage. This helps to compare performance over a period of time and for summarising performance numerically.

The scoring is appraised through self-assessment and by the multidisciplinary team (MDT). At each entry point, the minimum RMC function will be posted to remind health workers as they are providing services. It enables individuals to self-check and score their performance to observe their own progress. Five key RMC result statements are identified along with their corresponding sub-activities that are to be counted for scoring each key action. The total numerator is then added up and compared to denominators sum. The proportion described in percentage will indicate how much the minimum standards are met at the unit level or at the facility level.

Roles and responsibilities of MDT/CQI Team

General understanding

1. MDTs are expected to meet twice per month or as per the terms of the health facility
2. MDTs are preferably composed of the head of the facility, technical coordinator, and staff from the maternal health services unit
3. MDT or CQI teams are not supervisors; however, they can play the role of supervisor and assist in skill transfer to improve the clinical work and/or the health service system in general.

Specific Roles and responsibilities

- a. Identify a sub-team (2-3 people well versed on labour and delivery to measure clinical performance;
- b. Dedicate time to conduct an internal periodic quality monitoring supportive supervision in labour wards and score quality performance, and stress the importance of complete documentation to help determine whether or not patients are getting the care they deserve; (use Annex II)
- c. Conduct CQI process i.e. measure, testing changes, re-measure, apply the changes and continually move in a cycle of re-testing changes. All the reviews are undertaken to shape the service system to improvement.
- d. Discuss using the CQI process and develop a plan of action (*Annex III Action planning framework*) for self-use and for facility use.

Once the process of CQI is complete, documenting organised ideas using the action plan framework is important both for implementation and follow-up. When completing the column's cells, keywords are preferred over long statements (phrases) in any applicable situations. However, it is advisable to be cautious against the wrong interpretation of some terms/words.

Equally important is record keeping. Making changes resulting in improvement is not a mechanical process. People are involved and their individual, as well as team

efforts, should be clearly noted to be accountable for the changes made and for the feedback loops. Keeping all records safe and clean will enable the use of the findings to guide future actions.

- e. Report compilation and recording: The data generated from CQI process will primarily assist the facility to take its own action/s as well as serve as a reference on the continuous progress monitoring during the subsequent checks until a comfortable state of actions are obtained. It could also serve for proposals writing to solicit funds from donors to fill the gaps. Another important value is the documentation of best practices that are identified during the implementation process.

Annex I: World Health Organization statement on disrespect and abuse during facility-based childbirth

**World Health Organization**



The prevention and elimination of disrespect and abuse during facility-based childbirth

WHO statement

Every woman has the right to the highest attainable standard of health, which includes the right to dignified, respectful health care.



photo: UNICEF

Many women experience disrespectful and abusive treatment during childbirth in facilities worldwide. Such treatment not only violates the rights of women to respectful care, but can also threaten their rights to life, health, bodily integrity, and freedom from discrimination. This statement calls for greater action, dialogue, research and advocacy on this important public health and human rights issue.

Background

Ensuring universal access to safe, acceptable, good quality sexual and reproductive health care, particularly contraceptive access and maternal health care, can dramatically reduce global rates of maternal morbidity and mortality. Over recent decades, facility delivery rates have improved as women are increasingly incentivized to utilize facilities for childbirth, through demand generation, community mobilization, education, financial incentives or policy measures.

However, a growing body of research on women's experiences during pregnancy, and particularly childbirth, paints a disturbing picture. Many women across the globe experience disrespectful, abusive or neglectful treatment during childbirth in facilities. (1-3) This constitutes a violation of trust between women and their health-care providers and can also be a powerful disincentive for women to seek and use maternal health care services. (4) While disrespectful and abusive treatment of women may occur throughout pregnancy, childbirth and the postpartum period, women are particularly vulnerable during childbirth. Such practices may have direct adverse consequences for both the mother and infant.

Reports of disrespectful and abusive treatment during childbirth in facilities have included outright physical abuse, profound humiliation and verbal abuse, coercive or unconsented medical procedures (including sterilization), lack of confidentiality, failure to get fully informed consent, refusal to give pain medication, gross violations of privacy, refusal of admission to health facilities, neglecting women during childbirth to suffer life-threatening, avoidable complications, and detention of women and their newborns in facilities after childbirth due to an inability to pay.(5) Among others, adolescents, unmarried women, women of low socio-economic status, women from ethnic minorities, migrant women and women living with HIV are particularly likely to experience disrespectful and abusive treatment.(5)

Every woman has the right to the highest attainable standard of health, which includes the right to dignified, respectful health care throughout pregnancy and childbirth, as well as the right to be free from violence and discrimination. Abuse, neglect or disrespect during childbirth can amount to a violation of a woman's fundamental human rights, as described in internationally adopted human rights standards and principles.(6-9) In particular, pregnant women have a

right to be equal in dignity, to be free to seek, receive and impart information, to be free from discrimination, and to enjoy the highest attainable standard of physical and mental health, including sexual and reproductive health.(10)

Despite the existing evidence that suggests women's experiences of disrespect and abuse during facility-based childbirth are widespread,(1-3,5) there is currently no international consensus on how disrespect and abuse should be scientifically defined and measured. Consequently, its prevalence and impact on women's health, well-being and choices is not known. A considerable research agenda exists to better define, measure and understand disrespectful and abusive treatment of women during childbirth, and how it can be prevented and eliminated.

To achieve a high standard of respectful care during childbirth, health systems must be organized and managed in a manner that ensures respect for women's sexual and reproductive health and human rights. While many governments, professional societies, researchers, international organizations, civil society groups and communities worldwide have already highlighted the need to address this problem (11-14) in many instances policies to promote respectful maternal care have not been adopted, are not specific, or have not yet been translated into meaningful action.



photo: World bank

In order to prevent and eliminate disrespect and abuse during facility-based childbirth globally, the following actions should be taken:

1. Greater support from governments and development partners for research and action on disrespect and abuse

Greater support from governments and development partners is needed for further research on defining and measuring disrespect and abuse in public and private facilities worldwide, and to better understand its impact on women's health experiences and choices. Evidence on the effectiveness and implementation of interventions in different contexts is required to provide the necessary technical guidance to governments and health-care service providers.

2. Initiate, support and sustain programs designed to improve the quality of maternal health care, with a strong focus on respectful care as an essential component of quality care

Greater action is needed to support changes in provider behaviour, clinical environments and health systems to ensure that all women have access to respectful, competent and caring maternity health care services. This can include (but is not limited to) social support through a companion of choice, mobility, access to food and fluids, confidentiality, privacy, informed choice, information for women on their rights, mechanisms for redress following violations, and ensuring high professional standards of clinical care. The focus on safe, high-quality, people-centered care as part of universal health coverage can also help inform action.

3. Emphasizing the rights of women to dignified, respectful health care throughout pregnancy and childbirth

International human rights frameworks highlight disrespect and abuse during childbirth as an important human rights issue, (6-8, 15) and can aid women's health advocates in raising awareness and developing policy initiatives on the importance of respectful maternal care. Rights-based approaches to organizing and managing health systems can facilitate the provision of respectful, quality care at birth.

4. Generating data related to respectful and disrespectful care practices, systems of accountability and meaningful professional support are required

Health systems must be accountable for the treatment of women during childbirth, ensuring clear policies on rights and ethical standards are developed and implemented. Health-care providers at all levels require support and training to ensure

that childbearing women are treated with compassion and dignity. Those health services that already provide respectful maternity care, promote participation of women and communities and have implemented processes to track and continuously improve respectful care need to be identified, studied and documented.

5. Involve all stakeholders, including women, in efforts to improve quality of care and eliminate disrespectful and abusive practices

Ending disrespect and abuse during childbirth can only be achieved through an inclusive process, involving the participation of women, communities, health-care providers, managers, health professional training, education and certification bodies, professional associations, governments, health systems stakeholders, researchers, civil society groups and international organizations. We call upon these entities to join in efforts to ensure that disrespect and abuse is consistently identified and reported, and that locally appropriate preventative and therapeutic measures are implemented.

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በተቋማት ውስጥ በሚካሄድ ወሊድ ወቅት ክብረ-ነክ አያያዝና ጥቃትን መከላከልና ማስወገድ



photo: UNICEF

የዓለም ጤና ድርጅት (WHO) መግለጫ:-

በዓለም ዙሪያ የሚገኙ በርካታ ሴቶች በተቋም ውስጥ በሚወልዱበት ወቅት ጥቃትና ክብርን የሚነካ አያያዝ ያጋጥማቸዋል። እንደዚህ ያለው አያያዝ ክብራቸውን የሚጠብቅ እንክብካቤ የማግኘት መብታቸውን ከመጣሱ በተጨማሪ ለሕይወት ለጤና ለአካላዊ ደህንነት እና ከአድልዎ ነፃ የመሆን መብታቸውን ጭምር አደጋ ላይ የሚጥል ነው። ይህን አንገብጋቢ የሕዝብ ጤና እና የሰብዓዊ መብት ጉዳይ በተመለከተ እርምጃ ውይይት ጥናትና ምርምር እንዲሁም ትኩረት ማስፈለጉን ይህ መግለጫ ይጠቀማል።

ዳራ(መነሻ)

ጥንቃቄ የተሞላ ተቀባይነትና ጥራት ያለው የሰነ-ተዋልዶ ጤና አጠባበቅ በተለይም የወሊድ መቆጣጠሪያና የእናቶች ጤና አጠባበቅ ጠቅላላ ተደራሽነትን ማረጋገጥ በዓለም ደረጃ የሚገኘውን በወሊድ ጊዜ የሚከሰተውን እናቶችና የሕፃናት ሞት ቁጥር በከፍተኛ ደረጃ ይቀንሳል። ከቅርብ አስርት ዓመታት ወዲህ ከተለያዩ ማበረታቻዎች የተነሳ ለምሳሌ ለአገልግሎቱ ፍላጎት የሚጨምሩ ሁኔታዎችን በመፍጠር በማህበረሰቡ ትስታላ በትምህርት በገንዘብ ማበረታቻ ወይም በፖሊሲ እርምጃዎች ምክንያት በተቋሙ ውስጥ የሚወልዱ እናቶች ቁጥር ተሻሽሏል።

ይሁን እንጂ በአርገዝና ወቅት በተለይም በወሊድ ጊዜ የሴቶችን ገጠመኞች በተመለከተ የተደረጉ ቁጥራቸው እየጨመሩ የመጡት ጥናቶች ውጤት አዋኪ ሰዕልን ያሳያሉ። በዓለም ዙሪያ የሚገኙ ብዙ

ሴቶች በተቋም ውስጥ በሚወልዱበት ጊዜ ክብር የሚነካ ጥቃትና የችልተኝነት አያያዝ ያጋጥማቸዋል። (1-3) ይህ በሴቶችና በጤና አገልግሎት ሰጪዎቻቸው መካከል ሊኖር የሚገባውን ዕምነት ማጉደል ከመሆኑም በተጨማሪ ሴቶች የወሊድ ጤና አገልግሎት እንዳይሸና እንዳይጠቀሙ አሉታዊ ተፅዕኖ የመፍጠር ኃይል አለው። (4) ሴቶች በአርገዝናቸው ጊዜ በሚወልዱበት እና ከወለዱ በኋላ የጥቃት ወይም ክብራቸውን የሚነካ ሁኔታዎች ሊያጋጥሟቸው ቢችሉም ሴቶች በተለይ በወሊድ ወቅት ከሁሉ ጊዜ ይልቅ ለአደጋ የተጋለጡ ናቸው። ፡ እንደዚህ አይነት አስራሮች በእናቶችና በሕፃናት ላይ ቁጥተኛ አደጋና ችግር ሊያስከትሉ ይችላሉ።

በተቋም ውስጥ በሚካሄድ ወሊድ ወቅት ከሚከሰቱ ጥቃቶችና ክብርን የሚነኩ አያያዞች መካከል ፡- (በገሃድ) የተገለጠ አካላዊ ጥቃት ከባድ ማዋረድና የቃላት ጥቃት አስገዳጅና ያለፈቃድ የሚደረጉ የሕክምና አገልግሎቶች (መካን ማድረግን ጨምሮ) የታካሚን የግል መረጃ ሚስጥር አለመጠበቅ

በሙሉ አውቀትና መረዳት የሆነ የታካሚን ፈቃድ አለማግኘት የሰቃይ ማስታገሻ መድኃኒት ለመስጠት ፍቃደኛ አለመሆን ከፍተኛ የግል መብት ጥሰት በጤና ተቋም ውስጥ አልጋ እንዳይዙ (የአገልግሎት ተጠቃሚ እንዳይሆኑ) መከላከል በወሊድ ጊዜ እናቶችን ችላ በማለት ሕይወታቸውን አደጋ ላይ የሚጥሉ፤ በተለሉ መከላከል ይቻሉ ለነበሩ መዘዞች ማጋለጥና እንዲሁም የአገልግሎት ክፍያ መክፈል ባለመቻላቸው እናቶችንና አራስ ልጆቻቸውን በተቋሙ ውስጥ ማገትን እንደሚጨምሩ ሪፖርቶች ያሳያሉ (5)። በተለይም ደግሞ ወጣቶች ትዳር የሌላቸው በዝቅተኛ የማህበረሰብና የኢኮኖሚ ደረጃ ላይ የሚገኙ የእናት ብሔረሰብ አባላት ሰደተኞች እና ከኢች.አይ.ቪ ቫይረስ ጋር የሚኖሩ ሴቶች ላይ ክብረ- ነክና አገባብነት የጎደለው አያያዝ የመድረሱ ዕድል ከፍተኛ ነው።

ሁሉም ሴቶች ሊደረስበት የሚችለው ከፍተኛ የጤና ደረጃ ላይ የመድረስ መብት አላቸው፤ ይኸውም በአርገዝናቸውና በወሊድ ጊዜ ሁሉ ክብራቸውን የጠበቀና በአክብሮት የተሞላ የጤና አጠባበቅ መብትንና በተጨማሪም ከጥቃትና ከአድልዎ ነፃ የመሆን መብትን ያጠቃልላል። በወሊድ ጊዜ የሚደረግ አገባብ የጎደለው አያያዝ ችል መባል ወይም የክብር መነካት በዓለም አቀፍ ደረጃ ተቀባይነት ያላቸውን ሰብዓዊ መብቶችንና መርሆዎችን ከመጣስ ጋር አንድ ናቸው። (6-9) በተለይም ነፍሰ-ጡር ሴቶች በክብር እኩል የመሆን መብት መረጃ የመጠየቅ የማግኘትና የማስተላለፍ ነፃነት ከአድልዎ ነፃ የመሆን እና ሊደረስበት የሚችለው ከፍተኛው የአካላዊና የአዕምሮ ጤና፤ እንዲሁም የሰነ-ተዋልዶ ጤና እንክብካቤን ጨምሮ የማግኘት መብት አላቸው።(10)

በተቋም ውስጥ በሚካሄዱ ወሊዶች ወቅት ሴቶች የሚያጋጥሟቸው ክብረ-ነክና አገባብ የሌላቸው አያያዞች መስፋፋታቸውን የሚገልፁ ማስረጃዎች ቢኖሩም (1-3,5) በአሁኑ ወቅት ክብረ-ነክነትና ጥቃትን በሳይንሳዊ መንገድ ለመለካትና ለመተንተን የሚያስችል

በዓለም አቀፍ ደረጃ የተደረሰ ምንም ዓይነት ስምምነት የለም። ከዚህም የተነሳ ሁኔታው በሴቶች ጤና ደህንነትና በምርጫዎቻቸው ላይ የሚያደርሰው ተጽዕኖ በውል አይታወቅም፡፡ ሴቶች በወሊድ ጊዜ የሚያጋጥሟቸውን ክብረ-ነክ እና ጥቃታዊ አያያዞችን በተሻለ ሁኔታ ለመተንተን ለመለካትና ለመረዳት እንዲሁም እነዚህን እንደት መከላከልና ማስወገድ እንደሚቻል ለማየት ሰፊ ጥናት የሚጠይቅ ርዕስ ነው።

በወሊድ ጊዜ ከፍተኛ ደረጃ ያለው በአክብሮት የሆነ እንክብካቤ ላይ ለመድረስ ከተፈለገ የጤና አጠባባቂ ስርዓቶች የሴቶች የሰነ-ተዋልዶ መብትና ሰብዓዊ መብት መከበሩን በሚያረጋግጥ ሁኔታ መዋቀርና መተዳደር (መካሄድ) አለባቸው። በዓለም ዙሪያ የሚገኙ ብዙ መንግስታት የሙያ ማህበራት ጥናትና ምርምር አድራጊዎች ዓለም አቀፍ ድርጅቶች የተለያዩ ማህበራት እና ማህበረሰቦች ይህን ችግር መግታት ማስፈለጉን ቢገልፁም (11-14) በአብዛኛው ጊዜ በአክብሮት የሆነ የወሊድ አገልግሎትን የሚያበረታቱ ፖሊሲዎች ገና አልፀደቁም ግልጽና ተጥተኛ አልተደረጉም ወይም ትርጉም በሚሰጥ ሁኔታ ወደ ተግባር አልተለወጡም።

በዓለም ዙሪያ በተቋም በሚካሄድ ወሊድ ላይ የሚያጋጥሙትን ክብረ-ነክና አገልግሎት የሌላቸው አያያዞችን ለመከላከልና ለማስወገድ የሚከተሉት አርምጃዎች መወሰድ አለባቸው።



photo: World bank

1. ክብረ-ነክነትንና አገልግሎት የጎደለው አያያዝን በተመለከተ መካሄድ ለሚገባው ጥናት እና አርምጃ ከመንግስታትና ከልማት አጋሮች የበለጠ ድጋፍ መገኘት አለበት፡፡

በዓለም ዙሪያ በሚገኙ የመንግስትና የግል ተቋማት ውስጥ የሚከሰቱትን ክብረ-ነክነትና ጥቃቶችን ለመተንተን ለመለካትና እነዚህም በሴቶች የጤና ገጠመኞቻቸውና ምርጫዎቻቸው ላይ የሚያሳድሩትን ተፅዕኖዎች ይበልጥ ለመረዳት የሚያስችሉ ተጨማሪ ድጋፍ ያስፈልጋል። በተለያዩ ሁኔታዎች የተወሰዱ አርምጃዎችና ማስረጃዎች ለመንግስታትና ለጤና አገልግሎት ሰጪዎች አስፈላጊውን የቴክኒክ መመሪያ ከመስጠት አንፃር ወሳኝነት አላቸው።

2. የአንድ ጥራቱን የጠበቀ እንክብካቤ ወሳኝ አካል የሆነውን በአክብሮት የሆነ እንክብካቤን ተኩረታቸው ያደረጉ የወሊድ ጤና አጠባባቂን ለማሻሻል ያቀዱ መርሃ-ግብሮችን መጀመር፤ መደገፍ እና ማስቀጠል።

ሁሉም ሴቶች በአክብሮት የሆነ ብቃት ያለውና በቂ ጥበቃና ያረጋገጠ የወሊድ ጤና አጠባባቂ (እንክብካቤ) አገልግሎት ማግኘት እንዲችሉ የአገልግሎት ሰጪዎች አመለካከት የተቋሙ የህክምና ሁኔታ እና የጤና አጠባባቂ ስርዓት ይለውጥ ለማምጣት ለሚወሰዱ አርምጃዎች ድጋፍ መስጠት ያስፈልጋል። ይህም የሚከተሉትን (ሌሎችንም ሊጨምር ይችላል) አርምጃዎች ያጠቃልላል፡- በሚመርጡት ባልደረባ በኩል የሚደረግ የማህበረሰብ ድጋፍ እንደልብ መዘዋወር መቻል የምግብና የመጠጠጥ አትሪቦት ማግኘት የሚሰጥ መጠበቅ የግል መብት መጠበቅ ሁኔታዎችን ትክክል ከመረዳት የመነጨ ምርጫ መምረጥ መብቶቻቸውን በተመለከተ ለሴቶች መረጃ ማቅረብ ጥቃቶች ባጋጠሙ ጊዜ ካሳ የማግኘት ስርዓቶች መኖር እና የሙያ ደረጃቸውን የጠበቁ የጤና አገልግሎቶች መኖራቸውን ማረጋገጥ ናቸው። ከፍተኛ ጥራት በቂ ጥበቃ እንዲሁም ሰዎችን ያማከል እንክብካቤ ላይ የሚደረግ ትኩረት፡ ለሁሉም ተደራሽ የሆነ የጤና ሽፋን መርህ አካል መሆኑን መረዳት አርምጃዎችን ለመውሰድ የሚያስችል ግንዛቤን ይሰጣል።

3. በአርምጃ ወቅትና በወሊድ ጊዜ ሴቶች ክብራቸውን የጠበቁና በአክብሮት የሆነ የጤና አጠባባቂና እንክብካቤ የማግኘት መብት እንዳላቸው አፅንኦት (ትኩረት) መስጠት።

ዓለማቀፋዊ የሰብዓዊ መብቶች ሃሳቦችና መርሆች በወሊድ ጊዜ የሚከሰት ክብረ-ነክና አገልግሎት የጎደለውን አያያዝ አንድ ዋና የሰብዓዊ መብት ጉዳይ ይመለከቱታል (6-8, 15) በመሆኑም ለሴቶችን ጤና ድጋፍ የሚሰጡ ይህንን በተመለከተ ግንዛቤ ለማስጨበጥ ለሚሰሩ እንዲሁም ክብርን የሚጠብቁ የአናቶች ጤና እንክብካቤ አስፈላጊነት በተመለከተ ፖሊሲ ቀረፃ ላይ የሚሳተፉ ሰዎችን የሚያግዝ ነው። የጤና ስርዓቶች አወቃቀርና አስተዳደር መብት ላይ የተመሰረተ አካሄድ ቢኖረው ክብርና ጥራት የተላበሰ የወሊድ እንክብካቤ ለመስጠት እንዲቻል ያግዛል።

4. በአክብሮት የሆነና ክብረ-ነክ የአንክብካቤ ልምዶችን በተመለከተ መረጃ ማግኘት (መስብሰብ)& የተጠያቂነት ስርዓት መዘርጋትና& ትርጉም ያለው መያዪ ድጋፍ መስጠት አስፈላጊ ናቸው።

የጤና አጠባበቅ ስርዓቶች ሴቶች በወሊድ ጊዜ የሚያጋጥሟቸውን የአያያዝ ሁኔታ በተመለከተ ተጠያቂነት ሊኖራቸው ይገባል፤ይህም መብቶችንና ስነ ምግባርን በግልጽ ያስቀመጡ ፖሊሲዎች በመቀረጻቸውና ተግባር ላይ መዋላቸውን በማረጋገጥ ነው። ወላድ ሴቶች በርሀራሴና ክብራቸውን በሚጠብቅ ሁኔታ መያዛቸውን ለማረጋገጥ ከተፈለገ በሁሉም ደረጃ ለሚገኙ የጤና አገልግሎት ሰጪዎች ስልጠናና ድጋፍ መስጠት ያስፈልጋል፡ ክብር የተሞላ የወሊድ አንክብካቤ በመስጠት ላይ የሚገኙ የሴቶችንና የማህበረሰቡን ተሳትፎ የሚያበረታቱ እና ክብር የተሞላው አገልግሎት መስጠቱን ለማረጋገጥ የክትትል ማድረጊያ ሂደቶችንና ተከታታይ በክብር የሆነ አገልግሎትን የማሻሻያ ስልቶችን የቀየሱ የጤና አጠባበቅ አገልግሎቶችን ለይቶ ማወቅ ማጥናትና ተሞክሮዎቻቸውን (በስነድ) ማጠናቀር ያስፈልጋል።

5. የጤና አጠባበቅ ጥራትና ለማሻሻል እና ክብረ-ነክና አግባብነት የሌላቸውን ድርጊቶችን ለማስወገድ ለሚደረገው ጥረት ሴቶችንም ጨምሮ ሁሉንም ባለድርሻ አባላት ማሳተፍ

በወሊድ ጊዜ የሚከሰት ክብረ-ነክና አግባብነት የሌላቸውን ድርጊቶች ማስወገድ የሚቻለው ሁሉን በሚያካትት ሂደት ሲሆን የሴቶች የማህበረሰቦች የጤና አገልግሎት ሰጪዎች የአስተዳዳሪዎች የጤና ባለሙያዎች አስልማቶች የጤና ስርዓት ባለድርሻ አካላት ጥናትና ምርምር አድራጊዎች የሲቪል ማህበረሰብ ቡድኖች እና ዓለም አቀፍ ድርጅቶች ተሳትፎን ይጠይቃል። ክብረ-ነክና አግባብነት የሌለው ድርጊት በግልጽ ሁኔታ እንዲታወቅና ተጠቂዎች ትሬታ ማቅረብ ይችሉ ዘንድ እንዲሁም በአካባቢው ተገቢ የመከላከያና የሕክምና (ጥቃቱ ለደረሰባቸው) እርምጃዎች ተግባር ላይ መዋል ለማስቻል በሚደረጉ ጥረቶች እነዚህ ባለድርሻ አካሎች እንዲሳተፉ ጥሪዎችን እናቀርባለን።

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This statement is endorsed by:

American Refugee Committee
Artemis Association
Association for Improvements in the Maternity Services
Averting Maternal Death and Disability, Mailman School of Public Health, Columbia University
Barts Health NHS Trust, United Kingdom
Barts and the London School of Medicine and Dentistry, Queen Mary University of London, United Kingdom
BirthHouse Association (Hungary)
BJOG: An International Journal of Obstetrics and Gynaecology
California Association of Midwives
CARE
Center for Health and Gender Equity (CHANGE)
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Center for the Right to Health (CRH)
Commonwealth Medical Trust (Commat)
DONA LLUM, Associació Catalana per un Part Respectat
El Parto Es Nuestro, Spain
Elizabeth Glaser Pediatric AIDS Foundation
ENCA European Network of Childbirth Associations
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IntraHealth International

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Department of Obstetrics and Gynaecology
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Maternal and Child Survival Program
Maternal Health Task Force
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Perinatal Mental Health Project (PMHP), University of Cape Town, South Africa
Plan International
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Red Latinoamericana y del Caribe por la Humanización del Parto y del Nacimiento (Latin American and Caribbean Network for the Humanization of Childbirth)
Reproductive Health Matters
RODA Parents in Action, Croatia
Royal College of Midwives
Safe Motherhood Program, Bixby Center for Global Reproductive Health and Policy, Dept. of Obstetrics, Gynecology & Reproductive Sciences at UCSF
SafeHands for Mothers
SQUAT Birth Journal
Swedish International Development Cooperation Agency
Swiss Tropical and Public Health Institute
The Soapbox Collaborative
Thrive Center for Birth & Family Wellness
Umeå Centre for Global Health Research
University Research Co., LLC (URC)
University of Ibadan, Ibadan, Nigeria
United States Agency for International Development (USAID)
White Cross Foundation
Wits Reproductive Health & HIV Institute, South Africa
The White Ribbon Alliance

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Annex II: Facility-led RMC assessment checklist for continuous quality improvement

RMC standards	Measurement criteria O: observation; I: interview; RD: review of documents		NA	Remark
The woman is protected from verbal abuse	☐	1. Uses polite language, avoids use of harsh or rude language (O)		
	☐	2. Does not make judgmental or accusatory comments (O)		
	☐	3. Does not make threats to withhold treatment (O)		
	☐	4. Does not blame a woman for any feature of her birth outcome/s (O)		
Score	____ of ____			
The woman is protected from physical abuse	☐	1. Does not beat, slap, kick, or pinch a woman (O)		
	☐	2. Does not deny a woman to cry or scream during labour (O)		
	☐	3. Does not restrain (tie) a woman (O)		
Score	____ of ____			
The woman is not stigmatized or discriminated	☐	1. Serves a woman respectfully regardless of her religion/race/ethnicity/age/socioeconomic status/medical condition (O/I)		
	☐	2. Serves a woman respectfully regardless of her medical condition (O/I)		
Score	____ of ____			
The woman received professional standard of care	☐	1. Seeks for woman's consent prior to performing any procedure (O)		
	☐	2. Never shouts loudly when communicating woman's information to other staff (O/I)		
	☐	3. Keeps woman's personal information secure (O/I/RD)		
	☐	4. Performs vaginal examination very gently to minimize pain (O/I)		
	☐	5. Maintains woman's privacy while performing vaginal examination (O/I)		
	☐	6. Gives a woman pain relief when she needs it (O/I)		
	☐	7. Obtains woman's consent before preparing her for surgery (O/I)		
	☐	8. Responds to a woman immediately following her call (O/I)		
	☐	9. Never leaves a woman alone during labour (O/I)		
Score	____ of ____			
The woman received care with good provider rapport and communication	☐	1. Introduces himself/herself to a woman when he/she first meet her (I/O)		
	☐	2. Serves a woman in a polite manner (I/O)		
	☐	3. Does not ignore woman's concern/s while she is in labour (I/O)		

	☐	4. Speaks to a woman in a clear language (I/O)		
	☐	5. Gives a woman periodic updates of progress of labour (O/I)		
	☐	6. Gives credit to every effort a woman makes in labour (O/I)		
	☐	7. Allows a woman to move around during labour unless there is an indication to deny her (O/I)		
	☐	8. Allows a woman to take food or fluids if there is no other indication to deny her (I/O)		
	☐	9. Allows woman's birth companions for companionship (I/O)		
	☐	10. Allows a woman to assume position of her choice during labour (I/O)		
	☐	11. Allows a woman any cultural practice she wants to practice in labour (I/O)		
	☐	12. Does not objectify a woman in labour (I/O)		
	☐	13. Does not make a woman stay in the hospital without her will (I/O)		
	☐	14. Keeps a baby with his mom unless there is another indication (O/I)		
Score	___ of ___			
Grand score	___ of ___			

Annex III: Action plan matrix to improve respectful maternity care

Indicator (intended target)	Possible cause (key causes)	Action taken (test action)	Responsible person	Support required	Timeline (dd/mm/yy)	Evaluate/ lesson learned (study)	Action for the next cycle
I:	C1:						☐ Modify ☐ Expand ☐ Drop
T:	C2:						

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Appendix B-2: Respectful maternity care training schedules

Round I

Training on Respectful Maternity Care & Continuous Quality Improvement Approach (CQI) for Health Care Providers

Organized by Hawassa University, College of Medicine and Health Sciences in collaboration with the Federal Ministry of Health and SNNPR Health Bureau

April 25 - 27, 2018; Hawassa, Ethiopia

Training element	Responsible person		Time
Day 1 – Wednesday 25th April 2018	Facilitator	Moderator	
Registration	Facilitators	Facilitators	08:30 AM - 09:00 AM
Welcome & introduction of participants, orientation on training schedule & objectives of the training	Anteneh	Dr. Zenebe	09:00 AM - 09:20 AM
Pre-test	Facilitators	Facilitators	09:20 AM - 10:00 AM
Role play and brainstorming on respect during childbirth	Sr. Helen and Sr. Lemlem	Facilitators	10:00 AM – 10:30 AM
Tea break	<i>HU, CMHS</i>		10:30 AM - 10:50 AM
Maternal health and maternal mortality	Dr. Zenebe	Anteneh	10:50 AM - 12:30 PM
Lunch Break	<i>Self</i>		12:30 PM - 02:00 PM
Disrespect and abuse during childbirth	Anteneh	Dr. Zenebe	02:00 PM - 03:30 PM
Tea break	<i>HU, CMHS</i>		03:30 PM - 03:50 PM
Disrespect and abuse during childbirth	Anteneh	Dr. Zenebe	03:50 PM - 04:20 PM
Human rights and law in the context of health and reproductive health	Dr. Zenebe	Anteneh	04:20 PM - 05:15 PM
Daily evaluation	Facilitators	Facilitators	05:15 PM - 05:30 PM
Day 2 – Thursday 26th April 2018			
Recap	Participants	Dr. Zenebe	08:30 AM - 08:45 AM
Human rights and law in the context of health and reproductive health	Dr. Zenebe	Tilahun	08:45 AM - 09: 15 AM
Respectful maternity care: Concept and definition, RMC in the context of compassionate respectful and caring (CRC) initiative	Dr. Zenebe	Anteneh	09:15 AM - 10:30 AM
Tea break	<i>HU, CMHS</i>		10:30 AM - 10:50 AM
Respectful maternity care and safe motherhood	Anteneh	Tilahun	10:50 AM - 11:20 PM
Promoting respectful and dignified care during childbirth	Anteneh	Tilahun	11:20 AM - 12:30 PM
Lunch Break	<i>Self</i>		12:30 PM - 02:00 PM
Promoting respectful and dignified care during childbirth	Anteneh	Tilahun	02:00 PM - 03:30 PM
Tea break	<i>HU, CMHS</i>		03:30 PM - 03:50 PM
Professional ethics and respectful maternity care	Dr. Zenebe	Anteneh	03:50 PM - 05:15 PM

Training element	Responsible person		Time
Daily evaluation	Facilitators	Facilitators	05:15 PM - 05:30 PM
Day 3 – Friday 27th April, 2018			
Recap	Participants	Anteneh	08:30 AM - 08:45 AM
Introduction to CQI for respectful maternity care	Anteneh	Tilahun	08:45 AM - 10:30 AM
Tea break	<i>HU, CMHS</i>		10:30 AM - 10:50 AM
Introduction to CQI for respectful maternity care	Anteneh	Dr. Zenebe	10:50 AM - 12:30 PM
Lunch Break	<i>Self</i>		12:30 PM - 02:00 PM
Action planning and post-training focus group discussions	Tilahun	Dr. Zenebe	02:00 PM - 03:30 PM
Tea break	<i>HU, CMHS</i>		03:30 PM - 03:50 PM
Action planning and post-training focus group discussions	Tilahun	Dr. Zenebe	03:50 PM - 04:20 PM
Course evaluation	Facilitators	Facilitators	04:20 PM - 04:35 PM
Closing and certification	SNNPRHB and HU, CMHS	Tilahun	04:30 PM - 05:00 PM

Round II
Training on Respectful Maternity Care & Continuous Quality Improvement Approach (CQI) for Health Care Providers
Organized by Hawassa University, College of Medicine and Health Sciences in collaboration with the Federal Ministry of Health and SNNPR Health Bureau
May 02 - 04, 2018; Hawassa, Ethiopia

Training element	Responsible person		Time
Day 1 – Wednesday 2nd May 2018	Facilitator	Moderator	
Registration	Facilitators	Facilitators	08:30 AM - 09:00 AM
Welcome & introduction of participants, orientation on training schedule & objectives of the training	Anteneh	Dr. Zenebe	09:00 AM - 09:20 AM
Pre-test	Facilitators	Facilitators	09:20 AM - 10:00 AM
Role play and brainstorming on respect during childbirth	Participants	Facilitators	10:00 AM – 10:30 AM
Tea break	<i>HU, CMHS</i>		10:30 AM - 10:50 AM
Maternal health and maternal mortality	Dr. Zenebe	Anteneh	10:50 AM - 12:30 PM
Lunch Break	<i>Self</i>		12:30 PM - 02:00 PM
Disrespect and abuse during childbirth	Anteneh	Dr. Zenebe	02:00 PM - 03:30 PM
Tea break	<i>HU, CMHS</i>		03:30 PM - 03:50 PM
Disrespect and abuse during childbirth	Anteneh	Dr. Zenebe	03:50 PM - 04:20 PM
Human rights and law in the context of health and reproductive health	Dr. Zenebe	Anteneh	04:20 PM - 05:15 PM
Daily evaluation	Facilitators	Facilitators	05:15 PM - 05:30 PM
Day 2 – Thursday 3rd May 2018			
Recap	Participants	Dr. Zenebe	08:30 AM - 08:45 AM
Human rights and law in the context of health and reproductive health	Dr. Zenebe	Tilahun	08:45 AM - 09: 15 AM
Respectful maternity care: Concept and definition, RMC in the context of compassionate respectful and caring (CRC) initiative	Dr. Zenebe	Anteneh	09:15 AM - 10:30 AM
Tea break	<i>HU, CMHS</i>		10:30 AM - 10:50 AM
Respectful maternity care and safe motherhood	Anteneh	Tilahun	10:50 AM - 11:20 PM
Promoting respectful and dignified care during childbirth	Anteneh	Tilahun	11:20 AM - 12:30 PM
Lunch Break	<i>Self</i>		12:30 PM - 02:00 PM
Promoting respectful and dignified care during childbirth	Anteneh	Tilahun	02:00 PM - 03:30 PM
Tea break	<i>HU, CMHS</i>		03:30 PM - 03:50 PM
Professional ethics and respectful maternity care	Dr. Zenebe	Anteneh	03:50 PM - 05:15 PM
Daily evaluation	Facilitators	Facilitators	05:15 PM - 05:30 PM
Day 3 – Friday 4th May 2018			
Recap	Participants	Anteneh	08:30 AM - 08:45 AM

Training element	Responsible person		Time
Introduction to CQI for respectful maternity care	Anteneh	Tilahun	08:45 AM - 10:30 AM
Tea break	<i>HU, CMHS</i>		10:30 AM - 10:50 AM
Introduction to CQI for respectful maternity care	Anteneh	Dr. Zenebe	10:50 AM - 12:30 PM
Lunch Break	<i>Self</i>		12:30 PM - 02:00 PM
Action planning and post-training focus group discussions	Tilahun	Dr. Zenebe	02:00 PM - 03:30 PM
Tea break	<i>HU, CMHS</i>		03:30 PM - 03:50 PM
Action planning and post-training focus group discussions	Tilahun	Dr. Zenebe	03:50 PM - 04:20 PM
Course evaluation	Facilitators	Facilitators	04:20 PM - 04:35 PM
Closing and certification	SNNPRHB and HU, CMHS	Tilahun	04:30 PM - 05:00 PM

Appendix B-2: Respectful maternity care training evaluation forms

Daily Course Evaluation *(To be completed by Participants)*

Venue: _____ Date: _____

1. What is the most important information/activity you learned today?

2. What did you **not** like about the training today?

3. Please rate the following aspects of the training today.

	Strongly Agree	Agree	Disagree	Strongly Disagree
1. Meeting facilities were adequate for this training				
2. Participant Manual, and other tools for illustration were simple and easy to use				
3. Exercises or case studies were helpful				
4. Practicum was helpful				
5. There was enough time to cover all material				
6. Ideas were communicated clearly				
7. Presenters gave personal attention to participants when necessary				
8. Questions were answered to my satisfaction				

Additional Comments and suggestions for improving training:

End of Course Evaluation Form (To be completed by Participants)

Rate each of the following statements as to whether or not you agree with them, using the following key:

5 = strongly agree

2 = somewhat disagree

4 = somewhat agree

1 = strongly disagree

3 = neither agree nor disagree

	Rating				
Training program					
<i>I feel that...</i>					
The material was presented clearly and in an organized fashion	5	4	3	2	1
The pre- and post-tests accurately assessed my in-course learning	5	4	3	2	1
Technical information	5	4	3	2	1
I learned new information from this training.	5	4	3	2	1
<i>I will now be able to ...</i>					
Apply knowledge and understanding of the principles of compassionate and respectful care	5	4	3	2	1
Apply the skills for the effective practice of compassionate and respectful care	5	4	3	2	1
Apply skills for effective provider-client communication	5	4	3	2	1
Collect, analyze and act upon health system data to improve compassionate care	5	4	3	2	1
Training methodology					
The trainer's presentations were clear and organized	5	4	3	2	1
The training methods were participatory	5	4	3	2	1
The training methods used help me to acquire skills	5	4	3	2	1
The trainers encouraged my questions and input	5	4	3	2	1
Training location and schedule					
The training site and schedule were convenient.	5	4	3	2	1
The necessary materials were available	5	4	3	2	1

Any Additional comments:-----

Appendix C: Respectful maternity care posters

Appendix C-1 Universal rights of childbearing women (English)

In seeking and receiving maternity care before, during and after childbirth:

1 EVERY WOMAN HAS THE RIGHT TO
BE FREE FROM HARM AND ILL TREATMENT
NO ONE CAN PHYSICALLY ABUSE YOU

2 EVERY WOMAN HAS THE RIGHT TO
INFORMATION, INFORMED CONSENT AND REFUSAL, AND RESPECT FOR HER CHOICES AND PREFERENCES, INCLUDING COMPANIONSHIP DURING MATERNITY CARE
NO ONE CAN FORCE YOU OR DO THINGS TO YOU WITHOUT YOUR KNOWLEDGE AND CONSENT

3 EVERY WOMAN HAS THE RIGHT TO
PRIVACY AND CONFIDENTIALITY
NO ONE CAN EXPOSE YOU OR YOUR PERSONAL INFORMATION

4 EVERY WOMAN HAS THE RIGHT TO
BE TREATED WITH DIGNITY AND RESPECT
NO ONE CAN HUMILIATE OR VERBALLY ABUSE YOU

5 EVERY WOMAN HAS THE RIGHT TO
EQUALITY, FREEDOM FROM DISCRIMINATION, AND EQUITABLE CARE
NO ONE CAN DISCRIMINATE BECAUSE OF SOMETHING THEY DO NOT LIKE ABOUT YOU

6 EVERY WOMAN HAS THE RIGHT TO
HEALTHCARE AND TO THE HIGHEST ATTAINABLE LEVEL OF HEALTH
NO ONE CAN PREVENT YOU FROM GETTING THE MATERNITY CARE YOU NEED

7 EVERY WOMAN HAS THE RIGHT TO
LIBERTY, AUTONOMY, SELF-DETERMINATION, AND FREEDOM FROM COERCION
NO ONE CAN DETAIN YOU OR YOUR BABY WITHOUT LEGAL AUTHORITY

Disrespect and abuse during maternity care are a violation of women's basic human rights.

All rights are grounded in established international human rights instruments, including the Universal Declaration of Human Rights; the Universal Declaration on Bioethics and Human Rights; the International Covenant on Economic, Social and Cultural Rights; the International Covenant on Civil and Political Rights; the Convention on the Elimination of All Forms of Discrimination Against Women; the Declaration of the Elimination of Violence Against Women; the Report of the Office of the United Nations High Commissioner for Human Rights on preventable maternal mortality and morbidity and human rights; and the United Nations Fourth World Conference on Women, Beijing. National instruments are also referenced if they make specific mention of childbearing women.

Safe Motherhood is more than the prevention of death and disability...It is respect for every woman's humanity, feelings, choices, and preferences.

RESPECTFUL MATERNITY CARE: THE UNIVERSAL RIGHTS OF CHILDBEARING WOMEN

RESPECTFUL MATERNITY CARE
AND
KNOW YOUR RIGHTS

The White Ribbon Alliance
For Safe Motherhood

For more information visit:
www.whiteribbonalliance.org/respectfulcare



EVERY BIRTH IS UNIQUE

Some labours progress quickly, others don't.
Unnecessary medical interventions
should be avoided if the woman
and her baby are in good condition.



ALL WOMEN HAVE A RIGHT TO A POSITIVE CHILDBIRTH EXPERIENCE THAT INCLUDES:



- Respect and dignity
- A companion of choice
- Clear communication by maternity staff
- Pain relief strategies
- Mobility in labour and birth position of choice



**World Health
Organization**

ርህራሄ እና አክብሮት የተሞላበት የጤና አገልግሎት ማግኘት

የሁሉም እናቶች መብት ነው!!



I. ርህራሄ እና አክብሮት የተሞላበት የጤና አገልግሎት ምን ማለት ነው?

ይህ ፅንሰ-ሀሳብ ተገልጋይን ያማከለ የጤና አገልግሎት፣ የስነ-ምግባር መርሆችን (የእናቶች ነፃነት፣ ክብር፣ ስሜት፣ ምርጫዎች)፣ ሰብዓዊ መብትን፣ እንዲሁም የእናት-የዋንና የጨቅላ ህፃኑን ፍላጎት ግምት ውስጥ ባስገባ መልኩ ለእናቶች እና ጨቅላ ህፃናት ጤና አገልግሎት መስጠትን ያጠቃልላል።

በወላድ እናቶች ላይ የሚደርስ ርህራሄ እና አክብሮት የጎደለው አገልግሎት የሚገለፅባቸው መንገዶች

- አካላዊ ጥቃት፡ መምታት፡ መገፍተር ወይም እናቶችን ርህራሄ በጎደለው መልክ አካላዊ ምርመራ ማድረግ
- አክብሮት የጎደለው ክብካቤ፡ የእናቶችን ክብር የሚያዋርድ ቃል፣ ተግባር እና ሌሎች ከቃል ውጭ ያሉ የመግባብያ መንገዶችን መጠቀም፣ የእናቶችን በነፃ ሀሳብ የመግለፅ መብት መንፈግ እና በምርመራ ጊዜ ለእናቶችን ምቹ ሁኔታዎችን አለማድረግ
- በፈቃደኝነት ላይ ያልተመሰረተ ክብካቤ፡ በሚደረጉ ምርመራዎችና ህክምናዎች ዙርያ እናቶች ሊረዱት በሚችሉት ቋንቋ እና ደረጃ በቂ ገለፃ አለመስጠት እና በራሳቸው ውሳኔ ላይ እንዲደርሱ አለመርዳት
- ምስጢራዊነቱ ያልተጠበቀ ክብካቤ፡ ምስጢራዊነቱ ያልተጠበቀ የምክር አገልግሎት፣ የአካል ምርመራና ህክምና ማድረግ፣ የእናቶችን የህክምና እና የግል መረጃ በሚስጥር አለመጠበቅ፣ እናትና ጨቅላ ህፃን አንድ ላይ እንዲሆኑ አለመፍቀድ/አለማድረግ
- አድሎ ማድረግ፡ በእናቶች ብሄር፣ ባህል፣ ኢኮኖሚ እና ትምህርት ደረጃ ምክንያት የሚሰጣቸው ክብካቤ ላይ አድሎ ማድረግ
- እናቶች ማግኘት የሚገባቸውን ክብካቤ መከልከል/መሰሉ በሙሉ አለመስጠት፡ እናቶችን በወሊድ/በምጥ ጊዜ እና ከወለዱ በኋላ ባሉት ሰዓታት ብቻቸውን መተው እና እርዳታ ቢያስፈልጋቸው እንኳ እንዴት ሊያገኙ እንደሚችሉ መረጃ አለመስጠት። በወሊድ/በምጥ ጊዜ እና ከወለዱ በኋላ ባሉት ጊዜያት የሚመርጡት አጋር ለምሳሌ የቤተሰብ አባል፣ የልምድ አዋላጅ የመሳሰሉት አብረዋቸው እንዲሆኑ አለመፍቀድ።
- እናቶችን እና የወለዱትን ጨቅላ ህፃን በጤና ተቋማት ማገት፡ በተለያዩ ምክንያት ለምሳሌ ከአገልግሎት ክፍያ ጋር በተያያዘ ሳይከፍሉ እንዳይወጡ መያዝ የካትታል።

II. ለሁሉም በመውለድ እድሜ ክልል ላሉ ሴቶች የተሰጠ የቅድመ ወሊድ የወሊድና የድህረ ወሊድ ጤና ክብካቤና አገልግሎት የማግኘት አለም አቀፍ ሰብአዊ መብት ፡- ርህራሄ እና አክብሮት የተሞላበት የጤና አገልግሎት

አንቀፅ I: ማንኛውም ሴት ኢ-ሰብአዊ ከሆነ ወይም ክብሯን ከሚያዋርድ አያያዝ ወይም ጥቃት የመጠበቅ መብት አላት። ማንም ሰው አካላዊ ጥቃት ሊያደርስብሽ አይችልም።

አንቀፅ II: ማንኛውም ሴት መረጃ የማግኘት፣ በወሊድ ጊዜ አብሯት የሚሆን ሰው መምረጥን ጨምሮ በሚሰጣት ክብካቤና ህክምና ላይ በእውቀት ላይ የተመሰረተ የመስማማት ወይም ያለመስማማት መብት ያላት ሲሆን ምርጫዋም ሊከበርላት ይገባል። ማንም ሰው ያለ ፍቃድሽ በሃይል ሊያስገድድሽ አይችልም።

አንቀፅ III: ማንኛውም ሴት የግል ህይወቷ ግላዊነቷ እንዲሁም ሚስጥሯ የመጠበቅ መብት አላት። ማንም ሰው ሊያጋልጥሽ ወይም ሚስጥርሽን ሊያወጣ አይችልም።

አንቀፅ IV: ማንኛውም ሴት ሰብአዊ ክብሯን መልካም ስሟ የመጠበቅ መብት አላት። ማንም ሰው ሊያዋርድሽ ወይም የቃላት ጥቃት ሊያደርስብሽ አይችልም።

አንቀፅ V: ማንኛውም ሴት የዘር፣ የሃይማኖት፣ የብሄር፣ የሀብት፣ በፖለቲካ፣ በማህበራዊ አመጣጥ፣ በትውልድ ወይም በሌላ አቋም ልዩነት እና መድልዎ ሳይደረግባት በእኩል የመታከም መብት አላት። ማንም ሰው ስላንቺ ያልወደደው ነገር ቢኖር ሊያገልሽ ወይም መድልዎ ሊያደርግብሽ አይችልም ።

አንቀፅ VI: ማንኛውም ሴት ጤንነቷ ተጠብቆ የመኖርና የጤና ክብካቤ የማግኘት መብት አላት። ማንም ሰው የቅድመ ወሊድ የወሊድና የድህረ ወሊድ ጤና ክብካቤና አገልግሎት ከማግኘት ሊያግድሽ አይችልም።

አንቀፅ VII: ማንኛውም ሴት የነጻነት፣ ራስን በራስ የማስተዳደር፣ የራስን ዕድል በራስ የመወሰን ብሎም ያለመገደድ መብት አላት። ማንም ሰው በህግ ስልጣን ሳይኖረው ወይም በህግ ከተደነገገው ውጪ አንቺን ወይም ልጅሽን ሊይዝ ወይም ሊያቆይ አይችልም።

“ርህራሄ እና አክብሮት የተሞላበት የጤና አገልግሎት ለጤናማ እናትነት”



Appendix D: Survey questionnaires

Appendix D-1: Women's survey questionnaire

D-1.1 ENGLISH VERSION

Hospital: ☐ Adare hospital ☐ Leku hospital ☐ Yirgalem hospital

Section I: Socio-demographic characteristics

S.No	Questions	Possible responses	Remark/skip pattern
101.	Place of residence	1. Urban kebele 2. Rural kebele	
102.	Age in completed years	_____ Years	
103.	Age at first pregnancy (in years)	_____ Years	
104.	Marital Status	1. Single 2. Married 3. Separated 4. Divorced 5. Widowed	
105.	Religion	1. Protestant, Christian 2. Orthodox, Christian 3. Muslim 4. Christian Catholic 5. Others: specify.....	
106.	Ethnicity	1. Sidama 2. Amhara 3. Oromo 4. Wolayita 5. Others: specify.....	
107.	Educational Status	1. No education 2. Some primary but did not complete grade 8 3. Completed grade 8 4. Some secondary but did not complete grade 12 5. Completed grade 12 6. More than secondary	
108.	Occupation	1. Housewife 2. Farmer 3. Private Employee 4. Government Employee 5. Private business 6. Others: specify.....	
109.	How many child/children do you have?	_____ child/children	
110.	Do you have regular household monthly income?	1. Yes 2. No 3. I don't want to tell	If 2/3 → 201
111.	Your monthly Income (in Birr)	_____ Eth.Birr	

Section II: Obstetric and previous service utilization characteristics

S.No	Questions	Possible responses	Remark/skip pattern
201.	How many times have you delivered before? (including current one)	_____ times	If 1 → 203
202.	Where did you deliver your last (previous) child?	1. At health facility 2. At home 3. At traditional birth attendant's home 4. On the way to health facility	
203.	How many times have you delivered in health facility? (excluding current one)	_____ times	
204.	Did you have antenatal care visit during your current pregnancy?	1. Yes 2. No	If 2 → 206
205.	How many antenatal care visits did you have?	1. One 2. Two 3. Three or more 4. Do not remember	
206.	Did you have any complication during your current pregnancy?	1. Yes 2. No 3. I don't know	
207.	Did you have any complication during your current labor and delivery?	1. Yes 2. No 3. I don't know	

Section III: current delivery related characteristics

S.No	Questions	Possible responses	Remark/skip pattern
301.	Were you referred from another facility or directly came here?	1. Referred 2. Non-referred (direct visit)	
302.	What time did you get admitted to the hospital?	_____ AM (__ dd __ mm __ yy) _____ PM (__ dd __ mm __ yy)	
303.	What time did you deliver?	_____ AM (__ dd __ mm __ yy) _____ PM (__ dd __ mm __ yy)	
304.	What type of ward were you admitted in?	1. Private ward 2. Shared ward	
305.	What was the gender of the service provider who mainly assisted you in labor?	1. Female 2. Male	
306.	What type of birth did you have?	1. Vaginal birth 2. Caesarean birth after labour trial 3. Caesarean birth without labour trial	
307.	Did you have any procedure for an assisted delivery?	1. Yes 2. No	If 2 → 401

S.No	Questions	Possible responses			Remark/skip pattern
308.	Which procedure did you receive? <i>(Multiple responses possible)</i>		Yes	No	
		Vacuum	1	2	
		Forceps	1	2	
		Episiotomy	1	2	

Section IV: Respectful maternity care measurement questions

Read this for the woman: the following questions are related to your experience in your current childbirth. I will read the questions one by one, you have three options to choose from: “Yes” or “No” or “I do not remember”. Circle only on the corresponding response the woman made

S.No	DURING THIS ADMISSION FOR CHILDBIRTH...	Possible responses			Remark/skip pattern
		Yes	No	I don't know	
401.	Did the health workers use harsh or rude language?	1	0	3	
402.	Did the health workers make judgmental or accusatory comments about you?	1	0	3	
403.	Were you beaten, slapped, kicked, or pinched during childbirth?	1	0	3	
404.	Were you gagged during childbirth?	1	0	3	
405.	Were you physically restrained during childbirth?	1	0	3	
406.	Did the health workers make threats of withholding treatment?	1	0	3	
407.	Did the health workers blame you for any feature of your birth outcomes?	1	0	3	
408.	Did the health workers obtain your consent for all procedures?	1	0	3	
409.	Did the health workers keep information about you confidential?	1	0	3	
410.	Did you have any surgical procedure (episiotomy, caesarean section)?	1	0	3	If 0 → 412
411.	Did the provider ask your permission before performing surgery?	1	0	3	
412.	Did the health workers always come following your call?	1	0	3	
413.	Were you ever left for a prolonged period of time without attention during your labour?	1	0	3	
414.	Was a health provider present for the actual birth of your baby?	1	0	3	
415.	Did the health workers ever separate you from your baby without explaining the reason?	1	0	3	
416.	Did the health workers ask your permission before conducting a vaginal examination?				
417.	Did any provider conduct vaginal examination without maintaining your privacy?	1	0	3	
418.	Did the health workers speak to you in a language you do not understand?	1	0	3	
419.	Did the health workers give you periodic updates on your labor?	1	0	3	

S.No	DURING THIS ADMISSION FOR CHILDBIRTH...	Possible responses			Remark/skip pattern
420.	Did you want to have a birth companion in the labor ward?	1	0	3	If 0 →422
421.	Did the health workers allow you to have your birth companion present?	1	0	3	
422.	Did you want to move around during your labor?	1	0	3	If 0 →424
423.	Did the health workers allow you to move around during your labor?	1	0	3	
424.	Did you want to have food or fluids during your labor?	1	0	3	If 0 →426
425.	Did the health workers allow you to have food or fluids?	1	0	3	
426.	Did you have a preferred birthing position?				If 0 →428
427.	Did the health workers allow you to deliver in your preferred position?	1	0	3	
428.	Did you want to have a cultural practice in labor?	1	0	3	If 0 →430
429.	Did the health workers allow you this cultural practice in labor?	1	0	3	
430.	Did the health workers make you stay in the hospital against your will?	1	0	3	
431.	Did the health workers discriminate against you based on your religion /ethnicity/age/socioeconomic status/medical condition?	1	0	3	

D-1.2 AMHARIC VERSION

ከእናቶች ጋር የሚደረግ ቃለ መጠይቅ

ሆስፒታል ☐ አዳሬ ሆስፒታል ☐ ለኩ ሆስፒታል ☐ ይርጋዓለም ሆስፒታል
ክፍል አንድ፡ የማህበራዊ ገጽታ ጥያቄዎች

ተ.ቁ	ጥያቄዎች	አማራጭ መልሶች	አስተያየት/ዝላል
101.	የመኖሪያ አድራሻ	1. የገጠር ቀበሌ 2. የከተማ ቀበሌ	
102.	ዕድሜ	_____ ዓመት	
103.	የመጀመሪያውን እርግዝናዎ በስንት እድሜዎት ነበር ያረገዙት?	_____ ዓመት	
104.	የጋብቻ ሁኔታ	1. ያላገባች 2. ያገባች 3. የተለያዩች 4. የተፋታች 5. ባሏ የሞተባት	
105.	ሃይማኖት	1. ፕሮቴስታንት ክርስቲያን 2. ኦርቶዶክስ ክርስቲያን 3. ሙስሊም 4. ካቶሊክ ክርስቲያን 5. ሌላ ይጠቀስ.....	
106.	ብሔር	1. ሲዳማ 2. አማራ 3. ኦሮሞ 4. ወላይታ 5. ሌላ ይጠቀስ.....	
107.	የትምህርት ደረጃ	1. ምንም ያልተማረች 2. አንደኛ ደረጃ (ከ1ኛ-8ኛ ክፍል) 3. ስምንተኛ ክፍል ያጠናቀቀች 4. ሁለተኛ ደረጃ (9-12) 5. አሥራ ሁለተኛ ክፍል ያጠናቀቀች 6. ከአሥራ ሁለተኛ ክፍል በላይ	
108.	የሥራ ዓይነት	1. የቤት እመቤት 2. አርሶ አደር/አርብቶ አደር 3. የግል ተቀጣሪ 4. የመንግስት ተቀጣሪ 5. የግል ንግድ 6. ሌላ ይጠቀስ.....	
109.	ስንት ልጅ አለዎት?	ልጅ	
110.	ቋሚ ወርሃዊ የቤተሰብ ገቢ አለዎት?	1. አዎን 2. አይ	2 ከሆነ → 201
111.	አማካይ የወር ገቢ (ብብር)	_____ ብር	

ክፍል ሁለት፡ ከውልደት እና ጤና አገልግሎቶች ጋር የተያያዙ ጥያቄዎች

ተ.ቁ	ጥያቄዎች	አማራጭ መልሶች	አስተያየት/ዝላል
201.	ከዚህ በፊት ስንት ጊዜ ወልደዋል? (የአሁኑን ወሊድ ጨምሮ)	_____ ጊዜ	1 ጊዜ ከሆነ → 203
202.	የመጨረሻውን ልጅዎን የት ነው የወለዱት?	1. የጤና ድርጅት 2. ቤት	

ተ.ቁ	ጥያቄዎች	አማራጭ መልሶች	አስተያየት/ዝላል
		3. የልምድ አዋላጅ ቤት 4. ወደ ጤና ድርጅት ስመጣ በመንገድ ላይ	
203.	ከዚህ በፊት በጤና ድርጅት ውስጥ ስንት ጊዜ ወልደው ያውቃሉ? (የአሁኑን ወሊድ ሳይጨምር)?	_____ ጊዜ	
204.	በአሁኑ እርግዝናዎ የእርግዝና ክትትል አድርገው ነበር?	1. አዎን 2. አይ	2 ከሆነ → 206
205.	ስንት የእርግዝና ክትትል አደረጉ?	1. አንድ 2. ሁለት 3. ሦስትና ከዚያ በላይ 4. አላስታውስም	
206.	በአሁኑ እርግዝናዎ ወቅት ያጋጠመዎት የእርግዝና እክል /ችግር/ ነበር?	1. አዎን 2. አይ 3. አላውቅም	
207.	በአሁኑ ወሊድ ጊዜ ያጋጠመዎት እክል /ችግር/ ነበር?	1. አዎን 2. አይ 3. አላውቅም	

ክፍል ሦስት: ከአሁኑ ወሊድ ጋር የተያያዙ ሁኔታዎች

ተ.ቁ	ጥያቄዎች	አማራጭ መልሶች	አስተያየት/ዝላል																
301.	ከሌላ የጤና ተቋም ሪፈረስ ተጽፎልዎት ነው ወይስ በቀጥታ ነው ወደዚህ ሆስፒታል የመጡት?	1. ሪፈረስ ተጽፎልኝ 2. በቀጥታ																	
302.	መቼ እና በስንት ሰዓት ላይ ነበር ወደ ማዋለጃ ክፍል የመጡት?	____ ቀን (__ ቀቀ __ ወወ __ ዓዓ) ____ ማታ (__ ቀቀ __ ወወ __ ዓዓ)																	
303.	መቼ እና በስንት ሰዓት ላይ ነበር የወለዱት?	____ ቀን (__ ቀቀ __ ወወ __ ዓዓ) ____ ማታ (__ ቀቀ __ ወወ __ ዓዓ)																	
304.	በየትኛው አይነት ዋርድ/መተኛ ክፍል/ ውስጥ ነበር የተኙት?	1. የግል ዋርድ (አንድ ሰው ብቻ የሚተኛበት) 2. የጋራ ዋርድ																	
305.	በዋነኛነት ያዋለደዎት የጤና ባለሙያ ጾታ ምንድን ነው?	1. ሴት 2. ወንድ																	
306.	በምን አይነት ዘዴ ነበር የወለዱት?	1. በምጥ (በማህጸን በር) ብቻ 2. በምጥ ተሞክሮ ስላልተሳካ በአፕራሲዮን 3. ምጥ ሳይሞክር በቀጠጥታ በአፕራሲዮን																	
307.	ጤና ባለሙያዎች ልጅዎን ከማህጸን በር ለማውጣት የሚያግዝ መሳሪያ ተጠቅመው ወይም እስተፋት አድርገውለት ነበር?	1. አዎን 2. አይ	2 ከሆነ → 401																
308.	ምን አይነት ዘዴ/መሳሪያ/ ነበር የተጠቀሙት?	<table><tr><td></td><td>Yes</td><td>No</td><td></td></tr><tr><td>ጭንቅላት ላይ የሚደረግ የብረት ኩባያ (Vacuum)</td><td>1</td><td>2</td><td></td></tr><tr><td>ጭንቅላት ላይ የሚደረግ መቆንጠጫ (Forceps)</td><td>1</td><td>2</td><td></td></tr><tr><td>እስተፋት (Episiotomy)</td><td>1</td><td>2</td><td></td></tr></table>		Yes	No		ጭንቅላት ላይ የሚደረግ የብረት ኩባያ (Vacuum)	1	2		ጭንቅላት ላይ የሚደረግ መቆንጠጫ (Forceps)	1	2		እስተፋት (Episiotomy)	1	2		
	Yes	No																	
ጭንቅላት ላይ የሚደረግ የብረት ኩባያ (Vacuum)	1	2																	
ጭንቅላት ላይ የሚደረግ መቆንጠጫ (Forceps)	1	2																	
እስተፋት (Episiotomy)	1	2																	

ክፍል አራት: አክብሮት የተሞላበት የእናቶች ጤና አገልግሎትን የተመለከቱ ጥያቄዎች

ከዚህ በታች ያሉትን ጥያቄዎች ለተሳታፊዎ አንብቢ ፤ ካሉት ሦስት አማራጮች ተሳታፊዎ የሚመልሱትን አንዱን አክብቢ። ከዚህ ቀጥሎ ያሉት ጥያቄዎች በአሁኑ ወሊድዎ ጊዜ የነበረዎትን ተሞክሮ ለመዳሰስ የተዘጋጁ ናቸው። ጥያቄዎቹን አንድ በአንድ አነበልዎታለሁ፤ ለእያንዳንዱ ጥያቄ ሦስት አማራጮች (አዎን / አይ / አላስታውስም) የሚል አማራጭ

ተ.ቁ	ጥያቄዎች በአሁኑ ወሊድዎ ጊዜ.....	አማራጭ መልሶች			አስተያየት/ዝለል
		አዎን	አይ	አላስታውስም	
401.	ያዋለዱዎት የጤና ባለሙያ የሚያጸይፍ/ከብረ ነክ የሆነ ንግግር ተናግሮዎት ነበር?	1	0	3	
402.	ያዋለዱዎት የጤና ባለሙያ አርስዎን የሚፈርድ/ጥፋተኛ ለማድረግ ያለመ ንግግር ተናግረው ነበር?	1	0	3	
403.	በወሊድ ጊዜዎ የጤና ባለሙያ መትቶዎት/ቆንጥጦዎት/ገፍትሮዎት/ሰውነትዎን በጥፊ መትቶዎት ነበር?	1	0	3	
404.	በምጥዎ ጊዜ የጤና ባለሙያዎች ከምጥ ህመም የተነሳ እንዳያቃስቱ/እንዳይጮሁ አስገድዶዎት ነበር?	1	0	3	
405.	በምጥዎ ጊዜ እንዳይንቀሳቀሱ ታስረው/ታግደው ነበር?	1	0	3	
406.	ያዋለዱዎት የጤና ባለሙያ ከትትል/ሕክምና አልሰጥዎትም በማለት ዝተው ነበር?	1	0	3	
407.	ያዋለዱዎት የጤና ባለሙያ በወሊድዎ ጊዜ ለተፈጠረው ሁሉ ነገር ወቅሶዎት ነበር?	1	0	3	
408.	ያዋለዱዎት የጤና ባለሙያ ምርመራዎችን ሲያደርጉ የእርስዎን ፈቃድ ይጠይቁ ነበር?	1	0	3	
409.	ያዋለዱዎት የጤና ባለሙያ የእርስዎን የግል መረጃ/ሚስጥር ይጠብቁ ነበር?	1	0	3	
410.	በዛሬው ወሊድዎ ጊዜ እስቲትች/ኦፕራሲዮን (ቀዶ ጥገና) ተሰርቶልዎት ነበር?	1	0	3	o ከሆነ → 412
411.	የጤና ባለሙያው እስቲትች/ኦፕራሲዮን ከመስራታቸው በፊት የእርስዎን ፈቃድ ጠይቀው ነበር?	1	0	3	
412.	የጤና ባለሙያው አርስዎ እገዛ ፈልገው ሲጠሩአቸው ይመጡ ነበር?	1	0	3	
413.	በወሊድ ጊዜዎ ለረጅም ሰዓት ያለጤና ባለሙያ ከትትል ብቻዎን ተትተው ነበር?	1	0	3	
414.	ልጅዎን በወለዱ ሰዓት የጤና ባለሙያ አጠገብዎ ነበር?	1	0	3	
415.	ያዋለዱዎት የጤና ባለሙያ ምክንያቱን ሳይነግሩዎት ልጅዎን ከእርዎ የተለየ ቦታ አድርገው ነበር?	1	0	3	
416.	ያዋለዱዎት የጤና ባለሙያ የማህጸን ምርመራ ከማድረጋቸው በፊት የእርስዎን ፈቃድ ጠይቀው ነበር?				
417.	ያዋለዱዎት የጤና ባለሙያ ሌሎች ሰዎች እንዳያዩ መከለያ ሳያደርጉ የማህጸን ምርመራ አድርጎልዎት ነበር?	1	0	3	
418.	ያዋለዱዎት የጤና ባለሙያ በማይረዱት ወይም በማይገባዎት መልክ ይናገሩ ነበር?	1	0	3	
419.	ያዋለዱዎት የጤና ባለሙያ የምጥዎን ሂደት በየጊዜው ይነግሩዎት ነበር?	1	0	3	
420.	በወሊድዎ ጊዜ የራስዎ ሰው/ዘመድ (ድጋፍ ሰጪ) አብሮዎት ማዋለጃ ክፍል እንዲሆን/እንዲገኝ ፈልገው ነበር?	1	0	3	o ከሆነ → 422
421.	የጤና ባለሙያዎች የራስዎ ሰው/ዘመድ (ድጋፍ ሰጪ) አብሮዎት ማዋለጃ ክፍል እንዲሆን ፈቅደው ነበር?	1	0	3	
422.	በምጥዎ ጊዜ መንቀሳቀስ ፈልገው ነበር?	1	0	3	o ከሆነ → 424
423.	የጤና ባለሙያዎች በምጥዎ ጊዜ እንዲንቀሳቀሱ ፈቅደውልዎት ነበር?	1	0	3	
424.	በምጥዎ ጊዜ ፈሳሽ ወይም ደረቅ ምግብ መውሰድ ፈልገው ነበር?	1	0	3	o ከሆነ → 426
425.	የጤና ባለሙያዎች በምጥዎ ጊዜ ፈሳሽ ወይም ደረቅ ምግብ እንዲጠቀሙ ፈቅደውልዎት ነበር?	1	0	3	

ተ.ቁ	ጥያቄዎች በአሁኑ ወሊድዎ ጊዜ.....	አማራጭ መልሶች			አስተያየት/ዝለል
426.	በወሊድዎ ጊዜ እርስዎ የፈለጉት አቀማመጥ/አተኛኝነት ዘዴ ነበረዎት?				o ከሆነ → 428
427.	የጤና ባለሙያዎች በምጥዎ ጊዜ ለእርዎ የሚመችዎትን አቀማመጥ/አተኛኝነት ፈቅደውልዎት ነበር?	1	0	3	
428.	በወሊድዎ ጊዜ ባህላዊ ሥነሥርዓቶችን (ቡና ማፍላት/ገንፎ ማዘጋጀት/ቅቤ መቀባት/ወዘተ) ፈልገው ነበር?	1	0	3	o ከሆነ → 430
429.	በወሊድዎ ጊዜ ባህላዊ ሥነሥርዓቶችን (ቡና ማፍላት/ገንፎ ማዘጋጀት/ቅቤ መቀባት/ወዘተ) እንዲፈጽሙ ፈቅደውልዎት ነበር?	1	0	3	
430.	የጤና ባለሙያዎች ከወሊድዎ በኋላ ያለእርስዎ ፈቃድ በሆስፒታሉ እንዲቆዩ አድርጎዎት ነበር?	1	0	3	
431.	በወሊድዎ ጊዜ የጤና ባለሙያዎች በዘር/በሃይማኖት/በኢኮኖሚ አቅም/በዕድሜ የተነሳ መገለል አድርሰውቦት ነበር?	1	0	3	

D-1.3 SIDAMU AFO VERSION

Hospitaale: ☐ Adaare hospitaale ☐ Lekku hospitaale ☐ Yirgalamete hospitaale

Gufo I: Dagana dagoomittete gara

A.kii ro	Xa'muwa	Dawaro ikkara dandaannore	Qaagishsha/kub binanita
101.	Mama hee'ratta?	1. Katamu qawalera 2. Gaxarete qawalera	
102.	Me''e wo'ma diro ikkannohe?	_____diro	
103.	Umo godowitta woyite me''e diro ikkannohe?	_____diro	
104.	Mine assi'rate gari hiitooti?	1. Mine diassiroomma 2. Baxxe hee'remma 3. Giwame tidhamoomma 4. Galte'ya reytino	
105.	Amma'na	1. Protestaantete kirstianati 2. Ortodokisete kirstianaati 3. Muslimete kirstiyanati 4. Katolikete kirstiyanati 5. Wolehoro kuli _____	
106.	Daga	1. Sidama 2. Amhara 3. Oromo 4. Wolayita 5. Wolehoro kuli _____	
107.	Rosu deerri	1. Dirosoomma 2. Umi deerra rose, kayinni 8 digudoma 3. 8 gudoomma 4. Layink deerra, kayinni 12 digudoomma 5. 12 gudoomma 6. Layink deer aleenniti	
108.	Loosikki maati?	1. Mini amaati 2. Baatto loosi're galeemma 3. Umi'ya looso loosi'rema 4. Mengistete looso loosema 5. Umi'ya daddalo loosema 6. Woleretiro kuli _____	
109.	Me''e ooso noohe?	_____ooso/qaqqi nooe	
110.	Minikkira aganunni egennantino eo noohe?	1. Ee 2. Dinoe	Dawaro 2 ikituro → 201 sai.
111.	Aganunni afi'ratahu me''e ikkanno(birrunni)	_____birra	

Gufo II: Godowatenni ilate gedensiidinna sa'u yannara fayyimmate kaa'lo horonsirate gara			
A.kii ro	Xa'muwa	Dawaro ikkara dandaannore	Qaagishsha/ku bbinanita
201.	Xaahunni ledi xaa geeshsha me'e higge ilootta	_____hige	Dawaro 1 hige ikituro →203 sai.
202.	Sai qaaqqokki mama ilootta?	1. Fayyimmate uurrinshara 2. Mine 3. Ilshiishanno amuwi mine 4. Fayyimate uurrinsha haranni doogo	
203.	Fayyimmate mine me'e higge ilootta? (xaa qaaqqo agurranna)	_____hige	
204.	Konne qaaqqo Godowitta waro fayyimmate mine Godowinni noo amuwira uyyinanni owaante/kaa'lo afi'rate ha'rootta?	1. Ee 2. Dee'ni/diha'roomma.	Dawaro 2 ikituro → 206 sai.
205.	Owaante afi'rate me'e higge ha'rootta?	1. Mitte hige 2. Lame hige 3. Sase hige woyi hakuyi aleenni 4. Diqaagemma	
206.	Konne qaaqqo godowitta waro lowo fayyimmate qarri iille egenninoheni?	1. Ee 2. Dee'ni 3. diafoomma	
207.	Konne/tenne qaaqqo godowitta woyi ilitta woyite lowo qarri egenninoheni?	1. Ee 2. Dee'ni 3. diafoomma	
Gufo III: xaa ila ledi noore lainohunni.			
A.kii ro	Xa'muwa	Dawaro ikka dandaannore	Qaagisha/kubb inannita
301.	Wole fayyimmate uurrinshanni sonkeennahenso qaxxitahuni dayoota?	1. Sonkeennae dayoomma 2. Disonkeennae(mininni fulumma gedeenni dayoomma	
302.	Tenne hospitaalera goxke aka'ma mamote hanafootta?	1. Hawarro ___sa'atera (___barra___ agana___diro) 2. Soodihunni_____sa'atera (___barra___ agana___diro)	
303.	Ma yanna ilootta	1. Hawarro ___sa'atera (___barra___ agana___diro) 2. Soodihunni___sa'atera (___barra___ agana___diro)	
304.	Goxke fulitta kifile hiittoote?	1. Callu/mittu manchi kifileeti 2. Woluno goxanno kifileeti	

305.	Ilitta woyite fayyimmate ogeessi meyaatenso labbaaho?	1. Meyaate 2. Labbaaho	
306.	Hiiitonni ilitta?	1. Qarru nookkiha illanni widoonni 2. Shiimare wo'naalummahu gedensaanni darreenna iloomma 3. Shiimareno wo'naalummakki darreenna iloomma	
307.	Ilate kaa'loro yine wolere loonsiheri noonni?	1. Ee 2. Dee'ni	Dawaro 2 ikituro → 401 sai.
308.	Hiiittee ilate kaa'lo loonsonnihe?		Ee Dee' ni
	Qaaqqu umo amadatenni kaa'lannorichchinni	1	2
	Qarawu gedeechichinni kaa'linoonnie	1	2
	Illanni doogo shiimawa daratenni kaa'linoonnie	1	2

Gufo IV: Amuwaho assinanni ayirrinyi deerra keentanno xa'muwa.

Konne amate nabbawise: konni woroonni xa'mo xaa qaaqqo ilitta yanna noore lainohunniiti. Mitte mittenta xa'mo nabbaweemmohe, sas doorshi noohe. Hakkuno "Ee", "Dee'ni" woyimmi diqaageemma yitannote. Labbannote aana qoqqowi.

A.kii ro	Xa'muwa	Dawaro ikka dandaannore			Qaagisha/kubbina nnita
		Ee	Dee'ni	diqaageemma	
401.	Fayyimmate ogeeyye kaajjado giwisanno qaale horonsdhuheni?	1	0	3	
402.	Fayyimmate ogeeyye atere faradate woyi kassasate gedee hedo assitinoni?	1	0	3	
403.	Ilitta woyite ganihehu, qawaadihehu, kadihehu woyi qi'miidihehu noonni?	1	0	3	
404.	Ilitta woyite Fugamittani?	1	0	3	
405.	Ilitta woyite biso milli yaattakki gedee hoollonniheni?	1	0	3	
406.	Fayyimmate ogeeyye xagichcho ho'litanni waajjishiishshuheni?	1	0	3	
407.	Fayyimmate ogeeyye ileemmahu ma ikkannokka yitanni waajjottahura woqassuheni?	1	0	3	

A.kii ro	Xa'muwa	Dawaro ikka dandaannore			Qaagisha/kubbina nnita
408.	Fayyimmate Ogeeyye loossannohe loosira ate fajjo xa'mitinnnohe?	1	0	3	
409.	Fayyimmate Ogeeyye atewi affanno Misixire maaxxanno?	1	0	3	
410.	Darre loonsonniheni(illanni doogo dara, Godowa darreena ila)	1	0	3	Dawaro 0 ikituro → 412 sai.
411.	Fayyimmate ogeeyye godowakki darate albaanni ate fajjo xa'mitino?	1	0	3	
412.	Fayyimmate Ogeeyye woshshirita woyite rakke dagganno?	1	0	3	
413.	Fayyimmate ogeeyye gamete aana hee'dheenna seeda yannara ate callakki agurte hadhinoheni?	1	0	3	
414.	Fayyimmate Ogeeyye qaaqqu ilami yannara mule no?	1	0	3	
415.	Fayyimmate ogeeyye atera korkaata kultukkinni qaaqqokki atewiinni baddinoni?	1	0	3	
416.	Fayyimmate Ogeeyye illanni doogo mirmara assate albaanni ate fajjo xa'mitinohe?	1	0	3	
417.	Ayee fayyimmate ogeessi illanni doogo mirmara assanno woyite wolu la'annokki gede assikkinni la'annoheni?	1	0	3	
418.	Fayyimmate ogeessi ati afoottakki qaalinni coo'rinoheni?	1	0	3	
419.	Fayyimmate ogeessi gamete yannara yanna yannante heedhanno lexxo kulannohe?	1	0	3	
420.	Ilate gamete goxootta kifilera jaallakki ledokki ikkitara hasi'ratani?	1	0	3	Dawaro 0 ikituro → 422 sai.
421.	Fayyimmate ogeeyye jaallakki ledokki heedhannota fajjittinnohe?	1	0	3	
422.	Gamete yannara goxootta akawaawera milli yaa hasirottankanni?	1	0	3	Dawaro 0 ikituro → 424 sai.
423.	Fayyimmate ogeeyye milli yaatta gede fajjittinnohe?	1	0	3	
424.	Gamete yannara itattara woyi agattara hasi'rattani?	1	0	3	Dawaro 0 ikituro → 426 sai.
425.	Fayyimmate ogeeyye itattara woyi agattara fajjittinnohe?	1	0	3	
426.	Ilatta woyite hedhahera hasirootta ofolla woyi goxa doodhotani?	1	0	3	Dawaro 0 ikituro → 428 sai.
427.	Fayyimmate ogeessi ati doodhotta bayichcho heedhe ilattara fajjinnohe?	1	0	3	
428.	Gamete yannara budunni ilanno meentira assinannire atera assinahera hasi'rittani?	1	0	3	Dawaro 0 ikituro → 430 sai.

A.kii ro	Xa'muwa	Dawaro ikka dandaannore			Qaagisha/kubbina nnita
429.	Fayyimmate ogeeyye gamete yannara budunni amuwaho assinannire atera assinahera fajjitinnohe?	1	0	3	
430.	Fayyimmate ogeeyye ati hasi'rittakkinni Hospitaalete keeshshatta gede assitannoheni?	1	0	3	
431.	Fayyimmate ogeeyye amma'na, daga, diro, dagoommittete garanna keeranchimma kaima assite wolu mannira assinannihunni baxxino garinni lainohen?	1	0	3	

Appendix D-2: Service providers' survey questionnaire

Code: _____

Hospital: ☐ Adare hospital ☐ Leku hospital ☐ Yirgalem hospital

Section I: Socio-demographic and professional characteristics

Instruction: Circle on the number which corresponds to your choice under the "possible responses" column

S.No	Questions	Possible responses	Remark/skip pattern		
101.	Place of residence	1. Same town my hospital is located 2. Different town/city			
102.	Gender	1. Male 2. Female			
103.	Age in completed years	_____ Years			
104.	Marital Status	1. Single 2. Married 3. Separated 4. Divorced 5. Widowed			
105.	Religion	1. Protestant, Christian 2. Orthodox, Christian 3. Muslim 4. Christian Catholic 5. Others: specify.....			
106.	Average monthly income	_____ Eth.Birr			
107.	Current profession	1. Nurse (Degree/Diploma) 2. Midwife (Degree/Diploma) 3. Health officer 4. General practitioner 5. Integrated emergency surgeon 6. Obstetrician/Gynecologist			
108.	type of appointment/employment category/	1. Permanent 2. Contract			
109.	Total service year as health professional	_____ Year/s			
110.	Total service year in current hospital	_____ Year/s			
111.	Average number of night or weekend duties you have per week	_____ days			
112.	Have you ever completed training in the following?	Training	Yes	No	
		BEmOC	1	2	
		PMTCT	1	2	
		Continuous quality improvement (CQI)	1	2	
		Family Planning	1	2	

Section II: Health service providers' view on the approaches of provision of childbirth services

READ THE FOLLOWING STATEMENTS AND CIRCLE THE RESPONSE THAT BEST MATCHES YOUR OPINION.

S.No	Questions						Remark
		Strongly disagree	Disagree	Neutral	Agree	Strongly agree	
201.	It is not possible for nurses and doctors to change the way things are done in the labour room unless directed by the hospital administrators	1	2	3	4	5	
202.	It is sometimes necessary for health service providers to yell at a woman during labor	1	2	3	4	5	
203.	Ethiopian women understand that health service providers sometimes have to be harsh for the woman's own good	1	2	3	4	5	
204.	Husbands should be allowed in the labor room during the birth of their children	1	2	3	4	5	
205.	It is sometimes necessary for health service providers to slap a woman during labor	1	2	3	4	5	
206.	It is not necessary to ask for verbal consent from a labouring woman before conducting a vaginal examination	1	2	3	4	5	
207.	It is not always possible to screen women to ensure privacy when they are giving birth	1	2	3	4	5	
208.	Ethiopian women want to have a companion of their choice with them when they give birth	1	2	3	4	5	

Section III: Workplace experience

READ THE FOLLOWING STATEMENTS AND CIRCLE THE RESPONSE ACCORDING TO YOUR OWN EXPERIENCES IN THE PAST 30 DAYS ONLY

S.No	Questions	Possible responses	Remark/skip pattern
301.	Have you seen birth attendants ignore the concerns of a laboring mother?	1. Yes 2. No	
302.	Have you seen a laboring mother left alone for a long period of time?	1. Yes 2. No	
303.	Have you seen a healthy newborn kept in a different room from his/her mother?	1. Yes 2. No	
304.	Have you seen health workers conduct a vaginal examination on a labouring woman without maintaining physical privacy?	1. Yes 2. No	
305.	Have you seen a laboring mother denied foods or fluids when she wanted to have some?	1. Yes 2. No	
306.	Have you heard health workers use insults, intimidation, threats or coercion with a laboring mother or her companions?	1. Yes 2. No	
307.	Have you seen health workers discriminate against a laboring mother based on a specific attribute (age/marital status/ethnicity/education/HIV status)?	1. Yes 2. No	
308.	Have you seen health workers use physical force with a laboring mother (for example slapping, hitting, or tying on a bed)?	1. Yes 2. No	
309.	In your own personal capacity have you done anything that may have disrespected a woman in childbirth?	1. Yes 2. No	

Section IV: Health service providers own experiences of disrespectful behaviour

READ THE FOLLOWING STATEMENTS REGARDING YOUR OWN WORKPLACE EXPERIENCES AND CIRCLE THE RESPONSE MOST RELEVANT TO YOU.

S.No	Questions	Possible responses	Remark/skip pattern
401.	Have you ever felt disrespected or abused in your workplace by a patient or other staff member?	1. Yes 2. No	
402.	Does the management at this hospital treat you with respect?	1. Yes 2. No	

Appendix E: Qualitative interview guides

Appendix E-1: Focus group discussion guides

A) Focus group discussions with Health Service Providers – before respectful maternity care intervention

Pre-session introduction

Purpose of the study

This study aims to identify the factors that influence the quality of care provided to women when they give birth in hospitals, and to assess the effectiveness of an intervention designed to improve respectful care of women during childbirth. We are interested in understanding the barriers to respectful maternal health care from a range of perspectives including that of health service providers, which is why you are being invited to participate in a focus group discussion. The findings from this research will be used to make recommendations for improvements in maternal health care.

Process and guidelines

- A group facilitator will ask questions about your opinions and experiences of caring for women during labour.
- The discussion will take up to 60 minutes and will be digitally audio recorded not to miss any information during the discussion.
- Your active participation in the discussion is encouraged, but you do not have to answer any questions you would prefer not to.

Ground rules

- It is recommended that one person talks at a time.
- There are no right or wrong ideas/answers. All ideas are equally important
- It is not advisable to judge other participants based on the idea they forward during the discussion
- We ask participants to keep what is heard during the discussion confidential.

Background characteristics of discussants

Instruction: Circle the best option which corresponds to the questions

No	Characteristics	Options
1)	Health facility	1) Adare hospital 2) Leku hospital 3) Yirgalem hospital
2)	Age in completed year	_____ years
3)	Sex	1) Female 2) Male
4)	Profession	1) Nurse (Degree/Diploma) 2) Midwife (Degree/Diploma) 3) Health officer 4) General practitioner 5) Integrated emergency surgeon 6) Obstetrician/Gynecologist
5)	Service year in current profession	_____ years
6)	Service year in current health facility	_____ years

Interview guide

1. Have you previously heard of the concept 'respectful maternity care'? What do you know about respectful maternity care?
2. When a woman comes into a health facility for delivery, what helps to make her feel respected and well cared for?
 - *Staff behaviour, Environment, Processes*
3. What would make her feel disrespected and not well cared for?
 - *Staff behaviour, Environment, Processes*
4. What do you know about the concept of disrespect and abuse?
 - *Provide clear explanation of what disrespect and abuse is when saturation of ideas is reached for this specific question, including categories of D&A*
- 4b) What form/s of disrespect and abuse do you think women face during childbirth in health facilities? Can you give some examples?
- 4c) What do you think are the consequences of disrespect and abuse during childbirth in health facilities?
- 4d) In your opinion, what factor/s contribute to disrespect and abuse of women during childbirth?
 - *Attitude, Salary and incentives, workload, workplace harmony, infrastructure, governance issues, leadership, status-quo (adapted norm), hierarchy among professions*
5. What challenges do health care providers face when caring for women at the time of delivery?
6. What motivates health care providers to provide respectful services to women at the time of childbirth?
 - *Probe: professional ethics, organizational leadership, salary and incentives, workload, workplace harmony, infrastructure,*
7. What discourages health care providers from providing respectful childbirth services to women at the time of childbirth?
 - *Explore: salary and incentives, workload, workplace harmony, infrastructure, governance issues, leadership, status-quo (adapted norm), hierarchy among professions*
8. In your opinion, what would help to improve respectful maternity care or to prevent disrespect and abuse in health facilities?

B) Focus Group Discussion with Health Service Providers – after respectful maternity care intervention

Pre-session introduction

Purpose of the study

This study aims to identify the factors that influence the quality of care provided to women when they give birth in hospitals, and to assess the effectiveness of an intervention designed to improve respectful care of women during childbirth. We are interested in understanding the barriers to respectful maternal health care from a range of perspectives including that of health service providers, which is why you are being invited to participate in a focus group discussion. In this discussion, we ask you about your perceptions of the RMC training and the opportunities and challenges related to implementation of what you have learned from the training. The findings from this research will be used to make recommendations for improvements in maternal health care.

Process and guidelines

- A group facilitator will ask questions about your opinions and experiences of caring for women during childbirth.
- The discussion will take up to 60 minutes and will be digitally audio recorded not to miss any information during the discussion.
- Your active participation in the discussion is encouraged, but you do not have to answer any questions you would prefer not to.

Ground rules

- It is recommended that one person talks at a time.
- There are no right or wrong ideas/answers. All ideas are equally important
- It is not advisable to judge other participants based on the idea they forward during the discussion
- We ask participants to keep what is heard during the discussion confidential.

Background characteristics of discussants

Instruction: Circle the best option which corresponds to the questions

No	Characteristics	Options
1)	Health facility	4) Adare hospital 5) Leku hospital 6) Yirgalem hospital
2)	Age in completed year	_____ years
3)	Sex	3) Female 4) Male
4)	Profession	7) Nurse (Degree/Diploma) 8) Midwife (Degree/Diploma) 9) Health officer 10) General practitioner 11) Integrated emergency surgeon 12) Obstetrician/Gynecologist
5)	Service year in current profession	_____ years
6)	Service year in current health facility	_____ years

Interview guide

1a) What new concepts/knowledge did you get from the RMC training?

1b) Has the RMC training influenced your thoughts or attitudes in caring for women? If yes, how should women be treated during labor and delivery?

1c) What did you like most from the training and the quality improvement supportive visits?

- *Explore: content, delivery approach, training set-up, practicability, continuity*

1d) What did you like least from the training and the quality improvement supportive visits?

- *Explore: content, delivery approach, training set-up, practicability, continuity*

2. Having completed the RMC training, how were you able to promote respectful maternity care in your hospital?

2a) Other than what you have just mentioned, what else needs to be done to make respectful maternity care normal practice in health facilities?

- *Explore: involvement of other staff, infrastructure issue, human resource, standards and guidelines, corrective actions, community mobilization*

3. What challenge/s did you face in implementing the RMC training in your hospital?

- *Explore: birth companionship, supplies, management support, motivation, infrastructure issue, human resource, community awareness, etc*

3a) What type of support do you need to overcome these challenges?

3b) Who do you think should be actively involved in promoting RMC?

Appendix E-2: In-depth interview guides

A) In-depth interview with key-informants at hospital level

Background characteristics of key-informant

Organization	
Position	
Current profession	
Previous role in health facilities (Y/N)	
Service year in current position	
Service year in the health system	
Date of interview	
Interview date and time	__dd/__mm__yy From __:__ am/pm to __:__ am/pm

Interview guide

1. In your opinion what are the characteristics of high-quality care for women at the time of labour and birth?
 - Explore: infrastructure, human resource, client-provider relationships
2. What is your understanding about respectful maternity care?
 - Provide clear explanation of what respectful maternity care is when saturation of ideas is reached for this specific question
3. What is your understanding about disrespect and abuse?
 - Provide clear explanation of what disrespect and abuse is when saturation of ideas is reached for this specific question
4. What do you think is the status of respectful maternity care in health facilities in Ethiopia?
 - Explore: privacy, confidentiality, client-provider interaction, complaints on non-respectful care, etc
5. We know that women are sometimes disrespected and even abused at the time of labour and delivery. In your opinion, what factors contribute to this problem?
 - Explore: providers knowledge and attitude, staff shortage, staff motivation, team spirit, infrastructure, client load, etc
6. Does this hospital actively promote respectful maternity care? If yes, how? If no, why not?
7. What challenges do you encounter in promoting respectful maternity care in your hospital?
 - Explore: providers knowledge and attitude, staff shortage, staff motivation, team spirit, infrastructure, client load, etc
8. Is the “compassionate, respectful, and caring (CRC) health workforce” initiative being implemented in your hospital?
 - 8a) If yes, what activities are being undertaken? What are the achievements so far?
What are the challenges?
 - 8b) If no, what are the reasons?
9. In your opinion, what can be done to improve respectful maternity care in Ethiopian health facilities?
 - 9a) Activities in the scope of responsibility of hospital level
 - 9b) Activities in next higher level/s of the health system

B) In-depth interview with key-informants at zonal/regional level

Background characteristics of key-informant

Organization	
Position	
Current profession	
Previous role in health facilities (Y/N)	
Service year in current position	
Service year in the health system	
Date of interview	
Interview date and time	__dd/__mm__yy From __:__ am/pm to __:__ am/pm

Interview guide

1. In your opinion what are the characteristics of high-quality care for women at the time of labour and birth?
 - Explore: infrastructure, human resource, client-provider relationships
2. What is your understanding about respectful maternity care?
 - Provide clear explanation of what respectful maternity care is when saturation of ideas is reached for this specific question
3. What is your understanding about disrespect and abuse?
 - Provide clear explanation of what disrespect and abuse is when saturation of ideas is reached for this specific question
4. What do you think is the status of respectful maternity care in health facilities in Ethiopia?
 - Explore: privacy, confidentiality, client-provider interaction, complaints on non-respectful care, etc
5. We know that women are sometimes disrespected and even abused at the time of labour and delivery. In your opinion, what factors contribute to this problem?
 - Explore: providers knowledge and attitude, staff shortage, staff motivation, team spirit, infrastructure, client load, etc
6. Do health facilities in your administrative catchment promote respectful maternity care? If yes, how? If no, why not?
7. What challenges do you encounter in promoting respectful maternity care in your administrative catchment?
 - Explore: governance issues (accountability mechanisms, transparency, stewardship), leadership, financing, community engagement, providers knowledge and attitude, staff shortage, staff motivation, training, infrastructure, client load, etc
8. Is the “compassionate, respectful, and caring (CRC) health workforce” initiative being implemented in your administrative catchment?
 - 8a) If yes, what activities are being undertaken? What are the achievements so far?
What are the challenges?
 - 8b) If no, what are the reasons?
9. In your opinion, what can be done to improve respectful maternity care in Ethiopian health facilities?
 - 9a) Activities in the scope of responsibility of zonal or district levels
 - 9b) Activities in next higher level/s of the health system

Appendix F: Ethics approvals, plain language statements, and consent forms

Appendix F-1 Ethics approvals

01 December 2017

Associate Professor Michelle Kermode
Melbourne School of Population and Global Health
The University of Melbourne

Dear A/Prof Kermode

I am pleased to advise that the Health Sciences Human Ethics Sub-Committee approved the following Project:

Project title: **Improving respectful maternity care in Ethiopia: health system constraints and mitigation approaches**
Researchers: **Dr S Gebremedhin, A/Prof M A Kermode, Dr A Morgan, A Mekonnen**
Ethics ID: **1750054**

The Project has been approved for the period: **01-Dec-2017 to 31-Dec-2018**

Please note that the Committee requires you to submit a detailed progress report in 12 months.

It is your responsibility to ensure that all people associated with the Project are made aware of what has actually been approved.

Research projects are normally approved to 31 December of the year of approval. Projects may be renewed yearly for up to a total of five years upon receipt of a satisfactory annual report. If a project is to continue beyond five years a new application will normally need to be submitted.

Please note that the following conditions apply to your approval. Failure to abide by these conditions may result in suspension or discontinuation of approval and/or disciplinary action.

- (a) **Limit of Approval:** Approval is limited strictly to the research as submitted in your Project application.
- (b) **Variation to Project:** Any subsequent variations or modifications you might wish to make to the Project must be notified formally to the Human Ethics Sub-Committee for further consideration and approval. If the Sub-Committee considers that the proposed changes are significant, you may be required to submit a new application for approval of the revised Project.
- (c) **Incidents or adverse effects:** Researchers must report immediately to the Sub-Committee anything which might affect the ethical acceptance of the protocol including adverse effects on participants or unforeseen events that might affect continued ethical acceptability of the Project. Failure to do so may result in suspension or cancellation of approval.
- (d) **Monitoring:** All projects are subject to monitoring at any time by the Human Research Ethics Committee.
- (e) **Annual Report:** Please be aware that the Human Research Ethics Committee requires that researchers submit an annual report on each of their projects at the end of the year, or at the conclusion of a project if it continues for less than this time. Failure to submit an annual report will mean that ethics approval will lapse.
- (f) **Auditing:** All projects may be subject to audit by members of the Sub-Committee.

If you have any queries on these matters, or require additional information, please contact me using the details below.

Please quote the ethics registration number and the title of the Project in any future correspondence.

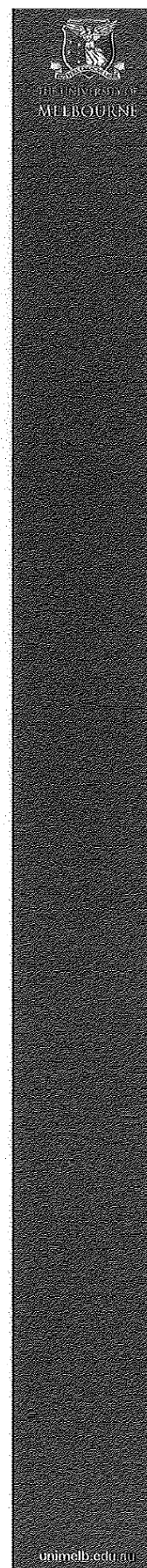
On behalf of the Sub-Committee I wish you well in your research.

Yours sincerely



Ms Hilary Young - Secretary
Health Sciences NESC
Phone: 03 8344 8595, Email: hilary.young@unimelb.edu.au

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መንግሥት ጤና ቢሮ
South Nations Nationalities and Peoples Regional
State Health Bureau

ቁጥር: 273-12/12926
Ref. No
ቀን: 25/04/2010
Date

**Southern Nations Nationalities and Peoples Regional State Health Bureau
Health Research Ethical Clearance Form (For office use)**

Name of the applying principal/s (PI/s) Anteneh Assefa
Name of the applying institution Hawassa University
Address of the applying PI(s) (Mobile) +2519-11-754684
Title of the project: Improving respectful maternity care in Ethiopia: Health system constraints and mitigation approaches

Dear/Sir/Madam,

The Regional Health Bureau Research Ethical Review Committee has reviewed the aforementioned project proposal with special emphasis on the following points;

	Yes	No
1. Are all ethical principles considered?	☒	☐
1.1 Respect for person:	☒	☐
1.2 Beneficence:	☒	☐
1.3 Justice:	☒	☐
2. Are the objectives of the study ethically achievable?	☒	☐
3. Are proposed research methods have ethical sound?	☒	☐

Comments of the ethics committee:

Based on the above mentioned ethical assessment, the regional Ethical clearance committee has

A. Approved the proposal for implementation	☒
B. Conditionally approved	☐
C. Not approved	☐

S.no	Review Members	Signature	Responsibility
1.	Ato Misganu Endrias		Secretary
2.	Sr.Fekert Abera		Member
3.	Ato Lopiso Erosie		Member
4.	W/ro Tsehay Assefa		Member

Chair man of REC

Signature

Date

25/04/10



አመክሮ መኮንን ፋሬ
ጤና ምርምርና ቴክኖሎጂ ሽግግር
ድጋፊ የሥራ ሂደት ባለ ኢት
Health research and technology
transfer support process owner

☑ 149
Awassa
{20-92-09}
{20-59-50}
{20-92-08}
{20-54-06}
{20-02-32}
Fax
20-57-92
20-59-55
20-54-09
E-mail
snpdhl@telecom.net.et
snpdpd@telecom.net.et
snpnrhiv@telecom.net.et
Code 251-0462

Appendix F-2 Plain language statements and consent sheets

Appendix F-2.1 Women's survey

Plain Language Statement: women's survey (Before and after respectful maternity care intervention survey)

**Melbourne School of Population and Global Health, Nossal Institute for Global Health,
Faculty of Medicine Dentistry and Health Science**

Project: Improving respectful maternity care in Ethiopia: health system constraints and mitigation approaches

Introduction

Thank you for your interest in participating in this research project. The following information describes the project, so that you can decide if you would like to take part in the study.

Please take the time to read this information carefully. You may ask questions about anything you don't understand or want to know more about.

What is this research about?

We are interested in learning more about the experiences of women who give birth in hospitals. In particular, we are interested in the attitudes of the health care providers who look after women at the time of childbirth. For this reason, we are inviting women who have delivered in this hospital to participate in a survey. The findings from this research will be used to make recommendations for improvements in the care of women during labour and delivery.

What will I be asked to do?

Should you agree to participate, we will ask you a series of questions about your background and your experiences during your current childbirth in this hospital. The interview will last for approximately 30 minutes to one hour.

What are the possible benefits?

There are no direct benefits to you personally, but better understanding of women's hospital experience's when giving birth will contribute to the development of recommendations for improving the quality of care for women in Ethiopian hospitals.

What are the possible risks?

If you have experienced any disrespectful care whilst in hospital, there is a small possibility that you may become distressed when talking about this, in which case we will stop the interview and provide comfort. The interview will not be resumed without your permission.

Do I have to take part?

Participation is completely voluntary. You do not have to take part in the study. Your decision to participate (or not) in the survey will not influence your access to care at this

hospital in the future. You do not have to answer any questions you do not wish to answer, and you can stop the interview at any time if you should want to.

What will happen to information about me?

The information that you provide will be kept confidential and will only be used for purposes of this study. No personal identifying information such as your name or address will be recorded – the questionnaires will be answered anonymously.

Will I hear about the results of this project?

The findings from this study will be communicated to the hospitals involved, district health offices, zonal health departments, and the regional health bureau via a study dissemination workshop. Additionally, the findings will be published in journals and presented at conferences.

Where can I get further information?

If you would like more information about the project, please contact the researchers; Anteneh Asefa [+251911754684], or Dr Samson Gebremedhin [+251916822815].

Who can I contact if I have any concerns about the project?

This research project has been approved by the Human Research Ethics Committees of The University of Melbourne Australia, and the Southern Nations Nationalities and Peoples Region Health Bureau-Ethiopia.

If you have any concerns or complaints about the conduct of this research project, which you do not wish to discuss with the research team, you should contact:

Health Research and Technology Transfer Support Process

Southern Nations, Nationalities and Peoples Regional State Health Bureau

Tel: +251462124079

OR

Manager, Human Research Ethics, Research Ethics and Integrity, University of Melbourne, VIC 3010. Tel: +61 3 8344 2073 or Email: HumanEthics-complaints@unimelb.edu.au. All complaints will be treated confidentially.

Consent Form: women's survey (Before and after respectful maternity care intervention survey) — LITERATE WOMEN

**Melbourne School of Population and Global Health, Nossal Institute for Global Health,
Faculty of Medicine Dentistry and Health Science**

Project: Improving respectful maternity care in Ethiopia: health system constraints and mitigation approaches

Name of Participant: _____

1. I have been provided with a written plain language statement to keep

I understand the following:

2. The purpose of this research is to assess childbirth experiences of women who give birth in hospitals
3. My participation in this project is for research purposes.
4. The possible benefits and risks of participating in this research project have been explained to my satisfaction.
5. I will be asked to respond to series of questions about my background and my experiences during current childbirth.
6. My participation in the study is **voluntary** and that I am free to withdraw from the survey at any time.
7. The confidentiality of the information I provide will be safeguarded and no personal identifying information will be recorded.
8. The data from this research project will be retained for 5 years after publication of the findings.
9. After I sign and return this consent form, it will be retained by the researcher.
10. Cognizant of the points mentioned above (1-9), I consent to participate in this survey.

Participant Signature: _____ **Date:** _____

Consent Form: women's survey (Before and after respectful maternity care intervention survey) — ILLITERATE WOMEN

Melbourne School of Population and Global Health, Nossal Institute for Global Health, Faculty of Medicine Dentistry and Health Science

Project: Improving respectful maternity care in Ethiopia: health system constraints and mitigation approaches

Name of Participant: _____

Information to be communicated

My name is We are interested in learning more about the experiences of women who give birth in hospitals. In particular, we are interested in the attitudes of the health care providers who look after women at the time of childbirth. For this reason, we are inviting you to participate in a survey.

This survey will take approximately 20-30 minutes of your time. This will involve an interviewer asking you questions about your background and your experiences during childbirth.

Your participation in this project is for research purposes only.

The questions will be about your treatment by health care providers during your hospital stay. If you feel any discomfort during the interview, it will be stopped and only recommenced with your permission.

Your participation in this study is voluntary and you are free to withdraw from the survey at any time. You do not have to answer any questions you would prefer not to.

Any information you give us will be confidential/private and we will not be recording your name or any other details that could identify you.

The data from this research project will be retained for 5 years after publication of the findings.

This form will be retained by the researcher.

Are you willing to participate in this survey? Yes ☐ No ☐

I have communicated the above information to participant no. _____ and she has agreed to be surveyed.

Signature: _____ Date: _____

Witness: _____ Date: _____

Plain Language Statement: women's interview (Before and after respectful maternity care intervention survey) – AMHARIC VERSION

ስለ ጥናቱ መረጃ - ከእናቶች ጋር የሚደረግ ቃለ መጠይቅ

በሜልበርን ዩኒቨርሲቲ የሜልበርን ሕብረተሰብና ዓለም አቀፍ ጤና አጠባበቅ ትምህርት ቤት የኖሳል ዓለም አቀፍ ጤና አጠባበቅ ኢንሰቲትዩት

የጥናቱ ርዕስ፡ በወሊድ ጊዜ የሚሰጠውን አክብሮታዊ አገልግሎት ማሻሻል - ተግዳሮቶች እና መፍትሔዎች

መግቢያ

በዚህ ጥናት ለመሳተፍ ፍላጎት በማሳየትዎ አመሰግናለሁ፡፡ ከዚህ በመቀጠል ያሉት መረጃዎች ስለ ጥናቱ በቂ መረጃ እንዲኖርዎ የተዘጋጁ በመሆኑ በመቀጠል እርስዎ በጥናቱ ለመሳተፍ ለሚያደርጉት ውሳኔ ይረዱዎታል፡፡

እባክዎን በቂ ጊዜ በመውሰድ ከዚህ ቀጥሎ ያሉትን መረጃዎች በጥንቃቄ ያንብቡ፡፡ ስላልገባዎት ነገር ወይም ተጨማሪ መረጃ ስላስፈለግዎት ነገር ጥያቄ መጠየቅ ይችላሉ፡፡

ጥናቱ ስለምንድን ነው?

የዚህ ጥናት ዓላማ በጤና ተቋማት የወሊድ አገልግሎት ያገኙ እናቶችን ስለ አገኙት የወሊድ አገልግሎት ያላቸውን ተሞክሮ ማወቅ ነው፡፡ በተለይም በወሊድ ጊዜ እናቶችን የሚያገለግሉ የጤና ባለሙያዎች ስለሚያሳዩት ባህሪ ለመገንዘብ ነው፡፡ ስለዚህም በዚህ ሆስፒታል የወሊድ አገልግሎት ያገኙ እናቶችን በዚህ ጥናት ላይ እንዲሳተፉ ጥሪ እያደረግን ነው፡፡ ከዚህ ጥናት የሚገኙ ውጤቶች ወደፊት እናቶች በጤና ተቋማት የሚያገኙትን የወሊድ አገልግሎት ለማሻሻል የሚደረጉ መላምቶችን ለመለየት ይረዳል፡፡

እኔ ምን እንዳደርግ ልጠየቅ እችላለሁ?

በዚህ ጥናት ለመሳተፍ ከተስማሙ ስለእርስዎ ግለሰባዊ ዋና ዋና መረጃዎችና በአሁኑ ወሊድዎ ጊዜ በዚህ ሆስፒታል የነበረዎትን ቆይታ የሚዳስሱ ጥያቄዎችን እጠይቅዎታለሁ፡፡ ቃለ መጠይቁ በአማካይ እስከ 30 ደቂቃ ሊወስድ ይችላል፡፡

እዚህ ጥናት ላይ መሳተፍ የሚያስገኘው ጥቅም ምንድን ነው?

በዚህ ጥናት ላይ በመሳተፍዎ የሚያገኙት ቀጥተኛ ጥቅም የለም፡፡ ነገር ግን እናቶች በወሊድ ጊዜ ከጤና ተቋማት በሚያገኙት አገልግሎት ላይ ያላቸውን ተሞክሮ ማወቅ ኢትዮጵያ ውስጥ በሚገኙ ሆስፒታሎች የሚሰጠውን የወሊድ አገልግሎት ለማሻሻል ከፍተኛ ሚና ይጫወታል፡፡

እዚህ ጥናት ላይ መሳተፍ የሚያመጣው ጉዳት ምንድን ነው?

በወሊድዎ ጊዜ በሆስፒታሉ አክብሮት የጎደለው አገልግሎት ካገኙ ወይም የጤና ባለሙያዎች አመናጭቀዎት ከሆነ ስለጉዳዩ በምንነጋገርበት ጊዜ እንደገና በማስታወስ መጠነኛ የሆነ መረበሽ ሊታይብዎት ይችላል፡፡ በዚህ ጊዜ ቃለ መጠይቁን በማቋረጥ የስነ ልቦና ድጋፍ እናደርግዎታለን፡፡ ከዚያ በመቀጠል ያለ እርስዎ ፈቃድ ቃለ መጠይቁ አይቀጥልም፡፡

መሳተፍ አለብኝ?

በዚህ ጥናት ላይ የመሳተፍ ወይም ያለመሳተፍ ውሳኔ በእርስዎ ሙሉ ፈቃድ ላይ የተመሰረተ ነው። በጥናቱ ላይ የግድ መሳተፍ የለብዎትም። የእርስዎ በጥናቱ ላይ መሳተፍ ወይም ያለመሳተፍ እርስዎ ከሆስፒታሉ በሚያገኙት አገልግሎት ላይ አንዳች ተጽዕኖ አይኖረውም። መመለስ ያልፈለጉትን ጥያቄ የመመለስ ግዴታም የለብዎትም፤ እንደገና ቃለ መጠይቁንም በፈለጉት ጊዜ የማቋረጥ ሙሉ ፈቃድ አለዎት።

ከእኔ የሚገኙ መረጃዎች ምን ይደረጋሉ?

ከእርስዎ የሚወሰዱት መረጃዎች በሚስጥር ይያዛሉ፤ ከዚህ ጥናት ውጪ ለሌሎች ጥቅሞች አይውሉም። በቃለ መጠይቁ የእርስዎ ስም እና ሌሎች የግለሰብ መለያ (ለምሳሌ ስም) ጥያቄዎች አይኖሩም። ቃለ መጠይቆቹ ላይም ምንም ዓይነት የመለያ መረጃዎች አይካተቱም።

ተጨማሪ መረጃ ከየት ማግኘት እችላለሁ?

ስለዚህ ጥናት ተጨማሪ መረጃ ማግኘት ከፈለጉ የጥናቱን ተመራማሪዎች ከዚህ በታች በተጠቀሱት አድራሻዎች ማግኘት ይችላሉ።

አቶ አንተነህ አሰፋ፡ +251911754684

ስለጥናቱ የተለየ ጥያቄ ካለኝ ማንን ማነጋገር እችላለሁ?

ይህ ጥናት በሚልበርን ዩኒቨርሲቲ እና በደቡብ ብሔሮች ብሔረሰቦች እና ሕዝቦች ክልላዊ መንግስት ጤና ቢሮ የጥናት ሥነ ምግባር ኮሚቴዎች ፈቃድ የተሰጠው ጥናት ነው። ስለ ጥናቱ ቅሬታ ወይም ስጋት ካለዎት እና ያንን ስጋት ከተመራማሪዎቹ ጋር መወያየት ካልፈለጉ ከታች በተጠቀሱት አድራሻዎች ከደቡብ ብሔሮች ብሔረሰቦች እና ሕዝቦች ክልላዊ መንግስት ጤና ቢሮ የጥናት ሥነ ምግባር ኮሚቴ አባላትን ማነጋገር ይችላሉ።

የደቡብ ብሔሮች ብሔረሰቦች እና ሕዝቦች ክልላዊ መንግስት ጤና ቢሮ የጥናት ሥነ ምግባር ኮሚቴ

ስልክ ቁጥር፡ +251462124079

የጠየቁዎቸው ሁሉም ጥያቄዎች በሚስጥር ይያዛሉ።

Consent Form: women's survey (Before and after respectful maternity care intervention survey) — LITERATE WOMEN – AMHARIC VERSION

የስምምነት ቅጽ - ማንበብና መጻፍ ለሚችሉ እናቶች

በሜልበርን ዩኒቨርሲቲ የሜልበርን ሕብረተሰብና ዓለም አቀፍ ጤና አጠባበቅ ትምህርት ቤት የኖሳል ዓለም አቀፍ ጤና አጠባበቅ ኢንሰቲትዩት

የጥናቱ ርዕስ፡ በወሊድ ጊዜ የሚሰጠውን አክብሮታዊ አገልግሎት ማሻሻል - ተግዳሮቶች እና መፍትሔዎች

የጥናቱ ተሳታፊ ስም -----

1. ስለዚህ ጥናት ዓላማና ሌሎች መረጃዎችን የያዘ መረጃ በግሌ እንዳስቀምጥ ተሰጥቶኛል ከዚህ በታች የተዘረዘሩትን ነጥቦች ተገንዝቤያለሁ
2. የዚህ ጥናት ዓላማ እናቶች በጤና ተቋማት ስላገኙት የወሊድ አገልግሎት ያላቸውን ተሞክሮ ማወቅ ነው
3. የእኔ በዚህ ፕሮጀክት ተሳትፎ ለጥናት ብቻ ነው
4. እዚህ ጥናት ላይ በመሰተፌ ሊኖሩ የሚችሉ ጥቅሞችና ጉዳዮች በበቂ ሁኔታ ተገልጸውልኛል
5. ስለእኔ መሰረታዊ ሁኔታዎችና በወሊድ ጊዜ ስለነበረኝ ተሞክሮ የሚዳስሱ ጥያቄዎችን እንደምጠየቅ ተነግሮኛል
6. በዚህ ጥናት ላይ በፈቃዴ ብቻ እንደምሳተፍ እና በፈለግኩት ጊዜ ማቋረጥ እንደምችል አውቃለሁ
7. ከእኔ የሚገኙ መረጃዎች በሚስጥር እንደሚያዙ እና ግለሰባዊ መረጃዎች (ለምሳሌ ስም) እንደማይጠየቁ እና እንደማይመዘገቡ ተነግሮኛል
8. ከዚህ ጥናት የሚገኙ መረጃዎች ለአምስት ዓመት እንደሚቀመጡ ተነግሮኛል
9. በዚህ ፎርም ላይ ከፈረምኩ በኋላ ፎርሙ ተመራማሪው ጋር እንደሚቀመጥ ተስማምቼያለሁ
10. ከተራ ቁጥር 1-9 የተጠቀሱትን ነጥቦች በመገንዘብ በዚህ ጥናት ላይ ለመሳተፍ ተስማምቼያለሁ፡፡

የጥናቱ ተሳታፊ ፊርማ -----

ቀን-----

Consent Form: women's survey (Before and after respectful maternity care intervention survey) — ILLITERATE WOMEN – AMHARIC VERSION

የስምምነት ቅጽ - ማንበብና መጻፍ ለማይችሉ እናቶች

በሚልበርን ዩኒቨርሲቲ የሚልበርን ሕብረተሰብና ዓለም አቀፍ ጤና አጠባበቅ ትምህርት ቤት የኖሳል ዓለም አቀፍ ጤና አጠባበቅ ኢንሱቲትዩት

የጥናቱ ርዕስ፡ በወሊድ ጊዜ የሚሰጠውን አክብሮታዊ አገልግሎት ማሻሻል - ተግዳሮቶቹ እና መፍትሔዎች

የጥናቱ ተሳታፊ ስም -----

ጤና ይስጥልኝ፤ ስሜ -----ይባላል፡፡ እናቶች በሆስፒታል ስላገኙት የወሊድ አገልግሎት ያላቸውን ተሞክሮ ለማወቅ እንፈልጋለን፡፡ በተለይም በተለይም በወሊድ ጊዜ እናቶችን

የሚያገለግሉ የጤና ባለሙያዎች ስለሚያሳዩት ባህሪ መረዳት እንፈልጋለን፡፡ ስለዚህም ዓላማ እርስዎ በዚህ ጥናት ላይ እንዲሳተፉ እንጠይቅዎታለን፡፡

ይህ ቃለ መጠይቅ በአማካይ ከ እስከ 30 ደቂቃ ሊወስድ ይችላል፡፡ የዚህ ጥናት መረጃ ሰብሳቢ ስለእርስዎ መሰረታዊ ሁኔታዎችና በወሊድ ጊዜ ስለነበረዎት ተሞክሮ የሚዳስሱ ጥያቄዎችን ትጠይቅዎታለች፡፡

የእርስዎ በዚህ ፕሮጀክት ላይ ተሳትፎ ለጥናት ብቻ ነው፡፡

በቃለ መጠይቁ ጊዜ የመረበሽ ችግር ካጋጠመዎት ቃለ መጠይቁን በማቋረጥ የስነ ልቦና ድጋፍ እናደርግዎታለን፡፡ ከዚያም ቃለ መጠይቁ በእርዎ ፈቃድ ብቻ ሊቀጥል ይችላል፡፡

የእርስዎ በዚህ ጥናት ላይ መሳተፍ በፈቃድዎ ላይ ብቻ የተመሰረተ ነው፡፡ በፈለጉት ጊዜ ማቋረጥ ይችላሉ፡፡ መመለስ ያልፈለጉትን ጥያቄም አለመመለስ ይችላሉ፡፡

ከእርስዎ የሚገኙ መረጃዎች በሚስጥር እንደሚያዙ እና ግለሰባዊ መረጃዎች (ለምሳሌ ስም) እንደማይጠየቁ እና እንደማይመዘገቡ አረጋግጥዎታለሁ፡፡

ከዚህ ጥናት የሚገኙ መረጃዎች ለአምስት ዓመት ይቀመጣሉ፡፡

ይህ ቅጽ ተመራማሪው ጋር ይቀመጣል፡፡

በዚህ ጥናት ላይ ለመሳተፍ ፈቃደኛ ነዎት? አዎን [] አይደለሁም []

ከላይ የተጠቀሱትን መረጃዎች ለተሳታፊ ቁጥር ---- አስተላልፌ ተሳታፊዎ በጥናቱ ላይ ለመሳተፍ ተስማምተዋል፡፡

ፊርማ -----

ቀን-----

ምስክር-----

ቀን-----

Plain Language Statement: women's interview (Before and after respectful maternity care intervention survey) – SIDAMU AFO VERSION

Leellanno qaali xawishsha (Mashalaqqete qoola)

Leellanno qaali xawishsha: amuwu xa'mo (Ayirrinyunni assinanni amuwu fayyimmate owaante albaanninna gedensaanni assinanni xinxallo)

Melbourne dagatenna Talqete Fayyimma, Nossal Talqete fayyimma Uurrinsha,

Hinkote Hakimenna fayyimmate sayinse uurrinsha.

Pirojekite: Itiyophiyaho amuwaho ayirrinyunni fayyimmate kaa'lo aate gara woyyeessate: Fayyimmate amanyooti giddeetanna ajishate hayyo.

E'O

Tenne xiinxallo hagiirrunni beeqqaancho ikkakkira lowo geeshsha galateemmohe/mmahe. Tenne xiinxallo giddo beeqatenna hoogate wossanatta gede, konni woroonni noo Mashalaqqe/xawishshi seekke xawisannohe.

Yanna adhite seekkite nabbawi. Roore afa hasi'rittaronna xawinohekkiri hee'riro xa'ma dandaatta.

Tenne xiinxalloti jawa hedo maati?

Hospitaalete ilanno amuwi/meenti gara woyi xaadannonsare afate lowo geeshsha hixamanyineemmo. Fayyimmate ogeeyye, amuwu ile ka'anno woyite kaa'litannorira, noonsa lao afate baxxino mixo noonke. Konni korkaati daafira, tenne hospitaalera ilino amuwa, tenne xiinxallora hedonsa beeqqanno gede gaabbansoommonsa. Tenne xiinxallonni anfanni gumi amuwu ilanno yannara hospitaalete assinanni fayyimmate kaa'loro lowo geeshsha kaa'lanno.

Maa loosammara xa'minannie?

Beeqqate sumuu yiittaro, boode heeshshokkireenna tenne hospitaalera ilitta yannara, xaadinohera xa'mineemmohe. Xa'mo 30 daqiiqinni 1:00 sa'ate geeshshi yanna calla adhitanno.

Afiratta kaa'lo/xiqime maati?

Ati umikkira baxxitino kaa'lo diheedhanno, kayiinni amuwu ilanno woyite xaadannonsari maatiro afatenni Itiyophiyaho islaanchimmase agartino amuwu fayyimmate kaa'lo hee'rate lowo horo heedhanno.

Waajjishara woyi qarrisara dandannori maati?

Itanni hospitaalete keeshshitta yannara ayirrinyunni kaa'linonnihekkiri hee'riheronna hakkonne kulate hagiidhancho ikka hoogge dadillittaro, xa'mo xa'ma uurrise atera injaannohe gede asseemmo. Tini xa'mo ate fajjo gobbaanni diikkitanno.

Xiinxallote beeqqaancho ikka gideetahoni?

Beeqqaancho ikka wo'munni wo'ma ate fajjo garinniti. Beeqqate gadadi dinohe. Tenne xiinxallora beeqatenna beeqqa hoogatenni hospitaalete fayyimmate assinanni kaa'lonni albiliteeno gatannoheri dihee'ranno. Qola hasi'rattakki dawaro qola dinohe. Qoleno xa'mama agura woyimmi uurrisa hasi'rittaro uurrisa dandatta.

Ani eemma Mashalaqgeri maa ikkanno?

Ati aatta Mashalaqqe xinxallote hajora hosiisate gobbaanni mittohono sayiinse dikullanni. Ate mayiimma hakkuno su'makki woyi hee'ratawa diborreessinanni. Xa'mo ayii qollotero kullikkinni qollannite.

Ani tenne pirojekitete xiinxallo guma macciisheemba?

Tenne xiinxallonni anfanni guma, xiinxallote e'u hospitaalera, woredu fayyimmate borro minira, zoonete fayyimmate borro mininna qoqqowu fayyimmate borro mini babbaxitino gambooshshira sayiinsanni. Hakkiinnino lende, alamete journal(maxaafira) borreessinanninna babbaxitino gambora shiqinshanni.

Roore mashalaqqe maminni afi'reemba?

Roore mashalaqqe afi'ra hasi'rittaro, xiinxallote anna ikkinoha,

Antene Asefa [+251911754684]

Xiinxallote pirojekite aana baxxitino hedo heedhuero aye xaada dandeemba?

Tenne xiinxallote pirojekite assinanni gede buuxxe fajjitinori Awustriyalihoo, Melbourne Yuniversite giddo heedhannori manchi beetti aana loonsanni xiinxallo manchi beeti qoosso kinsannikki gede assitannoreetinna itiyophiyu giddo wodiidi daga dagoominna qoqqowi fayyimmate borro mineeti.

Tenne pirojekitete xiinxallo assinanni yannara hedo woyi qarru hee'riheronna xiinxallote gaamo ledi tira dandiinannikkita ikkituro, xaada dandaattahu,

Fayyimmate xiinxallonni teknolojete sa'o kaa'lo assitannore,

Wodiidi daga dogoominna qoqqowu mengiste fayyimmate biirrooti.

Bilbila (silke)___ +251462124079

OR

Melbourne yuniversite giddo heedhanno, manchi beetti aana loonsanni xiinxallo amanyoote buuxxannori: VIC 3010. Bilbila(silke): +61383442073 Woyi imelensa : HumanEthics-complaints@unimelb.edu.au. Baalanta sumuu yaa giwinore(qirri yaannore) Mashalaqqekki wolehu kultukkinni tirtanno.

Consent Form: women's survey (Before and after respectful maternity care intervention survey) — LITERATE WOMEN – SIDAMU AFO VERSION

Fajjote forme: amuwu xiinxallo(Amuwuho Ayirrinyunni assinanni fayyimmate owaante albaanninna gedensaanni assinanni xinxallo): Rossino Amara

Melbourne dagatenna Talqete Fayyimma, Nossal Talqete fayyimma Uurrinsha,
Hinkote Hakimenna fayyimmate sayinse uurrinsha.

Pirojekite: Itiyophiyaho amuwaho ayirrinyunni fayyimmate kaa'lo aate gara
woyyeessate: Fayyimmate amanyooti giddeetanna ajishate hayyo.

Assoshiyete professorichchi: Michele Kermode (xiinxallote Halafichchi)

Silke: +61383441992, iimele: mkermode@unimelb.edu.au

Dr. Alison Morgan (xiinxallote layinkiha; iimele apmorgan@unimelb.edu.au)

Dr. Samson Gebremedhin (xiinxallote layinkiha; imeele: samsongmgs@yahoo.com)

Mr. Anteneh Asefa (PhD rosaanchi xiinxallaanchi; imeele: aasefa@student.unimelb.edu.au)

Beeqqaanchu su'ma _____

1. Borrote qixaawino qaale maaxidhinno gedde oommose.
- Konni woroonni nooha seekke huwatoomma.**
2. Tenne xiinxalloti qara mixo Hospitaalete iltanno ama qaaqo iltanno yannara xaadannosere afateeti
3. Tenne projekite beeqqancho ikka'ya xiinxallote mixora callaati.
4. Tenne xiinxallo beeqqaancho ikka'yanni afi'reemma kaa'lonna gudaati maatiro hagiirri'yanni xawisoomma.
5. Tenne/konne qaaqo ilumma yannara xaandoerenna heeshsho'yare bodere xa'mameemmata afoomma.
6. Tenne xiinxallo beeqqancho ikka'ya fajjo'yanni calla ikkinohura hasi'rummaro uurrisa dandeemma.
7. Anewii afi'nanni taje ayeerano dikullanni. Su'ma'ya woyi ane mayiimma kulannore mittoreno diborreessinanni.
8. Taje tenne xiinxallota ontu (5) diri gedensaanni hunne agurranni.
9. Malaatise qolummahu gedensaanni xiinxallote anni maaxe amadanno.
10. Aleenni (1-9) geeshsha kullie afenna buuxe xiinxallote beeqqaancho ikkate sumuu yoomma.

Beeqqaanchote malaate _____

Barra. _____

Consent Form: women's survey (Before and after respectful maternity care intervention survey) — ILLITERATE WOMEN – SIDAMU AFO VERSION

Fajjote forme: amuwu xiinxallo(Amuwuho Ayirrinyunni assinanni fayyimmate owaante albaanninna gedensaanni assinanni xinxallo): Rossinokki Amara

Melbourne dagatenna Talqete Fayyimma, Nossal Talqete fayyimma Uurrinsha,
Hinkote Hakimenna fayyimmate sayinse uurrinsha.

Pirojekite: Itiyophiyaho amuwaho ayirrinyunni fayyimmate kaa'lo aate gara
woyyeessate: Fayyimmate amanyooti giddeetanna ajishate hayyo.

Assoshiyete professorichchi: Michele Kermode (xiinxallote Halafichchi)

Silke: +61383441992, iimele: mkermode@unimelb.edu.au

Dr. Alison Morgan (xiinxallote layinkiha; iimele apmorgan@unimelb.edu.au)

Dr. Samson Gebremedhin (xiinxallote layinkiha; imeele: samsongmgs@yahoo.com)

Mr. Anteneh Asefa (PhD rosaanchi xiinxallaanchi; imeele: aasefa@student.unimelb.edu.au)

Beeqqaanchu su'ma _____

Xaadisi'ra hasiissanno tajubba.

- su'ma'ya _____ yinannie. Tenne hospitaalera ilanno amuwi ilanno yannara xaadannonsare afate lowo geeshsha hasi'neemmo. Wolunni baxxinohunni fayyimmate ogeeyye ilanno amuwi aana noonsa la'o maa labbannoro afate hasi'neemmo. Konni daafira, tenne xiinxallo beeqqancho ikkatta gede koyiinseemmohe.
- Tini xiinxallo hedotenni 20-30 deqiiqa adhitannohe. Tin yannano taje gamba assanno manchi ate heeshsho garanna ilate yannara fayyimmate ogeeyye ledi xaadinoheere xa'mateeti.
- Tenne projekite beeqqancho ikkottahu xiinxallote mixora callaati.
- Xa'muwano hospitaalete keeshshitta yannara fayyimmate ogeeyye uyitinohe fayyimmate owaante maa labbannoro afateeti.
- Xa'mote aana giwisannoheri hee'riro uurrisa dandaatta. Wirri yine xa'ma dandinannihehu ati fajjittaro callaati.
- Tenne xiinxallo beeqqancho ikkakki fajjokkinni calla ikkinohura hasi'ritta yannara uurrisa dandaatta. Qola hasi'roottakki xa'mo qola dinohe.
- Atewii afi'nanni taje ayeerano dikullanni. Su'makki woyi ate mayiimma kulannore mittoreno diborreessinanni.
- Taje tenne xiinxallota ontu (5) diri gedensaanni hunne agurranni.
- Tenne wonshini forme xiinxallote anni maaxe amadanno.

Beeqqaancho ikkate mahooyyee yootta. A. ee 2 dee'ni

Beeqqaanchote hasiissannose taje oommose nna iseno beeqqate sumuu yitino.

Malaate _____ barra _____

Naqaashshu su'ma _____ barra _____

Appendix F-2.2 Service providers' survey

Plain Language Statement: Health service providers' survey (Before and after respectful maternity care training survey)

**Melbourne School of Population and Global Health, Nossal Institute for Global Health,
Faculty of Medicine Dentistry and Health Science**

Project: Improving respectful maternity care in Ethiopia: health system constraints and mitigation approaches

Introduction

Thank you for your interest in participating in this research project. The following information describes the project, so that you can decide if you would like to take part in the study.

Please take the time to read this information carefully. You may ask questions about anything you don't understand or want to know more about.

What is this research about?

This study aims to identify the factors that influence the quality of care provided to women when they give birth in hospitals, and to assess the effectiveness of an intervention designed to improve respectful care of women during childbirth. We are interested in understanding the barriers to respectful maternal health care from a range of perspectives including that of health service providers, which is why you are being invited to participate in a focus group discussion. The findings from this research will be used to make recommendations for improvements in maternal health care.

What will I be asked to do?

Should you agree to participate in the study, you will be asked to complete a questionnaire that includes questions about your background, professional qualifications and experiences, knowledge of respectful maternity care, and experiences of disrespect and abuse of women in labour rooms. You will be asked to complete the questionnaire prior to undertaking respectful maternity care training, and once again following the training. The questionnaire will take you approximately 20-30 minutes to complete.

Additionally, you may also be invited to participate in a focus group discussion that will be conducted at the end of the training. The focus group discussion will take 30-90 minutes of your time, be audio-recorded, and ask about your perceptions of the RMC training and the opportunities and challenges related to implementation of what they have learned from the training.

What are the possible benefits?

There are no direct benefits to you personally, but understanding respectful maternity care from the perspective of health workers is important. The information you share will inform the development of recommendations for improving the quality of care for women in Ethiopian hospitals.

What are the possible risks?

The risks associated with participation in this survey and focus group discussion are minimal. Your decision to participate (or not) will not affect your employment with the hospital, and what you as an individual have to say will not be identifiable as the findings will be reported in a summarised version.

Do I have to take part?

Participation is completely voluntary. You do not have to take part in the study. You can take part in the survey and/or the focus group discussion i.e. it is not necessary to participate in both if you would prefer not to. Additionally, you do not have to answer any questions you would prefer not to, and are free to withdraw (quit) from the study at any time.

What will happen to information about me?

The information that you provide will be kept confidential and will only be used for purposes of this study. No personal identifying information will be recorded – the questionnaires will be answered anonymously. However, you will be allocated a study number so that we can compare your before and after training responses. The discussion will be audio-recorded so as not to miss what you have to say, but the audio-recording will be destroyed after transcribing the audio files into text.

Will I hear about the results of this project?

The findings from this study will be communicated to the hospitals involved, district health offices, zonal health departments, and the regional health bureau via a study dissemination workshop. Additionally, the findings will be published in journals and presented at conferences.

Where can I get further information?

If you would like more information about the project, please contact the researchers; Anteneh Asefa [+251911754684], or Dr Samson Gebremedhin [+251916822815].

Who can I contact if I have any concerns about the project?

This research project has been approved by the Human Research Ethics Committees of The University of Melbourne Australia, and the Southern Nations Nationalities and Peoples Region Health Bureau-Ethiopia.

If you have any concerns or complaints about the conduct of this research project, which you do not wish to discuss with the research team, you should contact:

Health Research and Technology Transfer Support Process

Southern Nations, Nationalities and Peoples Regional State Health Bureau

Tel: +251462124079

OR

Manager, Human Research Ethics, Research Ethics and Integrity, University of Melbourne, VIC 3010. Tel: +61 3 8344 2073 or Email: HumanEthics-complaints@unimelb.edu.au. All complaints will be treated confidentially.

Consent Form: Health service providers' survey (Before and after respectful maternity care training survey)

Melbourne School of Population and Global Health, Nossal Institute for Global Health, Faculty of Medicine Dentistry and Health Science

Project: Improving respectful maternity care in Ethiopia: health system constraints and mitigation approaches

Name of Participant: _____

I have been provided with a written plain language statement to keep _____

I understand the following:

The purpose of this research is to identify factors that influence the quality of care provided to women when they give birth in hospitals, and to assess the effectiveness of an intervention designed to improve respectful care of women during childbirth

My participation in this project is for research purposes.

The possible benefits and risks of participating in this research project have been explained to my satisfaction.

I will be asked to complete a survey questionnaire before and after participating in the respectful maternity care training

I may also be invited to participate in a focus group discussion that will be conducted at the end of the respectful maternity care training.

My participation in the study is voluntary and that I am free to withdraw from the survey at any time.

The confidentiality of the information I provide will be safeguarded and no personal identifying information will be recorded.

The data from this research project will be retained for 5 years after publication of the findings.

After I sign and return this consent form, it will be retained by the researcher.

Cognizant of the points mentioned above (1-10), I consent to participate in this survey.

Participant Signature: _____

Date: _____

Appendix F-2.3 Focus group discussions

Plain Language Statement: Focus group discussion with health service providers

**Melbourne School of Population and Global Health, Nossal Institute for Global Health,
Faculty of Medicine Dentistry and Health Science**

Project: Improving respectful maternity care in Ethiopia: health system constraints and mitigation approaches

Introduction

Thank you for your interest in participating in this research project. The following information describes the project, so that you can decide if you would like to take part in the study.

Please take the time to read this information carefully. You may ask questions about anything you don't understand or want to know more about.

What is this research about?

This study aims to identify the factors that influence the quality of care provided to women when they give birth in hospitals, and to assess the effectiveness of an intervention designed to improve respectful care of women during childbirth. We are interested in understanding the barriers to respectful maternal health care from a range of perspectives including that of health service providers, which is why you are being invited to participate in a focus group discussion. The findings from this research will be used to make recommendations for improvements in maternal health care.

What will I be asked to do?

Should you agree to participate in the study, you will be part of a focus group discussion with 6-9 other health service providers from your hospital. A group facilitator will ask questions on your opinions about and experiences of caring for women during labour. The discussion will take up to 60 minutes and will be digitally audio recorded. Your active participation in the discussion is encouraged, but you do not have to answer any questions you would prefer not to.

What are the possible benefits?

There are no direct benefits to you personally, but understanding the barriers and facilitators of respectful maternity care from the perspective of health workers is important. The information you share will inform the development of recommendations for improving the quality of care for women in Ethiopian hospitals.

What are the possible risks?

The risks associated with participation in this focus group discussion are minimal. Your decision to participate (or not) will not affect your employment with the hospital, and what you as an individual have to say will not be identifiable as the findings will be reported in a summarised version.

Do I have to take part?

Participation is completely voluntary. You do not have to take part in the study. If you do take part, you do not have to answer any questions you would prefer not to. Additionally, you are free to withdraw (quit) from the discussion at any time.

What will happen to information about me?

The information that you provide will be kept confidential and will only be used for purposes of this study. No personal identifying information will be recorded. The discussion will be audio-recorded so as not to miss what you have to say, but the audio-recording will be destroyed after transcribing the audio files into text.

Will I hear about the results of this project?

The findings from this study will be communicated to the hospitals involved, district health offices, zonal health departments, and the regional health bureau via a study dissemination workshop. Additionally, the findings will be published in journals and presented at conferences.

Where can I get further information?

If you would like more information about the project, please contact the researchers; Anteneh Asefa [+251911754684] or Dr Samson Gebremedhin [+251916822815].

Who can I contact if I have any concerns about the project?

This research project has been approved by the Human Research Ethics Committees of The University of Melbourne Australia, and the Southern Nations Nationalities and Peoples Region Health Bureau-Ethiopia.

If you have any concerns or complaints about the conduct of this research project, which you do not wish to discuss with the research team, you should contact:

Health Research and Technology Transfer Support Process

Southern Nations, Nationalities and Peoples Regional State Health Bureau

Tel: +251462124079

OR

Manager, Human Research Ethics, Research Ethics and Integrity, University of Melbourne, VIC 3010. Tel: +61 3 8344 2073 or Email: HumanEthics-complaints@unimelb.edu.au. All complaints will be treated confidentially.

Consent Form: Focus group discussion with health service providers (prior to respectful maternity care intervention)

Melbourne School of Population and Global Health, Nossal Institute for Global Health, Faculty of Medicine Dentistry and Health Science

Project: Improving respectful maternity care in Ethiopia: health system constraints and mitigation approaches

Name of Participant: _____

I have been provided with a written plain language statement to keep

I understand the following:

The purpose of this research is to identify the factors that influence the quality of care provided to women when they give birth in hospitals, and to assess the effectiveness of an intervention designed to improve respectful care of women during childbirth

My participation in this project is for research purposes.

The possible benefits and risks of participating in this research project have been explained to my satisfaction.

I will be required to participate in a group discussion regarding our opinions about and experiences of caring for women during labour.

The discussion will be audio recorded.

My participation in the discussion is voluntary and I am free to withdraw from the discussion at any time, and to withdraw any unprocessed data.

The audio file from this discussion will be destroyed after transcription, and the text data will be retained for 5 years after publication of the findings.

The confidentiality of the information I provide will be safeguarded and no personal identifying information will be recorded.

After I sign and return this consent form, it will be retained by the researcher.

Cognizant of the points mentioned above (1-10), I consent to participate in this discussion.

Participant Signature: _____ Date: _____

Consent Form: Focus group discussion with health service providers (after respectful maternity care training)

Melbourne School of Population and Global Health, Nossal Institute for Global Health, Faculty of Medicine Dentistry and Health Science

Project: Improving respectful maternity care in Ethiopia: health system constraints and mitigation approaches

Name of Participant: _____

I have been provided with a written plain language statement to keep

I understand the following:

The purpose of this research is to identify the factors that influence the quality of care provided to women when they give birth in hospitals, and to assess the effectiveness of an intervention designed to improve respectful care of women during childbirth

My participation in this project is for research purposes.

The possible benefits and risks of participating in this research project have been explained to my satisfaction.

I will be asked to participate in a group discussion about the respectful maternity care training and the opportunities and challenges we may have encountered when implementing it.

The discussion will be audio recorded.

My participation in the discussion is voluntary. I am free to withdraw from the discussion at any time, and to withdraw any unprocessed data.

The audio file from this discussion will be destroyed after transcription, and the text data will be retained for 5 years after publication of the findings.

The confidentiality of the information I provide will be safeguarded and no personal identifying information will be recorded.

After I sign and return this consent form, it will be retained by the researcher.

Cognizant of the points mentioned above (1-10), I consent to participate in this discussion.

Participant Signature: _____ Date: _____

Appendix F.2.3 In-depth interviews

Plain Language Statement: In-depth interview with Key-informants

**Melbourne School of Population and Global Health, Nossal Institute for Global Health,
Faculty of Medicine Dentistry and Health Science**

Project: Improving respectful maternity care in Ethiopia: health system constraints and mitigation approaches

Introduction

Thank you for your interest in participating in this research project. The following information describes the project, so that you can decide if you would like to take part in the study.

Please take the time to read this information carefully. You may ask questions about anything you don't understand or want to know more about.

What is this research about?

This study aims to identify the factors that influence the quality of care provided to women when they give birth in hospitals, and to assess the effectiveness of an intervention designed to improve respectful care of women during childbirth. We are interested in understanding the barriers to respectful maternal health care from a range of perspectives including that of experts such as yourself, which is why you are being invited to participate in an interview. The findings from this research will be used to make recommendations for improvements in maternal health care.

What will I be asked to do?

Should you agree to participate in the study, you will be interviewed by Mr Anteneh Asefa who will ask you about existing challenges in your administrative catchment in improving quality of maternal health care services, especially respectful care of women during childbirth. The interview will take 30-60 minutes of your time and will be audio recorded. It can be scheduled for a time and a place that suits you.

What are the possible benefits?

There are no direct benefits to you personally, but understanding the barriers and facilitators of respectful maternity care from the perspective of experts such as yourself is important. The information you share will inform the development of recommendations for improving the quality of care for women in Ethiopian hospitals.

What are the possible risks?

The risks associated with participation in this interview are minimal. What you as an individual have to say will not be identifiable as the findings will be reported in a summarised version with any identifying information removed.

Do I have to take part?

Participation in this interview is completely voluntary. You do not have to take part in the study. If you do take part, you do not have to answer any questions you would prefer not to. Additionally, you are free to withdraw (quit) from the discussion at any time.

Will I hear about the results of this project?

The findings from this study will be communicated to the hospitals involved, district health offices, zonal health departments, and the regional health bureau via a study dissemination workshop. Additionally, the findings will be published in journals and presented at conferences.

What will happen to information about me?

The information that you provide will be kept confidential and will only be used for the purposes of this study. No personal identifying information will be recorded. The discussion will be audio-recorded so as not to miss what you have to say, but the audio-recording will be destroyed after transcribing the audio files into text.

Where can I get further information?

If you would like more information about the project, please contact the researchers; Anteneh Asefa [+251911754684] or Dr Samson Gebremedhin [+251916822815].

Who can I contact if I have any concerns about the project?

This research project has been approved by the Human Research Ethics Committees of The University of Melbourne Australia, and the Southern Nations Nationalities and Peoples Region Health Bureau-Ethiopia.

If you have any concerns or complaints about the conduct of this research project, which you do not wish to discuss with the research team, you should contact:

Health Research and Technology Transfer Support Process

Southern Nations, Nationalities and Peoples Regional State Health Bureau

Tel: +251462124079

OR

Manager, Human Research Ethics, Research Ethics and Integrity, University of Melbourne, VIC 3010. Tel: +61 3 8344 2073 or Email: HumanEthics-complaints@unimelb.edu.au. All complaints will be treated confidentially.

Consent Form: In-depth interview with Key-informants

Melbourne School of Population and Global Health, Nossal Institute for Global Health, Faculty of Medicine Dentistry and Health Science

Project: Improving respectful maternity care in Ethiopia: health system constraints and mitigation approaches

Name of Participant: _____

I have been provided with a written plain language statement to keep

I understand the following:

The purpose of this research is to identify the factors that influence the quality of care provided to women when they give birth in hospitals, and to assess the effectiveness of an intervention designed to improve respectful care of women during childbirth

My participation in this project is for research purposes.

The possible benefits and risks of participating in this research project have been explained to my satisfaction.

I will be required to participate in an interview and share my opinions about respectful maternity care.

The discussion will be audio recorded.

My participation in the discussion is voluntary and I am free to withdraw from the interview at any time, and to withdraw any unprocessed data.

The audio files from this interview will be destroyed after transcription and the text data will be retained for 5 years after publication of the findings.

The confidentiality of the information I provide will be safeguarded and no personal identifying information will be recorded.

After I sign and return this consent form, it will be retained by the researcher.

Cognizant of the points mentioned above (1-10), I consent to participate in this interview.

Participant Signature: _____ Date: _____

Appendix G: Policy Brief



Policy brief (04/03/2020)

Reducing maternal mortality in Ethiopia: Respectful maternity care is key



Authors:

Anteneh Asefa^{1,2}

Alison Morgan²

¹School of Public Health, Hawassa University, Ethiopia

²Nossal Institute for Global Health, University of Melbourne, Australia

Executive statement

Ensuring quality health care and fostering a caring, respectful, and compassionate health workforce are among the health sector transformation priorities of the government of Ethiopia. This policy brief highlights the effectiveness of respectful maternity care training and identifies the health system constraints to the provision of respectful maternity care in Ethiopian health facilities.

Key messages and recommendations

- The mistreatment of women during facility-based childbirth is a public health concern in Ethiopia. Evidence on the effectiveness of respectful maternity care is meagre in the country.
- Recommendation 1: Developing and enforcing respectful maternity care guidelines
- Recommendation 2: Addressing respectful maternity care from health system strengthening perspective
- Recommendation 3: Conducting large scale implementation research to scale-up respectful maternity care interventions

Introduction/Problem/Context

Low utilization of maternal health care services, especially care during childbirth (48% in 2019), is a key challenge to reducing maternal mortality in Ethiopia¹. The level of mistreatment or disrespect and abuse of women during facility-based childbirth in Ethiopia is worryingly high and is among the key reasons for having home births²⁻⁴. Therefore, it is crucial to both improve the quality of childbirth services and mitigate mistreatment to attract more women to health facilities and thereby reduce preventable maternal and neonatal deaths^{1,5}.

Disrespect and abuse refers to interactions or facility conditions that local consensus deems to be humiliating or undignified⁶. It embodies categories such as physical abuse; verbal abuse; non-consented care; lack of information, privacy, and confidentiality; neglect and discrimination; and refusal of preference, for example, disallowance of birth companions^{6,7}. The 2014 World Health Organization statement on disrespect and abuse calls for: evidence synthesis on the effectiveness of interventions that aim to improve respectful maternity care and thereby mitigate mistreatment, defining and measuring mistreatment, and inculcating service providers with the culture of respectful care at the time of birth⁸. In Ethiopia, respectful maternity care initiatives are in early-stage development and currently limited to a few pilot health facilities. Consequently, there is an evidence gap regarding the implementation and effectiveness of respectful maternity care interventions in the country.

About the study

A mixed-methods intervention study was conducted to explore health system constraints to the promotion of respectful maternity care and to develop and assess the effectiveness of a locally adapted training manual in respectful care, in southern Ethiopia in 2018. The intervention included a three-day respectful maternity care training offered to 64 service providers from three hospitals (Adare general hospital, Leku primary hospital, and Yirgalem general hospital), placement of wall posters in labour rooms, and post-training on-site supportive visits for quality improvement. The Ministry of Health, the Institute for Healthcare Improvement, and the Southern Nations Nationalities and Peoples Region (SNNPR) Health Bureau, Ethiopia were collaborators of the study.

Results

Respectful maternity care intervention is associated with reduced level of mistreatment of women

The number of mistreatment components experienced by women was reduced by 18% after the respectful maternity care intervention. However, there are components (verbal abuse; lack of information, privacy and confidentiality; and neglect and discrimination) that did not change significantly after the training (Figure 1).

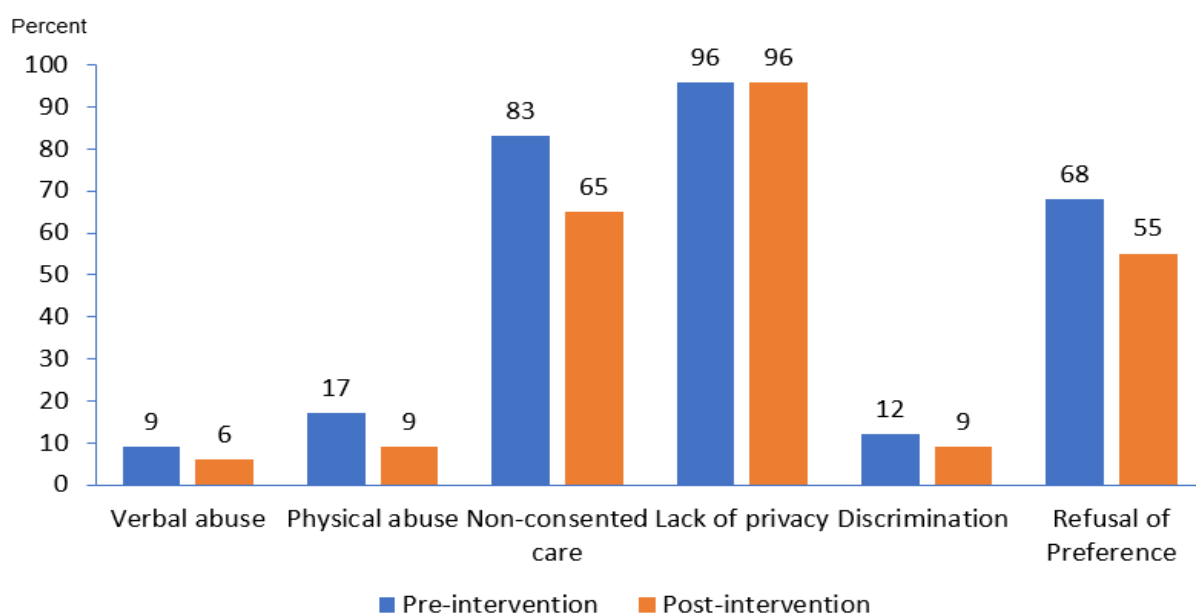


Figure 1 Women's experience of mistreatment during childbirth

Service providers' perceptions and experiences of the respectful maternity care training

- More than one-quarter (29.7%) of service providers reported they had mistreated a woman in the preceding month.
- The training improved the service providers' awareness of the rights of women during childbirth and their perceptions and attitudes about respectful maternity care were positively influenced.
- Service providers believed that the respectful maternity care training did not address providers' rights.
- Structural and systemic issues were the main challenges providers reported when trying to implement respectful maternity care in their contexts.

Health system constraints to the promotion of respectful maternity care had complex interactions and thus require system-wide approach

- Both system ‘hardware’ and ‘software’ constraints to the promotion of RMC were identified, and their interaction was complex. The ‘hardware’ constraints included insufficient supplies, shortage of professionals, weak infrastructure, and financing limitations. The ‘software’ constraints encompassed service providers’ attitudes, inadequate support and motivation, and low awareness of RMC.
- Interactions between these constraints included the privacy of women being breached when birth companions were introduced due to limited labour room space.
- Delayed reimbursement following the introduction of fee-exemption for maternity services resulted in the emergence of depleted revenues, shortage of supplies, and ultimately disrespectful behaviour among providers.
- Other financial constraints, including the insufficient or delayed release of funds, also led to complex interactions with the motivation of staff and the availability of workforce, supplies, resulting in poor adherence to RMC guidance.

Recommendations

Recommendation 1: Respectful maternity care guideline should be developed and institutionalized

The Ministry of Health and the technical working group should prepare and implement respectful maternity care guideline or charter and train service providers on the universal declarations of childbearing women.

Recommendation 2: Respectful maternity care should be promoted from the perspective of health system strengthening

Health system strengthening activities to address systemic and structural issues including the rights of providers of childbirth care should also be carried out by all stakeholders including the ministry of health, regional health bureaus and allied partners.

Recommendation 3: Implementation research on respectful maternity care should be prioritized

A collaboration between ministry of health and other stakeholders to conduct large-scale implementation research on respectful maternity care is required alongside the scale up of proven respectful maternity care innovations and interventions.

Limitations

The study is limited in generating evidence of the challenges service providers might face in implementing RMC recommendations in health centres and tertiary and specialized hospitals. Additionally, the short implementation period, and the lack of control group for the quantitative studies make attribution of the respectful maternity care training sub-optimal.

Acknowledgements

We would like to thank experts at the Ministry of Health, the SNNPR Health Bureau, the study hospitals, and Hawassa University for their support and coordination during the conduct of this study. We are indebted to the Institute for Healthcare Improvement (IHI) and the University of Melbourne for their financial assistance during the conduct of this study. We owe Dr Rose N. Oronje and Professor Mirkuzie Woldie a heartfelt thanks for reviewing this policy brief.

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Appendix H: Blog post



blog

Respectful maternity care to end mistreatment during facility-based childbirth: a people-centred care approach to accelerate UHC



By [Anteneh Asefa Mekonnen](#)
on March 17, 2017

As is well known, the target set by the MDGs to reduce global maternal mortality by 75% has fallen short – only a [45% reduction](#) was observed between 1990 and 2015. As a reminder: [50%](#) of global maternal deaths occurred in 5 developing countries (India, Nigeria, DRC, Ethiopia, and Pakistan) in 2015; 66 % of all deaths took place in Sub-Saharan African countries. This stems from non-utilization of and lack of access to life saving obstetric and maternal health care services, mainly in developing regions of the world.

Fear of mistreatment or Disrespect and Abuse (D&A) during facility-based childbirth is one of the main drivers of home deliveries which predispose women to death from highly preventable causes of maternal mortality. D&A is not only a deterrent to service utilization, but also a violation of basic human rights. A landscape analysis revealed [seven categories](#) of D&A during facility based childbirth: physical abuse, non-consented care, non-confidential care, non-dignified care, discriminatory care, abandonment of care, and detention in health facilities. D&A is fast becoming a global concern due to its increasing prevalence in health facilities. Following the categorization of D&A in 2010, the [Respectful Maternity Care Charter: Universal Rights of Childbearing Women](#) was developed by the White Ribbon Alliance (in 2011) and adopted by several countries and organizations in order to promote Respectful Maternity Care (RMC) across the globe. In 2014, the WHO released its [statement](#) on the prevention and elimination of D&A in light of the urgent need to address the high level of D&A and to promote human rights.

“Every woman has the right to the highest attainable standard of health, which includes the right to dignified, respectful health care.” WHO, 2014

The tragic story of [Salome Karwah](#), a Liberian Ebola fighter and survivor and a TIME person of the year, who recently passed away, shows that the road towards RMC is still long in (too) many health systems. Karwah did not discriminate against people during the Ebola epidemic, but showed empathy and cared for them, while others turned them away. Unfortunately, what she experienced during her own recent postpartum convulsion was rather different. Instead of getting the urgent treatment she deserved, she faced stigma and lack of care because she was seen as “an Ebola survivor” and health care workers did not want contact with her body fluids. In short, this would have been a preventable death if the health system had provided the RMC Karwah deserved for treatment of her convulsion.

Respectful maternity care, defined as “the humane and dignified treatment of a childbearing woman throughout her pregnancy, birth, and the period following childbirth” is an approach to mitigate D&A in health facilities. [Contributors to D&A](#) cover broad arrays of the health systems, ranging from individual to policy level factors. Hence, the main principles of RMC are drawn from the concept of [people-centred health care](#), comprising micro, meso, and macro level health systems factors. Tremendous efforts are required to halt these multifaceted drivers of D&A, which often include – let’s not forget – overburdened and underpaid staff.

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To better promote RMC, the “Quality” aspect of UHC should be given due emphasis apart from the global commitment to expand geographical and financial access to maternal health care services. [The \(just launched\) Lancet Global Health Commission on High-Quality Health Systems](#) in the SDG era is thus very timely – it will prioritize defining and researching health systems quality in the context of developing countries to better address the challenges in meeting the SDGs. RMC is not just about health facility related quality improvement activities; it should also engage in and capitalize on women’s empowerment to claim their rights, and community participation in the process. Taking into account the global burden of maternal mortality, equitable investment should also be allocated by international development agencies. Besides, countries should also increase their own commitment to finance the health sector in general and maternal health services more specifically to address issues related to D&A.

If the world is to achieve [SDG target 3.1](#) of reducing the maternal mortality rate to below 70 per 100,000 live births, a concerted effort by all stakeholders will be needed to promote and invest in RMC. Last but not least, Respectful Maternity Care is not only about dealing with “women’s issues”; it’s also about creating healthier families, communities and nations.

We better don’t wait till 2030 to make substantial progress on this key SDG agenda.

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