

BMJ Open Lay and healthcare providers' experiences to inform future of respectful maternal and newborn care in Tanzania and Malawi: an Appreciative Inquiry

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ABSTRACT

Objectives Disrespectful care, which remains prevalent in low and middle-income countries (LMICs), acts as a barrier to women accessing skilled birth attendance, compromising care when services are available. Building on what was positive in facilities, we aimed to explore lay and healthcare providers' experience of respectful care to inform future interventions.

Setting Five maternity facilities in Mwanza Tanzania and Lilongwe Malawi.

Participants 94 participants in Malawi (N=46) and Tanzania (N=48) including 24 women birthing live baby within the previous 12 months; 22 family members and 48 healthcare providers who regularly provided maternity care in the included facilities

Design The study was guided by Appreciative Inquiry (AI). Semistructured, one-to-one interviews were conducted between January and December 2019. Interviews were audio-recorded, translated where necessary, transcribed verbatim, and analysed using the framework approach.

Results Four main themes describing participants positive experience and their vision of respectful care were identified: (1) empathic healthcare provider–woman interactions including friendly welcome and courteous language, well-timed appropriate care and information sharing, (2) an enabling environment, characterised by improvement of physical environment, the use of screens, curtains and wall partitions for privacy, availability of equipment and provision of incentives to staff, (3) supportive leadership demonstrated by the commitment of the government and facility leaders to provision of respectful care, ensuring availability of guidelines and policies, supportive supervision, reflective discussion and paying staff salaries timely, (4) providers' attitudes and behaviours characterised by professional values through readiness, compassionate communication and commitment.

Conclusion The positive experiences of service users, families and healthcare providers provided insight into key drivers of respectful care in facilities in Tanzania and Malawi. Interventions targeting improved environment and privacy, healthcare provider communication and developing positive leadership structures in facilities could

Strengths and limitations of this study

- The use of an Appreciative Inquiry approach to explore women's, family members and healthcare providers' experience of respectful maternal and newborn care simultaneously for the first time in low and middle-income countries is the major strength of this study.
- The relatively large sample size, involving three important key players (women, family members and healthcare providers) of maternity care, is an additional strength to the study.
- The involvement of few men compared with women participants and being conducted in urban setting only are limits of the study.
- Study participants were not familiar with the Appreciative Inquiry approach and sometimes found it challenging to share positive experiences.

provide the basis for sustained improvement in respectful and dignified maternal and newborn care in LMICs.

BACKGROUND

Low and middle-income countries (LMIC) contribute more than 98% of the global burden of maternal and neonatal mortalities.^{1 2} Improving quality and increasing access to skilled care before, during and after childbirth are global priorities for maternal and neonatal health.^{3 4} The WHO vision for quality of maternal and newborn health highlights three domains under the experience of quality of care: respect and dignity, communication and emotional support.⁵

Dignity is defined as inherent in an individual's feeling of worth or value, which is closely associated with respect, recognition, self-worth and the ability to make choices.⁶ Upholding dignity mandates behaviours that respect individual values. Respect and

dignity are strongly associated, reflect basic human rights and are core ethical values underpinning quality healthcare.⁷ Maintaining women's and newborns' dignity during maternity care includes responsiveness, respectful health-worker client relationships, caring attitudes and personalised services.⁸

Several studies have addressed women's and providers' perspectives on respectful and dignified care globally. Recurrent themes include: providing timely care, protecting privacy and confidentiality, giving adequate information and promoting self-determination through obtaining consent before performing procedures.⁹⁻¹³ Further studies highlighted several more attributes to positive childbirth experiences, which include empathetic care, women-centred care, safety and psychosocial support during childbirth.^{14,15} However, to our knowledge, no study has reported on the perspectives of all three key players simultaneously (women, family members and healthcare providers) in maternal and newborn care.

Respectful maternity care has been discussed for almost 70 years; however, there is a dearth of evidence for policies aimed at improving respectful care.¹⁶ The sensitivity of the topic area and perceptions of criticism among providers and service managers in LMIC have been cited as barriers to progress in improving practice.^{17,18} Therefore, a positive approach has the potential to reveal novel insights. Using the Appreciative Inquiry (AI) approach,¹⁹ this study aimed at exploring lay (women and family members) people and healthcare providers' positive experience and drivers of respectful maternal and newborn care to inform future interventions.

METHODS

Study setting

The study was conducted between January and December 2019 in Malawi and Tanzania. In Malawi, two facilities were involved, a busy district maternity hospital and a health centre with approximately 15 000 and 9000 births per year, respectively, both located in Lilongwe. In Tanzania, one referral teaching hospital with 6200 annual births, one district hospital with 5800 annual births and one health centre with approximately 6000 annual births were included. The study sites were purposively selected to represent similar settings.

Patient and public involvement

In both countries, study design and conduct were supported by community involvement groups (CEI), including recent maternity service users, developed as part of an existing programme of members of the research team.²⁰ The CEI groups contributed to study design, recruitment strategy and reviewed participant facing materials.

Study design

This qualitative study represented the exploratory phase of an ongoing research programme, which aims to

improve respectful maternity care in Malawi and Tanzania. The programme is underpinned by AI.¹⁹ In contrast with traditional approaches in health research, which focus on problem-solving, AI promotes positive thinking and celebrates existing good practice to drive organisational change rather than attempting to fix problems. Given the sensitivity of the topic, it was believed that this approach would enable sharing of constructive thoughts about care, minimising perceived threat to participants. Guided by the 'discovery' and 'dream' phases of the AI cycle (figure 1), participants were encouraged to reflect on the 'best of what is' and 'what has been' surrounding their experiences. The 'dream' phase was initiated by encouraging thoughts on a vision of the future in relation to improving respectful care in facilities. These data will contribute to further participatory research to develop and test interventions continuing the AI cycle (figure 1). The research team consisted of midwives and an obstetrician (PM). Academic midwives (AC, RL, TAM, TL) are experienced in qualitative research and research capacity strengthening, TAM and TL have previous experience in AI. Research assistants (RC, LN, CP) had clinical/academic midwifery backgrounds and had participated in previous qualitative research capacity-strengthening programmes led by RL, AC and TL. Six of the researchers have direct experience of clinical practice in Malawi or Tanzania.

Sampling

A purposive sample of women aged 18 years and above, who birthed a live baby at included facilities within the previous 12 months, family members and healthcare providers were recruited. The sample size was based on data adequacy, the focus was achieving rich, in-depth data across a range of participants to achieve a nuanced understanding of experiences related to the study aims.²¹ Family member participants were identified by the woman as a partner/relative or friend who offered the main support during her maternity journey. Healthcare providers included nurse midwives, medical doctors, clinical officers and support staff who had been providing care for women during pregnancy or childbirth at the included facility for at least 12 months. Recruitment was done by an experienced research assistant in collaboration with CEI groups.

Data collection

Interviews were conducted by the research assistants (RC, LN, CP) who had additional training in AI, in a setting chosen by the participant, with due regard for participant and researcher safety. For women and family members, the majority were conducted in their homes, health provider interviews took place in a private room at the hospital or health centre. Women and family members were interviewed separately in their preferred language, healthcare providers were interviewed in English. Researcher-administered questionnaires were completed to record basic demographic and clinical information (for

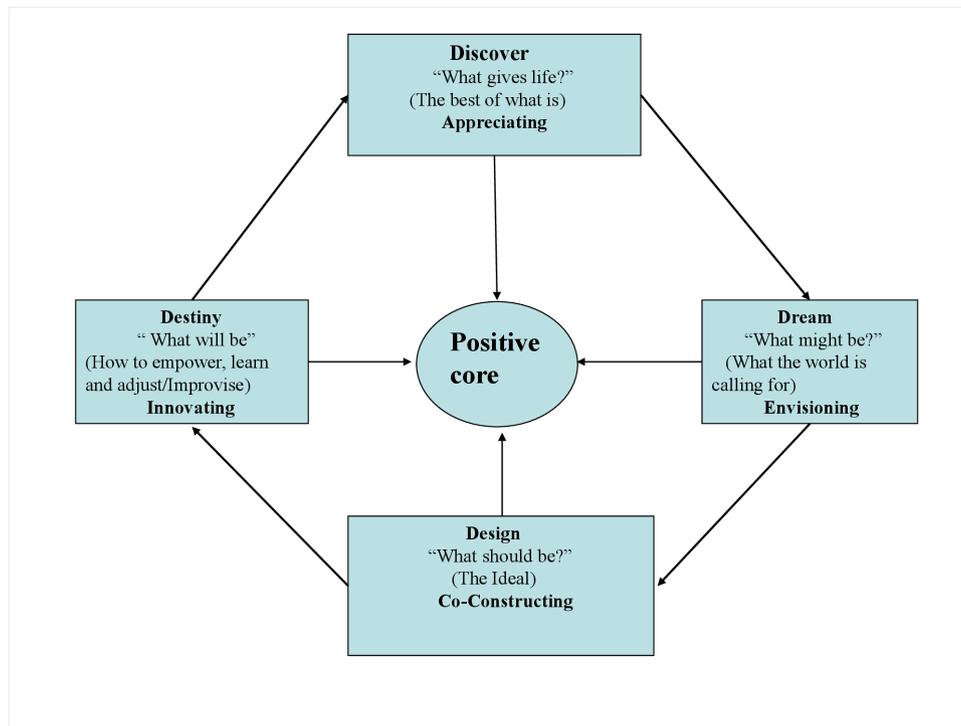


Figure 1 The 4D cycle of Appreciative Inquiry. 4D, Discovery, Dream, Design and Destiny.

women) prior to interviews, which were audio-recorded with consent.

An appreciative interview guide was used, designed around the ‘Discovery’ and ‘Dream’ phases and discussions with CEI leads.²² Participants were introduced to the topic, starting with a lead-in consisting of a verbal introduction to the topic supported by a short film (www.youtube.com/watch?v=pn9LsxQqr94), which was shown on a tablet or mobile phone and provided with a copy of the White Ribbon Alliance charter: Respectful Maternity Care: The Universal Rights of the Childbearing Women; https://www.whiteribbonalliance.org/wp-content/uploads/2020/02/WRA_RMC_Brochure_Desktop_8.5x11.pdf. An open respondent-led interviewing style was adopted. ‘Backward’ questions such as ‘Thinking about the care you had in this facility during your recent pregnancy or during the birth of your baby (ies). Can you tell me about some good experiences or things that went well? (Women)’ allowed participants to describe their experiences. These were further explored with reflection on the most important contributing factors. In the final stage of the interview, forward questions for example ‘In this unit, how can we ensure that all women and newborns feel that they were respected and received respectful care?’ allowed participants to explore the meaning of respectful care, what this would mean in practice and opportunities for development in services and practice.

At the end of the interview, the researcher summarised the main points to increase the credibility of data interpretation.²³ Field notes and reflexive diaries were completed shortly after each interview to provide an overall description; an analysis of the interview technique (including researcher–respondent relationship), to document

learning points and responses and record developing themes. Data were transcribed verbatim and translated into English soon after the interview.

Data analysis

Data were analysed using the framework method,²⁴ a systematic and rigorous approach. The first author read and re-read all the transcripts, developed the initial codes and themes in a Microsoft excel computer software. The initial codes and themes (Charts) were shared with two researchers (TAM, TL), who reviewed and refined the themes based on the transcripts. The recurrent themes were identified and imported into Microsoft Excel, which was then applied back to the raw data to determine fit and refine as needed. Three researchers conducted the initial analyses (PM, TAM and TL) and the overall interpretation was confirmed with the input of the whole research team to ensure dependability.²⁵

RESULTS

In total, 94 participants from Malawi (N=46) and Tanzania (N=48), including 24 women, 22 family members and 48 healthcare providers, were interviewed. The interview duration was between 32 min and 56 min. Demographic characteristics are presented in [table 1](#).

Through the discovery phase of AI, four main themes were identified: (1) empathetic healthcare provider–woman interaction, (2) enabling environment, (3) supportive leadership and (4) providers’ attitudes and behaviours.

Theme 1: empathetic healthcare provider–woman interactions

Initial interactions between healthcare providers and women on admission to facilities were identified as a

Table 1 Demographic characteristics of participants

	Healthcare providers n=48	Women n=24	Family members n=22
Gender	Female 30 Male 18	24	Female 21 Male 1
Age <35 years ≥35 years	30 18	20 4	10 12
Job title/occupation	Clinical officer 3 Medical officer 5 Nurse midwife 38 Support providers 2	Employed/business 14 Farmers 4 Housewife 4 Others 2	Employed/business 10 Farmers 5 Housewife 5 Others 2
Education level	Diploma 24 Bachelor's degree 21 Postgraduate 3	Primary school 18 Secondary school 6	Primary school 16 Secondary school 5 College 1
Main area of work	Administration 5 Clinical 42 Both 1		
Duration in current post	≤5 years 39 >5 years 9		
Time since qualification	≤5 years 16 >5 years 32		
Respectful maternity care training	Yes 19		

crucial first step in establishing a mutually respectful relationship. Participants identified three central components: friendly welcome and courteous language, well-timed appropriate care and information sharing.

A friendly welcome and courteous language

Lay and healthcare provider participants from almost all study sites described the importance of how the woman and her relatives/companions were received at the health facility. Women and family members recalled positive experiences as being made to feel welcome and non-judgmental attitudes by healthcare providers. Likewise, the healthcare providers recognised that receiving women in a 'proper way' involving greeting and introducing themselves by name on first contact was important. Using the woman's name and avoiding overfamiliar or patronising terms was valued. Participants also highlighted how women were spoken to was important, using a calm tone of voice and not shouting.

Honestly speaking, when I arrived at the reception, I was well received, they (nurses) gave me bed to rest on as I was waiting to give birth. When I was about to give birth, they took me to a delivery room, the nurses took good care of me and I delivered safely (Woman—Tanzania).

My daughter was welcomed well, and she did not go through any type of abuse till she was discharged. She was not abused at all and we were discharged properly (Family member—Malawi).

Provider's education, experience and motivation were all recognised as important facilitators of respectful communication. Lay participants believed that healthcare providers needed not only good preparation including

training but also effective role models in practice to develop skills to communicate respectfully.

What made them (healthcare providers) give me that type of care is because of the way the nurses were trained, because the care I received here is the same care I received at the nursery, it means that is how they were taught to do (Woman—Malawi).

Timely and appropriate care

Woman and family member participants identified prompt review, appropriate assessments and interventions meeting the woman's needs as integral to respectful approach. Women participants particularly valued the prompt initiation of care on arrival at the facility.

There was a doctor coming on time and informing me that you will continue with this and that even the medicine I have to receive (Woman—Tanzania).

Information sharing

Both healthcare providers and lay participants believed that provision of understandable information, was crucial to allow women to participate effectively in decision-making about their care and whether to accept interventions. Women participants appreciated detailed information provided to them and the freedom to agree or refuse interventions.

...they did not force me to close the uterus (tubal ligation), when they have prepared me they took me to the surgery room, they asked whether I was ready to close the uterus, they told me if I was ready to close the uterus, they would help..... I told them that I am ready, and when my husband came, they also

asked him, he agreed, and we signed and agreed with nurses (Woman—Tanzania).

Being informed of findings immediately after assessments and giving time to ask questions allowed women to feel empowered in their choices. Healthcare providers also recognised the value of providing women with clear explanations and actively involving them in decisions surrounding care, to protect their autonomy.

When assessing them, we tell them I am doing this because of a, b, c, d and then when we are giving them their treatment, we also explain to them why we are giving them that type of treatment. And we also give them a chance to refuse or accept the treatment. So, they have right to choose, to say I like this position, without shouting at them we give them the freedom to do that (Nurse—midwife—Malawi).

Alongside preservice education, providers recognised that clinical leadership and continuous professional development were important influences for improving and sustaining performance.

We do have a consultant midwife; this consultant midwife always provides in-service trainings like the continuous professional developments each and every week to make sure that we are giving these women the best care (Nurse—Midwife—Malawi).

Although participants focused on examples of positive contacts, several recounted negative experiences, either personal or anecdotal. Opportunities were identified to improve consistency and equity in care provision, through better communication and sharing of information that might require action by facilities and providers.

.....the nurse (Midwife) should inform the patient that 'we want to examine you' respectfully, not shouting at her at all, so she has to listen, rather than surprising her that 'hey stretch your hand I want to examine you' (Family member—Malawi).

Participants suggested more in-service training and improved status for healthcare providers could enhance respectful care.

Training them should be frequent. Also, salary should be increased to them so that they can provide service at their best (Woman—Tanzania).

Theme 2: enabling environment

Participants across both Malawi and Tanzania recognised recent improvements in the facility environments, which had increased privacy and improved care for women. Maintaining privacy was consistently identified as of key importance by women; for example, being covered during physical examinations and protecting confidentiality. Healthcare providers using screens and

curtains to protect women during physical examinations were important aspects of this.

...actually they didn't leave my body exposed before the mass [other people], they put screens to protect our body from being exposed so that anyone who is passing nearby should not be able to see us, if I'm in a bad condition they were very effective they come and assist me, when men were trying to move around there, they were blocked so they maintained privacy and confidentiality throughout my presence during healthcare, the curtains were well closed and only one nurse was there when giving healthcare (Woman—Tanzania).

Incentives and allowances were offered to healthcare providers by management at several facilities in both countries; these were viewed generally as positive, helping providers feel valued and motivating them in their work. Meals were provided to nurse-midwives on duty across all facilities in Malawi and some facilities in Tanzania, this was noted to be beneficial in saving time as they did not leave the facility to collect food and, therefore, leave women for prolonged periods:

...and the hospital decided that the labour Ward staff must be given hot meals during lunch hours and including the night, they always give us the hot meals so that we shouldn't be going out so that the care we are giving to women shouldn't be interrupted (Nurse—midwife—Malawi).

Also, the maternity leadership provide breakfast for all healthcare providers on duty so that they don't go out often to look for food. This is good because it motivates the healthcare workers (Nurse—midwife—Tanzania).

Women, family members and healthcare providers also valued the importance of good hygiene and cleanliness for quality care. Lay participants at one study facility in Malawi and two facilities in Tanzania appreciated the use of sterile equipment and clean bed linen in the facilities.

Many women in some study facilities of Malawi and Tanzania indicated a wish to have support from family or a chosen companion during the birth. Although many facilities did not actively promote access to labour companions, individual staff often accommodated them on an individual basis, using screens and separate areas for privacy. In one facility in Malawi, the labour ward manager provided a private room for women who wanted male partners to remain with them.

.....also, we encourage male companion for, we have a special room where the patient who came with the male companion were kept in that room..... Others should take that example that male companion is good because the woman also express herself in the presence of the husband (Labour ward manager—Malawi).

Both lay and healthcare providers' participants recognised that increased resources including medical supplies and hospital building improvements contributed to improving care overall, including dignity and respect. One healthcare provider noted the importance of co-operation at all levels in facilities.

And also, provision of adequate resources, because previously were issues of lack of resources but after sitting down with management, the leadership, the pharmacy people, they try their best to provide enough resources in our Labour ward since this is a busy maternity (Nurse—midwife—Malawi).

All participants, across both countries, acknowledged the need for further improvement in facility infrastructure, envisaging an optimal environment, which would have adequate buildings, curtains and screens and more space, which could reduce overcrowding and facilitate companionship during labour.

So, maybe if there were enough rooms, so that people should fit in, and then there should be spare beds without people. That would help us a lot. ... the rooms should be enough; they should be able to protect (provide privacy) us at the time of delivery (Woman—Malawi).

A family member added—*There should be the nurse, the patient and her guardian. If there are two beds, there should be something to screen them. They should work with their doctor, and so should the others...* (Family member—Malawi).

Theme 3: supportive leadership

Participants appreciated the commitment of their governments and facility leadership to promoting provision of respectful care. In Tanzania, recent change of government was perceived as having led to general improvements in the health sector and maternity care.

I think the leadership has contributed, it seems the leadership is good that's why it is like that.....I think another thing that has contributed to good services is our government to insist about saving mother and child's livessuch as a service of operation I think it has contributed at large (Woman—Tanzania).

Leadership was also influential at the facility level, for example, in promoting the development of policies and treatment guidelines. These were valued by healthcare providers in standardising practice and supporting decision-making in the clinical areas. Family members also recognised the positive impact of supportive leadership at the hospitals in improving care and outcomes for patients.

And the policies at this hospital, those who are in top positions give proper advice and they give proper explanations that, when a patient comes, you should treat them this way, take care of them properly (Family member—Malawi).

Healthcare provider participants valued supervision and mentorship, for example, from senior midwives and hospital matrons. In Malawi, consultant midwives were available to support less experienced midwives in practice. The consultant midwife had a 'hands-on' clinical role in the facility and provided role modelling, mentorship and clinical expertise to support other midwives, these midwives were highly respected by their peers. Healthcare providers across both countries valued the habit of discussion and debriefing after difficult clinical scenarios as opportunities for learning and reflection for nurse—midwives.

....and another thing is that there is adequate supervision in our facility. Even the matron, she comes and supervises. So, I think that is one of the things that has allowed us to provide respectful care (Nurse—midwife—Malawi)

Also, we have labour ward in-charge who keeps on reminding us every day and head of department sometimes comes for supervision to remind us about our policies and good practice (Nurse—midwife—Tanzania).

Good communication and feeling valued by the organisation were also important. Morning and monthly staff meetings in facilities were seen as important forum for discussing service provision:

There are monthly staff meetings where we discuss about work; these should be maintained (Nurse midwife—Tanzania).

The importance of supporting providers to enable them to provide effective care was consistently recognised at all levels across study facilities in both countries.

That person who supervises them is required to show love to the nurses who are working in that place, so that they themselves should also feel good when working (Woman—Malawi).

Healthcare providers' participants identified supportive supervision, opportunities for reflective discussions and organisational commitment to well-being as important. Perceptions of a 'blame culture' was identified as a barrier to openness and progress.

We can say that, not just point to the faults or the mistakes that our providers are making, but also promote the good, like appreciating them for the good work they do (Medical doctor—Malawi).

Paying healthcare providers' salaries in timely manner, increasing their salaries and giving additional allowances were identified as motivating them to provide optimal care. Non-monetary benefits, such as providing food when they are on duty, providing transport and housing near their working areas, were also identified as potentially helpful.

So, I think the hospital should try hard to appease the doctors and nurses and pay them quickly and on time because these people save a lot of lives (Woman—Malawi).

Theme 4: providers' attitudes and behaviours

Demonstrating professional values through readiness, compassionate communication and commitment were considered key positive attributes for health workers. The lay participants across both countries valued the willingness of healthcare providers to provide care to women despite resource pressure when facilities were busy or when they were coming to the end of a shift.

The thing that I noticed when receiving healthcare is that the nurses were very sensitive and active, they can't see someone who is in pain and just leave her like that, they took positive steps to help her (Woman—Tanzania)

I had found a nurse who was on night duty and was about to knock off, but she did not accept that she was knocking off. She still gave me care; she examined me and cleaned me properly (Woman—Malawi).

Compassionate care was an important contributor to family member's perceptions of positive experiences of their relatives at the study hospitals. For example, they identified nurses giving attention to babies in the neonatal unit when their mothers were unavailable. Also not leaving women alone for long periods, for example, during shift handovers was appreciated:

.....during hand overs we always make sure that they (women and newborn) are not left alone; they are always with someone to attend to them (Nurse midwife—Malawi).

These values were identified as integral to professionalism and could be acquired through effective education to facilitate quality care:

I feel that it was because she was well trained in her job; that's why she gave me care. There is nothing else because, by then, my guardian was not yet there, and that's the only reason, that she was well trained but also, she (nurse) is a compassionate woman (Woman—Malawi).

Although most healthcare providers displayed some degree of professionalism, participants identified need for strengthening of core values to underpin improvements in care:

So, for me, my wish is that those nurses should also take us women as human beings, the way they are, because of the way we feel. They are also women. If it's a man, he also sees maybe his wife, the way she suffers (Family member—Malawi).

DISCUSSION

This is the first study, we are aware of, to use an AI to explore respectful maternal and newborn care involving three key players (woman, family members and healthcare providers) simultaneously. This approach was selected for its potential to reveal solutions for improving respectful maternity care from within these settings. Four themes summarised participants' reflections, perceived drivers and ideal vision of the future of respectful maternal and newborn care in their settings. These comprised the quality of healthcare provider–woman interactions, enabling environment, supportive leadership including guidelines, clinical supervision and reflective staff meetings and healthcare providers' attitudes and behaviour.

Our study findings support global perspectives, including WHO recommendations, which emphasise the importance of respectful and supportive interactions between women and their healthcare providers for positive childbirth outcomes.²⁶ Courtesy, empathy and appropriate information were considered essential features of good communication during childbearing. These findings closely reflect studies^{9 10 13 27–29} from both low and high-income countries that have reported the value attached to communication, information sharing using polite language, freedom of choices and timely appropriate care by women and family members.

Healthcare providers' positive attitude and behaviour were found to be important in one Nigerian study. Words like being friendly and welcoming/receptive to women were used to describe the healthcare providers' positive attitudes towards women during childbirth.³⁰ In our study, participants described healthcare providers' positive attitude and behaviour as 'readiness', 'politeness' and 'commitment' during care provision. Studies conducted in Nigeria found that providers' rudeness and lack of commitment to their duties were among the barriers to utilisation of maternity health services and encouraged home births.^{31–33} Rudeness and arrogance were attributed to stress, lack of motivation and lack of training.³³ However, our findings show that organisational factors were also important and increased support and other incentives, such as extra duty allowances, contributed to positive providers' attitude and behaviour. Furthermore, participants valued on-job training as part of motivation that facilitated providers' behaviour change.

The influence of physical environment of care was also highlighted, for example, improvements which enhanced privacy and allowing labour companion. Kujawski *et al*³⁴ reported similar findings that restructuring of the maternity ward in Tanzania by moving the admission area to a private room, and the use of curtains for delivery and physical examination contributed a significant reduction in women's experiences of disrespect during childbirth.³⁴

Continuous support during childbirth, having the freedom of movement during labour, good communication between client and provider (including encouragement during the birthing process) and support of the mother–baby pair before and after birth (including



privacy received during birth) are known to support positive birth experience.^{35 36} Presence of labour companion during and after childbirth has been shown to reduce mistreatment during childbirth.^{37 38} In our study, participants acknowledged the importance of labour companion but highlighted the shortage of supportive infrastructure in the study facilities. However, they appreciated efforts that have been made in all study sites to promote companionship to the extent of allowing women to communicate with companions via phone. Inadequate infrastructure supportive to accommodating companions was the most significant barrier, concurring with previous reports, which found privacy concerns and inadequate physical space were concerns in LMIC settings.^{39 40}

Supportive leadership at all levels was highlighted as key driver to provision of respectful maternity care. National policy and government initiative supporting respectful care were important to raise awareness.⁴¹ However, in practice, the presence of visible role models, for example, the presence of consultant (senior experienced) midwives who offered hands-on clinical support whenever needed in Malawi study hospitals was of key importance to junior staff. Continuous supportive supervision carried out by seniors and hospital leaders (eg, Matron) coupled with provision of guidelines and policies contributed to the quality of care provision. The findings concur with a systematic review of the impact of general clinical supervision (provision of guidance of clinical practice for qualified health professionals by more experienced health professionals) of healthcare professionals on patient care, which significantly improved compliance with processes that were associated with enhanced patient health outcomes.⁴²

Healthcare providers' attitude and behaviour, supportive leadership and enabling physical environment appeared drivers of respectful maternal and newborn care provision in our study settings. Similarly, Bhupendrasinh et al (2017) review found that interactive and multifaceted continuous medical education programmes, training with audit feedback and clinical support systems were beneficial long-term behaviour change in clinical practice.⁴³ Well-educated and experienced healthcare providers appeared to have good attitude and behaviour, these findings resonate with those of Afulani et al⁴⁴ and Davis et al⁴⁵, that training and education interventions are effective methods of changing how providers communicate and also gave women positive childbirth experiences.^{44 45}

This study establishes the value of AI¹⁹ in exploring local facilitators of respectful care including service user priorities; insights gained from this approach can be used to develop strategies for improvements in care in Sub-Saharan Africa. The AI approach encourages individuals to consider the strength of their organisation and suggest innovative ways to strive for improvements.⁴⁶ Focus on the power of positive attributes and conversations to discover what gives 'life' to a system when it is at its best is particularly helpful when discussing sensitive topics.⁴⁷ In the context of respectful maternity care, traditional problem-centred approaches

to change are often perceived as overly critical by health providers, this might engender vulnerability and discourage open dialogue.⁴⁸

Our findings support the value of continuous professional development, clinical audits and reflective meetings as opportunities for improving respectful care provision, as also suggested by Warren et al⁴⁹ and Shimoda et al¹¹. Additionally, continuous compassionate hands-on clinical supervision was found to be an important driver of respectful maternal and newborn care in study hospitals. However, supervisors themselves need adequate preparation and institutional support to develop skills among their teams. Furthermore, efforts must be made to create enabling environments, which will enhance privacy and ensure availability of adequate resources (medicine, medical supplies and human resources). Healthcare providers must be informed of the desires of women, including prompt care on arrival to hospital and courteous communication; these are determinants of women's satisfaction.⁵⁰

Strength and limitations

The use of an AI approach to explore a sensitive topic enabled us to discover feasible, culturally acceptable solutions within the LMICs settings. Moreover, the study involved a relatively large sample from two sub-Saharan Africa countries, which strengthens the breadth of our findings.⁵¹

The study involved few male participants (1 out of 22 family members and 18 out of 48 healthcare) and all study hospitals were in urban setting, these limit the study findings. The study excluded women who had experienced perinatal loss and those with sick newborns, who may have different views. Furthermore, participants were not familiar with the AI approach and sometimes found it challenging to share positive experiences.

CONCLUSION

The affirmative experience reported by lay and healthcare providers' participants in this study, in conjunction with the potential drivers, reveal the potential for improving respectful care within the hospitals in Tanzania and Malawi. Building on the existing good practice in respectful maternal and newborn care including strengthening leadership, staff development; strategies to increase motivation and structural improvements are opportunities for improving respectful care in LMIC.

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Competing interests None declared.

Patient and public involvement Patients and/or the public were involved in the design, or conduct, or reporting, or dissemination plans of this research. Refer to the Methods section for further details.

Patient consent for publication Consent obtained directly from patient(s)

Ethics approval Research governance approvals were obtained from The University of Manchester, University of Malawi College of Medicine Research and Ethics Committee approval number 2019-6366-10657, and Catholic University of Health and Allied Science, Tanzania Review Board approval number CREC/399/2019. Administrative clearance was sought from the participating hospitals. Following written informed consent, all participants were allocated a unique study number and were invited to choose pseudonyms, which were used in transcription and verbatim quotations to maintain anonymity. None of the participants were reported to be upset or distressed during the interviews.

Provenance and peer review Not commissioned; externally peer reviewed.

Data availability statement Data are available upon reasonable request. All data relevant to the study are included in the article or uploaded as supplementary information. Anonymised data for this study are available through contacting the corresponding author via email pfdmoe@gmail.com.

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