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ABSTRACT

Objective There is an abundance of evidence illuminating the factors that contribute to disrespectful maternity care in sub-Saharan Africa. However, there is limited documented evidence on how some of the key influences on the mistreatment of women could be addressed. We aimed to document the perspectives of nurses and other healthcare workers on existing and potential strategies embedded at the health facility level to promote respectful delivery of healthcare for women during delivery and on what interventions are needed to promote respectful and equitable treatment of women receiving maternity care in rural Kenya.

Design, setting and participants We analysed relevant data from a qualitative study based on in-depth interviews with 24 healthcare workers conducted between January and March 2020, at health facilities in rural Kilifi and Kisii counties, Kenya. The facilities had participated in a project (AQCESS) to reduce maternal and child mortality and morbidity by improving the availability and the use of essential reproductive maternal and neonatal child health services. The participants were mostly nurses but included five non-nurse healthcare workers. We analysed data using NVivo V.12, guided by a reflective thematic analysis approach.

Results Healthcare workers identified four interconnected areas that were associated with improving respectful delivery of care to women and their newborns. These include continuous training on the components of respectful maternity care through mentorships, seminars and organised training; gender-responsive services and workspaces; improved staffing levels; and adequate equipment and supplies for care.

Conclusions These findings demonstrate some of the solutions, from the perspectives of healthcare workers, that could be implemented to improve the care that women receive during pregnancy, labour and delivery. The issues raised by healthcare workers are common in sub-Saharan African countries, indicating the need to create awareness at the policy level to highlight the challenges identified, potential solutions, and application or implementation in different contexts.

STRENGTHS AND LIMITATIONS OF THIS STUDY

⇒ We interviewed participants who had been working in the health facilities during the AQCESS Project interventions and could speak on their observed experience.
⇒ Our findings provide insights to guide policies in a neglected area in rural Kenyan facilities.
⇒ The small sample size of 24 healthcare workers in two distinct rural settings could be considered a limitation.
⇒ Findings could include bias with the staff who were recruited in the study work at participating health facilities that received the project interventions.

INTRODUCTION

There has been a considerable effort in Kenya to improve and increase equitable access to maternity care, including the provision of the free maternity care and the devolvement of the health system structures. Emphasis has been placed on bringing health facilities and healthcare services closer to the communities where people live.[1] Recent research from both service users and healthcare providers in Kenya indicates that, despite these efforts, quality of care for pregnant women remains low and breaches users' basic human rights principle of access to equitable and fair care.[2–4]

Research from Kenya and other sub-Saharan African countries links persistent cases of disrespectful maternity care (DMC) to inadequate health system factors, such as lack of essential equipment and supplies, inadequately trained staff, low staffing and lack of gendered private spaces.[5–9] Emerging research also highlights the lack

of person-centred maternity care, which does not recognise the importance of the patient experiences, including mothers who are adolescents, living with disabilities or from different cultural backgrounds, that directly and indirectly impact health outcomes and facility utilisation.[10–13]

Mistreatment of women during health facility utilisation occurs at the level of interaction between women and healthcare workers, with some women reporting feelings of infantilisation, neglect and abuse, isolation and disrespect.[11 14] This indicates that maternity care is intrinsically shaped by health workers' behaviours, attitudes and skills.[2–9] The WHO Quality of Care Framework recognises that both a knowledgeable and motivated health workforce as well as an effective health system are essential to good-quality maternity care.[15] WHO recommendations emphasise the need for quality interactions between healthcare providers and women as a prerequisite for positive maternal, newborn and child health (MNCH) outcomes.[16] Despite clinical guidelines and standards for respectful maternity care (RMC), these strategies have not been implemented broadly nor equitably.

The present study was conducted in Kilifi and Kisii, two rural subcounties in Kenya, at the end of a 4-year project, called Access to Quality Care through Extending and Strengthening Health Systems (AQCESS). The goal of AQCESS was to reduce maternal and child mortality and morbidity by improving the availability and the use of essential reproductive, maternal, newborn and child health services in Kilifi and Kisii. The project was implemented by the Aga Khan University (AKU) in partnership with the Aga Khan Foundation (East Africa), Aga Khan Health Services, and the county governments of Kilifi and Kisii.

AQCESS interventions in the study context included the following: (1) provision of clinical, leadership, and management training and mentorship through a series of courses on basic emergency obstetric and newborn care as well as comprehensive emergency obstetric and newborn care, integrated management of childhood illness, continuous quality improvement, supply management and infection control; (2) engaging communities to support pregnant women and their families to seek evidence-based MNCH information and services; (3) improve dissemination and use of reproductive, maternal, newborn and child health information and evidence through improved collection, analysis, and use of facility and community-level health data; and (4) refurbishment of facilities and creation of gendered private spaces for antenatal and postnatal women.

The present analysis builds on the baseline gender assessment study findings that reported systemic issues of poor care and maltreatment of pregnant women.[3] We previously reported findings from the present qualitative interview study related to healthcare workers' views on RMC[2] and plan to report findings related to healthcare workers' knowledge and sources of RMC.[17] To successfully implement interventions to improve healthcare delivery to women during pregnancy, labour and delivery, it is crucial that policymakers understand healthcare workers' perspectives on the current status of maternity care at health facilities as well as what interventions they envision would be helpful to promote RMC. As such, in the present analysis, we report findings from the study related to healthcare workers' views on interventions to reduce DMC.

METHODS

Study design and context

We conducted a qualitative interview study of healthcare workers from Kilifi and Kisii counties in Kenya between January and March 2020. The overall aim of the study was to investigate various factors related to RMC. All interviews were transcribed in full and thematically analysed, and analyses were divided into several reports. We previously reported findings from this study related to healthcare workers' views on RMC[2] and plan to report findings related to healthcare workers' knowledge and sources of RMC.[17] In the present analysis, we report findings from the same study related to healthcare workers' views on interventions to reduce DMC.

We conducted qualitative descriptive in-depth interviews (IDIs) with 24 healthcare workers across Kilifi and Kisii counties. The two sites where data for this paper were collected are rural and dissimilar, with Kilifi in Kenya's Coast Province and Kisii in Western Kenya. Participating health facilities included both large county hospitals and dispensaries where women deliver. Most of the dispensaries serve rural populations, with many health workers living within the dispensaries' catchment area. The area and facilities were part of the AQCESS Project's interventions. Detailed information on the social and economic context of Kilifi and Kisii can be found in our recent published papers from the AQCESS Project.[2 3 17–21]

Study recruitment and sample

Healthcare workers participating in this study were purposively sampled by the AQCESS Project managers to ensure that relevant facilities and workers meeting inclusion criteria were captured. AQCESS Project managers approached health facility managers and shared our research aims and inclusion criteria for the participants. Criteria for participation included healthcare workers who lived in the study area at the time of the interview and who had worked at the health facility for the last 1 year to be able to speak on their experiences during AQCESS Project implementation. We focused on healthcare workers because we sought to understand their perspectives on the potential opportunities for improving RMC for women attending facility-based maternity services.

While conducting qualitative research in a homogeneous group, saturation can be gained at 12 interviews.[22 23] We therefore interviewed 24 healthcare workers (18 women and 6 men), 12 in each county, who worked in the health facilities within the AQCESS Project target

areas. Most of the participants were nurses working in the maternity ward, in the antenatal and postpartum clinics. Five of the participants were non-nurse healthcare workers who came in contact with women or assisted women on their pathway to delivery (pharmacist(s), nutritionist(s), and member(s) of the admission and discharge team). In reporting our findings, we have not included the gender, facility and title of the healthcare workers in order to maintain confidentiality.

Interview process

IDIs were conducted with healthcare workers in private locations at the facilities where they worked and at a time of participants' convenience. Research assistants who helped with note taking were trained by the principal investigator and familiarised themselves with the interview guide, the participant information sheet and informed consent forms. The active consenting process entailed explaining the study purpose, confidentiality and privacy issues, and the unencumbered right to refuse to answer specific questions and to voluntarily withdraw from the study. All participants provided active consent by signing the consent forms. Interviews were conducted using a topic guide (online supplemental appendix 1).

All interviews were audio recorded and a debrief statement was read at the end of each interview during which participants were given the opportunity to ask questions. Interviewees were asked about measures embedded at their facilities that promote RMC, their views on the effectiveness of these strategies, and what interventions and measures they would like to see undertaken to further promote RMC in these facilities.

Data management and analysis

All interviews were transferred from the audio recorders to the Monitoring and Evaluation and Research Learning Unit at the Centre of Excellence in Women and Child Health at the AKU, Kenya. All data from audio recorders were transcribed verbatim by a qualified transcriber and all transcripts were emailed through a secure link to the AKU server. The research team anonymised all the data by removing names of the interviewees. To further ensure confidentiality of participants, the gender of the healthcare worker was not provided for specific vignettes below; however, each section included at least one quote from a male healthcare worker.

We employed Braun and Clarke's six stages of reflective thematic data analysis.[24] Data analysis began with AML's and SW's reflections of the field notes and reading of the transcripts to familiarise with the participants' narratives. We each analysed three transcripts and separately developed the codebook which we both discussed and agreed on the coding framework which we used in NVivo V.12 to code the remaining datasets. We discussed emerging codes and linkages in our debrief coding sessions and once we completed the coding, we merged our files and worked through the coded data to develop categories and themes. Following the completion of the coding process, we held separate workshops in both Kisii and Kilifi subcounties with some of the study participants, project staff and key stakeholders including Ministry of Health officials, service users and local leaders to share our findings. We also wanted to check with the participants if our data analysis was a true reflection of their views and experiences. The issues raised in our Results section were confirmed by participants in these workshops, who emphasised the need for interventions.

Patient and public involvement

Patients and/or the public were not involved in the design, conduct, reporting, nor dissemination plans of this research.

RESULTS

Our study found that there was a need to improve gender-responsive workforce and facilities, train healthcare workers, and improve staffing levels and healthcare equipment.

Limited current strategies embedded at the health facilities to promote RMC

Gender-responsive facilities and workforce

The study findings show limited current available strategies to assist healthcare workers in providing RMC, in both Kisii and Kilifi. We found that, while at some facilities, there is an attempt to increase private spaces and a commitment to staff hiring to avert staff burnout reduction and prevention, it was limited in practice. Findings across the two sites indicate that following AQCESS interventions, there was expanded access to gender-responsive services and infrastructural improvements at some health facilities. Infrastructural improvements included the provision of additional rooms to promote privacy during consultations, which is an important aspect of RMC. In addition, gender-responsive toilets and private rooms were constructed at some facilities where the AQCESS Project was implemented.

> To support respectful maternity in hospital… we used to have just one room where we [nurses] usually conducted our deliveries, but they [AQCESS project] built a big maternity, a modern maternity that have a good space and several rooms whereby you can be able to put even partitions so that at least when we are attending to one pregnant mother, they cannot be able to see the other… (IDI, nurse, Kilifi)

Although gendered spaces were mentioned in Kilifi, the benefits were not shared across all AQCESS health facilities. Some healthcare workers, who did not work in facilities where AQCESS Project construction of extra maternity spaces occurred, passionately emphasised the importance of increasing spaces at the health facilities.

> …For me, things of priority, if we may get enough space or adequate space. Working space that is, the

ideal working space for handling those mothers, I may be glad… (IDI, nurse, Kilifi)

In Kilifi, the health facilities are small compared with the proportion of women who use them and interventions should not only consider refurbishments of these facilities but constructing larger facilities proportionate to the population of women. In many small facilities, the AQCESS Project did not add additional spaces but rather rehabilitated the existing buildings, implying that space remained an issue. It seems clear that during any renovations or construction, investing in gender-responsive infrastructure and services would be a way forward to endorsing RMC in these settings. However, gender-responsive facilities must also be accompanied by availability of gender-responsive staff. For instance, some women may refuse to be attended to by male healthcare workers.

Most of them [pregnant women] were saying 'no pulling panty or a gentleman [male healthcare worker] looks at me? No, no, no…' So, we [male healthcare worker] had to request for a lady [female staff] at least to help in that situation. (IDI, nurse, Kilifi)

The employment of a female healthcare worker recently…yes. Initially there were so many services based on the maternal part like cervical cancer screening. …, it is easier for a lady to accept service from a male staff when she is in labour but for other services like cervical cancer screening it is not easy. Even if you do, you give all that information it is not easy to convince them. (IDI, nurse, Kilifi)

As these narratives show, gender-responsive staff and facilities are central components of RMC. Even though the AQCESS Project attempted to institute some changes at some health facilities in its programme area, these findings suggest that it is an area that requires interventions—as it is a major barrier to women's use of health facility care.

Strategies to improve RMC

Healthcare workers were asked to share some of the changes that have been implemented at their facilities and probed to propose solutions to improve RMC. Suggested solutions to improve RMC include offering continuous professional development opportunities, increasing staff numbers, and ensuring availability of adequate equipment and commodities.

Human resource

Suggestions for improvements in human resource capacity were also made to address the problem of understaffing as a broad challenge in the public health system. Participants indicated that increases in the numbers of healthcare workers may create a motivated workforce to deliver quality maternity care by mitigating staff burnout and fatigue, which both contribute to DMC. Healthcare workers from both Kisii and Kilifi accentuated the need to have at least two staff members on duty.

There are things that we may recommend, but they are beyond our capability for example if there is good staffing, burn out, the issue of burn out will be left out, yet the mothers will be getting the best services. (IDI, nurse, Kilifi)

…The county should look into the issues of staffing. Yeah, it is a big, big challenge that is biting the hospitals especially the public hospitals… (IDI, non-nurse healthcare worker, Kilifi)

So what we can do maybe, we find in a normal setup that, because we go for four nights, we be two staffs, yes, it can at least help(ful) if this one is doing this [chores] the other will do that [chores] and you will find that the work is not that much, …when the other is writing, another doing procedure and another finishing delivery… it can also help… (IDI, nurse, Kisii)

In rural Kilifi and Kisii counties, the number of women seeking maternity care at the health facilities increased following the introduction of the free maternity care policy that allowed women to deliver at the facilities free of charge. The number of staff did not keep up with the new policy and concomitant increase in the number of service users in these facilities. As a result, and as the above quotes show, low staffing, where only one on-duty staff member is available to fill many roles, compromises the quality of care to women during delivery.

Provision of continuous professional development opportunities

Continuous and targeted training was suggested as a solution to combat negative behaviours, update practices and address disrespectful attitudes of healthcare workers. In Kilifi, for instance, participants identified the positive impact of the mentorship programme implemented through the AQCESS Project and their preference to have it continue. Accordingly, the mentorship and training programme improved healthcare workers' interpersonal communication skills as they learnt how to communicate with clients in a respectful and empathetic manner leading to an increase in the uptake of facility services among mothers. As the following quotes illustrate, in Kilifi, where our previous research found a high level of DMC,[3] some healthcare workers reported that the mentorship and training opportunities aided in addressing some of their negative attitudes and behaviours, while improving their ability to deliver RMC.

…another thing is the service providers the way they communicate to the clients, they are always being reminded to speak to them politely…It was about the mentorship [AQCESS project training] …The mentors … they covered the issue of communication, the issue of consent [patient consent to care]. (IDI, nurse, Kilifi)

Participants also emphasised the need for mentorship programmes as a way to build capacity among staff. Findings suggest that mentorship programmes improved

practice and encouraged more mothers to use maternity services and start delivering at the facilities.

> For example, us [a facility] before, before the mentorship programs our deliveries had started going down but we didn't really know the reason after mentorship, our deliveries are now okay [more deliveries]. That's one thing. Our attitude also has changed more… It was, it was normal but it has changed more [improved]. Now, now that we were informed that we should be respectful to the mothers. (IDI, nurse, Kilifi)

> …Continual, continual trainings usually help. Because you know someone can forget sometime and the guidelines also should be in place so that the healthcare workers remind themselves the respectful mother care. And also… (IDI, nurse, Kilifi)

> Then the issue of trainings, maybe these trainings are being organized for those, for us health workers, we attend those trainings, so, we acquire, okay we have those knowledge and skills from college, but if these trainings are organized, it may be good, maybe our outcome will be… (IDI, nurse, Kilifi)

Similar views were reported in Kisii, but with greater emphasis on training to curtail stigma and discrimination and improve general patient communication as well as interactions with adolescent mothers.

> …Also, on job training for those that have not gotten the information, it can also assist in curbing irrespective maternity care and then continuous learning, and emphasizing on respectful maternity care… (IDI, nurse, Kisii)

> … there should be training on how to handle those mothers, like that of customer care, communication is very important. Mostly in maternity is very important because in maternity we understand it is, there is a lot of work. You have to persevere, so, either in bench marking, bench marking is good because we went to one with the AQCESS project, we took as one, it was very nice by the way it is educative. You can change from benchmarking… (IDI, nurse, Kisii)

> …And then, that is why am saying we need, I think we should have somebody who come and support us on the terms of, on the part of the training, on attitude change… (IDI, nurse, Kisii)

> …like a seminar must be held in the health, among the health workers or anybody like, let's say if the donor who is coming or the health facility in charge to talk to these staff about, could talk the staff on how to handle these mothers when they come. Yes, during delivery… (IDI, nurse, Kisii)

The need for staff training was discussed as a major gap that needed to be addressed. Further, some healthcare workers felt that even training on the available and updated government policies on maternity care, for example, protection against the retention of mothers at hospitals after delivery for failure to pay hospital fees, must be communicated to healthcare workers through training to prevent potential violations of mothers' basic rights.

> Yes, and in fact it has to be cutting across. Because, I am not seeing the reason as to why the mother has to be retained simply because she has not cleared [hospital bill], yet the government has policies that services have to be delivered. So, I am saying the government policies has to cut across for both private and government facilities… (IDI, non-nurse healthcare worker, Kilifi)

Provision of adequate equipment and supplies

A conducive environment with proper functioning equipment and adequate commodities is required for the proper provision of maternal care. Participants outlined that equipment and maternity spaces are foundational to assist healthcare workers in their ability to deliver quality care. These improvements ranged from the availability of maternity commodities, such as clean water and gauze, to functional equipment, such as screens for promoting privacy, revealing the interconnected nature of RMC strategies.

> …The first thing, if we can get enough equipment which is needed in the maternity. Secondly, we need like there's supposed to be a screen when a mother is in the delivery couch even the sub staff who is doing cleaning should not see that mother… (IDI, nurse, Kisii)

> …Then commodities, maternity commodities, availability of maternity commodities, at times you may get stock-outs, things like cotton, they may get out of stock, things like gauze they may go out of steady and supple of those commodities should be well. (IDI, nurse, Kilifi)

DISCUSSION

In this paper, we analysed relevant data from a qualitative study based on interviews with 24 healthcare workers and report on potential solutions to curtail DMC from healthcare workers' perspectives in Kilifi and Kisii counties, Kenya.

Our findings revealed that healthcare workers identified a number of interconnected recommendations to aid in the provision of RMC that included infrastructure, adequate staffing, mentorship and training, and adequate equipment and supplies. First, gender-responsive infrastructure and services were seen as key promoters of RMC. Some of the health facilities participating in the AQCESS Project made improvements in infrastructure and facility design to improve privacy in maternity care. Improvements in infrastructure and the creation of gender-responsive spaces for maternity care

have previously been identified in a study in Tanzania and can only be addressed through sustained and increased investment.[11]

Second, a major strategy to improve RMC demands was to increase staff deployments at health facilities. Notably, this was done to address both issues of patient privacy and patient preferences, as well as to prevent fatigue and burnout among healthcare workers. This is consistent with evidence that linked burnout to the suboptimal delivery of maternity care perpetuating a cycle of DMC.[2 8 9 11]

Third, the provision of continuous professional development opportunities emerged as a prominent theme from healthcare workers' narratives to improve care. There were suggestions for scale-up through mentorship and training, citing the success of AQCESS mentorship interventions and the improvement in healthcare workers' capacities to provide RMC. Participants indicated that the provision of the continuous professional development opportunities helped to curb poor attitudes and facilitate positive communication with mothers, in particular, improved interactions with pregnant adolescents. The importance of providing support to healthcare workers in achieving RMC through access to continuing professional development opportunities and the provision of culturally appropriate interventions that promote good-quality care cannot be overstated.[13 15 16]

Lastly, the availability of adequate and properly functioning equipment and commodities has a significant role in improving service delivery and ensuring RMC. This includes consumables and equipment, such as screens to improve privacy, necessitated by the lack of gender-responsive maternity spaces inherent in the design of some of the health facilities in the AQCESS Project catchment areas. Previous studies have suggested that the absence of basic supplies and equipment can discourage women from accessing facility-based maternity care as well as contribute to poor attitudes and behaviours among healthcare workers.[3]

Findings reported in this paper promote our understanding on the possible solutions that can eradicate DMC, which is rampant in health facilities in Kenya.[2 3] The issues around low staffing, health system infrastructure, inadequate training and a lack of gender-sensitive facilities are well reported as barriers to the delivery of good-quality maternity healthcare in low/middle-income countries. RMC is a central component in encouraging women to attend facility care; however, as our findings show, there is much to be done to attain respectful care of women during pregnancy, labour and delivery. Cohesiveness between government policies and their translation to the healthcare workers through training is key. Our findings underscore the urgent need for training through continuous mentorship at the facility on both soft skills, such as communication, as well as understanding the policies concerning RMC.

Limitations for this study were the recruitment of participants by AQCESS Project officers who were familiar with the facilities where project interventions had taken place. Although this may have impacted our findings, especially participants' reluctancy to openly discuss issues affecting them at the facilities, there was an elaborate interview schedule and interviews were conducted by a qualified social scientist experienced in probing. Second, our settings were rural Kilifi and Kisii, with recruited sites including both large county hospitals and small dispensaries receiving AQCESS interventions. While healthcare workers' sentiments on possible solutions were similar, these results would have been improved if comparisons with non-AQCESS interventions health facilities were captured. Lastly, our study did not factor in the age range and the years of experience during data analysis and how this may have influenced their views on areas of interventions.

Future studies should assess the effectiveness of health system interventions and their impact on provision of RMC, including linking knowledge of RMC to maternal and newborn outcomes and healthcare worker attitudinal change and communication skills. In addition, the perspectives of healthcare workers should be considered alongside user perspectives to determine points of intersection where there is potential for greatest yield in case of intervention.

CONCLUSIONS

To improve RMC for women during pregnancy, labour and delivery, our findings underline the need for continuous healthcare training on the key components of RMC. This could be implemented through mentorship, which was proven to be successful through seminars at the facilities on how staff can change attitudes toward mothers and the provision of information on various RMC-related policies. Gendered staff at facilities would also encourage mothers who prefer receiving care from a health provider of the same gender to attend services at the health facilities. Importantly, having more than one staff member on duty, private workspace and adequate commodities on the ward were highlighted as facilitators to RMC.

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Contributors AML—conceptualisation, data collection, analysis and writing of the original manuscript. JO—conceptualisation, supervision and writing. SW—data interpretation and validation. LN and KM—field coordination. MT—overall supervision and manuscript validation. MT—overall content as the guarantor.

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Competing interests None declared.

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Patient consent for publication Not required.

Ethics approval This study involves human participants and ethical approval was received from the Aga Khan University Kenya Institutional Ethics Committee

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Data availability statement Data are available upon reasonable request. The datasets generated for this study cannot be publicly shared due to ethics requirements. Narratives from the participants can be easily deduced or linked to them if shared in public. Confidential data may be shared with researchers who meet the criteria with ethics approval.

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REFERENCES

1 Masaba BB, Moturi JK, Taiswa J, *et al*. Devolution of healthcare system in Kenya: progress and challenges. *Public Health* 2020;189:135–40.
2 Lusambili A, Wisofschi S, Shumba C, *et al*. Health care workers' perspectives of the influences of Disrespectful maternity care in rural Kenya. *Int J Environ Res Public Health* 2020;17:8218.
3 Lusambili AM, Naanyu V, Wade TJ, *et al*. Deliver on your own: Disrespectful maternity care in rural Kenya. *PLoS One* 2020;15:e0214836.
4 Ndwiga C, Warren CE, Ritter J, *et al*. Exploring provider perspectives on respectful maternity care in Kenya: "Work with what you have". *Reprod Health* 2017;14:99.
5 Munabi-Babigumira S, Glenton C, Willcox M, *et al*. Ugandan health workers' and mothers' views and experiences of the quality of maternity care and the use of informal solutions: a qualitative study. *PLoS One* 2019;14:e0213511.
6 Afulani PA, Sayi TS, Montagu D. Predictors of person-centered maternity care: the role of socioeconomic status, empowerment, and facility type. *BMC Health Serv Res* 2018;18:360.
7 Wilunda C, Putoto G, Dalla Riva D, *et al*. Assessing coverage, equity and quality gaps in maternal and neonatal care in sub-Saharan Africa: an integrated approach. *PLoS One* 2015;10:e0127827.
8 Ni Bhuinneain GM, McCarthy FP. A systematic review of essential obstetric and newborn care capacity building in rural sub-Saharan Africa. *BJOG* 2015;122:174–82.
9 Gebremichael MW, Worku A, Medhanyie AA, *et al*. Women suffer more from disrespectful and abusive care than from the labour pain itself: a qualitative study from women's perspective. *BMC Pregnancy Childbirth* 2018;18:392.
10 Bohren MA, Vogel JP, Hunter EC, *et al*. The mistreatment of women during childbirth in health facilities globally: a mixed-methods systematic review. *PLoS Med* 2015;12:e1001847.
11 Ratcliffe HL, Sando D, Lyatuu GW, *et al*. Mitigating disrespect and abuse during childbirth in Tanzania: an exploratory study of the effects of two facility-based interventions in a large public hospital. *Reprod Health* 2016;13:79.
12 Machira K, Palamuleni M. Women's perspectives on quality of maternal health care services in Malawi. *Inter J Womens Health* 2018;10:25–34.
13 Downe S, Finlayson K, Tunçalp Ö, *et al*. What matters to women: a systematic scoping review to identify the processes and outcomes of antenatal care provision that are important to healthy pregnant women. *BJOG* 2016;123:529–39.
14 Wesson J, Hamunime N, Viadro C, *et al*. Provider and client perspectives on maternity care in Namibia: results from two cross-sectional studies. *BMC Pregnancy Childbirth* 2018;18:363.
15 Ö T, Were W, MacLennan C. Quality of care for pregnant women and newborns—the who vision. *BJOG Int J Obstet Gy* 2015;122:1045–9.
16 WHO. *WHO recommendation on respectful maternity care during labour and childbirth*, 2018: 1–11.
17 Lusambili. A qualitative enquiry of health care workers voices on Respectful maternity care (RMC). *Submitted to PLOS ONE under review*.
18 Nyanja N, Nyamu N, Nyaga L, *et al*. Application of the Ultra-Poverty graduation model in understanding community health volunteers' preferences for socio-economic empowerment strategies to enhance retention: a qualitative study in Kilifi, Kenya. *Hum Resour Health* 2021;19:104.
19 Lusambili AM, Wisofschi S, Shumba C, *et al*. A qualitative Endline evaluation study of male engagement in promoting reproductive, maternal, newborn, and child health services in rural Kenya. *Front Public Health* 2021;9:670239.
20 Lusambili AM, Muriuki P, Wisofschi S, *et al*. Male involvement in reproductive and maternal and new child health: an Evaluative qualitative study on facilitators and barriers from rural Kenya. *Front Public Health* 2021;9:644293.
21 Lusambili AM, Nyanja N, Chabeda SV, *et al*. Community health volunteers challenges and preferred income generating activities for sustainability: a qualitative case study of rural Kilifi, Kenya. *BMC Health Serv Res* 2021;21:642.
22 Guest G, Bunce A, Johnson L. How many interviews are enough? *Field methods* 2006;18:59–82.
23 Sandelowski M. Sample size in qualitative research. *Res Nurs Health* 1995;18:179–83.
24 Braun V, Clarke V. Using thematic analysis in psychology. *Qual Res Psychol* 2006;3:77–101.