Factors influencing dignity in sub-Saharan African health systems: a qualitative systematic review

Sarah MacGregor Bald

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Supervised By: Associate Professor Jill Olivier

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Abstract

Dignity, as a basic human right, is demonstrated across numerous leading human rights declarations, covenants, conventions and is reflected in many national constitutions globally. The World Health Organization, along with corresponding United Nations agencies, have also regularly identified dignity as a guiding principle for health systems, service provision, and reform, as dignity is commonly used to measure or achieve quality, person-centred, respectful, and responsive health systems. The prioritization of dignity is argued to improve health outcomes, strengthen professional dignity, and contribute to stronger, more responsive, and rights-based health systems. Yet despite these perceived benefits and the pervasiveness of dignity as a core issue and right, there is a surprising lack of evidence documenting what role dignity has in a health *system*, for example, whether it influences systems functioning or performance. To address this gap, a qualitative systematic review was conducted in two parts, starting with an initial global scoping review of evidence on dignity in health systems, followed by a systematic review to identify facilitators and barriers to supporting dignity in sub- Saharan African health systems according to the three levels of the health system: interpersonal (micro), organizational (meso), and system-wide (macro). This study found facilitators and barriers to dignity are prominent and present within the health system; and that facilitators and barriers can mainly be viewed as manifestations of prevailing socio-political and health system contexts which shape organizational hardware and software and influence interpersonal engagements between health system actors. For example, national contexts of health care worker shortages and strikes resulted in inadequate staffing levels at facilities, which attributed to decreased supervision, deviations from standards of care, strained professional dignity, and influenced organizational culture normalizing verbal abuse against patients. These contexts ultimately shaped rushed and hostile interactions between a patient and healthcare workers and consequently acted as a barrier to both patient and professional dignity in the health system. Like any system, barriers and facilitators to dignity were closely related to each other and were observed at all levels of the health system. Policy, discrimination, resource availability, organizational culture, staffing and professional dignity, and accountability were re-occurring, and interconnecting factors described as facilitators of and barriers to dignity in SSA health systems. While enabling international guidelines and human-rights declarations, health policy, private, nongovernmental, primary health care (PHC) facilities, birth companions, training, and health care worker resiliency were identified as supportive factors to dignity in health systems, overwhelmingly challenges associated with pervasive discrimination, organizational culture, and structural inadequacies described at health facilities acted as an unequivocal barrier to both patient and professional dignity in sub-Saharan African health systems. This systematic review study confirms that dignity is a critically important issue to health systems and health policy and systems research – but that it is still poorly conceptualized, theorized, or evidenced in relation to how it influences systems functioning and performance.

Acronyms and abbreviations

AHPSR	Alliance for Health Policy and Systems Research
CASP	Critical Appraisal Skills Programme
CBO	Community Based Organizations
CRPD	Convention on the Rights of Persons with Disabilities
EWEC	Every Woman Every Child
GNP+	Global Network of People Living with HIV
HCW	Health care worker
HIC	High- Income Countries
HIV	Human Immunodeficiency Virus
HRH	Health and Human Rights
HPSR	Health Policy and Systems Research
HREC	Human Research Ethics Committee
ICCPR	International Covenant on Civil and Political Rights
iERG	Independent Expert Review Group
LGBTQI	Lesbian Gay Bisexual Transgender Queer Intersex
LMIC	Low-and Middle-Income Countries
MPH	Master of Public Health
MSM	Men Who Have Sex with Men
NGO	Nongovernmental Organization
NHI	National Health Insurance
PHC	Primary Healthcare
SES	Socio economic status
SOC	Standards of care
STI	Sexually Transmitted Infection
UDHR	Universal Declaration of Human Rights
UHC	Universal Health Coverage
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
WHO	World Health Organization
WHR	World Health Report
WHS	World Health Survey

Glossary

Dignity	"… dignity implies a bundle of rights and freedoms ensuring that all individuals are treated with respect and remain free to pursue their own hopes and dreams" (Gostin et al. 2003, p. 3).
Health and human rights	"… complementary approaches for defining and advancing human-well-being" (Mann 1994, p. 6).
Health policy and systems research	"… seeks to understand and improve how societies organize themselves in achieving collective health goals, and how different actors interact in the policy and implementation processes to contribute to policy outcomes" (Gilson 2012, p. 21).
Health system	"A health system consists of all organizations, people and actions whose primary intent is to promote, restore or maintain health" (WHO 2007, p. 2). The health system is a living system which is dynamic, interconnected, and shaped by broader socio, political, and economic contexts (De Savigny and Adam 2009; van Olmen et al. 2012).
Health system barriers	Factors which violate, challenge, compromise, or weaken dignity in health systems.
Health system facilitators	Factors which positively support, enhance, or promote dignity in health systems.
Macro level	System wide interface representing national health system, societal, economic, and political contexts along with broader global and societal contexts (Sheikh et al. 2011; Smith and Hanson 2011; Gilson 2012).
Meso level	Organizational interface representing local health systems, organizations, and health facilities (Sheikh et al. 2011; Gilson 2012).
Micro level	Interpersonal interface representing individual actors and interactions between the two actors in the health system (Sheikh et al. 2011; Gilson 2012).
Organizational hardware	Represents the tangible aspects of an organization such as human resources, financing, infrastructure, equipment, and supplies (Sheikh et al. 2011; Asefa et al. 2020).
Organizational software	Represents the intangible aspects of an organization such as processes, systems, relationships, culture, and norms of the health system or institution (Gilson 2012; Asefa et al. 2020).
Professional dignity	Having self-respect and being recognized, motivated, respected, and viewed as professionally competent within the context of the health system as a health care worker (Stievano et al. 2012; Froneman et al. 2019; Combrinck et al. 2020).
Responsiveness	Health system responsiveness "indicates the ability of a health system to meet the population's legitimate expectations regarding non-medical and non-financial aspects of the care process" (Khan et al. 2021, p. 8). To measure these "non-medical and non-financial aspects" (Khan et al. 2021, p. 8) eight processes related to care, referred to as the responsiveness domains, were developed - "autonomy, choice, communication, confidentiality, dignity, prompt attention, quality of basic amenities and support (access to family and community support)" (Valentine et al. 2002, p. 575-576).
Rights-based	"… encompass an exciting range of ways that the United Nations, governments, and non-governmental organizations incorporate human rights into public health effort" (Gruskin et al. 2010, p. 259).
Ubuntu	"The wisdom of ubuntu lies in the recognition that it is not possible to build a healthy community at peace with itself unless the human dignity of all members of the community is safeguarded" (Murithi 2000, p. 282).

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Part A: Study Protocol

Introduction

"*Every human being is entitled to the enjoyment of the highest standard of health conducive to living a life of dignity.*" General Comment 14: The Right to the Highest Attainable Standard of Health (2000)

Dignity is a basic human right (United Nations, 1948). Numerous international charters state this, 162 constitutions refer to this, and a multitude of legal frameworks govern dignity as a right (Paust 1984; Ojwang et al. 2010; Shulztiner and Carmi 2014). According to many of these policies and protocols, dignity is to be afforded to every individual (see Table 1)[1] (Ojwang et al. 2010). Dignity is seen as a basic human right and a universal 'human aspect' (see more below) (Gewirth 1992; Ojwang et al. 2010). By treating an individual with dignity, their human right is fulfilled (Mann 1998; Gostin 2001).

In the space of health, health care, and public health, dignity as a human right is also considered to be important. Dignity has been said to be "thriving in health" (Jacobson, 2007, p. 292) and is described as a "valuable catalyst" for global health advancement and human development by the editor of *The Lancet* (Horton, 2004, p. 1085). In a tribute to the late human rights pioneer, Gostin (2001) argued that Jonathan Mann saw that "the primary function of public health is to promote dignity…" (p.123). Furthermore, dignity is recognized as a catalyst for improving health outcomes (Beach et al. 2005; WHO 2013; WHO 2018). In the sub-fields of palliative care, geriatric care, and nursing, dignity is consistently identified as a key concept (Lothian and Philp 2001; Chochinov 2002; Rassin 2008). Similarly, the World Health Organization (WHO) and other United Nations (UN) agencies have regularly identified dignity as a guiding principle for health systems, service provision, and reform (GNP+ and UNAIDS 2011; WHO 2013; WHO 2018). Dignity is important in health, because like health, it is a basic human right (Mann 1998; Gostin 2001).

Table 1: Examples of dignity seen as a universal human aspect in international instruments, covenants, charters, and national constitutions

Dignity as a universal human aspect	
Universal Declaration of Human Rights (UDHR), 1948 Article 1	"All human beings are born free and equal in dignity and rights"
Interconal Covenant on Civil and Political Rights (ICCPR), 1966 Article 10	"All persons deprived of their liberty shall be treated with humanity and with respect for their inherent dignity of the human persons."
African (Banjul) Charter on Human and Peoples Rights, 1981 Article 5	"Every individual shall have the right to the respect of the dignity inherent in a human being and to the recognition of his legal status."
Chapter 2 Bill of Rights, South African Constitution, 1996 Article 10	"Everyone has inherent dignity and the right to have their dignity respected and protected."

Source: Scoping review by Author (see methods below) drawing on Ojwang et al. 2010

Within the field of Health Policy and Systems Research (HPSR)[2], dignity appears as an unsung core issue across multiple areas, interests, and levels of the health system (see more below in the literature review). Here,

[1] Full records to the Universal Declaration of Human Rights (UDHR), 1948 (https://www.un.org/en/about-us/universal-declaration-of-human-rights), Interconal Covenant on Civil and Political Rights (ICCPR), 1966 Article 10 (https://www.ohchr.org/en/professionalinterest/pages/ccpr.aspx) African (Banjul) Charter on Human and Peoples Rights, 1981 (https://www.achpr.org/legalinstruments/detail?id=49) and Chapter 2 Bill of Rights, South African Constitution, 1996 (https://www.gov.za/documents/constitution/chapter-2-bill-rights.

[2] As defined by the Alliance for Health Policy and Systems Research (AHPSR), Health Policy and Systems Research "seeks to understand and improve how societies organize themselves in achieving collective health goals, and how different actors interact in

dignity is frequently presented as an issue relating to micro-level experiences within the health system, usually at the interpersonal interface between the patient and health care worker (HCW) (Gallagher 2004; Pringle et al. 2015) (see Figure 1 on levels of the health system). This interpersonal experience is seen to potentially affect the provision of quality care and ultimately impact the patient's health outcomes (Beach et al. 2005; Kane et al. 2018). For example, when patients perceive that they are provided dignified care, they are more likely to report higher satisfaction, treatment adherence, and receptivity towards preventative care (Beach et al. 2005). Conversely, when perceived or experienced dignity violations occur, not only are human rights violated, but access is also compromised as non-dignified care is widely understood to act as a deterrent for future or continued health system utilization (Duby et al. 2018; Kane et al. 2018). Violations to dignity continue to be reported in health systems worldwide and across patient types - but are also frequently observed among vulnerable patients who are marginalized, poor, and sick (Malhotra and Do 2012; Atinga et al. 2016b; Barclay 2016).

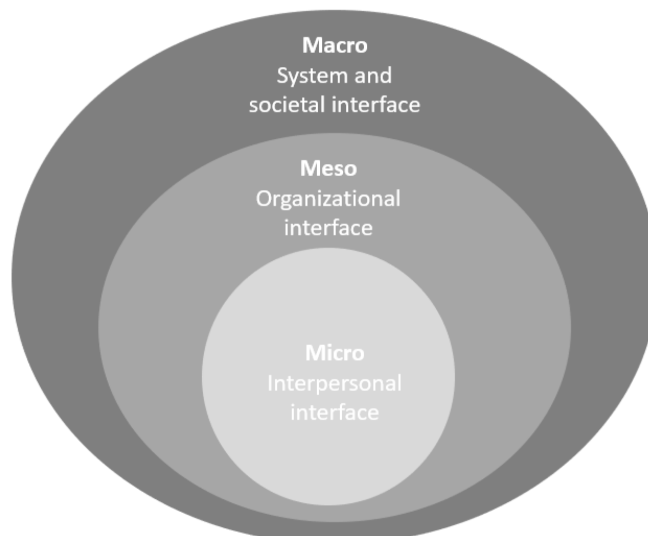

Figure 1: Levels of the health system
Adapted from Sheikh et al. 2011

To a lesser degree, there are also examples of dignity relating to meso-level concerns, at an organizational level, such as issues emerging from human resource capacity and organizational culture, facility-level policies, or basic infrastructure availability (Pringle et al. 2015; Shirzad et al. 2019; de Kok et al. 2020; Mohammadi et al. 2020). For example, adequate health staffing is known to be a facilitator to dignity in health service provision, as trained not-overburdened staff can adequately attend to the needs of patients, explaining medical diagnosis, providing treatment options, or engaging in polite conversation - all of which can support dignity (Baillie 2009; Banks et al. 2017; Asmaningrum and Tsai 2018). Conversely, the under-resourcing and -staffing of health facilities can act as a barrier to both patient and professional dignity[3] as organizational infrastructure might limit a patient's privacy or restrict a HCW's ability to fulfill their clinical responsibilities (Sabatino et al. 2014; Banks et al. 2017; Shirzad et al. 2019; Cobrinck et al. 2020). This is suggestive of a hypothesis that health systems that are generally less poorly resourced might then have less dignity in the health system – however, this has not been proven (and might be entirely false).

the policy and implementation processes to contribute to policy outcomes" (https://ahpsr.who.int/what-we-do/what-is-health-policy-and-systems-research-(hpsr).

[3] Stieveno et al (2012) defines professional dignity as "complex, multivalent concept, composed of social elements and intrinsic characteristics of the person. These elements are inextricably interconnected. The main factors of these two concepts overlap and are constituted of: personal characteristics of every, person, intra- and inter-professional relations, workplace characteristics, teamworking, professional competence and experience of nurses, social recognition by the general public, and professional autonomy" (p. 342).

At the macro system-wide interface, dignity is often described as critically important (in relatively general terms), but it is rarely addressed in detail (Horton 2004). For example, dignity is mentioned in relation to policies that support the improved quality of care and ensure more accountable health systems. Still, there are few indications on how this should be operationalized or implemented. There are also limited insights into what role dignity plays (beyond being a general descriptor) at a global and national, system-wide level (GNP+ and UNAIDS 2011; WHO 2013; WHO 2017; WHO 2018). For example, the Second Report of the independent Expert Review Group (iERG) on Information and Accountability for Women's and Children's Health to support the Every Woman: Every Child (EWEC) initiative[4], urged for increased country accountability and identified quality of care as "the route to equity and dignity for women and children" (WHO, 2013, p. 5), but further guidance to achieving dignity, or connection to prevailing social norms which might support greater national implementation, is lacking.

Within the global health and HPSR terrains, dignity is made visible as a key indicator for assessing health system responsiveness[5] – one of the three key health system performance goals[6] identified in the 2000 World Health Report (WHR2000) (WHO 2000). Both the World Health Survey (2002)[7] and the Multi-country Survey Study (2000-2001), along with large scale international surveys measuring health system responsiveness, have consistently identified dignity as one of the most valued domains of responsiveness (Valentine et al. 2008; Rashidian et al. 2011; Mohammed et al. 2013). For example, according to the WHO's General Population Survey of 41 countries, dignity is named right after prompt attention (Valentine et al. 2008). National responsiveness surveys in Nigeria (Mohammed et al. 2013) and Iran (Rashidian et al. 2011) reported dignity as the second most important aspect of health system responsiveness.

Despite dignity being important as a human right and carrying a wide footprint across the health and health system territories, a scoping review of current literature (reported below) indicates that dignity is poorly theorized or conceptualized and rarely considered (in its own right) within health systems, or within HPSR. As dignity plays an integral role in international national health systems policy and reform, we need greater clarity on what is known about dignity in health systems. Furthermore, with continuous movement and realization of rights-based health systems (Gruskin et al. 2010; London et al. 2014), and in efforts toward Universal Health Coverage (UHC), the provision of quality services to all patients, including those most vulnerable, remains paramount (Ghebreyesus 2017). Better description and clarity of systems issues relating to dignity should support improved quality, equity, and the improved systems functioning necessary for UHC gains. Jonathan Mann (1998) also notes that attention to dignity in health systems is, in fact, urgent:

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[4] The former United Nations Secretary General Ban Ki-moon set in motion the 2010 *Every Woman Every Child* initiative to gain multisectoral support to end preventable death of women during childbirth and support the health of women and children more broadly. The initiative continues today across countries and in partnership with UN agencies (WHO, 2017).

[5] Health system responsiveness "indicates the ability of a health system to meet the population's legitimate expectations regarding non-medical and non-financial aspects of the care process" (Khan et al. 2021, p. 8). To measure these "non-medical and non-financial aspects" (Khan et al. 2021, p. 8) eight processes related to care, referred to as the responsiveness domains, were developed - "autonomy, choice, communication, confidentiality, dignity, prompt attention, quality of basic amenities and support (access to family and community support)" (Valentine et al. 2002, p. 575-576).

[6] As defined by the WHO (2000) the three health system performance goals are fairness in financing, health, and responsiveness.

[7] As described by the WHO, "The WHS was launched by the WHO to strengthen national capacity to monitor critical health outcomes and health systems through the fielding of a valid, reliable, and comparable household survey instrument." The WHS builds on the earlier WHO Multi-Country Survey (as mentioned above) and includes findings from 46 countries globally.

"Future health professionals may look back at current limited and narrow understanding of health and wonder how we could have missed seeing violations of dignity as sources of injury and well-being" (p. 37).

Literature Review

A scoping literature review was conducted of materials relating to dignity with a focus on dignity in health systems, across peer-reviewed and grey literature, in the English language, with no time limitations, and with a global focus but with attention narrowing to LMIC settings (see methods below).

While it was the 1948 Universal Declaration of Human Rights (UDHR) that "popularized" dignity (McCrudden, 2008, p. 655), dignity has been discussed and debated back to ancient times (Jacobson 2007). According to Jacobson (2007; 2009a), the history of 'dignity' can be understood through three periods of time in which the guiding principles, the justifications for the concept's existence, and the distinction regarding who 'holds' dignity varied (see table 2 below) (Jacobson 2007; Jacobson 2009a; Jacobson 2009b). In contrast, in modern times, dignity is most commonly understood as an inherently human, universal aspect, with human rights being grounded in the notion of human dignity (Gewirth 1992; Mann et al. 1994). As described by Gewirth (1992), "The relations between human dignity and human right are many and complex, but one relation is primary: human rights are based upon or derivative from human dignity. It is because humans have dignity that they have human rights" (p. 10).

Table 2: Three historical periods of dignity

	Dignity holders and justification	**Guiding principle**
Ancient Greek to Middle Ages **1200 BC –15th Century**	Dignity is held by all human beings because they were created by and depictions of God.	Theology
Renaissance Period **14th Century –17th Century**	Dignity is reserved for only certain members of society because dignity is tied to social rank.	Hierarchy
Enlightenment Period **18th Century**	Dignity is held by all humans because humans are autonomous beings.	Rationality and freedom

Source: Adapted from Jacobson 2007, 2009b

Though there is a consensus that dignity is afforded to all human beings today (Gostin et al. 2003; Jacobson 2007; Ojwang et al. 2010), further efforts to arrive at a common definition or conceptualization have proved challenging, especially as it relates to operationalization or implementation. The term has been described as complex, ambiguous, vague, subjective, and contradictory both in the health sector, and more generally (Schachter 1983; Mann 1998; Horton 2004; Griffin-Heslin 2005; Jacobson 2007). For example, in human rights law, McCrudden (2008) found the concept's ambiguity has resulted in "judicial manipulation" (p. 656), increasing individual judicial discretion and thus hindering fair and just trials. While some have likened the vagueness to the intrinsic nature of the concept, and subsequently embraced individual interpretations of the term (Schachter 1983), others have ridiculed its variations and identified dignity as a "useless concept" (Macklin, 2003, p. 1419). Noting weak consensus, implications for linguistic malpractice, and a need to defend dignity as a *useful* concept, attempts have been made to clarify the term through either direct or indirect conceptual work across both health and non-health sectors (see table 3 below) (Schachter 1983; De Silva and Valentine 2000; Hodson 2001; Gostin et al. 2003; Baillie 2009; Killmister 2010). Health specific contributions include disciplinary work in nursing (Gallagher 2004; Baillie 2009; Clark 2010), palliative care (Chochinov 2002), bioethics (Andorno 2009; Killmister 2010), occupational health (Hodson 2001), and health systems (De Silva and Valentine 2000; Valentine et al. 2003). Traditionally non-health fields have made additional contributions

through developments in human rights and law (Schachter 1983; Gostin et al. 2003) and northern and African philosophy (Ikuenobe 2018; Jacobs 2001; Kolnai 1976; Metz 2012).

Table 3: Definitions of dignity across disciplines

Discipline	Definition
African philosophy	"A plausible African view distinguishes between, on one hand, one's innate, metaphysical capacities, dignity, or the natural human rights of an abstract, sole, isolated individual and, on the other hand, moral dignity and substantive rights that one has and that are protected and respected in a community" (Ikuenobe 2018, p. 603).
Bioethics	"The capacity to live by one's standard and own principles" (Killmister 2010, p. 160).
Health systems	"The right of care seeker to be treated as a person in their own right rather than merely as a patient who due to asymmetric information and physical incapacity has rescinded his/her right to be treated with dignity" (De Silva & Valentine 2000, p. 1).
Human rights	"… dignity implies a bundle of rights and freedoms ensuring that all individuals are treated with respect and remain free to pursue their own hopes and dreams" (Gostin et al. 2003, p. 3).
Law	"… intrinsic worth" (Schachte 1983, p. 849).
Northern philosophy of nursing	"… dignity appears to be a conceptual something that all persons have and therefore can lose…that persons are born with and want to die with (Jacobs 2001, p. 31)
Nursing	"Patient dignity is feeling valued and comfortable psychologically with one's physical presentation and behaviour, level of control over the situation, and the behaviour of other people in the environment" (Baillie 2009, p. 33).
Occupational health	"Dignity is the ability to establish a sense of self-worth and self- respect and to appreciate the respect of others" (Hodson 2001, p. 3).

Source: Scoping review by Author (see methods below)

Alongside varying definitions, two main typologies have been described: dignity derived from within, and dignity derived from broader social recognition (Mann 1998; Gallagher 2004; Jacobson 2007). Mann (1998) calls this "internal dignity" and "external dignity" (p. 30). Jacobson (2007) refers to it as "human dignity" and "social dignity" (p. 292) while Gallagher (2004) distinguishes it as "self-regarding dignity" and "other-regarding dignity" (p. 587). While the selection of words varies, their meaning aligns. Due to the intrinsic nature of dignity, it comes from within thus it is considered 'human- 'or 'internal dignity' (Mann 1998; Gallagher 2004; Jacobson 2007). Human dignity is common in law and legal frameworks (see table 1 above) and serves as the basis for human rights (Schachter 1983; Gewirth 1992; Gostin 2001). Dignity can be social because its meaning is reinforced through external recognition thus earning the title, social, external, or other-regarding dignity (Mann 1998; Gallagher 2004; Jacobson 2007). In health, and particularly within health systems, 'social dignity' is most frequently referenced relating to how the health system or social engagements within the system promote or violate an individual's dignity (Jacobson 2007). Unlike human dignity, social dignity can be taken away through social engagements (Jacobson 2009b).

In summary, while dignity is often poorly conceptualized within health and HPSR, there are ideas within the broader literature, such as 'human-' and 'social dignity', which can be applied to improve our understanding of how dignity functions within a health system, and perhaps functions differently in different contexts, such as variations between High-Income Country (HIC) and LMIC health systems.

Globally, as mentioned earlier, dignity serves as a driver of health reform, service delivery improvements, and the application of ethical codes (Horton 2004; Andorno 2009; GNP+ and UNAIDS 2011; WHO 2018). Here, dignity is commonly used as a 'measure' or indicator to assess quality levels, person-centred goals, and whether health systems are responsive or not in their performance – see table 4 (Valentine et al. 2003; WHO 2013; De Silva 2014; Afulani et al. 2017; WHO 2018). 'Undignified' care has been attributed to the persistence

of suboptimal rates of maternal mortality both globally and in LMICs (Penn-Kekana et al. 2004; Kruk et al. 2014; Mannava et al. 2015; Ishola et al. 2017). Consequently, when the WHO - and other bodies - have developed frameworks[8] calling for reduction in maternal mortality and improved quality including respectful care, dignity promotion is usually mentioned - as a catalyst for maternal health advancement and as a core aspect of the standard of care (SOC) guidelines (see below) (Kinney et al. 2016; WHO 2016; WHO 2018). Frameworks to increase quality health service for people living with HIV have also identified dignity as a guiding principle for ethical conduct, service provision, as described by UNAIDS (2011), "Positive Health, Dignity and Prevention[9] is built on a broader basis that includes improving and maintaining the dignity of the individual living with HIV, to support and enhance that individual's physical, mental, emotional and sexual health, and which, in turn, among other benefits, creates an enabling environment that will reduce the likelihood of new HIV infection" (p. 4). Frameworks to harness greater support for mental health services similarly identify dignity as a pathway for mental health legislative gains (Funk et al. 2015). Patients' Rights Charters (Rider and Makela 2003; Parsapoor et al. 2014; Yarney et al. 2016) and medical professional codes (particularly nursing) are also commonly grounded in dignity (Gallagher 2004; Baillie 2009; Shahriari et al. 2013). Horton (2004) explains the persistence of 'dignity discourse' across global health, noting, "Human dignity is a linguist currency that will buy a basketful of extraordinary meanings" (p. 1018).

Table 4: Dignity as a tool to measure quality, person-centred, and responsive health systems

	Measurement	**Example of standards of care or survey questions used to measure dignity**
Quality of care in maternal and child health	Standards of care	"Standard 5: Women and newborns receive care with respect and preservation of their dignity. Quality statements - 5.1: All women and newborns have privacy around the time of labour and childbirth, and their confidentiality is respected - 5.2: No woman or newborn is subjected to mistreatment, such as physical, sexual, or verbal abuse, discrimination, neglect, detainment, extortion or denial of services. - 5.3: All women have informed choices in the services they receive, and the reasons for interventions or outcomes are clearly explained" (WHO 2016, p. 3).
Health system responsiveness	Survey questions	1. "How would you rate your experience of being greeted and talked to respectfully? 2. How would you rate the way your privacy was respected during physical examinations and treatments?" (Valentine 2003, p. 595).
Person-centred maternity care[10]	Survey questions	1. "Did the doctors, nurses or other staff at the facility treat you with respect? 2. Did the doctors, nurses and other staff at the facility treat you in a friendly manner? 3. Did you feel the doctors, nurses, or other HCWs shouted at you, scolded you or insulted, threatened, or talked to you rudely?

[8] The WHO's (2018) framework for quality maternal and new-born care entitled *Quality, Equity Dignity: the network to improve quality of care for maternal newborn and child health*, identifies dignity as one of the three core values and describes dignity and respect as one of four domains for person-centred care alongside communication, emotional support, and continuity of care. According to the theory of change model presented in the framework, improved dignity, access, satisfaction, and quality of care will result in "survival, less morbidity, user satisfaction, and dignity" (WHO, 2018, p.12)

[9] The complete framework can be found here: https://www.unaids.org/sites/default/files/media_asset/20130802_Positive_Health_Dignity_Prevention_Operational_Guidelines_0.pdf

[10] In broader literature outside of maternal health, dignity has also been described as one of the key domains of person-centred care (De Silva 2014).

		4. Did you feel like you were treated roughly like pushed, beaten, slapped pinched, physically restrained, or gagged?[11] 5. During the examination in the labour room, were you covered up? 6. Do you feel your health information was or will be kept confidential at this facility?" (Afulani et al. 2019, p. e 100).

Source: Scoping review by Author (see methods below)

This scoping review also highlights that theoretical frameworks on dignity have frequently been based on empirical evidence from HICs, with less emerging from LMICs. While there are a few global reviews on dignity conceptualized quite broadly (Jacobson 2007; Jacobson 2009b), more often reviews and empirical research on dignity in health target specific service types, such as palliative care, geriatric care, nursing, or focused on chronically ill or hospitalized patients (Chochinov 2002; Gallagher 2004; Lin et al. 2012; Cairns et al. 2013). Several literature reviews on dignity relate to what Chochinov and colleagues (2005) call clinical 'dignity therapy' intervention in palliative care, discussed more below (Fitchett et al. 2015; Zahran et al. 2016; Martínez et al. 2017; Scarton et al. 2018; Xiao et al. 2019).

Alongside these interests, routinely research has focused on dignity at a patient-provider interface with less identification of broader health system factors that support dignity (Walsh and Kowanko 2002; Anderberg et al. 2007; Baillie 2009; Lin et al. 2012). Frequently, the research identifies threats to dignity, develops frameworks or therapeutic intervention, and outlines opportunities to support the preservation of patient dignity, often at a patient-provider interface. Such contributions include Chochinov's (2002) dignity model, Chochinov and colleagues' dignity therapy (2005), Anderberg's (2007) understanding of dignity attributes and antecedents, Jacobson's (2009b) framework on conditions of a dignity interaction and taxonomy of social processes involving dignity promotions and dignity violation, Ballie's (2009) identification of factors which impact a patients dignity, Walsh's (2002) phenomenological study on HCW and patient perception of patient dignity and Lin and colleagues (2012) review findings on factors influencing dignity of hospitalized patients. The main contributions from these researchers' work are summarized in Table 5 below.

Table 5: Key frameworks and findings on dignity

	Contribution
Dignity model Chochinov (2002)	Categorized dignity as "illness related concerns, dignity-conserving repertoire, and social dignity inventory" (p. 2255) and suggests therapeutic interventions to support patient dignity. Illness-related concerns could involve death anxiety. Dignity conserving repertoire could involve a patient's fear of compromised independence. Social dignity inventory could involve a patient's concerns related to how they will be remembered.
Dignity therapy [12] Chochinov et al. (2005)	Developed a clinical intervention to address "psychological existential distress among terminally ill patients" (p. 5520). The intervention includes a package of six psychotherapy questions asked by a trained HCW to a palliative care patient which are aimed to promote lifelong reflection and mitigate distress.
Health worker and patient perception of patient dignity	Described Australian HCWs and patients' perception of dignity. Core features of patient dignity according to HCW: "respect, privacy, control, advocacy, and time" (p. 143).

[11] As noted later in this scoping review, other related areas of maternal health research have clearly differentiated dignity from physical abuse (Bowser and Hill, 2010).

[12] Chochinov and colleagues (2005) dignity therapy builds on findings from Chochinov's (2002) dignity model. More information about dignity therapy as a psychotherapy clinical intervention can be found here: https://dignityincare.ca/en/.

Walsh and Kowanko, (2002)	Core features of patient dignity according to patients: "respect, privacy, control, choice, humour and matter-of-factness" (p. 143).
Attributes and antecedents of dignity Anderberg et al. (2007)	Found dignity to be understood in terms of attributes and antecedents. Attributes of dignity: "individualized care, control restoration, respect, advocacy, and sensitive listening" (p. 143). Antecedents necessary for the provision of dignified care: "professional knowledge and training, responsibility, reflection, and non-hierarchical organization" (p. 635).
Conditions of dignity dimensions and taxonomy of social processes involved in dignity promotion and dignity violation Jacobson (2009b)	Framed dignity encounters as a multi-level experience involving actors, settings, and broader social order. Reported that dignity violations are most likely to occur "when an actor is in a position of vulnerability", one is in a position of "antipathy", a relationship is asymmetrical, contexts are characterized by "hierarchical and rigid, full of distraction and stress and urgency, but lacking in resources", and broader social contexts reinforce an "an order of inequity" (p. 4). Developed a taxonomy of 24 social processes involved in dignity violations and 22 social processes involved in the promotion of dignity. Dignity violations ranged from indifference and suspicion to bullying and assault. Dignity promotion involved aspects such as: authenticity, courtesy, love, and empowerment.
Factors impacting patient's dignity Baillie (2009)	Identified three factors that either threaten or promote patient dignity in an English hospital: "[hospital] environment, staff behaviour, patient factors" (p. 23).
Perception of dignity experiences of hospitalized patients Lin et al. (2012)	Based on narrative review findings identified four factors which can impact a hospitalized patient's experience of dignity: hospital environment, staff behaviour, organizational culture, and patient independence

Source: Scoping review by Author (see methods below)

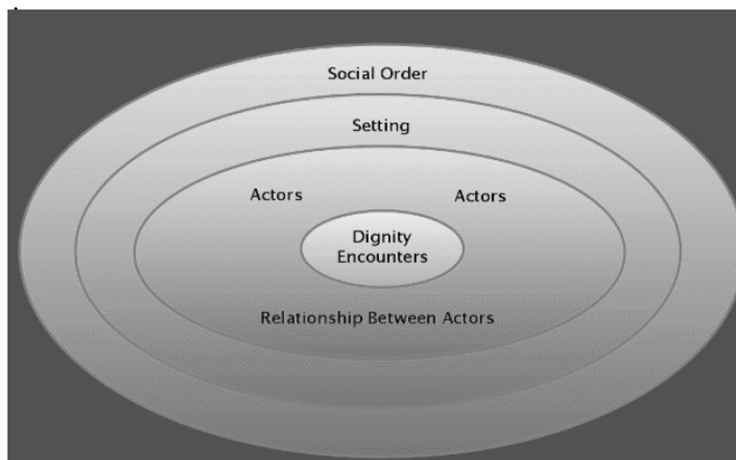
The above contributions (see Table 5) provide some guidance for understanding dignity across all the levels of the health system. Though a landmark piece of literature in the space of health and dignity and palliative care, Chochinov and colleagues (2002, 2005) therapeutic interventions to support dignity is specific to palliative care patients. With an exclusive focus on end of life care, Chochinov's (2002, 2005) findings are not generalizable across the health systems as such findings are not applicable to patients who are healthy or those living without terminal illnesses. Furthermore, these findings speak largely to 'human/ internal dignity' and thus weakly encompass health system interactions. Following research in an Australian hospital, Walsh and Kowanko (2002) identified respect, privacy, and control to be the key features of dignity identified by both HCW and patients. These core features reflect the broader literature (De Silva & Valentine, 2000; Jacobson, 2007; Killmister, 2010) and unlike Chochinov (2002, 2005), the findings are more transferable to other health system settings and general patients. While minimally discussed, health system factors, such as care environment and inadequate staffing, were described as barriers to dignity by patients and HCWs (Walsh & Kowanko, 2002). As described by Walsh and Kowanko (2002),

> "*The 'system' was blamed by some nurses who stated that patient lost their personhood at the front door of the hospital and became passive recipients of care who turned into an object to be cared for"* (p. 150).

Anderberg and colleagues (2007) identify health system antecedents necessary for the provision of dignified care including professional knowledge and training, responsibility, reflection, and non-hierarchical organization and thus view dignity in greater complexity, at intersections of the health system. Jacobson (2009b), building on earlier work of Mann's (1994) dignity violations, argued that "every human interaction holds the potential to be a dignity encounter-an interaction comes to the fore and may either be violated or promoted" (p.3), thus reinforcing dignity in health largely as 'social dignity'. While not intentionally HPSR

focused, Jacobson's (2009b) framework bears strong resemblance to a health system understanding of dignity as the framework (see Figure 2 below) embodies elements of a micro (dignity encounter, actors), meso (setting), and macro-level (social order) understanding of the health system. Noting the complexity of dignity in health, alongside broader critiques of the concept describe earlier, Jacobson (2009) also developed an extensive taxonomy of social processes involved in dignity promotion and dignity violations which can either be supported or violated during an engagement with the health system.

Figure 2: Jacobson's (2009b) "conditions of the dignity dimension of an interaction" (p. 4).



Adapted from Jacobson 2009b

Baillie (2009) Identified three factors that either constrain or enable dignity in an English hospital: "the environment, staff behaviour, patient factors" (p. 23). Here however broader macro-level health system factors are weakly considered (Baillie, 2009). Lastly, in the narrative review, Lin and colleagues (2012) present stronger systemic factors that influence dignity, such as increased support for patient rights spurred by national health systems movement; however, the narrow inclusion criteria of the review restricted findings to only dignity in relation to hospitalized settings. Additionally, while the review stated that the literature on dignity "has become more international" (p. 4), Taiwan (Lin et al., 2011) and China (Ying Lai and Levy 2002) were the only two non HICs mentioned among the 37 articles included in a 'global 'review (Lin et al. 2012). Though there is some mention of organizational aspects (Walsh and Kowanko 2002; Anderberg et al. 2007; Baillie 2009), connection to macro-level issues such as patients' rights (Lin et al. 2012), and Jacobson's (2009b) framework does offer a more comprehensive interconnected micro, meso, macro, understanding, a thorough and intentional health system lens is lacking as these findings do not encompass research from LMIC settings. Further concerning, these contributions (Anderberg et al. 2007; Baillie, 2009; Chochinov, 2002; Jacobson, 2009b; Lin et al. 2013; Walsh & Kowanko, 2002) are grounded within the context of HIC health systems, not LMIC health systems.

As described earlier, human dignity is intrinsic and cannot be taken away from an individual (Gewirth 1992); however, social dignity is focused on the interaction between individuals and can be either violated or prompted (Jacobson 2007; Jacobson 2009b). Globally there appears to be agreement that dignity in health and the health system (social dignity) often involves core aspects such as respect, communication, privacy, friendliness, and confidentiality, (Walsh and Kowanko 2002; Griffin-Heslin 2005; Lin et al. 2012; Pringle et al. 2015; Banks et al. 2017; Asmaningrum and Tsai 2018; Duby et al. 2018; Jamalimoghadam et al. 2019; Shirzad et al. 2019). However, during this global scoping review of literature on dignity, it was found that these overlapping core aspects are defined and operationalized differently. For example, communication and friendliness in a HIC setting has been described in terms of HCW consideration, acknowledgment, and sensitive listening (Chochinov 2002; Walsh and Kowanko 2002; Baillie 2009; Tauber-Gilmore et al. 2018). While communication in an LMIC maternity ward has been defined in terms of humiliation, mockery, verbal threats, and verbal abuse (Banks et al. 2017; Afulani et al. 2019b; Buser et al. 2020; Kujawski 2021). Furthermore,

privacy in a HIC has been defined in terms of having privacy while discussing a health condition with a HCW (Tauber-Gilmore et al. 2018), but in an LMIC, non-dignified care can involve having no privacy throughout a patient's *entire* engagement in a health facility due to broader health system and organizational constraints (Ansari and Yeravdekar 2020). The varying forms of dignified care are further described below in Table 6 from Walsh and Kowanko's (2002) findings in Australia and Ijadunola and colleagues' (2019) survey in Nigeria.[13]

Table 6: Dignified and undignified care

Forms of dignified and undignified care (Walsh 2002)		**Forms of undignified care** (Ijadunola et al. 2019)
In-depth interviews on the perception of dignity with hospital patients in Australia		Cross- sectional survey on recently delivered women in south-western Nigeria
Dignified	Undignified	Undignified
Having time Being seen as a person Being acknowledged Consideration Discretion	Being exposed Being rushed Body objectivation	Shouted at Insulted Threated Use of harsh words/ tone of voice Intentionally humiliated

Source: Scoping review by Author (see methods below)

It is recognized that dignity is not universally defined (Jacobson 2007; Leung and Cohen 2011; Lin et al. 2012; Asmaningrum and Tsai 2018; Jamalimoghadam et al. 2019; Bagherian et al. 2020); however, these claims have largely been justified on the basis of micro-level, individual characteristics or social and cultural values[14], not the economic context or the setting of a health system. De Silva and Valentine (2000) reported a disparity between research on dignity in HICs and LMICs, noting that research on dignity in HIC health systems tends to focus on broader issues related to palliative care, euthanasia, and cloning because the promotion of dignity in the medical setting was already understood to be a priority (De Silva and Valentine 2000). Conversely, research on dignity in LMIC settings remains in its infancy and thus more 'opulent' topics such as dignity in relation to cloning were outside of LMIC interests (De Silva and Valentine 2000). Accordingly, HICs have long reported dignity because "there is little debate today in developed countries regarding the importance of maintaining an individual's dignity in medical settings… On the other hand, developing countries are only beginning to focus on such research now" (De Silva & Valentine, 2000, p. 8). While there has been an increase in research on dignity in LMIC settings, based on scoping review findings (see methods below) dignity research in LMICs has not nearly reached the level of saturation described in HICs and the two regions operationalize dignity differently. Appendix 2 provides a summary overview of 20 key LMIC articles on dignity.

Within LMIC settings, much of what is known about dignity comes from health system issues, mentioned earlier, and are in relation to and attached with quality, respectful, person-centred, and responsive health systems (see more below). The overwhelming focus comes from research related to maternal health[15], but

[13] Appendix 1 provides additional examples of survey questions and observational checklists used to measure dignity globally in terms of quality of care in an Italian hospital (Ferri et al. 2015), health system responsiveness (Valentine et al. 2003) person centred care (Atinga et al. 2016b), and respectful maternity care (Banks et al. 2017; Okedo-Alex et al. 2021)

[14] For example, a young female Muslim seeking reproductive health services might view dignity in health differently in comparison to an elderly Christian man receiving dialysis as their priorities in health along with their identity impacts their view on dignity (Bagherian et al. 2019; Jamalimoghadam et al. 2019). And macro-level influences such as cultures which value collectivism versus individualism also shape how dignity is perceived. For example, the inclusion of family members in health care related decisions can be more closely tied to a patient's dignity in a society that values strong familial ties as opposed to individualism (Asmaningrum et al. 2017).

[15] An example of this cluster of studies on maternal health and dignity in LMICs includes: (Hulton et al. 2007; Banks et al. 2017; Shirzad et al. 2019; Asefa et al. 2020; Mohammadi et al. 2020)

research has also been informed by, international, regional, and national health system responsiveness surveys and research[16], health and human rights[17], and some literature on quality and patient-centred care beyond maternal health (see more below). While research outside of maternal health is less common, pockets of evidence exist but have not yet been synthesized [18]. Dignity serves as a key indicator and aspect for quality, respectful maternal care (Afulani et al. 2019b; Shakibazadeh et al. 2018; Bowser and Hill, 2010). Within the space of maternal health, non-dignified care is considered one of the forms of disrespect and abuse in childbirth (Bowser and Hill 2010). Conversely, dignity preservation falls within the 12 domains of respectful maternity care (Shakibazadeh et al. 2018). Various methodologies have been used to research disrespect and abuse in childbirth, including quantitative and qualitative research methods (see more below in the micro-level subsection). Here dignity is frequently defined in relation to communication, discrimination, respect and friendliness, patient involvement, care environment, and privacy (Bowser and Hill 2010; Mannava et al. 2015; Okafor et al. 2015; Asefa et al. 2020). While the above-mentioned person-centred survey (Afulani et al. 2019) considered dignified care to not involve experiences of physical abuse, other research and frameworks clearly segregate undignified care from physical abuse[19] (Bowser and Hill 2010; Okafor et al. 2015; Shakibazadeh et al. 2018). While there has been a broad range of maternity disrespect and abuse prevalence rates from 19.5% in Tanzania (Kruk et al. 2014), 98% in Nigeria (Okafor et al. 2015), and 100% in Pakistan (Hameed et al. 2021), non-dignified care, has consistently been the most reported, used, or observed form of disrespect and abuse (Okafor et al. 2015; Shimoda et al. 2020). Like maternal health, health system responsiveness surveys, including the World Health Survey (WHS)[20] and the Multi-country Survey, mentioned earlier ask respondents about their experiences of dignity with regard to respect, communication, discrimination, and privacy. Results from these surveys show that dignity is valued by service users, and experiences of undignified care are prevalent and disproportionately experienced by those most vulnerable (see Table 6 below for more details) (Valentine et al. 2008; Malhotra and Do 2012; Mohammed et al. 2013). Patient-centred care surveys have also discussed dignity at an interpersonal level, with themes of communication, discrimination, respect and friendliness, privacy, and care environment to impact a patient's dignity (Afulani et al. 2017).

As described earlier, while many have aimed to add clarity to the meaning of dignity through the identification of key themes (Walsh and Kowanko 2002; Anderberg et al. 2007; Jacobson 2009a), based on scoping review findings there has been inadequate inclusion of how LMICs operationalize dignity (Lin et al. 2012). And because there appears to be a variation on how dignity is operationalized in HICs and LMICs (see example in Table 6 above) along with a deficient synthesis on the meaning of dignity in LMIC settings, during the scoping review a contextually based model formed by LMIC-driven accounts dignity emerged in relation to six themes (see figure 2 below). Unfortunately, unlike much of the research documented in HICs (Walsh and Kowanko 2002; Anderberg et al. 2007; Baillie 2009; Ferri et al. 2015), the LMIC- driven accounts of dignity have been less commonly based on rich qualitative research focused *solely* on individuals' perception of dignity. While there are some accounts specifically on the topic of dignity, many from Iran (Ebrahimi et al. 2012; Jamalimoghadam

[16] An example of this cluster of studies on responsiveness and dignity in LMICs includes (Mohammed, et al. 2013; Malhotra & Do, 2012)

[17] An example of this cluster of studies on health and human rights includes: (Duby et al. 2018; Nara et al. 2020)

[18] An example of this cluster of studies on quality of care broadly includes: (Bagheri 2012; Asmaningrum and Tsai 2018; Hosseini et al. 2018; Jamalimoghadam et al. 2019)

[19] See Appendix 3 for an overview of the leading frameworks which identify forms of disrespect and abuse in maternal health.

[20] Data from the WHS are open source and country data can be viewed here: https://apps.who.int/healthinfo/systems/surveydata/index.php/catalog/whs#_r=&collection=&country=&dtype=&from=2000&page=5&ps=&sid=&sk=&sort_by=nation&sort_order=&to=2014&topic=&view=s&vk=

et al. 2019; Bagherian et al. 2020), dignity is often in attachment to other (and similar) health system issues thus robust and vivid discussions on the concept are less. Despite this, dignity-related survey questions tailored to specific contexts, systematic reviews unique to regions, WHO responsiveness surveys, and qualitative research more broadly proved to be sufficient to understand dignity in LMICs[21].

As described in Figure 2, based on scoping review the six central themes to dignity are: communication (Kruk et al. 2014; Jamalimoghadam et al. 2019; Atukunda et al. 2020b; Nara et al. 2020), respect and friendliness (Asmaningrum and Tsai 2018; Hosseini et al. 2018; Jamalimoghadam et al. 2019; Shirzad et al. 2019; Atukunda et al. 2020b), non- discrimination (De Silva and Valentine 2000; Banks et al. 2017; Duby et al. 2018; Nara et al. 2020), privacy and confidentiality (Hosseini et al. 2018; Shirzad et al. 2019; Ansari and Yeravdekar 2020; Buser et al. 2020), patient involvement (Banks et al. 2017; Colley et al. 2018; Mohammadi et al. 2020), and care environment (Mwai et al. 2013; Banks et al. 2017; Hosseini et al. 2018). The subsequent sections will discuss these themes within the context of an LMIC health system.

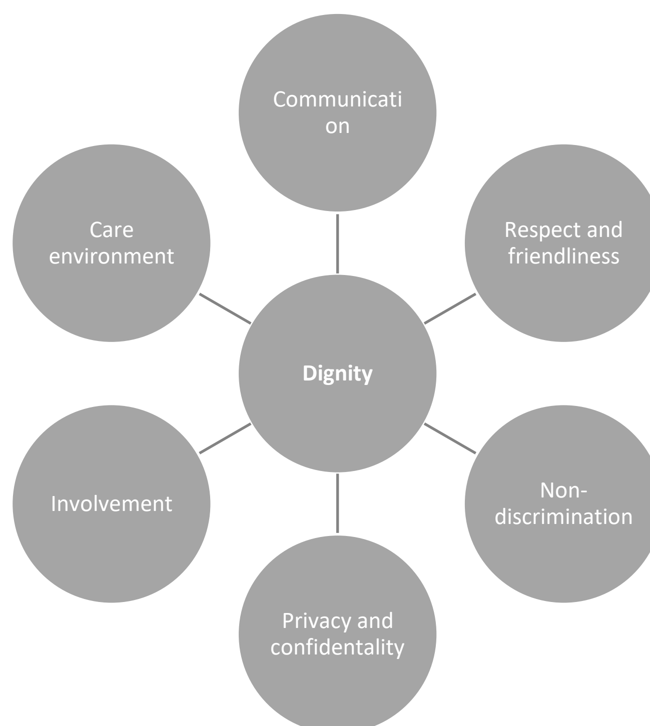


Figure 2: Themes of LMIC patient dignity

Source: author

Communication refers to how the patient is spoken to, and the type of language used during communication at a health facility. Malicious laughter, threats, or scolding would be considered non-dignified communication while a provider listening or using a language understood and used by a patient supports dignified communication (Kruk et al. 2014; Okafor et al. 2015; Jamalimoghadam et al. 2019; Atukunda et al. 2020b). Though not necessarily tailored specifically to LMICs, according to the Multi-Country Survey, the provision of

[21] Broader representation of dignity in LMIC health system is demonstrated in this cluster of studies (McMahon et al. 2014; Banks et al. 2017; Ishola et al. 2017; Asmaningrum and Tsai 2018; Afulani et al. 2019b; Shirzad et al. 2019; Ansari and Yeravdekar 2020).

dignity in the health system involves dignified communication from clinical and nonclinical staff (Darby et al. 2003; Valentine et al. 2003)[22].

Respect and friendliness refer to how a health facility engages with and supports patients. Unfriendly provider behaviour, bribery, humiliation, or blaming would indicate non-dignified respect and friendliness while offering support, calling a patient by their name, or congratulating a patient on the birth a child demonstrates respect and friendliness (Darby et al. 2003; Kruk et al. 2014; Asmaningrum and Tsai 2018; Jamalimoghadam et al. 2019; Shirzad et al. 2019; Bagherian et al. 2020). As described by Murry and Frenk (2000) in the context of responsiveness, “Respect for dignity also includes interactions with providers, such as courtesy and sensitivity to potentially embarrassing moments of clinical interrogation or physical exploration” (p. 719).

Non-discrimination refers to a patient being treated equitably and not regarding a certain status or group membership (Atinga et al. 2016a; Banks et al. 2017; Duby et al. 2018; Nara et al. 2020). Discriminating against a patient on the basis of an ethnic identity, age, income, or education status would be considered undignified care while equitable treatment regardless of a patient’s identity would support dignity (Valentine et al. 2003; Jamalimoghadam et al. 2019; Atukunda et al. 2020a; Mohammadi et al. 2020). Privacy and confidentiality refer to how a patient’s information such as medical records are kept confidential and how physical barriers are used to maintain a patient’s privacy at a health facility (Darby et al. 2003; Hulton et al. 2007; Hosseini et al. 2018). Lack of audio and visual privacy threatens privacy and confidentiality while the use of drapes can support privacy and thus a patient’s dignity (Ansari and Yeravdekar 2020; Asefa et al. 2020; Buser et al. 2020).

Involvement refers to how a patient participates in decision making and how their care preferences are supported during a visit at a health facility (Banks et al. 2017; Hosseini et al. 2018). Clear explanation, allowing time for questions, or accommodating a patient’s care preference, such as the inclusion of traditional practice in a health facility, supports patient involvement and thus their dignity (Banks et al. 2017; Mohammadi et al. 2020). When patients participate in decision making, they feel dignified (Green and Baston 2003; Hosseini et al. 2018). Some have considered involvement to fall within the domain of communication (Kujawski 2021), however, while allowing time for questions is a form of communication, the greater purpose of this exercise is often to involve and include the patient in decisions related to their health (Hosseini et al. 2018; Mohammadi et al. 2020).

Lastly, care environment refers to the environment where a patient seeks care. It is frequently related to cleanliness, infrastructure, and availability of human resources (Banks et al. 2017; Downe et al. 2018; Umar et al. 2020). An unclean health facility, sharing of hospital beds as a result of insufficient supply of bed space, or seeking services from an untrained HCW is described as an undignified care environment, while a dignified care environment is depicted by a clean space, sufficient equipment, and trained health workers (Banks et al. 2017; Downe et al. 2018; Bagherian et al. 2020; Umar et al. 2020).

Health system perspective on dignity

While much of the six themes of dignity have been tied to interpersonal engagement with a HCW (Kruk et al. 2014; Okafor et al. 2015; Jamalimoghadam et al. 2019; Atukunda et al. 2020b), based on scoping review

[22] As argued by Valentine et al. (2002) the inclusion of both clinical and non-clinical related providers reinforces the broader purpose of health system responsiveness which is grounded in *non-medical* related experiences in the health system. As reported, “The communication domain applies to all types of contacts between the population and the health system, not just to the clinical interactions between a patient and a provider. For example, people need to understand what type of services they can obtain, and where, as well as how to complete any paperwork required for health insurance reimbursements” (Valentine et al. 2002, p. 578).

findings (see methods below) these six forms of dignity are also products of the broader systemic issues related to the health system. Because these themes of dignity are related to the broader system, a new framework needs to be developed to better understand dignity in the health system.

Within the context of respectful maternal care, Bowser and Hill (2010), Freedman and colleagues (2014), and Mannava and others (2015) developed frameworks to view mistreatment at a system level; however, problematically these frameworks are bound exclusively to maternal health users and as described earlier (Chochinov 2002; Lin et al. 2012), frameworks bound to certain populations limits transferability across the health system Secondly problematic is that dignity is segregated from other forms of disrespect and abuse(Bowser and Hill 2010; Shakibazadeh et al. 2018). While dignity should indeed be separated from physical abuse, based on scoping review findings dignity has been described as an interconnected concept closely relating to confidentiality, non-discrimination, and communication for example (Malhotra and Do 2012; Kujawski et al. 2015; Jamalimoghadam et al. 2019; Ansari and Yeravdekar 2020). Yet, current frameworks (Bowser and Hill 2010; Shakibazadeh et al. 2018) inadequately consider the multidimensional nature of the concept and consequently minimize the complexities of 'dignity.' The seminal report by Bowser and Hill in 2010, draws global evidence of disrespect and abuse of women in childbirth globally and points to broader laws, governance and service delivery, and provider and individual characteristics which can result in disrespect and abuse; however, their understanding of dignity is narrowed by considering communication as the sole and principal form of dignity (Bowser and Hill, 2011). Freedom and colleagues (2014) urged for greater structural and policy-level understanding of disrespect and abuse and differentiate "individual disrespect and abuse" (i.e., HCW behaviour) from "structural disrespect" (i.e., inadequate staffing because of health system constraints). Still, their framework falls short in recognizing social, economic, and political contexts that can influence dignity in health systems (Nara et al. 2020). In a systematic review of maternal health provider behaviours, Mannava and colleagues' (2015) see disrespect and abuse at a three-tiered level which aids understanding in cultural beliefs and contextual dimensions, but this framework is again bound to maternal disrespect and abuse and is not specific to dignity. Also absent from these findings (Bowser and Hill 2010; Freedman et al. 2014; Mannava et al. 2015) is adequate attention to HCWs' professional dignity. As discussed more below, like patients, HCWs are impacted by the broader environment and such contexts can and do shape their dignity alongside their ability to provide dignified care (Sabatino et al. 2014).

Considering the limitations and recognizing the strengths of the above-mentioned findings and conceptual models, a new framework was designed to understand dignity for *all* patients from a health system perspective. This scoping review's framework was guided by dignity-centred theoretical framings mentioned earlier (Anderberg et al. 2007; Baillie 2009) and specifically adapted Mannava and colleagues' (2015) and Jacobson's (2009b) distinction between societal, organizational, and individual-level factors to show the three levels of the health system – macro, meso, and micro. It also builds on Bowser and Hill's (2010) and Freedman and colleagues (2014) view that broader systemic issues contribute to gaps in dignity. Furthermore, it captures this scoping review's findings (see methods below) which identified six key themes to dignity in the health system. As shown in Figure 3 the framework views dignity as the result of macro, meso, and micro- level health system factors which are interconnected. Corresponding subthemes and codes[23] are identified to the right of the figure and are further described in the scoping review findings directly below.

[23] Subthemes and codes are further discussed in the methods section of this scoping review.

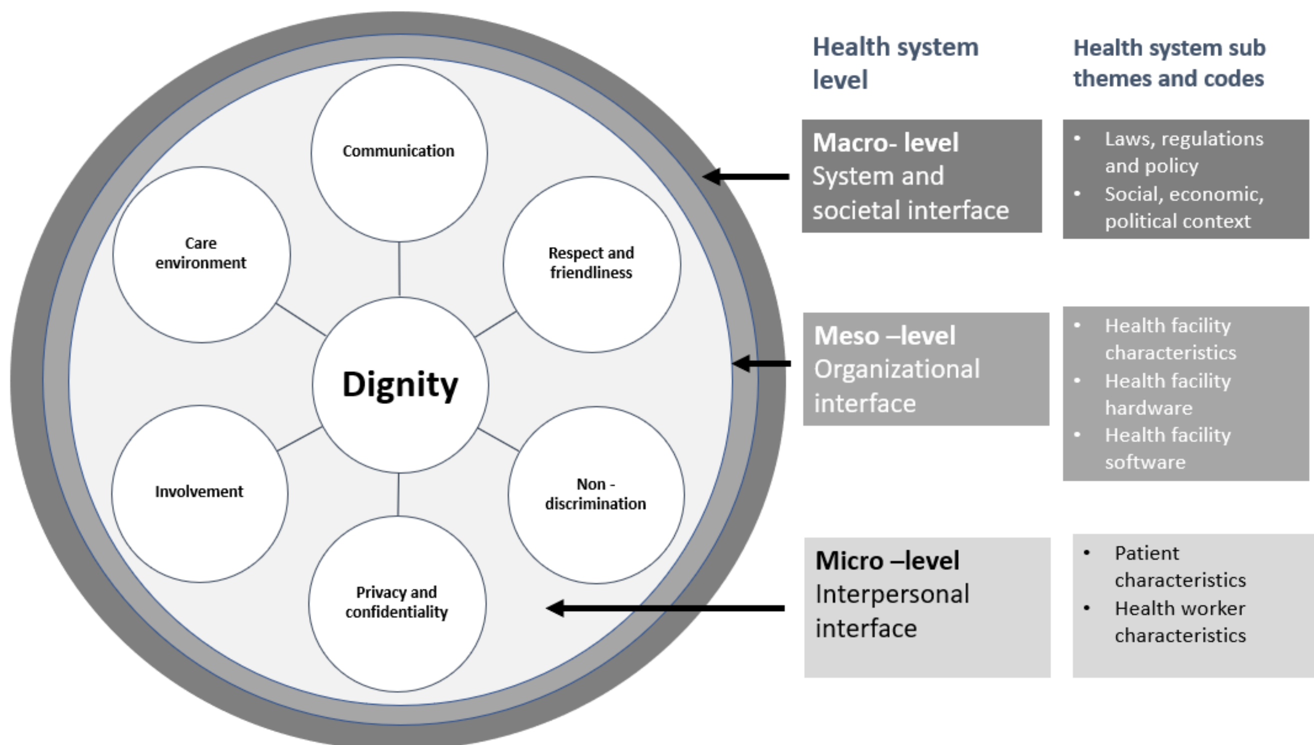


Figure 3: Framework on dignity in the health system

Source: Author, drawing on Jacobson 2009b; Mannava et al. 2015; Bowser and Hill, 2010; Freeman et al. 2014

Micro -level

The micro-level refers to the “Individuals within the system” (Gilson 2012, p. 25). As mentioned earlier, dignity in the health system is most reported, at an interpersonal interface. Two themes at this level emerged in relation to patient characteristics and HCW characteristics which at times have been met at the intersection of discrimination (Malhotra and Do 2012; Afulani et al. 2019b; Hameed et al. 2021). Income, education, age, marital status, and sexual orientation have all been some of the characteristics documented that impact a patient’s experience of dignity in the health system (Atinga et al. 2016b; Malhotra and Do 2016; Zirak et al. 2017; Asmaningrum and Tsai 2018; Duby et al. 2018). Large scale international surveys (Afulani et al. 2019b), regional systematic reviews (Mannava et al. 2015) quantitative studies (Malhotra and Do 2012; Zirak et al. 2017; Hameed et al. 2021), and qualitative research (Amroussia et al. 2017) confirm that, much like findings from the global community (Jacobson 2009a; Barclay 2016), those most vulnerable frequently experience a disproportionate burden of dignity violations in the health system. For example, maternal health users In Tunisia report that the undignified services that they received was a result of their marital status (Amroussia et al. 2017). Similarly, in Pakistan, lower female empowerment and lower maternal health knowledge have been described as a barrier to dignity because women who have less education and weaker access to support systems are more vulnerable to incidences of disrespect and abuse (Hameed et al. 2021). Table 7 below describes the quantitative evidence on the prevalence of non-dignified care along with the differing experiences of dignity in health according to patient characteristics.

Table 7: Prevalence of non-dignified care and differing experience of dignity according to patient characteristics

	Key finding

Malhotra and Do, 2012	In a sample of nearly 7000 of India's health facility users, Malhotra and Do (2012) report the poorest were less likely to describe their experience of dignity in a health facility as 'very good' compared to high-income service users' rating of dignity.
Okafor et al. 2015	In Nigeria 159 women (29.1% of participants) reported non-dignified care during childbirth.
Banks et al. 2017	In rural Ethiopia, the provision of non-dignified care was the most directly observed form of disrespect and abuse during childbirth[24].
Afulani et al. 2019	In an LMIC survey of over 2500 women in rural and urban Kenya, Ghana, and India, on the dignity and respect subscale, only roughly half of all women surveyed reported consistently being treated in a friendly manner by health facility staff and clinicians. Analysis in all three countries also showed different experiences of dignity according to facility level and patient socioeconomic status.
Shimoda et al. 2020	In Tanzania, nearly 30% of 439 participants of maternal HCWs reported use of non-dignified treatment by shouting or threatening their clients.

Source: Author

While much of the literature has focused on barriers to dignity in maternity wards[25], barriers to dignity have also been reported by adolescents (Asmaningrum and Tsai 2018) and by patients accessing tuberculosis (Sagbakken et al. 2013), sexual reproductive health (Hazel et al. 2021), and primary health care (PHC) (Larson et al. 2019) services. Literature from the global north has confirmed that patient characteristics impact a patients experience and that those most marginalized are particularly vulnerable (Jacobson 2007; Jacobson 2009a; Jacobson 2009b; Barclay 2016) but barriers and enablers of patient characteristics – in relation to dignity - within a regional context have not been synthesized.

An additional theme that emerged in the literature that impacts a patient's dignity is HCW characterization. Some have acknowledged that health system factors, beyond micro-level, have fuelled undignified care or promoted dignified treatment (Penn-Kekana et al. 2004; Freedman et al. 2014; Ishola et al. 2017) but much of the debate has placed responsibility on individual care provider's duty to uphold dignity rather than attention to the other actors and broader system in place (Asefa et al. 2020). A HCW who is friendly, courteous, caring, and adequately technically trained is frequently identified as an enabler to dignity (Lin et al. 2012; Atukunda et al. 2020) while a HCW who is described as discriminatory, unfriendly, and verbally abusive has been seen as a micro-level related barrier h to dignity in the health system (Mannava et al. 2015; Afulani et al. 2019b).

Meso – level

The meso-level refers to health facilities, organizations, and district health systems (Gilson, 2012). Organizational constraints and enablers to respectful care (and dignity) have been described in the space of maternal health (Bowser and Hill 2010; Freedman et al. 2014; Mannava et al. 2015); however, based on scoping review findings organizational factors related to dignity in LMICs remains largely un-synthesized. As such, following scoping review, three themes emerge from empirical studies and reviews (drawing on empirical evidence) related to how organizational factors impact dignity[26]: health facility characterization, health facility software, and health facility hardware (see Table 8 below for an overview).

Firstly, health facility characteristics appear to be a factor influencing a patient's dignity as surveys and qualitative research describe that a public or a rural health facility can impact a patient's experience of dignity (Mannava et al. 2015; Afulani et al. 2019b). Additionally, health facility hardware defined in terms of policy,

[24] Appendix 2 describes Banks et al. (2017) criteria used for measuring observable forms of non-dignified care.

[25] An example of this cluster of studies includes: (Asefa et al, 2020; Atukunda et al. 2020; Banks et al. 2017; Colley et al. 2018; Hulton et al. 2007; Ishola et al. 2017; Kruk et al. 2014; Kujawski, 2021; McMahon et al, 2014; Mohammadi et al. 2020; Okafor et al. 2015; Shimoda et al. 2020; Shirzad et al.2019)

human resources, financing, medical equipment and supplies, technology, and service infrastructure (Sheikh et al. 2011), was also a key theme to dignity. Adequate, and thorough training of HCWs has been identified as a hardware issue related to dignity, as it supports a dignified care environment (Pringle et al. 2015; Rahman et al. 2019). Additionally, facility-level policy that can accommodate for patient preferences (Banks et al. 2017) and facilities that have privacy barriers can support dignity in the health system (Mohammadi et al. 2020). Dignity is also affected by a health facility's software. "Software encompasses institutions (norms, traditions, values, roles and procedures) embedded within the system" (Gilson, 2012, p. 26). In a systematic review of high-income settings, non-hierarchical facility environments were shown to support the provision of dignified care (Anderberg et al. 2007) while weak trust between HCWs has acted as a barrier to respectful maternal care (de Kok et al. 2020). Also important regarding software is the notion of professional dignity (Griffin-Heslin 2005; Sabatino et al. 2014; Valizadeh et al. 2016). As Giriffin-Heslin (2005) reported, "[HCWs] need to possess dignity in order to maintain it for their patient" (p. 256). Contexts of resource constraints can further reduce professional dignity as HCW might not have the resources necessary to support their clinical responsibilities (Griffin-Heslin 2005). Thus, in the absence of their own dignity, health workers struggle to provide dignified care for their patients (Hosseini et al. 2018). Health facility characteristics and issues of organizational hardware and software can act as barriers or facilitators of dignity and additional research is necessary to further synthesize these reports.

Macro- level

Macro- level factors refer to the broader system, societal-level factors, and increasingly international contexts which shape the overall architecture of the health system (Smith and Hanson 2011; Gilson 2012). This level is less reported in the literature, however, there have been some findings on policy decisions, health system responsiveness and economic influences, and broader social context for example, which can impact dignity that requires further review (Rashidian et al. 2011; Lin et al. 2012; Mwai et al. 2013; Cole et al. 2018). The first theme which relates to macro-level are laws, regulation, and policy. As noted earlier many countries identify dignity in their legislative frameworks (Shulztiner and Carmi 2014) and further analysis is necessary to see how national frameworks have impacted dignity in the health system. Similarly, and as described throughout this scoping review, numerous international and national health system frameworks, policies, and standards of care guidelines have been developed to support more dignified, respectful, responsive, and accountable health systems (De Silva and Valentine 2000; GNP+ and UNAIDS 2011; WHO 2018; Dawson-Rose et al. 2020). Within these policies, accountability mechanisms such as budgetary support to ensure increased supervision at facilities or policy provision increasing community participation in the health system have been described as needed and advantageous for more responsive, rights-based system systems (WHO 2013; WHO 2017; Cole et al. 2018; Afulani et al. 2019a) but synthesized empirical results reporting on the implementation of these policies in relation to dignity is lacking.

Secondly, social, political, and economic contexts is an additional theme that emerged within the macro-level of a health system. While quantitative research, drawing on secondary data analysis from the World Health Survey (WHS), found that political rights and civil liberties are positively associated with improved rates of dignity for outpatient care and health system responsiveness more broadly (Witvliet et al. 2015)[26], it is not

[26] The results of this quantitative research on civil liberties and responsiveness are summarized by Witvliet et al. (2014): "political rights showed positive associations with dignity (regression coefficient = 0.086 [standard error = 0.039]), quality (0.092 [0.049]), and support (0.113 [0.048]) for inpatient care and with dignity (0.075 [0.040]), confidentiality (0.089 [0.043]), and quality (0.124 [0.053]) for outpatient care" (p. 622).

clear if empirical reports, have similarly identified broader political contexts of increased civil freedoms to translate into more dignified health system. Additionally, humanitarian settings and economic recession have been shown to influence the provision of dignity and further assessment is needed to discuss these macro-level aspects (Nunes et al. 2015; Nara et al. 2020). Several theologians, political leaders, and researchers have argued that dignity is an inherently African concept (Sachs 2005; Metz 2012; Ikuenobe 2018), long predating the global popularization of dignity with the 1948 Universal Declaration of Human Rights (UDHR). However, greater clarity is needed to understand if and how the cultural inherence of the subject has shaped broader social contexts and consequently influenced the health system (London et al. 2014). Furthermore, while this scoping review found that operationalization of dignity in a resource-constrained context can appear differently than findings from the global north, greater understanding of how these settings support and prioritize dignity is needed as competing clinical priorities could result in viewing dignity, like respect in the health system, as "luxury add on" (WHO, 2018, p. 8) and thus prioritized differently (Bohren et al. 2020). Bohren and colleagues (2020) call for urgency in further research investigating how LMIC health systems can support respectful and dignified care, "More work is needed to understand how respectful care can be provided, particularly in lower-resource contexts, and how non-recommended practices can be removed from clinical settings" (p. 123).

Conclusion

Based on scoping review findings, there has been an increase in research on dignity in LMIC settings since 2000 (De Silva and Valentine 2000); however, much of the currently synthesized research on the topic has taken place within the context of maternal health. Yet there is evidence that dignity is different from disrespect and abuse and that threats to dignity are happening beyond the maternity ward (Duby et al. 2018; Jamalimoghadam et al. 2019; Larson et al. 2019; Bagherian et al. 2020). And most critically, dignity is not seen as a health systems issue that can have structural, systematic solutions (Jacobson 2009a). Instead of identifying systemic issues and providing systematic solutions, conversations continue to occur at a micro-level of engagement.

> "*While there is currently a lot of attention on disrespectful maternity care, our results suggest that this is a problem that goes beyond this single health issue and should be addressed by horizontal health system interventions and policies*" (Larson et al. 2019, p. 508)

Dignity is a basic human right and the health system is responsible for fulfilling this right (Mann 1998; Gostin et al. 2003), yet this scoping demonstrates that there are barriers to dignity in the health system (see methods below). A health system perspective is urgently needed as it transcends macro, meso, and micro- levels of analysis through understanding of the broader 'architecture of the system, functioning of an organization, and assessment of an individual within the system' (Sheikh et al. 2011). As such, a health system perspective should provide systematic solutions necessary for a more dignified health system. There is a significant body of evidence from across the sub-Saharan African (SSA) region available that needs to be synthesized, described, and shared. The noted inherence of dignity tin sub-Saharan Africa makes study of this concept particularly pertinent (Metz 2012; Ikuenobe 2018; Sachs 2005).

Review question

This proposed systematic research project seeks to answer: **What are the health system barriers and facilitators of dignity within sub-Saharan African health systems?**

Review objectives

1. To provide synthesis on the scope of literature on dignity across time, sectors, and geographical locations.
2. To systematically review published literature on macro-, meso- and micro-level factors that influence dignity in sub-Saharan African health systems.
3. To describe how and what macro-, meso- and micro-level factors influence patient dignity in sub-Saharan African health systems.
4. To identify possible policy and research related implications based on findings.

Methods

This qualitative systematic review study was conducted in two parts – the first phase being an organized scoping review, and the second phase being a qualitative, descriptive systematic review (Butler et al. 2016) strategy. The research was divided into two parts because preliminary research is necessary to inform the systematic review process. By first scoping the literature, the research question is created, search terms are optimized, the data extraction sheet is constructed and inclusion and exclusion criteria for systematically reviewed literature are identified (Tranfield et al. 2003; Roehrich et al. 2014; Munn et al. 2018). "A comprehensive, unbiased search is one of the fundamental differences between a traditional narrative review and a systematic review" (Tranfield et al. 2003, p. 215). As such, key processes undertaken during the first phase of this scoping review will enable a thorough and unbiased systematic review search. An overview of key processes involved in this two-part qualitative systematic review study is described in Table 8.

Table 8: Overview of key processes involved in this two-part systematic review study

Part 1: Scoping Review	Part 2: Qualitative Systematic Review
1. Review literature broadly on dignity in health systems [Based on scoping review finding] 2 Optimize thesis research question 3 Establish systematic review search terms 4 Build systematic review data extraction sheet 5 Define inclusion and exclusion criteria for systematic review purposes	1. Systematic search the literature 2. Include/ exclude literature based on predetermined inclusion and exclusion criteria 3. Critically appraise literature 4. Extract data according to data extraction sheet 5. Analyze and interpret results 6. Report findings

Source: Author

Qualitative systematic reviews "provide credible, quality recommendations based on best available evidence at a given time" (Butler et al. 2016, p. 249). A qualitative systematic review on dignity in health systems could therefore synthesize the existing literature and provide evidence-based recommendations. Systematic reviews have traditionally been aimed at evaluating interventions based on available, and frequently quantitative data (Jones 2004). While our review approach does broadly consider the quality of included studies, as described below, our primary objective is not to evaluate the rigour of included literature. Instead, our objective is to synthesize and describe the literature on dignity in health systems.

Part 2: Qualitative systematic review

The second phase of this research study is a qualitative, systematic review (Butler et al. 2016). A qualitative systematic review was selected as the research strategy because such reviews are optimally placed on synthesizing empirical qualitative studies and providing evidence-based policy recommendations (Finfgeld-Connett 2013; Butler et al. 2016). As dignity is a guiding principle in the provision of health services and supported across numerous national health systems, findings from this study should support macro-level strides, including policy-recommendations, towards a 'more dignified health system.' Additionally, a

qualitative systematic review was selected because of the complex nature of dignity in health systems. Though systematic reviews have historically been in the form of quantitative findings, greater descriptive, narrative research is necessary to understand complex social phenomena (Dixon-Woods et al. 2006; Creswell and Poth 2016). Dignity is a social phenomenon that requires a descriptive, qualitative review strategy. A quantified review on dignity would be unable to provide descriptive insights and contextual understanding necessary to uncover health system factors that function as barriers of, or facilitators to, dignity in the health system. Given these reasons, a qualitative systematic review was therefore selected.

As indicated in Table 8 above, the qualitative systematic review (part 2) will commence with an electronic systematic search of literature focused on dignity in sub-Saharan African health systems. This region was selected as the geographic area of focus because upon literature review findings it was found that a review on dignity, across all patient populations, services, and HCWs has not yet been conducted within the region despite demonstrated availability of literature. Noting the gap of reviews on dignity in the health system within the Africa region, it is critical to add to the evidence. Three electronic databases, PubMed, CINAHL, and EBSCOhost, are planned to be used to solicit findings. PubMed and CINAHL are routinely used in public health, the broader health sector, and have been used successfully in other systematic reviews related to dignity (Kassa et al. 2020). EBSCOhost is often used to elicit findings specific to the African region. Considering our health systems and Africa focus, these three databases were selected as they are the most relevant. The primary author will record a detailed history of search terms and results in the final thesis.

Inclusion criteria

This research protocol will encompass:

1. Primary research articles, reviews, digital books or chapters in books, relevant sources of grey literature such as dissertations or theses, and institutional reports which show peer review processes.
2. Literature published between 2000 and July 2021. As this is the first systematic review on dignity in sub-Saharan African health systems, it is critical to ensure a broad and thorough representation of finding which could provide timeless guidance. Along with providing a 21-year range, this date also aligns with the 2000 World Health Report which identified dignity as a key health system performance indicator (WHO 2000).

Exclusion criteria

The exclusion criteria for this research project are as follows:

1. Records not in English will be excluded.
2. Records without full text will be excluded as full text is necessary for data extraction sheet purposes (see more below).

3. Research conducted outside of sub-Saharan Africa[27] will be excluded.[28]

Criteria appraisal

The quality of this review is only as good as the quality of the studies reviewed (Harris et al. 2013). To support this, the Critical Appraisal Skills Programme (CASP) critical appraisal tool[29] will be utilized on articles that meet inclusion criteria to ensure such standards. The CASP checklist has been implemented successfully in research on or related to dignity (Pringle et al. 2015; Ishola et al. 2017) along with other qualitative systematic reviews (Wakida et al. 2018). The tool, in the form of a checklist, asks a series of ten questions which relate to an article's ethics, rigour, reflexivity, and credibility. The responses to these to the ten questions will be included in the research's database and made available to the independent reviewer (MPH supervisor). Should a document reviewed not meet the CASP checklist requirements by failing multiple questions on the checklist, this demonstrates research of low quality and will not be included in the final review (Aromataris and Pearson 2014).

Data extraction

Results which meet inclusion/ exclusion criteria and identify macro, meso and micro-related factors that act as facilitators of or barriers to dignity in sub-Saharan African health systems will have data extracted and recorded in the data extraction database. Data extraction tools are commonly used to mitigate human error and further ensure rigour in systematic reviews (Tranfield et al. 2003; Büchter et al. 2020). Data will be extracted by the primary reviewer (MPH student); however, it will also be a supervised process as one independent reviewer (MPH supervisor) will offer oversight to the process. Through routine communication and consultation, both the primary reviewer and independent reviewer can discuss and resolve any challenges experienced during data extraction processes.

The scoping review phase of this project has indicated possible codes of dignity in relation to communication, respectfulness and friendliness, non-discrimination, privacy and confidentiality, involvement, and care environment and as such, literature which mentions this theme or themes of dignity will be recorded. Additionally, the scoping review led to the identification of micro, meso, and macro-level factors of the health system which act as either facilitator of or barrier to health system dignity. A column for each of these three levels has been provided in the data extract sheet. The scoping review also indicated sub themes in relation to each of the three levels of the health system including HCW and patient characteristics, health facility characteristics, hardware, and software, and laws, regulations, and policy, and social, economic political context. These subthemes will additionally be coded in relation to the level of the health system. The proposed data extraction sheet is provided in Appendix 4. A summary of the data extraction sheet will be included in the final systematic review.

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[27] The WHO sub- Saharan Africa region includes the following countries: Algeria, Angola. Benin. Botswana, Burkina Faso, Burundi Cameroon, Cabo Verde, Central African Republic, Chad, Comoros, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Equatorial Guinea, Eritrea, Ethiopia, Gabon, Gambia, Ghana, Guinea, Guinea-Bissau, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mali, Mauritania, Mauritius, Mozambique, Namibia, Niger, Nigeria, Rwanda, Sao Tome and Principe, Senegal, Seychelles, Sierra Leone, South Africa, South Sudan, Eswatini, Togo, Uganda, United Republic of Tanzania, Zambia, and Zimbabwe.

[28] Should a record include multiple countries, either in Africa or outside of Africa, the country which data is extracted from will be recorded in the data extraction sheet and records which include both non-African and African coutnires will only have data extracted from African countries.

[29] The CASP checklist can be found here: https://casp-uk.net/casp-tools-checklists/,

Data analysis

Information extracted into the data extraction sheet will be analyzed using thematic analysis. Thematic analysis is routinely utilized to analyze both field-based and desk-based research including qualitative systematic review findings (Thomas and Harden 2008; Chan et al. 2017). This is one of the most common forms of analysis because of the flexibility and ability to capture a range of findings, as described by Guest and colleagues (2011), "We feel that a thematic analysis is still the most useful in capturing the complexities of meaning within a textual data set" (p. 11). Given that dignity in health systems has been presented in a variety of ways across multiple areas of health system research and interests and across varying levels of the health system (furthering complexity), thematic analysis is an optimally suited form of analysis. The above-mentioned themes related to the micro, meso, and macro-level of the health system will also support analysis.

Rigour

Rigour for this study will be supported through the implementation of several strategies. Firstly, we will meticulously record and present each step of the systematic review process in both the protocol and final thesis write up (Dixon-Woods et al. 2006). A thorough presentation of methodological decisions and processes is necessary as qualitative systematic reviews have experienced threats to rigour due to weakly defined and described methods (Finfgeld-Connett 2013). As discussed by Mays and colleagues (2005) this vivid description of processes and decisions should be so clear that it could be replicated by an external researcher. Explicitly defined methodological and analysis reporting will enable replication and support this study's rigour. Secondly, we will ensure rigour through triangulation. As described by Patton (1999), "The logic of triangulation is based on the premise that no single method ever adequately solves the problem of rival explanation. Because each method reveals different aspects of empirical reality, multiple methods of data collection and analysis provide more grist for the research mill" (p. 1192). As such, multiple databases and a variety of search terms will be used, and an additional reviewer (MPH supervisor) will be involved in the data collection and analysis process. Such processes are what Patton (1999) calls "methods triangulation, triangulation of sources, and analyst triangulation" (p. 1193) and will enable rigorous systematic review research practices. Additionally, rigour will be supported through the researcher's reflexivity (Green and Thorogood 2018). Own assumptions and biases can distort analysis findings and therefore, it is critical throughout the research process to practice research reflexivity by assessing and identifying researcher assumptions (Gilson 2012). As described above, the use of criteria appraisal tools and a data extraction sheet will further support a rigorous systematic review (Tranfield et al. 2003; Dixon-Woods et al. 2006).

Risks and benefit

This study has no risk involved as this is a systematic (desk-based) review. However, there is potential for re-exposure of health systems, which have poorly maintained a patient's or HCW's dignity. While there is the risk, such findings have already been shared publicly thus, we are not revealing any new episodes of dignity violations. This review has the potential to support continued strides towards right-based, responsive, and quality health systems. Furthermore, it has the potential to support strides towards 'a more dignified health system' and as such, the benefits of this review outweigh the minimal (if any) risks associated with this research study.

Study limitations

There are several limitations to this research study. The first limitation of this study is the potential for overrepresentation of barriers to dignity in health systems. During qualitative interviews, Jacobson (2009b) found that dignity violations were often eagerly and vividly reported by patients while examples of promotive dignity experiences were fewer and required greater participant memory elicitation. Similarly, in a systematic review on attitudes and behaviours of maternal HCWs, Mannava and colleagues (2015) found that of the 55 articles reviewed, only five studies reported factors influencing positive behaviours of HCWs. With a disproportionate representation of negative health worker behaviours, discussion on factors that support positive interactions was, therefore, limited (Mannava et al. 2015). While this research is a systematic review and does not involve any contact with health system users and this research is not specific to dignity violations in maternal health like Mannava, these two researchers' experience of weakly promotive findings could be characteristic of this review. Consequently, it could appear that this systematic review weakly considers facilitators of dignity in sub-Saharan health systems when in fact such findings are characteristic of the broader evidence base. Despite the potential for an uneven distribution of findings, a systematic review dense with identification of health system barriers to dignity will still provide key learnings for policy recommendations. Secondly, due to budgetary limitations, only articles written in English will be considered in this systematic review. Thirdly, due to resource and time limitations of this systematic review, stakeholders have not and will not be involved in this research process. Stakeholders play a critical role in research development, analysis, dissemination, and implementation (Langlois et al. 2019); however, due to this being a self-funded project and without adequate time or resources to facilitate these influential members' involvement, they will not play a role during this research.

Ethical considerations

As this is a desk-based review and as reported in the methodology, no humans will be involved in this study. Literature included in this review is already available publicly and no new information will be elicited from any human subjects. Consequently, ethical clearance is not needed or required.

Timeline

This systematic review is estimated to span across ten months. As reported above and indicated below, this is a two-part systematic review study - the first part being a global scoping review and the second part being a systematic review with varying activities at each phase of this project (see table 10 below). Throughout this research project, there will be routine communication with the MPH supervisor.

Table 10: Estimated timeline for two-part systematic review study

		Timeline									
Part	**Keys actions and/or activities**	**Feb 2021**	**Mar 2021**	**Apr 2021**	**May 2021**	**June 2021**	**July 201**	**Aug 2021**	**Sept 2021**	**Oct 2021**	**Nov 2021**
Part 1: Scoping review	Global scoping review	■	■	■	■						
	Review protocol development				■	■					
	Submission of review protocol to HREC					■					

Part 2: Systematic review	Qualitative systematic review data collection										
	Qualitative systematic data extraction and analysis										
	Draft journal manuscript										
	Final edits and review of whole thesis										
	Submission of thesis for examination										

Source: Author

Part 1: Scoping review

The first phase of this research was to conduct a scoping review. Scoping reviews are frequently used as a precursor to systematic reviews as they are helpful instruments in understanding the depth and breadth of the existing literature (Munn et al. 2018). "True to their name, scoping reviews are an ideal tool to determine the scope or coverage of a body of literature on a given topic and give clear indication of the volume of literature and studies available as well as an overview (broad or detailed) of its focus" (Munn et al., 2018, p. 1440). By reviewing the existing literature broadly, scoping reviews identify research gaps, key concepts, and inform the researcher on the variety and forms of evidence available (Pham et al. 2014). As described above in Table 8 scoping findings enabled the formation of a research question, search terms, a data extraction sheet, and relevant inclusion and exclusion criteria (Arksey and O'Malley 2005; Tricco et al. 2016).

To initiate the scoping review, keyword searches in PubMed, Scopus, EBSCOhost, and Google Scholar were conducted. These four databases were selected to ensure a broad coverage of literature necessary to conduct a rigorous scoping review (Arksey and O'Malley 2005). While Google Scholar features less bibliometric tools, use of this database was critical in ensuring a comprehensive overview of both academic and non-academic findings such as grey literature encompassing conference proceedings, government reports, or theses (Mingers and Meyer 2017). Additionally, to ensure broad coverage of literature reviewed, further searches for grey literature were also conducted on institutional databases like the World Bank (https://openknowledge.worldbank.org/) and WHO (https://www.who.int/en/).

As described in Table 9 below, search terms included ''dignity," 'health systems," and later "LMIC." Search terms included relevant linguistic variations and combinations formed through Boolean operators of AND," "OR," and "NOT". Initially, only "dignity" and "health systems" were used as the main search terms. As familiarity with the literature increased; however, there appeared to be a geographical deficit on research concerning dignity in LMIC health systems. Considering this finding, the geographically bound search term of LMIC was included as the third key search term to elicit findings from the region. According to Arksey and O'Malley (2005), scoping reviews are an iterative process. As such, the amendment or addition of search terms is common practice in the scoping review processes because as a researcher's familiarity with the literature increases so does the identification of research gaps and thus the inclusion, adjustment, or optimization of key search terms (Arksey and O'Malley 2005). Given these reasons, the decision to include the third search term was a permissible action according to the scoping review methodology. Though it was permissible to

include additional search terms to the scoping review, key to the scoping review process is typically to limit literature inclusion criteria (Arksey and O'Malley 2005). As such, to ensure a comprehensive overview and scope of evidence during this initial scoping, no date restrictions were applied. However, due to resource constraints, only literature published in English was included.

Table 9: Examples of scoping review search

Main term	Variations
Dignity	"Dignity;" "dignified"; "non-dignified"; "not dignified"; undignified"; "dignified care"; "dignified treatment"; "dignified health"; "dignity in health"; "dignified health"; "dignity and respect"; "undignified"; "dignity and friendliness"; "dignity and non-discrimination"; "dignity and privacy"; "dignity and confidentiality"; "dignity and involvement"; "dignity and care environment"
Health systems	"Health systems;" "health care system"; "health service"; "health service delivery"; "health"; "health care"; "health care delivery"; "health systems research;" "public health"; "public health system"; "public health service"; "health facility"; "health systems strengthening"; "responsiveness"
LMIC countries[30] and related-phrases	"Afghanistan"; "Algeria"; "Angola"; "Bangladesh"; "Belize"; "Benin"; "Bhutan"; "Bolivia"; "Burkina Faso"; "Burundi"; "Cabo Verde"; "Cambodia"; "Cameroon"; "Central African Republic"; "Chad"; "Congo, Dem. Rep"; "Comoros"; "Congo, Rep."; "Côte d'Ivoire"; "Djibouti"; "Egypt, Arab Rep. "; "El Salvador"; "Eritrea"; "Eswatini"; "Ethiopia"; "Gambia"; "Ghana"; "Guinea"; "Guinea-Bissau"; "Haiti"; "Honduras"; "India"; "Indonesia"; "Iran, Islamic Rep"; "Kiribati"; "Korea, Dem. People's Rep"; "Kenya"; "Kyrgyz Republic"; "Lao PDR"; "Lesotho"; "Liberia"; "Madagascar"; "Malawi"; "Mali" ; "Mauritania"; "Micronesia, Fed. Sts"; "Mongolia"; "Morocco"; "Mozambique"; "Myanmar"; "Nepal"; "Nicaragua"; "Niger"; "Nigeria"; "Pakistan"; "Papua New Guinea" "Philippines"; "Rwanda"; "Samoa"; "São Tomé and Principe"; "Senegal"; "Sierra Leone"; "Solomon Islands"; "Somalia"; "South Sudan"; "Sri Lanka"; "Sudan"; "Syrian Arab Republic"; "Tajikistan"; "Tanzania"; "Timor-Leste"; "Togo"; "Tunisia"; "Uganda"; "Ukraine"; "Uzbekistan"; "Vanuatu"; "Vietnam"; "West Bank and Gaza"; "Yemen, Rep." "Zambia"; "Zimbabwe"; "Low-income country;" "middle income country"; "developing country"; "less developed"; "middle income economics"; "poor countries"; "under- developed countries"; "underdeveloped economies"

Source: Author

Based on the organized scoping review findings, we established our research question, formulated the data extraction sheet, identified and optimized key words and search terms, and confirmed the relevance of inclusion and exclusion criteria (Tranfield et al. 2003; Munn et al. 2018).

Anticipated budget

This research project is being undertaken in South Africa (the primary author's country of residence) and is being conducted in partial fulfilment of the requirements for a Master's in Public Health. This research project is self-funded and apart from the items listed below (see table 11 for research budget), there are no direct costs associated with conducting research activities. The primary author declares no conflict of interests.

Table 11: Anticipated research project budget

Item	Total Cost
Pens	R 100.00
Pencils	R100.00
Highlighters	R90.00
Notebooks	R110.00

[30]Low – and Lower-Middle Incomes (LMIC) countries identified as per the World Bank classification as of August 2021 (https://datahelpdesk.worldbank.org/knowledgebase/articles/906519)

Miscellaneous printing including a final hard copy of dissertation for editing purposes	R3400.00
Total	**R3,800**

Source: Author

Communication of findings

The findings from this study will be shared in thesis format and in the format of a journal manuscript. The thesis format will be shared with the University of Cape Town's open access research database. Additionally, the findings will be communicated in the format of a journal manuscript intended for publication in a relevant journal read by key public health professionals, researchers, and health system stakeholders. Lastly, findings from this study will be disseminated on the primary author's social media accounts which have some relevant health system related followers.

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Appendix 1: Survey questions and observational checklists used to measure dignity globally

	Purpose	Context	Survey questions or observational checklist used
Responsiveness	**Multi-country Survey Study 2000-2001** (Valentine, 2002 p. 954)	International health system responsiveness survey	1. "How often did other HCWs treat you with respect? 2. How often did the office staff, such as receptionists or clerks there, treat you with respect? 3. How often were your physical examinations and treatments done in a way that your privacy was respected? 4. How would you rate your experience of being treated with dignity?"
Quality care	**General hospital survey to measure patient perception of dignity** (Ferri et al. 2015, p. 5)	General hospital survey among hospitalized patients in Italy	1. "Before you exposed the private parts of your body in order to undergo medical procedures, had nurses closed the door of your room? 2. Did you receive enough privacy when you needed to use the bedpan and/or urine bottle to urinate, e.g., did nurses cover you with a bed sheet or blanket? 3. Did nurses take care to cover the private parts of your body at the end of each procedure? 4. Did you have privacy to use the bathroom? 5. While undergoing medical procedures which required the exposure of private parts of your body, did the door of your room remain closed? 6. Did nurses ask your permission before performing care procedures on your body? 7. Did nurses provide information on the diagnostic and therapeutic procedures that you needed? 8. Did the nurses involve you in your health program and allow you to make decisions in this regard? 9. Did nurses let you do daily activities (bathing, dressing, feeding) if you were able to perform them by yourself? 10. Did nurses introduce themselves to you at your first meeting in hospital? 11. Did nurses ever refer to you using respectful language without calling you by nicknames? 12. Did nurses treat you with respect without using excessively familiar manner? 13. When talking to other health care professionals, did nurses refer to you using your name rather than the number of your bed? 14. Did nurses interact with you using a kind and warm tone? 15. During the discussion of personal matters, did nurses ensure sufficient privacy?"
Person-centred	**Questions asked under the respect and dignity subscale** (Antinga, 2016, p. 372)	Survey on patient centred care in Ghana among private and public service users	1. "I can say that I feel being worthwhile or valued by the doctors. 2. I feel revered by the doctors in 'relations with me. 3. I feel that I am sometimes discriminated against."
Respectful maternity care	**Forms of non-dignified care** (Okafor, 2015, p. 112)	Survey on disrespect and abuse in facility-based childbirth in Nigeria	1. "Patient blamed or intimidated during child- birth 2. Patient threatened with casern delivery to discourage patient from shouting 3. Patient received slanderous remarks (aspersion) from birth attendant 1. Patient scolded, shouted, or called stupid"

	Observable Sub-components measured for non-dignified care during childbirth (Banks, 2018, p. 322)	Cross-sectional study on the prevalence and risk factors for disrespect and abuse for childbirth in Ethiopia	1. "Mother not welcomed in a kind and gentle manner 2. Health care work did not introduce themselves to patient 3. Use of non-dignified language during history taking 4. Delivery midwife did not introduce herself by name if the provider and patient had not met 5. Delivery service provide did not congratulate mother after birth 6. Mother not cleaned after birth and third stage of labour 7. No pad provided to mother 8. Mother not allocated own bed in post-natal word 9. Bed in post-natal ward not cleaned 10. Mother not called by her name throughout interactions 11. Mother not asked about preferred birth position 12. Mother not allowed to practice religious or cultural customs if requested"

Source: Scoping review by Author (see methods above)

Appendix 2: Summary overview of 20 key articles on dignity in LMICs

Author(s)	Country	Key Findings
Afulani et al. 2019	Kenya, Ghana, India	Quantitative research on person centred maternity care with over 2500 women in rural and urban Kenya, Ghana and India, found low levels of dignity and respect. According to the dignity and respect subscale, only roughly half of all women surveyed reported consistently being treated in a friendly manner by health facility staff and clinicians. Analysis in all three countries also showed different experiences of dignity according to facility level and patient socioeconomic status.
Amroussia et al. 2017	Tunisia	Qualitative study on disrespect and abuse in childbirth among single mothers in Tunisia. Based on in-depth interviews with single mothers, the researchers found that single mothers experienced barriers to accessing maternal health services as a result of social stigma attributed to single motherhood. As described by the researchers this social stigma was enabled by religion, culture, and workplace culture that stigmatizes single women.
Asefa et al. 2020	Ethiopia	Qualitative study on health system barriers to respectful maternity care interventions in three southern Ethiopia hospitals. The authors identified hardware and software health system factors which impact the provision of respectful maternity care. Software factors related to service provider characteristics, such as motivation and awareness of respectful maternity care policy, were identified as supporting aspects to dignity while hardware factors related to supply (including bed space, infrastructure, and human resource availability) adversely impacted dignity.
Asmaningrum et al. 2017	Indonesia	Qualitative study on patient's understandings of dignity in Indonesia identified responsiveness, respect and friendliness and individualized care as the core aspects to support dignity. Responsibility was placed on the individual HCW to promote a patient's dignity while less responsibility was placed on the broader health system that can either enable or prohibit the provision of dignified care; however, cultural norms and societal beliefs around greetings such as smiling or inclusion of family members in health decision making were described as facilitators to supporting dignity. Findings document how dignity is context-specific and attention to societal beliefs, norms and culture can support dignity in the health system.
Atinga et al. 2016	Ghana	Cross-sectional study on patient-centred care in private and public hospital wards in Ghana viewed patient care according to four dimensions including: "respect and dignity, emotional support, interpersonal relations, and interpersonal relations and information sharing" (p. 370). Patients using private facilities and who were older, higher educated, and higher income earners reported greater satisfaction, including experiences of dignity, compared to public health service users. The uneven experiences of dignity were attributed to the socioeconomic difference between the public and private service users as those using public services were low income.
Atukunda et al. 2020	Uganda	Qualitative study based on interviews with 30 post-partum women in rural southwestern Uganda reported that women wanted a supportive environment during childbirth. Fears around the inability to deliver in a supportive, private, accommodating, dignified environment that was staffed by trained HCWs were described as barriers to facility delivery. The researchers identified the need for greater attention to facility-level software such as building trust between clients and patients and facility-level hardware such as training.
Bagherian et al. 2019	Iran	In a qualitative study on perception of dignity upon cancer patients in Iran, privacy and personal space, respect and moral support were identified as three key themes related to dignity. While HCW characteristics (i.e., caring, respectful and skilled) were identified as facilitating factors to dignity. Some attention to broader system level factors were discussed. For example, health facilities with a disproportionate number of female workers were described as a barrier to dignity for males as their privacy was reduced in the company of an opposite gender health worker. The unavailability of basic supplies, medication, and inadequate staffing along with unaccommodating insurance policies adversely impacted dignity.

Banks et al. 2017	Ethiopia	Cross sectional study on the prevalence of disrespect and abuse during childbirth in Ethiopia reported that 21.1% of survey respondents experienced at least one form of disrespect and abuse during childbirth. Constraints associated with accountability mechanisms to regulate patient-provider interactions were identified as a barrier to respectful, dignified services.
Buser et al. 2020	Zambia	Qualitative study on factors associated with health-seeking practices in four rural Zambia communities. HCWs identified "social preservation of dignity" (p.6) as a reason for antenatal clients' male partner's delay in seeking HIV testing. While HIV/STI testing was prescribed by national health policy, men were resistant to testing as it contradicted societal beliefs that HIV testing is a personal issue. Furthermore, there was resistance to testing as health facilities were seen to weaken masculinity because they were perceived to be exclusively for female use.
Duby et al. 2018	South Africa	Qualitative study on access to health services for men who have sex with men (MSM), female sex workers, and people who use drugs in South Africa found that patients interviewed avoided seeking care at health facility as a result of dignity denying experiences by being shamed, scolded, and embarrassed by HCW. Organizational informal policy of not providing sexual reproductive supplies to MSM along with broader social, cultural, and economic stigmatizing men who have sex with men were described factors which adversely impacted the patient's dignity.
Hosseini et al. 2019	Iran	Qualitative study on patients' perception of dignity in Iranian and hospital described four key aspects of dignity in a health facility setting: a respectful environment, privacy, attention, and involvement in decision making. The findings were connected to the varying levels of the health system. For example, interpersonal characteristics of the health worker (i.e., professional dignity) were noted as facilitators of dignity. Organizational infrastructure to support privacy (i.e., physical barriers) also impacted dignity. And at a societal level the importance of having a companion respected was explained in terms of the cultural value of connectivity. Not only was it important for the patient to have their dignity respected in the hospital, but the dignity of the companion was of equal importance. Such a view reinforces the cultural value of connectivity and collectively in both Asian and Iranian cultures.
Hulton et al. 2007	India	Mixed methods case study used observations, in-depth interviews, document reviews, and surveys to assess quality of maternal health services in India. Dignity violations were described in terms of lack of privacy, including irregular use of drapes or forced child delivery in crowded spaces. While varying experiences of dignity were not reported across different health facilities included in the study, experiences of dignity did differ according to patient characteristics (i.e., only 8% of Muslim women compared to 22% and 28% of Buddhist and Muslim women were explained medical procedures and process) thus suggesting inequitable distribution of dignity. Additionally, high income earners and literate women more commonly reported promotive experiences of dignity compared to low income and illiterate women.
Ishola et al. 2017	Nigeria	Based on systematic review of 14 articles documenting disrespect and abuse during childbirth in Nigeria, defined non-dignified care as a patient being shouted at, insulted, humiliated, threatened, and or a HCW using harsh words/ tone of voice during childbirth. The review used predominantly quantitative and mixed methods research while 1 exclusively qualitative study was included.
Jamalimoghadam et al. 2019	Iran	Qualitative study on hospitalized adolescents' perception of dignity in Iran reported adolescents found dignity through maintenance of privacy, autonomy, individualism, and intimate communication. HCW characteristics that were trustworthy, and respectful to the age and gender of the adolescent, and generally friendly were described as supportive for dignity. Several hospital level policies were described to adversely impact the dignity of patients, such as policies mandating all adolescents, even those on the cusp of adulthood, be placed in inadequately equipped children's wards. Hospital policy restricting patient movements while admitted was also described to adversely affect dignity.
Kyaddondo et al. 2017	Uganda	Qualitative study in Uganda on expectations for quality childbirth found that preservation of dignity and respectful staff attitudes were core features of quality

		maternity care. According to participants, respect for traditional practices such as herbal medicines, access to timely information and trained HCW, and a clean environment supported quality of care and thus dignity.
Malhotra & Do 2012	India	Secondary analysis on data related to health system responsiveness found that experiences of dignity in the health system varied according to income level in India. Based on findings from nearly 700 of India's health service users, the poorest were less likely to describe their experience of dignity in a health facility as 'very good' compared to high-income service users' rating of dignity. Further analysis found that reported disparities between income groups were prevalent in both public and private facilities. Findings provide evidence that socioeconomic status can influence a patient's experience of dignity in the health system regardless of facility type.
McMahon et al 2014	Tanzania	Qualitative study on experiences and reactions to disrespect and abuse during childbirth according to men and women in the Morogoro region of Tanzania. Identified health system hardware constraints as a barrier to dignified maternity care. According to respondents, HCWs scolded clients who did not bring their own gloves thus adversely impacting a patient's dignity. Experiences of undignified care acted as a barrier to continued health facility access.
Mohammadi et al. 2020	Iran	Qualitative study on caretakers' perception of women's dignity during childbirth in Iran found that respecting privacy, respecting patients' preference including involvement in treatment decisions or tolerance for religious practices, and thorough attention including non- discrimination to be the three most important aspects of dignity during childbirth. National legislation banning companions from accompanying women during childbirth was described as a barrier to dignity for some patients; however, as described by some of the caretakers in response to this policy they assumed the position of a pseudo -companion by providing comprehensive attention to the patient and thus supporting their dignity. HCW adoption of such practices demonstrates resiliency.
Nara et al. 2020	Uganda	Multi-method qualitative study on Congolese refugees' experiences of sexual reproductive health care in Uganda found that both refugee camp context along with an individual's identity as a refugee living in Uganda adversely impacted access and quality of health services. Broader economic, political context of a refugee camp, along with health system hardware including staffing, bed availability, equipment and supplies adversely impacted access, quality, and dignified care.
Shirzad et al. 2019	Iran	Qualitative study in Tehran on women's perspectives on health system factors related to selection of mode of childbirth was attributed Iran's unusually high rates of caesarean sections to health system constraints which adversely impact dignity during childbirth. As described, "preserving women's dignity was another factor that women valued which sometimes women felt could only being achieved by choosing to have a caesarean section" (p.8). Dignity was viewed as largely a result of interpersonal interaction between the HCW and patient, "Dignity in maternity care means encompassing respect and autonomy during labour and birth. It largely depends on care that women receive from their professional caregivers" (p. 8). Additionally, facility level characteristics such as weak adherence to standards of care acted as a barrier to dignity.

Source: Scoping review by Author (see methods above)

Appendix 3: Leading frameworks on respectful maternity care

Framework	Context	Forms, domains, and factors
Seven categories of disrespect and abuse in childbirth (Bowser and Hill 2010, p. 3)	Based on review findings of evidence on disrespect and abuse during facility - based childbirth	1. "Physical abuse 2. Non-consented clinical care 3. Non-confidential care 4. Non dignified care (including verbal abuse) 5. Discrimination based on specific patient attributes 6. Abandonment of care 7. Detention in facilities"
Defining disrespect and abuse of women in childbirth (Freedman et al. 2014, p. 916)	Defining disrespect and abuse of women in childbirth in terms of individual, structural, and policy level- factors	1. "Behaviour that all actors agree is disrespect and abuse 2. Normalized disrespect and abuse 3. Poor treatment caused by system deficiencies and considered disrespectful by women and providers 4. Poor treatment or conditions cause by system deficiency seen as normal or acceptable 5. Deviation from national standards of good quality of care 6. Deviation from human rights standards (available, accessible, acceptability, quality"
Twelve domains of respectful maternity care (Shakibazadeh et al. 2018, p. 935)	Based on global qualitative evidence synthesis findings on respectful maternity care	1. "Being free from harm and mistreatment 2. Maintaining privacy and confidentiality 3. Preserving women's dignity 4. Prospective provision of information and seeking informed consent 5. Ensuring continuous access to family and support 6. Enhancing quality of physical environment and resources 7. Providing equitable maternity care 8. Engaging with effective communication 9. Respecting women's choices that strengthen their capabilities to give birth 10. Availability of competent and motivated human resources 11. Provision of efficient and effective care 12. Continuity of care"

Source: Scoping review by Author (see methods above)

Appendix 4: Proposed data extraction sheet

Document 1																
Document Information						**Research context and focus**			**Defining dignity**	**Facilitator of Dignity**						
Author	Year	Title	Document Type	Country	Conceptual or empirical	Public, Private, Non-state Provider	Specific population recorded?	Specific health service recorded?	How is dignity defined/ framed/ measured?	Dignity theme (s)	Micro Theme	Micro Notes	Meso Theme	Meso Notes	Macro Theme	Macro Notes
										Barrier to Dignity						
										Dignity theme (s)	Micro Theme	Micro Notes	Meso Theme	Meso Notes	Macro Theme	Macro Notes

Source: Author

Part B: Journal Article

Dignity in sub-Saharan African health systems: a qualitative systematic review

Target journal: Health Policy and Planning[1]

Sarah Bald[2]

Abstract

Dignity, like health, is a basic human right. Dignity is consistently identified as a vehicle for health system reform and improvements of service provision - but is a poorly understood concept within health systems, and within health policy and systems research. A two-phase qualitative systematic review was undertaken on facilitators and barriers to dignity in sub-Saharan African health systems – focusing on three levels of the health system: interpersonal (micro), organizational (meso), and system-wide (macro). Seven platforms were searched for published and grey empirical studies, resulting in 113 items meeting inclusion criteria. Barriers and facilitators of dignity in the health system can be understood as manifestations of prevailing social and health system contexts which shape organizational hardware and software and influence interpersonal engagements between health system actors. Barriers and facilitators to dignity are interconnected and transcend across all three levels of the health system and relate to policy, discrimination, resource availability, organizational culture, staffing and professional dignity, and accountability. While enabling international guidelines and human-rights declarations, health policy, private, nongovernmental, primary health care (PHC) facilities, birth companions, training, and health care worker resiliency were identified as supportive factors to dignity in health systems, overwhelmingly challenges associated with pervasive discrimination, organizational culture, and structural inadequacies described at health facilities acted as an unequivocal barrier to both patient and professional dignity in sub-Saharan African health systems. Should dignity continue to be identified as a vehicle for health system reform and service provision, more research, increased recognition of prevailing social discrimination, heightened focus on professional dignity, and greater support to ensure implementation is necessary.

Keywords: Dignity, health system, sub-Saharan Africa, health and human rights, responsiveness

Key messages

- Dignity is consistently identified as a key driver of health system reform and improvements made to service provision in sub-Saharan Africa.
- Dignity is still poorly conceptualized and theorized in the health systems terrain - and more framing, operationalization, and empirical work is urgently needed
- Barriers and facilitators to dignity can be understood as manifestations of prevailing social and health system contexts which shape organizational hardware and software and influence interpersonal engagements.

[1] Instructions for the authors are included in Appendix 3.
[2] For minor dissertation examination purposes, the student is the first and sole author.

- The (interconnecting) barriers and facilitates considered most important to dignity across SSA health systems include policy, discrimination, resource availability, organizational culture, staffing and professional dignity, and accountability.

Introduction

"Every individual shall have the right to the respect of the dignity inherent in a human being..."

African Banjul Charter on Human and Peoples Rights, 1981, Article 5

Dignity, like health, is a basic human right (Mann 1998; Gostin 2001). The promotion of dignity has been described as the primary purpose of public health (Mann et al. 1994; Gostin 2001). It is a fundamental principle underlying the field of medicine (Stievano et al. 2013; Percival 2014) with nursing, palliative, and geriatric care identifying dignity as a key concept (Lothian and Philp 2001; Chochinov 2002; Gallagher 2004; Rassin 2008). The World Health Organization (WHO) along with other United Nations (UN) agencies have also regularly identified dignity as a key principle for health systems reform and strengthening, and service provision improvements (GNP+ and UNAIDS 2011; WHO 2013; WHO 2018). Dignity is also frequently used as a key measure or indicator in assessments of quality of care, person-centred care, respectful care, and health system responsiveness (Valentine et al. 2003; De Silva 2014; Afulani et al. 2017a; WHO 2018).

The focus on dignity in health has proved valuable for patients and health care workers (HCWs) – as its prioritization has been shown to improve patient health outcomes, support treatment adherence, and build trust between individuals and their health system (Beach et al. 2005; Afulani et al. 2017b; Gray et al. 2018). In a highly referenced article identifying a clear link between dignity and health, Beach et al. (2005) found that patients who were treated with dignity were more likely to be satisfied with health services (0.70 vs 0.39, P < .001) and respond to preventative care compared to those not treated with dignity (0.0.68 vs 0.63, P < .001). Furthermore, HCWs whose professional dignity is supported, are more likely to be motivated and feel pride in their career, which in turn enables them to deliver quality dignified care to their patients (Stievano et al. 2013; Sabatino et al. 2014). Dignity is also understood to underpin health system responsiveness[3], one of three core health system goals (De Silva and Valentine 2000), and based on findings from 41 countries, it was the second most important aspect of health responsiveness globally (Valentine et al. 2008). Therefore, if there are high levels of dignity within a health system, this should affirm citizen's- and patients' basic rights, it should be beneficial to both the patient and the provider, and ultimately should strengthen the health system by encouraging the provision of quality and human rights-based care and improving health systems performance (De Silva and Valentine 2000; Gostin et al. 2003; WHO 2018).

However, despite the importance of dignity in human rights and health terrains, 'dignity' is poorly conceptualized or operationalized in health (Macklin 2003; Ashcroft 2005; Pringle et al. 2015), and even more opaque within health policy and systems research (HPSR, more below). The broader literature does provide a useful categorization, dividing dignity into: 'human dignity 'and 'social dignity' (Mann 1998; Gallagher 2004; Jacobson 2007)'. Human dignity (as the "inalienable value that belongs to every human being by virtue of being human" (Jacobson 2007, p. 294)) and 'social dignity' ("can be lost or gained, threatened, violated, or promoted "(Jacobson 2007, p.295)) offers clarity and social dignity bares particular pertinence to health

[3] Health system responsiveness "indicates the ability of a health system to meet the population's legitimate expectations regarding non-medical and non-financial aspects of the care process" (Khan et al. 2021, p. 8). The eight domains used to measure responsiveness are: "autonomy, choice, communication, confidentiality, dignity, prompt attention, quality of basic amenities and support (access to family and community support)" (Valentine et al. 2002, p. 575-576).

system settings (Jacobson 2007; Jacobson 2009b), greater clarity is lacking (Gallagher 2011). In an initial scoping review (reported below),[4] we found that while there were some reviews on dignity and health care more broadly (Jacobson 2007; Lin et al. 2012), and numerous relating to palliative and geriatric care (Fitchett et al. 2015; Pringle et al. 2015; Rodríguez-Prat et al. 2016; Zahran et al. 2016; Scarton et al. 2018), very little could be found on *dignity in health systems*, especially dignity in low-and-middle-income countries (LMICs). Historically, what literature there is on dignity in health has been dominated by findings from high-income countries (HICs) (De Silva and Valentine 2000). The limited literature demonstrates that while research on core features - such as respect, communication, privacy, and friendliness - overlap (Walsh and Kowanko 2002; Griffin-Heslin 2005; Banks et al. 2017; Asmaningrum and Tsai 2018; Combrinck et al. 2020), dignified care is operationalized differently in HICs and LMICs, especially for LMICs where the broader context of overburdened and under-resourced health systems dominates (Naicker et al. 2009; Mills 2014). For example, in HICs, non-dignified care is often reported as not having privacy while discussing a sensitive topic with a HCW (Tauber-Gilmore et al. 2018); while in LMICs, it might rather be reported as a lack of privacy for the entire stay due to structural deficiencies such as lack of space, overcrowding, or understaffing (Ansari and Yeravdekar 2020).

Dignity in sub-Saharan African (SSA) health systems is of particular interest since, despite the promotion of dignity across global and national legal frameworks (Table 1 below) (Chaskalson 2000; Ojwang et al. 2010), health systems and standard of care (SOC) guidelines and frameworks (WHO 2018; Dawson-Rose et al. 2020; Raphalalani et al. 2021), and African inherence of the concept (see more below) (Murithi 2007), numerous barriers to dignity in the health system remain (Gostin et al. 2003; Ojwang et al. 2010; Ishola et al. 2017; Mengesha et al. 2020). These barriers to dignity are frequently seen within SSA maternity wards as dignity is one of the core domains guiding quality maternity care as envisioned by the WHO (Tunçalp et al. 2015). In relation to maternity care, dignity is a principal indicator for measuring disrespect and abuse (Bowser and Hill, 2010) and person-centred maternity care (Afulani et al. 2017a)[5]. Within this terrain, it has been reported that one in three women report violations to dignity during childbirth by being verbally abused by HCWs (Okafor et al. 2015; Banks et al. 2017; Mihret 2019; Ukke et al. 2019). There is also evidence that undignified care is not confined to maternity wards in SSA (Larson et al. 2019; Hazel et al. 2021). For example, in the SSA literature, barriers to dignity have been described by mental health service users (Mayers et al. 2010), marginalized and vulnerable communities (Duby et al. 2018; Nara et al. 2020), general service users (Fassin 2008), and among HCWs (Combrinck et al. 2020).

Table 1: Dignity in national constitutions

Constitution	Article
South African Constitution (1996) Chapter 2 Bill of Rights, Article 10	"Everyone has inherent dignity and the right to have their dignity respected and protected."
Kenyan Constitution (2010) Chapter 4 Bill of Rights, Article 28	"Every person has inherent dignity and the right to have that dignity respected and protected."
Ethiopian Constitution (1994) Chapter 3, Fundamental Rights and Freedoms, Article 24	"Everyone has the right to respect for his human dignity, reputation and honour."

Source: As indicated

[4] Reported in Part A, Literature Review

[5] Examples of indicators and survey questions used are reported in Part A scoping review.

Interestingly, within the maternal health space, there has been a push to see disrespect and abuse as a broader systems issue (Bohren et al. 2014; Freedman et al. 2014); however, dignity is still rarely seen or studied as a broader 'horizontal' health systems issue (Larson et al. 2019). As reported by Larson and colleagues,

> "*While there is currently a lot of attention on disrespectful maternity care, our results suggest that this is a problem that goes beyond this single health issue and should be addressed by horizontal health system interventions and policies*" (Larson et al. 2019, p. 508)

The initial review conducted for this study showed that in the current SSA literature, dignity is predominantly viewed as an individual matter, mainly an issue in the micro-level patient-provider interactions (Atinga et al. 2016; Duby et al. 2018; Oosthuizen et al. 2020). There is some smaller recognition that organizational aspects of a health facility (meso-level) impact patients' dignity (Fassin 2008; Duby et al. 2018). However, there is little which focuses on dignity 'systems-wide', which takes the context which shapes dignified care into account, or macro-level issues such as health policy or systems design into account (Grant et al. 2011; Lusambili et al. 2020b). There is mention of existing legislation which should ensure dignity, like national Constitutions or Patient Charters (Andresen et al. 2009; Ojwang et al. 2010), however, the implementation of such policies across the health system is not clear. A particular absence of work is scholarship that connects concepts of dignity with an understanding of local cultures, philosophies, and religions (Sachs 2005; Metz 2012; Ikuenobe 2018). For example, while dignity is noted as a universal human aspect (Gewirth 1992; Gostin 2001), non-westerns theologians, political leaders, and researchers have argued that 'human-dignity' is also an inherently African concept (Sachs 2005; Metz 2012; Ikuenobe 2018), long predating global popularization of dignity with the 1948 Universal Declaration of Human Rights (UDHR) (Murithi 2007). African philosophers describe human-dignity as being grounded in communalism, humanness, and likened to the cultural concept of 'ubuntu', as described by Murithi (2007), "The wisdom of ubuntu lies in the recognition that it is not possible to build a healthy community at peace with itself unless the human dignity of all members of the community is safeguarded" (p. 282). While it is argued that national efforts toward rights-based systems should be led by "[a] nuanced understanding of human rights, informed by cultural perspectives" (London et al. 2015, p 943), it is unclear if such recommendations have influenced policy reform in SSA health systems, nor if these kinds of cultural inheritance could be an enabler of a more 'dignified health system'.

For all such reasons, understanding how dignity functions within- and potentially influences the functioning of SSA health systems, is of great interest and relevance. To the best of our knowledge, this is not an issue that has been previously reviewed, in any way. Our attention to dignity requires urgency as cautioned by Jonathan Mann (1998),

> *"Future health professionals may look back at current limited and narrow understanding of health and wonder how we could have missed seeing violations of dignity as sources of injury and well-being"* (p. 37).

Methods

A two-phase qualitative systematic review was undertaken between April and December 2021 to answer the research question: 'What are the health system barriers and enablers of dignity within sub-Saharan African health systems?' The qualitative approach was selected because of the complex nature of 'dignity' as a

compound concept[6], and the qualitative nature of the available evidence. Dignity is a contextually defined, deeply entangled social phenomenon that necessitates descriptive analysis (Dixon-Woods et al. 2006; Creswell and Poth 2016). The first phase conducted was a full-scale scoping review on dignity and health systems in the global literature.[7] This phase established the substantive relevance of the topic for further systematic review (dignity in SSA health systems), scoped the available literature, and developed a conceptual framework for the next phase of the systematic review. In this framework development process, a useful categorization was found to be: 'interpersonal' (micro), 'organizational' (meso – inclusive of a hardware[8]/software[9] differentiation), and 'system architecture or societal context' (macro-level). Further, key thematic areas were identified, a typology of 'dignity' was developed, and search terms and extraction sheet headings were clarified (see Appendix 1). We did not force a differentiation between tangible and intangible software aspects[10] in our analysis, as the included studies did not often make this distinction.

In the systematic review phase that followed, seven search platforms were utilized: PubMed, Scopus, Web of Science, Africa Wide, CINAHL, Academic Premier, and Google Scholar[11] – and limited to English-language results. Because of the lack of previous review on this topic, a relatively wide remit was required, so materials were gathered from 2000 to mid-2021 – a date range which also aligns with the publication of the 2000 World Health Report which identified dignity as a core domain of health system responsiveness (De Silva and Valentine 2000). Eligible studies included peer-reviewed articles, digital books and book chapters, theses, and some qualifying grey literature such as organizational reports with evidence of internal review. Literature displaying qualitative, quantitative, and mixed methods study designs and data were all included. Due to practical constraints, only English records were included for review. Further rounds of analysis resulted in the inclusion of empirical studies (so the exclusion of reviews, thought pieces, and commentaries); and exclusion of items which did not identify an enabler or barrier to dignity in the health system.

As mentioned, extraction and analysis were guided by the review framework developed in the first phase (see Part A), and data was extracted into a pre-designed data extraction sheet, including items such as study characteristics, and how dignity was defined, framed, or measured in each included item (see Appendix 2 for a summary of data extraction sheet).

Search results from each database were imported into Rayyan[12], and following the removal of duplicates, all titles and abstracts were screened for eligibility, relevance, and quality (see below). Next, under full-text review, inductive and deductive approaches were utilized for extraction and coding. Codes (categories and themes) that were developed during the scoping review were updated to represent the systematic review findings more adequately. Table 1 provides an overview of the codes used, according to the level of the health

[6] As described earlier, dignity is frequently attached to other health system issues such as respectful, quality, and responsive health systems. Due to the compounding, overlapping, and routine similarities of these concepts, dignity has been identified as a compound concept.

[7] Reported in Part A of the thesis and summarized above.

[8] Organizational hardware represents the tangible aspects of an organization such as human resources, financing, infrastructure, equipment, and supplies (Sheikh et al. 2011; Asefa et al. 2020).

[9] Organizational software represents the intangible aspects of an organization such as processes, systems, relationships, culture, and norms of the health system or institution (Gilson 2012; Asefa et al. 2020).

[10] The distinction between tangible and intangible software is not consistently applied across the literature reviewed. For example, in Gilson 2012 and Asefa et al. 2020 intangible and tangible software are merged under software.

[11] To ensure a broad range of results, additional databases were included to the proposed set of databases described in Part A.

[12] Rayyan is a no-cost web- and mobile- based application for systematic reviews (Ouzzani et al. 2016).

system.[13] The primary author conducted the main review, and the secondary author provided checking rounds on key items.

Table 1: Codes utilized

Level of the health system	Codes (categories and themes)
Macro	International policy, national context, health policy
Meso: Hardware	Infrastructure, staffing
Meso: Software	Organizational structure and culture, accountability, professional dignity and motivation, organizational formal and informal policy, and resiliency
Micro	HCW factors, patient factors and discrimination

Source: Author

All included studies were critically appraised based on quality - guided by the Critical Appraisal Skill Programme (CASP) for health research checklist, which has been used successfully in research on or related to dignity (Pringle et al. 2015; Ishola et al. 2017).[14]

Results

The initial search yielded a total of 1668 records – after removing 705 duplicates, the remaining 936 records were examined by title and abstract for relevance. Of the 936 screened, 322 were included for full text review – and after eligibility assessment, 113 items were included in this review. Reference list checking and alternative database searches did not result in any items meeting the inclusion criteria at later stages of the review.

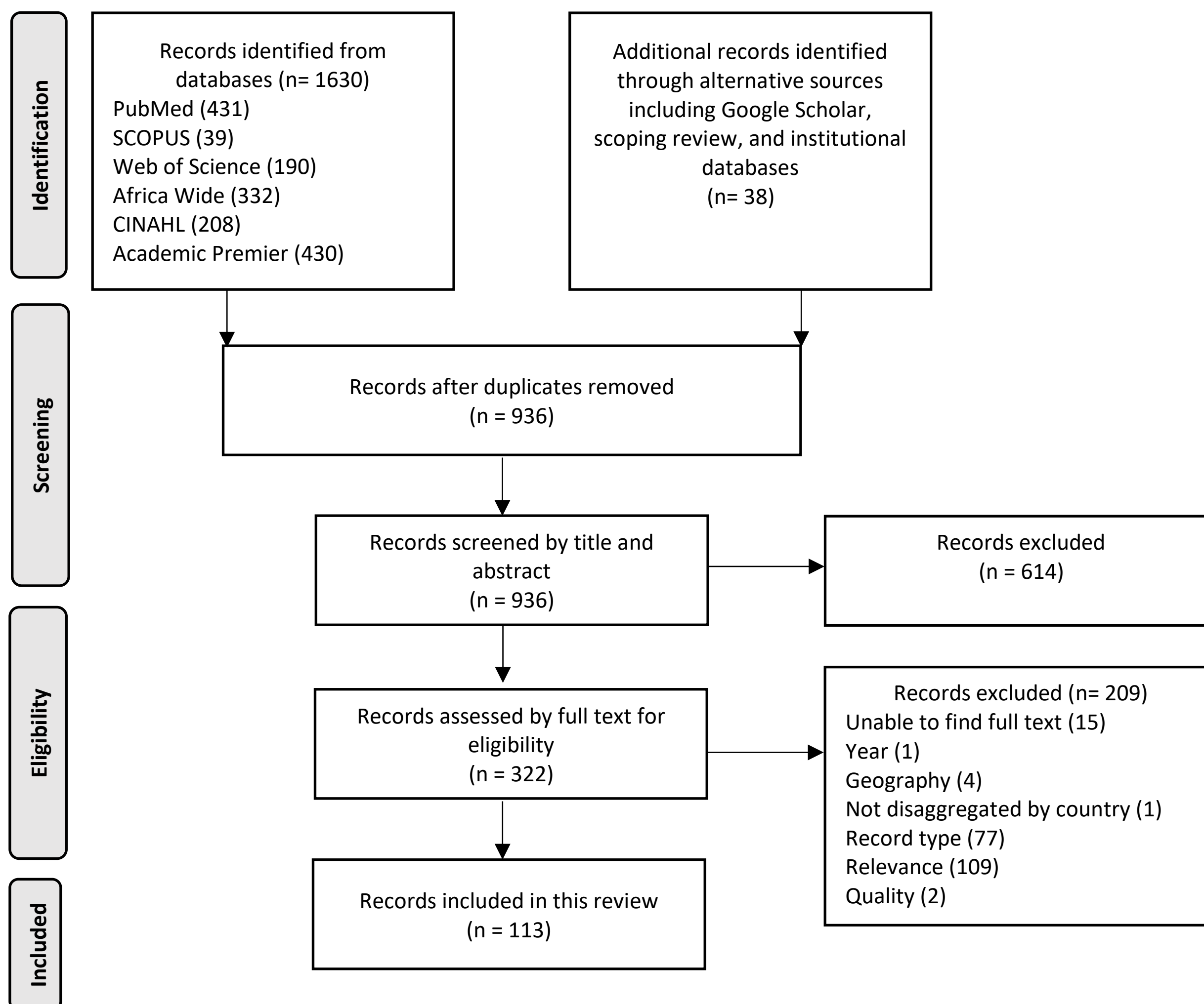
Several items were excluded because of being deemed 'non-empirical'. Others lacked relevance, particularly when 'dignity' was used widely but descriptively, and a clear health system enabler or barrier to dignity was not identified. For example, several items emerging from the 'advocacy space' were excluded because of a lack of empirical content or lack of mention of what could be deemed a health system barrier or enabler - despite dignity being mentioned frequently, and advocacy being a general health systems concern.

The included studies cover 21 countries, with the most prominent being Ethiopia (24/113), Kenya (23/113), South Africa (17/113), Tanzania (15/113), and Nigeria (11/113). In terms of study methods and data, included items displayed qualitative (48/113), quantitative (4/113), and mixed methods (21/113) approaches. The majority (75%) of the included articles were published within the last five years between 2016 and August 2021. Nearly all of the items were journal articles, and only two pieces of grey literature were included (Chigwenembe 2011; Rucell 2017)[15] – showing evidence of internal peer review

[13] For purposes of this review, international context, such as international health guidelines from global health organizations, was understood to fall within the space of the broader architecture and as such was categorized as a macro-level factor. This categorization is in line with increased recognition that broader international contexts, like national context, influence the health system (Smith and Hanson 2011; Gilson 2012)

[14] When an item fails to meet multiple questions on the checklist, this is illustrative of low quality (Aromataris and Pearson 2014) and when this happened, following consensus between reviewers, such items were excluded.

[15] While institutional databases such as the World Bank (https://www.worldbank.org/en/home) WHO (https://www.who.int/), Alliance for Health Policy and Systems Research (https://ahpsr.who.int/), and academic establishments (http://www.lib.uct.ac.za/lib/search/theses-dissertations and https://researchonline.lshtm.ac.uk/view/theses/archive.html) were searched for grey literature, majority of the retrieved results lacked relevance and/ or did not meet inclusion/ exclusion criteria. For example, of the top 20 articles from the World Bank, 10 results were blog posts related to dignity and advocacy while the remaining lacked relevance to the health system. As such, these results were not included in the review.



Source: Author

Figure 1: Prisma diagram

As described below (Table 2), the overarching health system topics or issues addressed relate to quality of care, health and human rights, responsiveness, access, and accountability. No article addressed a single health system issue or 'building block'[16], instead articles addressed numerous concerns simultaneously. In the included articles, 81/113 focused on maternal health[17]. Other prominent focal points included vulnerable populations, responsiveness, and professional dignity (see Table 2). Included items overwhelmingly focused on service delivery, and specifically on experiences of labour and delivery ('childbirth') (74/113), general inpatient or outpatient care (20/113), other maternal health services such as antenatal care (6/113) and combined maternal and child health care (3/113), sexual reproductive services (2/113), palliative care (2/113), mental health services (2/113), and health services and policy related to Ebola (1/113).

Table 2: Overview of health systems issues and topical areas of focus in included studies

[16] The WHO Health System Framework (2007) identifies (1) service delivery, (2) health workforce, (3) health information systems (4) access to essential medicines, (5) financing, and (6) leadership and governance as the six health system building blocks.

[17] These articles are specifically related to disrespect and abuse, respectful maternity care, quality, and person-centred maternity care.

Health system issues	Focus	Number
Quality of care, health and human rights, responsiveness, access, and accountability	Maternal health	81
	Vulnerable populations: MSM, gay lesbian, bisexual, transgender, sex worker (5) mental health (2), deaf (1), and displaced (1) patients	9
	Responsiveness	6
	Quality of care generally	5
	Health and human rights	3
	Professional dignity	3
	Palliative care	2
	Maternal and child health	2
	Ethics and nursing	1
	Ebola / policy	1
	Total	113

Source: Author

The patient's perspective was the most reflected view described (all, except three articles - (Froneman et al. 2019; Combrinck et al. 2020; Combrinck et al. 2021)); followed by the view of frontline HCWs. However, as described more below, 31/113 articles featured indirect discussions on professional dignity. Generally, dignity for patients was described as the need to be respected and be seen as a human. More specifically, the notion of 'personhood', and 'humility', alongside the same key analytical themes found in the scoping review (communication, respect and friendliness, non-discrimination, privacy and confidentiality, involvement)[18], were most commonly used to frame dignity in the health system[19]. Unlike professional dignity, for patients dignity in health systems was an experience of care resulting from engagement with an HCW. As illustrated by a maternal health patient in Uganda, "...they [HCWs] have to change the way they treat us… they should be more friendly, compassionate, and treat us like human beings" (Ganle et al. 2016, p. e245). In describing violations to dignity and in claiming a right to dignity, patients clarified their human standing (Scorgie et al. 2013; Kyaddondo et al. 2017; Rucell 2017; Sendo et al. 2021) and some (Mayers et al. 2010; Moyer et al. 2014; Mukamurigo et al. 2017; Atukunda et al. 2020; Oosthuizen et al. 2020) identified the difference between humans and animals as a justification for deserving dignity. For HCWs (also discussed more below), central to professional dignity were considerations such as self-worth, recognition, respect from the health system and patients, value identification, and motivation. As summarized in qualitative research findings in South Africa,

> *"…professional dignity of midwives is determined by their own perspectives of the contribution that they make to the optimal care of patients, the respect that they get from others and the support that hospital management gives them."* (Froneman et al. 2019, p. 1062).

Additional direct or indirect quotations of dignity are provided in table 3 below.

Table 3: Examples of (direct or indirect) quotations relating to dignity in the health system, showing different perspectives

Perspective	Quotation

[18] While the analytical themes identified in the scoping review (communication, respect and friendliness, non-discrimination, privacy and confidentiality, involvement, and care environment) adequately encompassed patient expressions of dignity in the health system, these six themes did not account for professional dignity. As described more below, recognition and motivation were core aspects found in relation to professional dignity. Care environment was also identified as a theme to dignity during the scoping review but was later found to be better understood in relation to meso-level factors (more below).

[19] As described in the scoping review (see part A), dignity is noted as different from physical harm (Bowser and Hill 2010; Shakibazadeh et al. 2018). As such, forms of physical violence were not considered to fall within dignity during the review processes and therefore were not included.

Patient perspective on dignity in health systems in Ethiopia	"They (providers) have to respect their clients because human beings naturally need respect and dignity in childbirth " (Sendo et al. 2021, p.6).
Research summary on dignity during abortion services in Kenya	"The women we interviewed desired service providers that treated them with respect and dignity and offered them personalized information and counselling that helped them feel prepared and reassured" (Baum et al. 2021, 1367).
Midwife's perspective indirectly on professional dignity in Mozambique	"Respect has to be mutual. I respect you; you respect me. If there is some kind of disrespect between the two the other one will not feel comfortable. And in this hospital, in this institution, midwives are not respected" (Galle et al. 2020, p.4).
Private HCW perspective on professional dignity in South Africa	"If you have self-respect, and if you have respect for other people around you, things start to fall in place'" (Combrinck et al. 2020, p. 398).
Health manger perspective indirectly on professional dignity of midwives in Kenya	"How do you expect a midwife to be in a good mood if she works with no break and has many clients to attend to in a dirty working environment?" (Warren et al. 2017, p. 7).

Source: Author

As noted above, barriers and facilitators to dignity in SSA health systems were categorized according to the three levels of the health system with the organizational level being sub-divided again into hardware and software concerns. Overall, barriers and facilitators to dignity can be understood in relation to policy, discrimination, resource availability, organizational culture, staffing and professional dignity, and accountability. As the health system is understood as a complex, interactive, and interconnected system (De Savigny and Adam 2009), an overarching factor was not bound to one level of the health system. Similarly, a barrier and enabler classified in relation to one overarching factor was met at the insertion of other competing factors and constraints[20]. The subsequent sections discuss these findings based on the three levels of the health system and italics script denotes the codes utilized (see table 1 above)

Macro-level

International policy: Over half of the results (68/113) described international human rights covenants, WHO guidelines, and charters as broader enablers to dignity in the health system as such global frameworks were seen to legitimize the relevance of a rights-based health system. The international Respectful Maternity Care Charter[21] was the most frequently referenced piece of international literature. Others that were frequently mentioned were the Universal Declaration of Human Rights (UDHR), the African Charter on Human Rights People, and the Convention on the Rights of Persons with Disabilities (CRPD). While such frameworks were described as supportive, Haricharan (2013) found that a loophole in the Convention on the Rights of Persons with Disabilities (CRPD), permitting deferment of action, based on cost, resulted in the exclusion of professional interpreters from national health budgets in South Africa. This loophole then acted as a broader macro-level barrier to dignity in the heaths system, as deaf patients' right to health and dignity was violated and discrimination on the basis of disability was furthered (Haricharan et al. 2013).

National contexts: While national constitutions affirming the right to dignity and health were seen as broader enablers to respect and dignity in the health system (Andresen et al. 2009; Mayers et al. 2010; Ojwang et al.

[20] This is not surprising because categorization is somewhat artificial and it is obvious how there is cross over, between say, macro-policy contexts, organizational culture, and individual discrimination

[21] Established in 2011, the White Ribbon Alliance Respectful Maternity Care Charter has been utilized as a guide by countries both in SSA and globally to ensure the basic human rights of women during childbirth. As described here https://www.whiteribbonalliance.org/respectful-maternity-care-charter/ the Charter includes ten core rights during childbirth which are reinforced by existing international and regional charters and covenants.

2010; Haricharan et al. 2013; Duby et al. 2018; Mafuta et al. 2018; Malatji and Madiba 2020; Birhanu et al. 2021; Raphalalani et al. 2021), other national policies, and frameworks not specific to health acted as a barrier (Ehlers et al. 2001; Kennedy et al. 2013; Scorgie et al. 2013; Peters 2016; Duby et al. 2018). Research focused on lesbian, gay, bisexual, transgender, queer, and intersex (LGBTQI), sex worker, and men who have sex with men (MSM) populations, all identified the criminalization of these identities as barriers to dignity in the health system (Ehlers et al. 2001; Kennedy et al. 2013; Scorgie et al. 2013; Peters 2016; Duby et al. 2018). Such policy reduced accessibility to state services including health facilities providing LGBTQI specific health services (Kennedy et al. 2013; Ehlers et al. 2001; Duby et al. 2018). A few studies reported on absent and uncomprehensive frameworks for prosecuting medical malpractice as additional national legal barriers, as patients often had no mechanism for laying claims against the health service or system (Okafor et al. 2015; Warren et al. 2017b; Tekle Bobo et al. 2019). Conversely, the existence of such legislation was described as a facilitator of dignity in the health system, as the potential for ligation increased accountability among facilities and HCWs (Ijadunola et al. 2019). However, even with legislation in place, uneven power dynamics, fear of retribution, and poverty usually challenged patient pursuits towards filing charges against health facilities through national legal frameworks (more below). As noted by Warren (2017b) in the context of disrespectful maternity care, "The process of seeking legal redress is also seen as expensive and time demanding, and many witnesses decline to participate for fear of backlash" (p. 9).

The broader social and national context was also found to be influential. Contexts of poverty and those involving refugees were reported as barriers to dignity, as such contexts limited ppatients'access to facilities, restricted patients' ability to compensate for under-resourced facilities (more below), and in the case of refugee settings, weakened patient autonomy (Pinehas et al. 2016; Nara et al. 2020). In one report, political violence in Kenya following elections resulted in increased 'tribal' or cultural discrimination at health facilities (Warren et al. 2017b). Though less discussed, additional barriers included HCW shortages (Andresen et al. 2009; Kane et al. 2018; Lavender et al. 2021), HCW strikes (Afulani et al. 2017b; Gwacham-Anisiobi and Banke-Thomas 2020), health system devaluations (Abuya et al. 2015a), and national ineffective reimbursement systems (Afulani et al. 2017b; Asefa et al. 2020a) - and such factors were said to result in inadequate availability of personal to provide high quality care, strained professional dignity, led to gaps in supervision, and in the context of HCW shortage, weakened the effectiveness of accountability mechanisms due to limited availability of alternative HCWs (Kane et al. 2018).

Discrimination across all levels of the health system acted as a substantial barrier to dignity in SSA health systems. For example, social norms tied to discrimination against LGBT people and sex workers were seen as legitimized through national laws mentioned above and/ or prevailing cultural beliefs (Ehlers et al. 2001; Kennedy et al. 2013; Scorgie et al. 2013; Duby et al. 2018). Though less frequently studied, some identified patriarchal systems, inequitable gender norms, and high contexts of gender- based violence as broader barriers to dignity because, though illegal, these norms legitimized and normalized discrimination (Abuya et al. 2015b; Rucell 2017; Oduenyi et al. 2021). Moralistic and cultural beliefs around adolescent pregnancy, abortion, and marriage were also noted to be social and contextual barriers to dignity in the health system, as commonly held beliefs in the community were usually reflected within health facilities (Kane et al. 2018; Baum et al. 2021; Sewpaul et al. 2021). In describing moralistic views held by HCWs regarding adolescent pregnancy, Sewpaul reported (2021), "…due to their young age … HCWs made them feel as though they were guilty of committing a crime…" (p. 5). With older patients, however, social norms in Kenya and Ghana around respect

for the elderly were found to positively support dignity in the health system because such norms guided HCW behaviour and motivated respectful care[22] (Ojwang et al. 2010; Atinga et al. 2016).

Health policy: Overarching national health policies such as Patients' Rights and Charters Mental Health Acts, national guidelines outlining and operationalizing respectful, and quality care, and specialized initiatives promoting respectful care, were reported as facilitators to dignity in the health system in nearly half (48/ 113) of the included items. As again they provided substantive relevance to prioritizing rights-based approach, and dignity respect in the health system. Political will was also seen as a facilitator (16/113), and as such, strong leadership could result in increased prioritization of policy, resource allocation, enforcement of accountability mechanisms, and lead ideological shifts countering HIV discrimination. However, three maternal health-related items reported that the heightened focus on abuse violations resulted in HCWs feeling villainized and blamed (Rucell 2017; Warren et al. 2017a; Asefa et al. 2020a), thus acting as a barrier to professional dignity. For example, referring to South Africa's Department of Health's zero-tolerance policy against HCW abuse against patients, Rucell (2017) notes, "This [policy] is meant to pressure managers and staff to work more and work better. Instead, however, it creates a fear among staff and in fact constrains their ability to work at all" (p. 295).

While supportive health policy and broader international guidelines exist, there are tremendous barriers to implementation, mainly due to infeasibility because of inadequate resourcing, gaps in organizational culture, and accountability (more below). The inadequacy of policy was particularly apparent with user fee removal, the most identified (14/113) national health policy barrier. Largely[23], user fee removal policies were uncomprehensive and were not met with adequate resources to support an influx of patient volume and they were not comprehensive as patients were still required to pay for certain services or at times mandated to bring their own supplies. Under-developed policy in Sierra Leone during the earlier stages of Ebola policy was thought to adversely impact on dignity because of poor operating procedures and weak respect for cultural and religious beliefs during burials (Gray et al. 2018). At times, the heteronormative and partnership-normative nature of national procedures around reproductive health acted as barriers to dignity in health systems, as they assumed heterosexuality (i.e., bring an opposite-sex partner for testing) (Kennedy et al. 2013) and marriage (bring husband to health facility) (Kane et al. 2018). Health policy mandating HIV-testing of pregnant women's partners in Zambia was also described as a barrier to dignity, as the policy was perceived as contradicting societal beliefs that HIV testing is a personal issue, and that attendance at a sexual reproductive health facility weakened masculinity since such facilities were perceived to be exclusively for female use (Buser et al. 2020).

Implemented policy that was identified as a facilitator to dignity was often tied to increased financing and featured forms of fiscal motivation. For example, increased investment in primary health care (PHC) facilities, results-based financing, and National Health Insurance schemes were described to support dignity in health systems as such policies provided adequate resources, improved facility motivation, and offered greater patient choice of providers (Mohammed et al. 2013; Kapologwe et al. 2020). Some (Adesanya et al. 2012; Peltzer and Phaswana-Mafuya 2012; Scorgie et al. 2013; Atinga et al. 2016; Afulani et al. 2019c; Dagnaw et al.

[22] Other research (Hazel et al. 2021) however found that the cultural norms of respect for the elderly did not necessarily translate to improved health system experiences for all elder patients. It could also result in increased expectations from patients to be treated with dignity.

[23] Asefa et al (2018) described that the removal of user fee policy supported dignity in health systems because it led to a reduction of detention in facilities due to lack of payment.

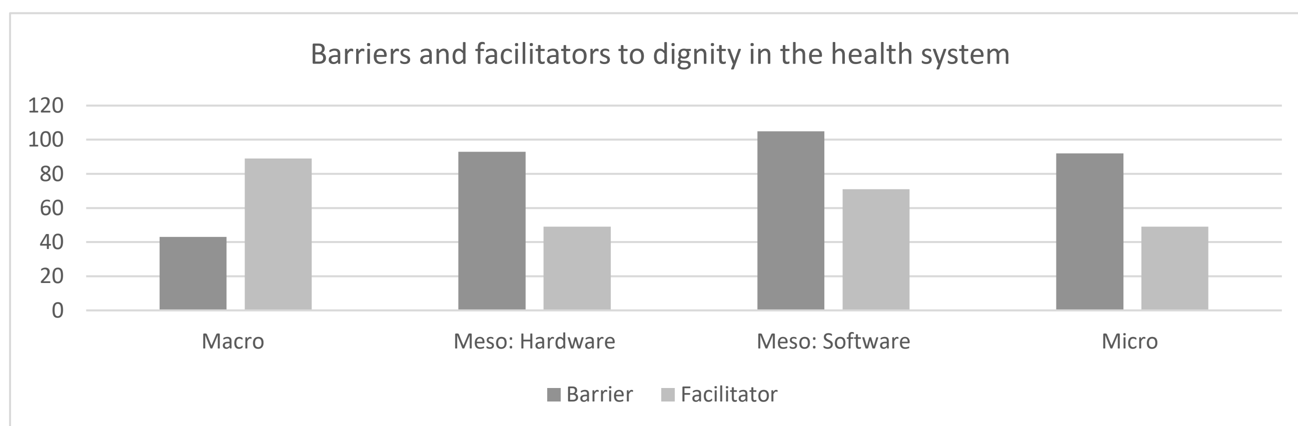
2020; Gwacham-Anisiobi and Banke-Thomas 2020; Ogbuabor and Nwankwor 2021) also identified financially inclined private health facilities as supportive to dignity in the health system due to increased fiscal motivation to ensure high quality of care and retention, greater supervision, adequate staffing and training, and equipment available (see more below). As reported by Adesanya et al. (2012):

> *"Private hospitals therefore put more effort into recruiting, training, and retaining good quality staff. Public hospitals, which are non-profit organizations, have less of an incentive to focus on patient retention and dignity" (p. 5).*

Meso-level

The meso-level of the health system was the most reported level of the health system, in which barriers and enablers were identified (Figure 2). Here barriers and enablers were further organized according to hardware (tangible aspects such as infrastructure, and equipment) and software factors (intangible aspects such as organizational culture, systems and policy[24]). At the meso-level, the interactions between levels become apparent, with organizational influences shaped by broader macro factors, and influencing micro-level interactions (more below).

Figure 2: Frequency of barriers and facilitators of dignity



Source: Author

Organizational hardware

Infrastructure: The majority of items (93/113) identified gaps to organizational hardware including the availability of space, equipment, supplies, and staff - as a clear and persistent structural barrier to dignity in SSA health systems. While the removal of user fees heightened infrastructural constraints, structural barriers to dignity were less commonly connected to national resource allocation decisions and instead portrayed because of facility-based deficiencies. Over one-third of the articles reported gaps to patient privacy, reporting overcrowding; and an issue that further compromised privacy was the multifunctioning and insufficiently sized nature of consultation rooms and wards (see table 4). At times a lack of beds resulted in multiple patients lying in the same bed or lying on the floor[25]. Facilities did not consistently have supplies, machines, or functioning equipment and some were without water and ablutions, which were said to compromise the dignity of both patients and HCWs. In contrast, the availability of pain management medication for palliative care patients

[24] Due to the nature of informal policy, for purposes of this systematic review policy was considered to be a software issue.

[25] The sharing of beds or laying on floors was reported in the following articles (Chigwenembe 2011; Sando et al. 2014; Sando et al. 2016; Afulani et al. 2017b; Bohren et al. 2017; Mukamurigo et al. 2017; Sudhinaraset et al. 2019; Umar et al. 2019; Lusambili et al. 2020b; Nara et al. 2020)

was described as a facilitator of dignity as such medication supported comfort and enabled a dignified death (Coenen et al. 2007; Grant et al. 2011).

Table 4: Infrastructural constraints

	Drapes, curtains, and privacy	**Crowding**	**Supplies and medication**	**Bed availability**	**Unclean**	**Water**
Frequency of structural deficiency reported	50/113	41/113	34/113	21/113	17/113	5/113

Source: Author

While the use of curtains, drapes, and room dividers was described to positively support dignity in health systems, availability and quality of these modifiable barriers was inconsistent (Table 5). Furthermore, even if drapes or curtains were available, other constraints, such as lack of staffing, resulted in these not being utilized, as reported by a HCW in Kenya:

> *"Because we are short in staffing…I would not want them to be under the curtain because if she is changing conditions there while I am busy doing other things, by the time I realize, things [patient health condition] are worse" (Ndwiga et al. 2017b, p 8).*

Table 5: Dignity and privacy

Country	**Utilization of drapes and privacy**
Tanzania	Cross sectional study among midwives (n= 439) on self-reported forms of disrespect and abuse found that not draping women was the most commonly reported form of disrespect and abuse (Shimoda et al.)
Malawi	Based on quantitative observation (n=2109) at 40 health facilities, insufficient audio and visual privacy was described in 58.2% of observations (Sethi et al. 2017).
Ethiopia, Kenya, Zanzibar, Rwanda, Madagascar, and Tanzania	Direct observations of respectful maternity care in Ethiopia (facilities = 19, n=108), Kenya, (n=417), Zanzibar (n=110), Rwanda (n 186), Madagascar (n=275), and Tanzania (n=298) found that 44.9%, 24.2%, 47.4%, 68.4%, 85.9%, 46.1%, and 48.5% of providers draped a client prior to delivery (Rosen et al. 2015).

Source: Author

Several studies from Ethiopia, Kenya, Nigeria, and Uganda and Malawi, identified primary health care (PHC) facilities and community-based organizations (CBOs) as facilitators of dignity in health systems[26], because relative to higher-level facilities, they often had manageable patient volumes, sufficient infrastructure, staffing, training, and stronger community integration. Despite this, several articles (Ukke et al. 2019; Asefa et al. 2020a; Galle et al. 2020) reported societal preference to seek care at high level facilities due to perceived increased quality; however, national budgets lacked reflection of this practice, and consequently, resources were further depleted (Chigwenembe 2011).

Staffing: As already mentioned several times, insufficient staffing and inadequate training was a clear and common barrier to dignity in the health system, with over half of the studies (71/113) mentioning this in some way. Understaffing threatens professional and patient dignity as it constrains HCWs ability to provide high quality, person-centred care, desired by patients, and envisioned in national health policy (see more below).

[26] (Bulto et al. 2020; Abate et al. 2021; Ukke et al. 2019; Tekle Bobo et al. 2019; Adinew et al. 2021; Sheferaw et al. 2017; Ogbuabor and Nwankwor, 2021; Grant et al. 2011; Afulani et al. 2019)

Understaffing also results in overtime, reduced supervision, high stress, and restriction of HCWs' time with patients. For example, it was reported that understaffing can result in clinical staff assuming support staff responsibilities (Asefa et al. 2020b), and clinical management assuming frontline roles (Chigwenembe 2011). Several reports briefly mentioned security personnel, cleaners, and birthing companions fulfilling clinical responsibilities (Mayers et al. 2010; Umar et al. 2019; Galle et al. 2020), and patients assuming support staff with cleaning linens and toilets (Chigwenembe 2011).

Training was also reported as an enabler and a barrier to dignity in the health system. Several articles identified HCWs who were trained and unable to adapt to new procedures due to perceived infeasibility (Fassin 2008; Asefa et al. 2020a). A smaller cluster showed that an absence of training further restricted the implementation of policy and institutional cultures promoting dignity - for example, as a result of lack of training on key ethical principles (i.e. Patient Rights) (Fassin 2008; Vivian et al. 2011; Asefa et al. 2020a; Birhanu et al. 2021), quality or person-centred care (Afulani et al. 2019b), technical competencies (i.e. alternative birthing positions or quality of care) (Sheferaw et al. 2017; Mselle et al. 2018; Abate et al. 2021), and HCW resiliency (i.e. coping strategies) (Afulani et al. 2019c).

Training that was reported to be as supportive (enabling) of dignity in health systems, was that which was comprehensive, recent, reoccurring, innovative, involved value identification, and contextually- and culturally relevant to populations served, as such training could result in improved institutional cohesion, non-discrimination[27], and even lead to the adoption of policy which reflected patient cultural practices[28] (Mengistu et al. 2021). Facilities that were trained to support the specific health needs of certain populations (often non-profit facilities) such as nomads in Mali (Ag Ahmed et al. 2019) and LGBTQI and sex worker communities (Ehlers et al. 2001; Kennedy et al. 2013; Scorgie et al. 2013; Duby et al. 2018), were also described as supportive to dignity because of tailored, non-discriminatory care and broader organizational culture. As noted by a patient in Zimbabwe, "It's generally safer for us to go to the sex workers' clinic than to the public clinic where you will get people judging you or laughing at you because you are a sex worker…" (Scorgie et al. 2013, p. 485).

Yet even if training was innovative or contextually based, it was usually reported as vertical interventions to horizontal health system problems (Ndwiga et al. 2017; Warren et al. 2017b; Dzomeku et al. 2021; Mengistu et al. 2021). For example, training was often short in duration, not reoccurring, and was not held facility-wide (rarely including clinical and support staff such as security guards or cleaners), and most critically, training was not reported to resolve broader macro-level barriers like widespread discrimination nor debilitating infrastructural and staffing constraints[29]. As summarized by Dzoemeku et al. (2021) following a four-day training on respectful maternal care,

> *"Despite the positive influence of the training… the policy and the built environment in the hospital does not support the exploration of alternative birthing positions. Also, the hospital lacked the required logistics to ensure privacy for multiple childbearing women in the open labour ward" (p. 1).*

Organizational software

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[27] (Ehlers et al. 2001; Grant et al. 2011; Fujita et al. 2012; Abuya et al. 2015a; Afulani et al. 2019a; Afulani et al. 2020b; Asefa et al. 2020a; Asefa et al. 2020b; Birhanu et al. 2021; Dzomeku et al. 2021)

[28] Following an innovative, culturally grounded training at an Ethiopian hospital, the facility decided to permit coffee rituals during childbirth.

[29] Research from yearlong and multi-year long respectful maternity care interventions, where increased training was a core output, identified the limitations of training as a singular intervention (Ndwiga et al. 2017; Warren et al. 2017a).

While hardware barriers to dignity in the health system were prominent, software-related barriers were even more so, mentioned in 106/ 113 of the included items – for example, reporting on barriers to facility culture, accountability mechanisms, policy, and professional dignity as barriers.

The most identified barrier at the meso-level was challenges associated with organizational structure and culture (99/113). Facility culture was frequently centred around one-way communication, lack of involvement of patients in care decisions, weak acknowledgement of individual patient circumstances, and poor attention to care preferences. Patients often reported not feeling welcomed, respected, or involved in care decisions. As described by a patient in Rwanda (Mukamurigo et al. 2017),

> *"I was feeling like a cow they were taking to slaughter, when people are looking at things without explaining to you…. When a person doesn't tell you that you have a certain problem, you wonder if you will die or live" (p. 8).*

While there was some discomfort with greater involvement among patients, often described as a result of low health literacy, empowerment, and uneven power (Mafuta et al. 2018; Sudhinaraset et al. 2019), the vast majority of patients wanted more involvement and stronger communication from the health system; they wanted to know why exams were performed, told the results of their exams, and they wanted greater to explanations to grow their health knowledge. Greater involvement, such as feeling welcomed into a facility (Grant et al. 2011; Liambila and Kuria 2014; Ughasoro et al. 2017), or simply a security guard offering directions to the admissions area (Chigwenembe 2011) were identified as facilitating software factors which supported dignity.

Further acting as a barrier to dignity was organizational culture tied to the normalization of verbal abuse which was at times a result of exclusive prioritization of health outcomes. Clinical prioritization was directly visible in monthly reports and emphasis on administrative tasks (Asefa et al. 2020b; Combrinck et al. 2020; Galle et al. 2020; Mbugua et al. 2021); but, largely reinforced through institutional culture and norms that viewed patient dignity as a secondly to clinical care (Fassin 2008; Oluoch-Aridi et al. 2018; Afulani et al. 2020a). Most of the included studies described HCW verbal abuse towards patients as a means to gain medical compliance, control workload, or prevent injury or death thus prioritizing health outcomes. Verbal abuse was usually legitimized during times of high stress and sickness, with several quantitative studies reporting increased abuse during times of sickness compared to routine check-ups (Larson et al. 2019), caesarean sections compared to vaginal deliveries (Wassihun and Zeleke 2018), and complicated births compared to uncomplicated births (Banks et al. 2017; Dynes et al. 2018). As described by a HCW, "If we are yelling at the mother, it's mostly for the interest of the baby. And the mother will even thank us for that afterwards" (Galle et al. 2020, p. 6). Some studies described such behaviours as being normalized in organizational culture (Fassin 2008; Andresen et al. 2009; Abuya et al. 2015b; Asefa and Bekele 2015; Abate et al. 2021). Some patients also seemed to expect abuse, and consequently omitted questions to HCWs to avoid reprimand, "I'm scared they will shout at us" (Andresen et al. 2009, p. 93). The intersection of broader constraints tied to resource availability, accountability, staffing, discrimination, and policy, further enabled organizational over prioritization of clinical outcomes and under prioritization of dignity, and normalization of verbal abuse (see more below).

Deviations from standards of care (SOC) including, consent procedures, privacy, confidentiality, communication, and discrimination, were reported by many (71/113) articles as a barrier to dignity at health facilities. Though articles infrequently specified that organizational culture was grounded in deviations from standards of care, the regularity and normalization of deviations, acceptance or even anticipation from HCW

and patients was illustrative of broader culture (Abuya et al. 2015b; Freedman et al. 2018; Mafuta et al. 2018; Galle et al. 2020). Like other barriers, failures in assuring care protocols, were the result of a multitude of factors relating to staffing, supervision, normalization, and broader contexts of weak patient rights awareness as noted by Mafuta (2018) in the Democratic Republic of Congo, "… women were unaware that they have the right to be treated with respect and dignity or to receive the defined medical standard of the interventions and services…" (p. 10). While many articles described poor adherence to standards of care, some particularly from the private and non-state sector, along with some PHC facilities described earlier, identified assurance of standards of care as facilitators of dignity in health systems which was often the result of adequate staffing, training, space, guidelines, time, and culture of non-discrimination (Scorgie et al. 2013; Atinga et al. 2016; Oluoch-Aridi et al. 2018). As described by a patient in Zimbabwe, "I had an STI last month and I went to a private clinic. They treated me well and even I had told them that I am gay and a sex worker, they were still friendly" (Scorgie et al. 2013, p. 459).

Also discussed at the organizational level were complaint systems as a form of accountability (in 20/113 studies). While these systems were supposed to act as a facilitator of dignity, like the national legal pathways discussed earlier, they were reported to be largely ineffective[30], and underutilized, due to patients' weak rights awareness, organizational hierarchy, power imbalances, fears of retaliation and retribution, or concerns over compromised access should a facility close due to lodged complaints (Vivian et al. 2011; Mafuta et al. 2018; Birhanu et al. 2021). Feedback systems usually referred to patients' ability to lodge complaints against a health facility. Interestingly, some HCWs reported an absence or ineffective functioning of systems to file claims against patients (Galle et al. 2020) and against colleagues (Vivian et al. 2011). As reported by a Medical Student in South Africa while filing a complaint, "We actually wrote down specific instances in the evaluation form. But no one ever got back to us, we don't know if anything was done about it" (Vivian et al. 2011, p. 4).

Despite the challenges associated with compliant systems, facility committees (McMahon et al. 2014) and birth companions[31] (15/113) were identified as organizational accountability mechanisms which acted in support of dignity. Birth companions were reported to support patients' emotional needs, which were often unmet due to broader organizational inadequacies, and the third party encouraged greater accountability in standards of care[32]. However, several articles (24/113) reported inconsistent inclusion of birth companions, usually due to structural inadequacies or lack of either organizational or national policy, and thus challenged the provision of dignified care in these health systems. As reported by a patient in Rwanda, "They should let us give birth in the presence of our husbands. This strengthens our security" (Mukamurigo et al. 2017, p. 8).

Of the included studies, 34/113 either directly or indirectly[33] identified gaps to professional dignity as a barrier to dignity in the health system[34]. Unfair pay, weak motivation, lack of institutional recognition, limited

[30] In one incident, a complaint system committee at a mental health hospital struggled to address complaints as at times files placed in the compliant box were undecipherable. Consequently, these ineffective complaints systems acted as a barrier to dignity in health systems as many concerns were unable to be addressed by the health facility (Raphalalani et al. 2021).

[31] Birth companions are in place to support the emotional health needs of a woman during childbirth. A companion is often a family member, partner, or other personal contacts of the delivering woman.

[32] In Ethiopia, for example, women without a birth companion were nearly ten times more likely to experience disrespect and abuse compared to patients without a companion (Tekle Bobo et al. 2019).

[33] As noted earlier, only three articles directly discussed professional dignity. However, the remaining 31 were illusive of professional dignity in discussions related to HCW recognition, motivation, and respect from the health system.

[34] As outlined earlier, only three articles had direct mentions of professional dignity. The remaining 31 articles had discussions of professional dignity; however, they were not classified as "professional dignity" instead often indirectly described as health system issues related to motivation, financial compensation, respect, and organizational culture.

professional development opportunities, weak supervision, poor workplace culture and cohesion, insufficient infrastructure, burnout, and though less discussed (Asefa et al. 2020a; Lusambili et al. 2020a) broader economic contexts restricting HCW mobility, HCW shortages, and infeasible health policy from the health system were identified barriers to professional dignity (Combrinck et al. 2020; Galle et al. 2020; Adinew et al. 2021; Lavender et al. 2021). Rigid professional hierarchy, restricting lower-level professionals' involvement in patient care decisions also acted as a barrier to professional dignity as some HCW felt that their clinical expertise was undervalued (Froneman et al. 2019; Combrinck et al. 2020; Galle et al. 2020; Adinew et al. 2021). In Tanzania, Daynes et al. (2018) found providers who perceived they had fair pay, had significantly higher respectful, maternal care scores compared to providers who did not feel their compensation was fair. The intersection of compensation, policy, and feelings of HCW villainization (described earlier) are portrayed by a HCW in Ethiopia,

> *"…I had a long night assisting women, but I am not paid fairly. Is it fair to accuse me of violating women's rights? … a lot must be done from top to bottom in responding to providers right before trying to maintain women's rights" (Asefa et al. 2020a, p. 468).*

As mentioned previously, while the private sector was portrayed as having advantages to dignity, several (Combrinck et al. 2020; Galle et al. 2020; Combrinck et al. 2021) described how the capitalist nature of the sector resulted in weakened professional dignity, due to increased pressure to meet targets seen as unreasonable. The dualistic and interrelated nature of barriers and facilitators to dignity are described in table 6 below.

Table 6: Examples of dualistic and interrelated nature of barriers and facilitators to dignity

Example	**Facilitator**	**Barrier**
User fee removal policies	Certain services at no cost to the user.	Only certain select services are covered. Heightened resource depletion with increased patient volume.
Political will	Shifts cultural norms and motivates health systems policy change.	Can strain professional dignity as some HCWs feel villainized.
Private facilities	Greater availability of resources and heightened motivation to ensure patient retention.	Strained professional dignity as a result of increased pressure to meet fiscal targets.
Increased education, rights awareness, and advocacy	Ability to advocate for high quality services and due to increased health literacy comply with care.	Threatens organizational hierarchy and challenges professional expertise.

Source: Author

While less reported (10/113)[35], facilitators of professional dignity were said to involve value-recognition from patients and facilities, fair pay, institutional cohesion, support and recognition, adequate staffing and infrastructure, the ability to fulfill professional duties, and heightened self-respect - as described by a HCW in Benin,

> *"I feel happy to see a happy woman and her family after she gives birth. Women and their families rely on and appreciate me. I feel like I am integrated into the family as a result of accomplishing my task" (Fujita et al. 2012 p. 484).*

[35] (Adesanya et al. 2012; Fujita et al. 2012; Warren et al. 2017a; Dynes et al. 2018; Combrinck et al. 2020; Galle et al. 2020; Mihret et al. 2020; Shimoda et al. 2020; Combrinck et al. 2021; Mbugua et al. 2021)

Both informal and formal organizational policy and systems were described as barriers to dignity in 54/113 included articles. Formal policy prohibiting companions, restricting patient movement, or ineffective processes related to admissions or procurement were several organizational policy related barriers. Often due to broader macro-level contexts relate to policy (i.e., user fees removal) and discrimination, insufficient infrastructure, gaps to accountability, facilities adapted informal policy[36] including restricted services, treatment, supplies, or hours of operations (Chigwenembe 2011; Afulani et al. 2017b), and informal levying of fees. Though several articles described bribery as an enabler to dignity because it supported higher quality care or facilitated access to basic services (McMahon et al. 2014; Gwacham-Anisiobi and Banke-Thomas 2020) more commonly there was frustration about unwritten and unethical practices (Scorgie et al. 2013; Bohren et al. 2017; Umar et al. 2019; Manu et al. 2021). While all patients were exposed to unwritten rules (Andresen et al. 2009; Larson et al. 2019), those most vulnerable (such as LGBTQI, sex workers, and adolescents) were at a heightened risk for exposure as facilities could feel a moral imperative to enact unwritten rules (Scorgie et al. 2013; Duby et al. 2018; Hazel et al. 2021; Sewpaul et al. 2021). As explained by a HCW in South Africa,

> *"… I don't think that this facility can provide homosexuals with lubricant … Because we do not encourage that kind of sexual intercourse … The aim is to prevent intolerable behaviour, that's our aim … trying to discourage all the inappropriate behaviours" (Duby et al. 2018, p. 4).*

Though less frequently reported, HCW resilience was identified as an enabler of dignity in the health system. As a result of broader ineffective policy, processes, and structural insufficiencies health facilities sought alternative solutions; some procured supplies from other health facilities or non-government organizations (Warren et al. 2015), sourced goods from locally based materials (Mengistu et al. 2021), covered patient beds to ensure longevity of infrastructure (Chigwenembe 2011), and raised money through crowd funding to relieve hardware constraints (Rucell 2017).

Micro-level

Most articles (92/113) reported barriers to dignity at the micro-level. As described earlier, patients largely viewed their dignity in relation to an interaction with a HCW and as such, these interpersonal barriers were frequently reported. Like other barriers and enablers to dignity, the micro-level was usually acknowledged to be shaped by broader circumstances in particular organizational culture, and deviations from standards of care.

Interactions between HCWs and patients that were reported as combative, verbally abusive, disrespectful, lacked privacy and confidentiality, did not adhere to standards of care, and were humiliating were frequently characterized as micro-level barriers to dignity. These micro-levels were reported across all groups and areas of research but were particularly well documented from research related to respectful maternity care as indicators used to measure quality of care are based on individual provider behaviour (Okafor et al. 2015; Banks et al. 2017; Afulani et al. 2019c). HCWs described as rude, disrespectful, unfriendly, cruel, and discriminatory were identified as micro-level barrier. As reported by a patient in Kenya, "When you have been addressed like that, you don't feel good within you. For some nurses, even if you greet her, she does not respond. She just looks at you coldly" (Ojwang, 2010, p. 109).

[36] The issue of informal policy was seen as an organizational barrier, not a micro-level barrier as a result of interaction between patients and HCWs, due to the commonality of these policies and broader constraints that enabled the creation and continuation of such practices.

While some of these characteristics, particularly discrimination, can be viewed as manifestations of broader social contexts and organizational constraints, over 20/113 articles recounted HCWs inhumane actions and communication that were weakly explainable based on broader contexts. For example, HCW's demands for lyrical performances as a form of entertainment from restrained mental health patients demonstrated weakly explainable behaviour based on broader contexts (Mayers et al. 2010) and is illustrative of a micro-level barrier rather than a meso-level constraint[37]. While our review did not explicitly seek to record the results of undignified care in health systems, numerous articles[38] identified undignified engagements and communications with HCWs as a deterrent for future access and a barrier to trust. As noted by a maternal health patient in South Africa, "I will rather die than go back there" (Malatji & Madiba, 2020, p. 9).

While many HCWs were described as disrespectful, 37/113 articles described HCWs, who are respectful, empathetic, supportive, friendly, trusting, informative, non-discriminative, and took time to build rapport with patients as micro-level facilitators to dignity in health systems as such characteristics often embodied patient's perception of quality care and dignity in the health system. As described by Ojwang (2010),

> *"…patients indicated a preference for nurses who gave elaborate explanations to their questions and addressed their worries. They also reported that they liked nurses who addressed them slowly repeated names at least twice, talked without spite, and had a friendly tone" (p. 110).*

Research from across all patient groups identified discrimination against patients based on identity as an integral barrier to dignity across all three levels of the health system. While discrimination was experienced against HCW based on professional qualifications or gender (Froneman et al. 2019; Oduenyi et al. 2021), the brunt of discrimination was reported against patients as a result of their socio-economic status (SES), national or cultural identity, age or marital status, illness or disability, and sexual and gender identity (see table 6).

Table 6: Patient identities associated with discrimination

	Discrimination	**Frequency**
Socio economic status (SES)	Poor, less educated, and rural-dwelling patients reported heightened experiences of discrimination often as a result of their perceived lower social standing and increased vulnerability. Less commonly was this discrimination against the poor connected to prevailing social beliefs (Adinew et al. 2021; Lonnie et al. 2021).	48/113
Tribe, ethnicity, nationality, refugee status	Patient tribe, nationality, refugee status, or membership in linguistic groups which were contrary to HCW, or support staff group membership reported increased experiences of discrimination because of differing cultural or national backgrounds. In one article (Warren et al. 2017b), tribal discrimination was tied to increased tensions following 2008 election violence in Kenya.	13/113
Age and marital status	As a result of moralistic views around sexual activity and pregnancy and, increased vulnerability due to young age and perceived weak access to support, patients described as younger and unmarried were at times more likely to be discriminated against compared to older and married individuals.	12/ 113
Illness or disability	Nine articles described experiences of either covert or overt discrimination on the ground of HIV status or disability. Organizational discrimination and system- wide discrimination such as lack of sign language interpreters was reported in one article and acted as a barrier to dignity in health systems (Haricharan et al. 2013). However, as a result of strong organizational culture, norms political will three articles reported non-	9/113

[37] As described by a mental health patient "I would come up with something that will please them (HCW) otherwise if I don't please them, I know he's going to increase that haloperidol …he would ask me …what can you sing for us? Even if you haven't got a song, you have to compose your song" (Mayers et al. 2010, p. 67).

[38] A sample of these articles include: (Ehlers et al. 2001; Vivian et al. 2011; Kennedy et al. 2013; Scorgie et al. 2013; Okafor et al. 2015; Warren et al. 2017b; Duby et al. 2018; Kane et al. 2018; Malatji and Madiba 2020; Raphalalani et al. 2021; Sewpaul et al. 2021)

	discrimination against HIV was reported (Chigwenembe 2011; Sando et al. 2014; Jolly et al. 2019).	
Sexual and gender orientation and identify	As a results of moralistic views, cultural norms and tradition, and legal frameworks, discrimination on basis of sexual and gender orientation and identity, was reported as barrier in eight articles. This discrimination could manifest into national policy or informal organizational procedures that were heteronormative. Social contexts with high rates of gender-based violence and patriarchal preference were also described as barriers as such contexts could legitimize discrimination against women.	8/113

Source Author

Overwhelmingly, the most reported form of discrimination was based on socio-economic status (SES). Many (48/113) articles described patients who are poor, less educated, and rural residents at increased risk for violations of dignity and discrimination in the health system[39]. As reported by a street connected youth (SCY)[40] in Kenya, "They treat us with contempt because we are dirty but if you are clean, you will be treated. They have their preferences" (Lonnie et al. 2021, p. 10). The poor[41] were commonly described by patients, HCWs, and researchers as being perceived as less deserving of quality care in health facilities, and due to resource limitations, their access to alternative facilities was severely restricted, and thus with limited alternatives to care subjected to dignity violations (Ganle et al. 2016b; Kyaddondo et al. 2017; Lonnie et al. 2021). As reported by a patient in Ethiopia,

> *"We are begging for our rights. When we say this tablet is expensive... they don't accept us. They may throw us away. Then, don't you think we have returned to our home with our illness? Look! It is difficult to argue with an educated person!"* (Birhanu et al. 2021, p. 13).

Low levels of education resulting in weak health literacy resulted in increased vulnerability to verbal abuse as means to ensure medical compliance as described earlier, however, high levels of empowerment could conversely be a barrier as it could be seen to threaten professional standing (Lavender et al. 2021; Sewpaul et al. 2021). While some organizational factors and policy described earlier were mentioned as indirect forms of discrimination from the broader system, more often discrimination against the poor would be described as a micro-level barrier and less viewed as a broader systems issue (Andinew et al. 2021; Birhanu et al. 2021; Lonnie et al. 2021). As described in Table 7 below (along with other barriers and facilitators to dignity in the health system), discrimination against disability, HIV status, alongside tribe, nationality, and refugee status were also reported barriers to dignity.

Table 7: Barriers and enablers to dignity in the health system

Overarching factor	**Categorization**	**Barrier**	**Facilitators**
Policy	Macro	Discriminatory national legislation criminalizing sexual and gender identities and sex workers	International human rights covenants, charters and national constitutions which support dignity

[39] Though less commonly described several articles reported that higher-income patients were more likely to report barriers to dignity and respectful care (Mihret, 2019; Sewpaul et al. 2021; Larson et al. 2019). This was attributed to quantitative methodological limitations, such as sample size, or high SES patients' greater rights awareness, and ability to identify increased incidences of discriminations and rights violations, or challenge HCW professional dignity, however, such findings were in the minority (Mihret, 2019; Sewpaul et al. 2021; Larson et al. 2019)

[40] Street connected youth (SCY) refers to an adolescent or young adult who is low income, often does not have a stable home, or is homeless (Lonnie et al. 2021).

[41] 'The poor' refers to individuals collectively described as low-income, less educated, and rural residents.

	Macro	Absent or uncomprehensive national legal frameworks to file medical malpractice suits and compromised access to lodge claims	National legal frameworks to file medical malpractice lawsuits
	Macro	Unclear, underdeveloped, inadequate, and normative national policy	National health policy on Patient Rights and technical guidelines operationalizing standards of care to promote dignity
	Macro	Heightened political will and national policy villainizing HCWs as perpetrates of abuse against patients	Political will resulting in increased prioritization of guidelines, increased investment, effective accountability mechanisms, and leading ideological shifts countering HIV discrimination
	All levels	Constraints to implementation of national policy due to the perceived or experienced infeasibility of proposed policy	Increased financing and financial motivation to ensure high quality care and implementation of policy
	Software	Ineffective, non-existent formal policy or processes at health facilities	
	Software	Creation of informal organizational policy restricting service, hours of operation, and levying of informal fees	
Discrimination	Macro	Prevailing social norms grounded in discrimination against certain populations	Social and cultural beliefs reinforcing respect for the elderly
	All levels	Discrimination on the basis patient identity including SES, national and cultural identity, age or marital status, sexual and gender identity, and illness or disability status	Equitable treatment regardless of identity
Resource availability	Macro	Border contexts of poverty and refugee setting limiting mobilization, access, and patient autonomy	
	Hardware	Organizational constraints such as inadequate space, equipment, supplies, beds, cleanliness, water, and electricity at health facilities	Adequate availability of resources and infrastructure including drapes at health facilities
	Hardware	Strained organizational resource availability as a result of widespread social preference of patients to seek care at higher level facilities	Private, NGO, PHC, and community-based organizations featuring sufficient resources and time with patients
Organizational culture	Software	Organizational culture of weak patient involvement, poor communication between HCW and patients, and over prioritization of clinical care	Organizational culture encouraging the involvement of patients and institutional cohesion welcoming patients into facilities
	Software	Organizational culture normalizing verbal abuse, rights violations, and deviations from standards of care	
	Micro	Interactions between HCW and patients that were combative, verbally abusive, disrespectful, and lacked adherence to standards of care	Interactions between HCW and patients that were respectful, friendly, and supportive to patients needs
Staffing and professional dignity	Hardware	Inadequate staffing at health facilities	Adequate staffing levels
	Hardware	Gaps to ethical and clinical technical training and vertical training, without broader health system involvement	Training that was recent, reoccurring, innovative, involved value identification, and was contextually and culturally relevant to patient populations served
	Software	Lack of institutional support, recognition, HCW motivation, and organizational hierarchy resulting in strained professional dignity	Adequate HCW compensation, value recognition from organization and patients, and ability to perform professional responsibilities resulting in strengthened professional dignity
	Macro	Health worker strikes, understaffing, ineffective HCW pay systems, and health system devaluation	
Accountability	Hardware	Routine organizational deviations from standards of care creating organizational normalization of abuse	Assurance of standards of care at facilities often in the NGO and private sector
	Hardware	Ineffective or compromised access, as a result of hierarchy and power, to organizational-based complaint systems	Community involvement in the form of facility committees and birth companions offering patient emotional support and encouraging HCW behaviour regulation
	Micro	Unjustifiable violations to patient dignity	

Source: Author

Discussion

The studies included in this review substantiate the observation that dignity is not clearly understood as a health systems issue. While we categorized issues and items into barriers and enablers (and other categories), this categorization might mask the complexity of the issue that is dignity within health systems. Clearly, there is a need to look beyond individual encounters between patients and HCWs and instead consider factors such as the prevailing social and health systems contexts which shape organizational hardware and software and influence these interpersonal engagements between HCWs and patients. Policy, discrimination, resource availability, organizational culture, staffing and professional dignity, and accountability were re-occurring, and interconnecting factors described as enabling- and constraining of dignity in SSA health systems.

In 2000, when dignity made its appearance within the context of health system responsiveness ("the non-health enhancing, non-financial aspects of the health system" (p.5)), De Silva & Valentine (2000) reported that dignity in LMIC health systems was an understudied area of research lacking prioritization. While this review has shown an increase of research and publication on dignity in SSA health systems, especially in the last five years, this research is largely focused on maternal health, is mainly service-oriented – and the issues relating to dignity often need to be parsed out from other entangled interests in these study reports such as quality of care and responsiveness. This overwhelming (and constraining) focus on dignity at a service level has similarly been described in research mapping the health system responsiveness literature, which led authors to call for differentiation between 'health system responsiveness' and 'health service responsiveness' (Khan et al. 2021). This differentiation could similarly be advantageous for dignity as 'health systems dignity'' and 'health services dignity' but more theoretical work is needed. The heavy service-orientation of the included items in this review is somewhat ironic given that current policy**,** standards of care guidelines (GNP+ and UNAIDS 2011; WHO 2013; WHO 2018), and national legal frameworks (Ojwang et al. 2010; Ebert and Oduor 2012; Addis 2015) explicitly state that foundations of 'the system' are grounded in dignity. The WHO's quality of care strategic objectives for maternal, newborn, and child health state, "The vision is underpinned by the core values of quality, equity and dignity" (p. 10). While some of the maternal-health focused studies did include representation from Ministerial Officers and national stakeholders (Ndwiga et al. 2017; Warren et al. 2017a), greater representation from national stakeholders, the architects of the system responsible for vision, goals, and overall leadership (Curry et al. 2012), was lacking, and thus likely furthered the tendency towards service orientation and weakened attention to the broader architecture of the system. As such without broader representation of national leadership and a heavy focus on dignity at an organizational level, 'health service dignity' was furthered. The absence of tools or indicators to assess a 'more dignified health system' also limits a systems orientation for dignity, as prevailing measures of dignity are service-oriented and focused on care experience (Valentine et al. 2003; Bowser and Hill 2010; Rosen et al. 2015; Afulani et al. 2019c). Considering such limitations, this review shows that additional indicators and approaches to assessing dignity as part of health system performance should be developed and implemented to better understand strides towards a more dignified health system.

The scoping review part of this study indicated that dignity has been operationalized differently in HIC and LMIC settings (Walsh and Kowanko 2002; Griffin-Heslin 2005; Banks et al. 2017; Asmaningrum and Tsai 2018; Combrinck et al. 2020). The systematic phase confirmed this and showed that certain features of dignity in health services are found globally, for example relating to communication, respect, privacy, and personhood, or the lack thereof (Gallagher 2004; Scorgie et al. 2013; Pringle et al. 2015; Sendo et al. 2021). There are, however, also key differences – such as the way dignity is ascribed to crowding, resource constraints,

normalization of verbal abuse, and organizational cultures in different SSA health systems. Reports of bed-sharing or laying on the floor due to an absence of bed space are not likely in a HIC (Medina-Mirapeix et al. 2013) but have been described in relation to dignity in SSA as a result of strained infrastructure (Mukamurigo et al. 2017; Umar et al. 2019). Similarly, though barriers to patient involvement are also described in HIC health systems (O'Brien et al. 2013), in SSA barriers to involvement have been shaped by organizational culture normalizing verbal abuse as means to gain compliance and control workload (Andresen et al. 2009). Noting the differences between HIC and SSA conceptualizations is important in efforts towards generalizing ideas about how dignity functions within health systems – and how it might influence the functioning of health systems in different contexts. Furthermore, such evidence demonstrates the need for greater theoretical frameworks to better understand dignity in low resource settings.

Notably, numerous articles pointed to broader health policy and guidelines, national Constitutions, and international human-rights conventions which act in support of dignity in the health system (Haricharan et al. 2013; Mafuta et al. 2018; Raphalalani et al. 2021). However, despite these frameworks, implementation was clearly challenged and visible as records that identified supportive macro-level features almost unanimously also reported barriers to dignity at organizational and micro-levels (see data extraction sheet). Barriers to policy implementation are complex (Hawe 2015) and well documented broadly in health (Buse et al. 2005; Passchier 2017), within the space of human rights (Gostin 2001) and have been described in relation to several of the policies mentioned outside of this review in relation to user fee removal (Diarra and Ousseini 2015), respectful maternal care (Hulton et al. 2007), and Patients' Rights Charters (Erasmus et al. 2017). Dignity is consistently identified as a vehicle for reform (GNP+ and UNAIDS 2011; WHO 2013; WHO 2018; Dawson-Rose et al. 2020) and successful implementation of such policy requires adequate staffing and resource allocation, stronger communication, training, increased HCW involvement, stronger community involvement, and firmer grounding in social solidity (Walker and Gilson 2004; Buse et al. 2005; London et al. 2014), all of which were routinely lacking.

This review confirms earlier findings that macro-level research on dignity is insufficient. While policy was described as an important barrier and facilitator to dignity, there were numerous reports that national policy was weakly informed of prevailing cultural and religious contexts (Gray et al. 2018), lacked reflection of societal practices such as seeking care at high level facilities (Chigwenembe 2011), and was heteronormative (Kennedy et al. 2013). Further and critically missing from this review was attention to macro-level facilitators focused on supporting professional dignity. While national Patient Rights policy and human rights convention exist (Haricharan et al. 2013; Birhanu et al. 2021), these policies are centred on patients' dignity in the health system, not HCWs. Our findings urge for greater consideration as to how current legislation, national budgets, and trainings are designed to promote the dignity of HCWs and ultimately strengthen the health system.

These findings contribute to growing interest in professional dignity (Griffin-Heslin 2005; Stievano et al. 2019) and increased recognition that HCWs need to be supported and respected by the health system in order to provide dignified quality care to their patients (World Health Organization et al. 2016; Ndwiga et al. 2017; Hosseini et al. 2018). Professional dignity bears strong similarities to HCW motivation (a massive research field in comparison), which also reports that fair pay, professional development and training, infrastructure, resource availability, recognition and appreciation, support, and trusting workplace culture are central to improved motivation (Willis-Shattuck et al. 2008; Okello and Gilson 2015). However, unlike HCW motivation, professional dignity has a stronger intrinsic nature as it also encompasses how HCWs see themselves regarding their professional standing (Stievano et al. 2013; Sabatino et al. 2014). Nevertheless, professional dignity (and

motivation) was a persistent barrier to dignity in the health system and further efforts toward more dignified health systems must place equal importance on both the dignity of patients and HCWs.

While these findings encompass dignity as it relates to a broad range of populations from maternal health users (Wassihun and Zeleke 2018), street connected youth (Lonnie et al. 2021), sex workers (Scorgie et al. 2013), refugees (Pinehas et al. 2016), adolescents (Sewpaul et al. 2021), and HCWs (Froneman et al. 2019), palliative care patients and geriatric medicine is severely underrepresented as there were only two articles speaking directly to this field (Coenen et al. 2007; Grant et al. 2011). While geriatrics and palliative care is less commonly researched and often not a core aspect to many SSA health systems (Frost et al. 2015; Rhee et al. 2017), global research on dignity has consistently placed these members of the population as central to the discipline due to increased vulnerability with old age and end of life decisions (Lothian and Philp 2001; Chochinov et al. 2005). With continued strides toward Universal Health Coverage (UHC), attention to dignity for those most vulnerable including the elderly should be a priority (Ghebreyesus 2017; Gebremariam and Sadana 2019).

To fully understand dignity in any health system, additional health policy and systems research is needed. While this exploratory review was the first of its kind, a multisectoral evidence-mapping study on dignity in LMIC health systems would provide a more comprehensive understanding on how dignity has evolved and how it is researched, understood, and defined today. Current analysis indicates tensions of the entangled nature of dignity in relation to disrespect and human rights. Further research should seek to map out the different dimensions of dignity to mitigate tensions between opposing yet synergistic constituent elements of dignity. More theoretical work is also critically needed, relating to the conceptualization of dignity as a health systems issue, as well as consideration of how dignity interacts with concerns of health systems performance, functioning, and strengthening – and such theoretical development needs to be tested in context. Furthermore, as most of the theoretical work on dignity in health[42] has been grounded in findings from HICs and many are not recent (Chochinov 2002; Jacobson 2009b; Jacobson 2009a), it is important that LMIC-based scholarship is encouraged. As previously mentioned, the development of indicators and research tools to measure and assess 'health systems dignity' is needed and should be preceded by a thorough global review of the 'measures' used to assess dignity (including those outside of the health field).

Alongside evidence mapping, theoretical work, and tool development, field-based research, specifically phenomenological studies with patients, HCWs, and stakeholders to gain a greater contextual understanding of dignity in health systems is needed. While core conceptualization of both patient and professional dignity was noted, phenomenological studies offer greater depth necessary to understand a social concept (Norlyk and Harder 2010). and could offer greater insights to contextual and cultural dimensions of dignity which are not sufficiently recorded in these review's findings[43]. Furthermore, this research found that results-based financing acted as a facilitator of dignity but could also act as a barrier to professional dignity within the private sector (Combrinck et al. 2020; Galle et al. 2020; Combrinck et al. 2021). In the context of increased attention toward result based financing (James et al. 2020) implications of professional dignity alongside ongoing interests in relation to HCW motivation (Feldacker et al. 2017) should be considered.

[42] There has been numerous theoretical and philosophical research on dignity in the SSA theoretical reports from African philosophers in relation to dignity. However, these have not been specific to health.

[43] One particular dimension that could be valuable for future research would be attention toward HCW's moral injury. As HCWs could find their professional dignity is strained as a result of witnessing normalized abuse against patients and colleagues.

Community accountability mechanisms in the form of birth companions and health facilities committees reported enablers to dignity. As dignity is a health system issue, alternatives to birth companions for non-maternal health patients should be explored. Outside of this review, community-based health care workers (CHWs) have been described as facilitators of dignity (Mwai et al. 2013). But more investigation is needed to see if and how specifically facility based CHWs could act in support. While organizational hierarchy described in findings from this review and noted in the broader space of CHWs (Schneider et al. 2008; Pallas et al. 2013; Grant et al. 2017), could pose a threat to their involvement, a third-party representative primarily focused on the emotional needs of the patient while simultaneously encouraging standards of care could be advantageous for supporting dignity in the health system. Alongside greater attention to CHWs, increased consideration of traditional practitioners and dignity should be studied. There was limited discussion of traditional practitioners in the included studies and further exploration of these health workers' role in supporting dignity in the health system might prove valuable.

Limitations

There are several limitations associated with this review. Firstly, most of the enablers and barriers to dignity in the health system were derived from maternal health research with limited representation from the LGBTQI community and other marginalized populations. While this predominance was anticipated in the scoping review and should be expected considering that 81/113 were related to childbirth, other patients' *and professionals'* dignity are underrepresented in this review due to the lack of available evidence. The saturation of maternal health research can be explained by the consistent application of dignity as a quality of care indicator for maternal care (Bohren et al. 2014; Shakibazadeh et al 2018). To the best of our knowledge, besides health system responsiveness and maternal health, dignity as an indicator is not habitually applied in other research areas. Similarly, in only 3/113 results (Froneman et al. 2019; Combrinck et al. 2020; Combrinck et al. 2021) dignity was the primary and exclusive health system focus. While this was also anticipated and dignity, like other health systems issues, should be viewed as an interconnected issue, at times this lack of breadth and depth restricted the ability to consider existing theoretical frameworks, categorizations, and concept models. On a related note, the complexity and multifaceted nature of dignity means that some references could have been missed in our search results if the word dignity was not explicitly mentioned. Although the scoping review tested variations. Lastly, as most of these results were based on self-reports of dignity in the health system, the true volume and lived experiences of dignity violations among patients and HCWs could be underrepresented. In contexts of normalized abuse and power differentiation, some research participants might not view their injustice as a dignity violation or might be unable to report due to hierarchal constraints. Future research should therefore consider positionality and, when possible, utilize third-party observation in combination with self-reported data collection strategies

Conclusion

In conclusion, a health systems lens was applied to 'dignity', and was found to be a useful perspective for considering new ideas relating to the role dignity plays in SSA health systems. Several ideas are theoretically generalizable outside of the SSA context. For example, barriers and enablers to dignity are interconnected, intersecting, and transcend across all levels of the health system. Our findings confirm that dignity should be understood and researched as a 'systems-wide' issue, and that horizontal health systems interventions that take dignity into account, should be considered. This review acts as a reminder that the most vulnerable are particularly at risk for discrimination and violations to dignity, and that health systems that are moving towards Sustainable Development Goals, and Universal Health Coverage, need to take this more seriously into consideration. Dignity is widely desired, but poorly implemented within health systems. Should dignity

continue to be identified as a vehicle for health system reform, greater support from across the health system is needed.

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Appendix 1: Summary of search terms

Main term or filter	Variations
Dignity	"Dignity" OR "dignified" OR "non-dignified" OR "dignified care" OR " dignified- care" OR "dignity and respect" OR "respectful" OR "dignity promotion" OR "undignified" OR "dignity violation" OR "indignity"
Health system	Health system*" OR "health care system*" OR "healthcare system*" OR "public health system*" OR "private health system" OR "national health system*" OR "public health care" OR "private health care" OR "health service*" OR "health facility" OR "private health facility*" OR "hospital*" OR "clinic*" OR "health organization*" OR "health systems research" OR "health systems and policy research" OR "health system responsiveness" OR "health and human rights" OR "responsiveness" OR "accountability") OR ((Respect[MeSH Terms]) OR (Personhood[MeSH Terms]))
Sub-Saharan Africa	Algeria OR Angola Or Benin OR Botswana OR "Burkina Faso" OR Burundi OR Cameroon OR "Cabo Verde" OR "Central African Republic" OR Chad OR Congo OR "Republic of the Congo" OR "Côte d'Ivoire" OR "Ivory Coast" OR "Democratic Republic of the Congo" OR "Equatorial Guinea" OR Eritrea OR Eswatini OR Swaziland OR Ethiopia OR Gabon OR Gambia OR Ghana, Guinea OR "Guinea-Bissau" OR Kenya OR Lesotho OR Liberia OR Madagascar OR Malawi OR Mali OR Mauritania OR Mauritius OR Mozambique OR Namibia OR Niger OR Nigeria OR Rwanda OR "Sao Tome and Principe" OR Senegal OR Seychelles OR "Sierra Leone" OR "South Africa" OR "South Sudan" OR "Togo" OR Uganda OR "United Republic of Tanzania" OR "Africa" OR "sub-Saharan Africa" OR "East Africa" OR "Eastern African" OR "Southern Africa" OR "East and Southern African" OR "Eastern and Southern Africa" OR "West Africa" OR "Western Africa" OR "Central Africa
Filters[74]	English
	2000 – 2001

Source: Author

[74] A record of the total number of search results before filters were applied was noted in the thesis's database.

Appendix 2: Summary of full data extraction sheet

Title	Title	Country	Focus	Method	Service	Dignity of focus	Framing of dignity	Compound concept themes	Micro barrier	Hardware barrier	Software barrier	Macro barrier	Micro facilitator	Hardware facilitator	Software facilitator	Macro Facilitator
Abate et al. 2021	Compassionate and respectful care among outpatient clients at public health facilities in Northwest Ethiopia: A mixed-methods study	Ethiopia	Quality of care	Mixed methods	General health services	Patient	As an aspect of respectful compassionate care	Respect, involvement, trust, discrimination, friendliness	Patient factors - SES HCW factors	Staffing Infrastructure	Professional dignity Culture and structure			Infrastructure (PHC)		International policy Health policy - Guidelines
Abuya et al. 2015	The effect of a multi-component intervention on disrespect and abuse during childbirth in Kenya	Kenya	Maternal health	Mixed methods	Childbirth	Patient	As an aspect of respectful maternity care	Respect, discrimination, privacy, humanness	Patient factors - SES, unmarried HCW factors	Staffing Infrastructure	Accountability Culture and structure Professional dignity	Health policy - user fee National context - HCW shortage, devolution health system		Staffing	Structure and culture	International policy National context - political will
Abuya et al. 2015	Exploring the Prevalence of Disrespect and Abuse during Childbirth in Kenya	Kenya	Maternal health	Quantitative	Childbirth	Patient	As an aspect of disrespect and abuse	Privacy, confidentiality, respect, humiliation, discrimination	Patient factors - Age, marital status, SES HCW factors		Accountability Structure and culture Informal policy	National context - Social - GBV	Patient factors - Married, high SES		Accountability	National context - Political will Health policy - Companion, guidelines
Abuya et al. 2018	Measuring mistreatment of women throughout the birthing process: implications for quality-of-care assessments	Kenya	Maternal health	Quantitative	Childbirth	Patient	As an aspect of disrespect and abuse	Discrimination, communication, involvement, autonomy	Patient factors - Increased births HCW factors	Staffing Infrastructure	Culture and structure Accountability Professional dignity			Infrastructure	Accoutnablity	International policy
Adesanya et al. 2012	Exploring the responsiveness of public and private hospitals in Lagos, Nigeria	Nigeria	Responsiveness	Quantitative	General health services	Patient	As an aspect of health system responsiveness	Communication, respect, privacy, humanness, and friendliness		Infrastructure (Public) Staffing (Public)	Structure and culture (Public) Professional dignity (Public)			Staffing (Private) Infrastructure (Private)	Structure and culture (Private) Policy (Private) Professional dignity (Private)	International policy

Adinew et al. 2021	I Would Have Stayed Home if I Could Manage It Alone: A Case Study of Ethiopian Mother Abandoned by Care Providers During Facility-Based Childbirth	Ethiopia	Maternal health	Qualitative	Childbirth	Patient	As an aspect of respectful maternity care	Communication, friendliness, involvement, privacy	HCW factors Patient factors - noncompliance	Infrastructure Staffing	Structure and culture Accountability					International policy
Adinew et al. 2021	Disrespect and abuse during facility-based childbirth in central Ethiopia	Ethiopia	Maternal health	Quantitative	Childbirth	Patient	As an aspect of disrespect and abuse	Discrimination, consent, communication, and discrimination	HCW factors Patient factors - SES	Infrastructure Staffing	Culture and structure Accountability Professional dignity Informal policy	National context - Social, SES discrimination		Staffing (PHC) Infrastructure (PHC)		International policy National context - Political will
Afulani et al.2020	Providers' perceptions of disrespect and abuse during childbirth: a mixed-methods study in Kenya	Kenya	Maternal health	Mixed methods	Childbirth	Patient	As an aspect of disrespect and abuse	Communication, discrimination, friendliness, privacy	HCW factors Patient factors - SES	Infrastructure Staffing	Culture and structure Professional dignity Accountability	Health policy - user fee		Staffing	Accountability	International policy
Afulani et al. 2019	Person-centred maternity care in low-income and middle-income countries: analysis of data from Kenya, Ghana, and India	Kenya, Ghana, and India	Maternal health	Quantitative	Childbirth	Patient	As an aspect of person-centred maternity care	Respectfulness, friendliness, privacy, confidentiality, discrimination	Patient factors - SES, marital status (all) HCW factors (all)		Culture and structure (all) Accountability (all)		Patient factors - High SES, married (Kenya)	Staffing (Kenya private and PHC) Infrastructure (Kenya private and PHC)		International policy
Afulani et al. 2019	Can an integrated obstetric emergency simulation training improve respectful maternity care? Results from a pilot study in Ghana	Ghana	Maternal health	Quantitative	Childbirth	Patient	As an aspect of person-centred maternity care	Privacy, communication, cleanliness, crowdedness, humaneness, respect, friendliness, discrimination	HCW factors	Infrastructure Staffing	Accountability Culture and structure		Patient factors- higher SES, empowered	Staffing	Structure and culture	International policy
Afulani et al. 2019	Quality of antenatal care and associated factors in a rural county in Kenya: an assessment of service provision and experience dimensions	Kenya	Maternal health	Quantitative	Maternal health services:	Patient	As an experience of quality care	Privacy, communication, cleanliness, respect, discrimination	Patient factors - SES, tribe, age	Infrastructure Staffing	Culture and structure	Health policy - user fee	Patient factors - high SES, less complication			International policy Health policy - Guidelines
Afulani, Kirumbi, and Lyndon, 2017	What makes or mars the facility-based childbirth experience: thematic analysis of women's childbirth experiences in western Kenya	Kenya	Maternal health	Qualitative	Childbirth	Patient	As an aspect of quality care	Respect, friendliness, privacy, cleanliness, discrimination, communication, humiliation	HCW factors Patient factors - Tribe, SES, Age	Infrastructure Staffing	Policy Accountability Culture and structure	National context - political, strike, HCW shortage Health policy - user fee	HCW factors	Infrastructure	Structure and culture	International policy Health policy - Guidelines

Ag Ahmed, Hamelin-Brabant, and Gagnon, 2019	Nomads' perceptions of quality, accessibility, and affordability of health services as determinants of using skilled birth attendants in Gossi, Mali	Mali	Maternal health	Qualitative	Childbirth	Patient	As an aspect of quality care	Respect, non-discrimination, privacy, humanization (acknowledgment of different needs based on nomadic life)	Patient factors - SES, tribe HCW factors	Infrastructure	Culture and structure Accountability		HCW factors (NGO, TBA)	Staffing (NGO, TBA)	Structure and culture (TBA, NGO)	
Andresen et al. 2009	Delivery of the Nutrition Supplementation Programme in the Cape Town metropolitan area from the perspective of mothers of under-5s: a qualitative study	South Africa	Maternal and child health	Qualitative	Child health	Patient	As an aspect of quality care	Communication, involvement, time, respect, and humanization (acknowledgment of different needs)	HCW factors	Infrastructure Staffing	Accountability Culture and structure Policy	National context - brain drain, HCW staff Health policy - not comprehensive	HCW factors		Structure and culture	National context - Constitution Health policy - Guidelines
Asefa and Bekele, 2015	Status of respectful and non-abusive care during facility-based childbirth in a hospital and health centres in Addis Ababa, Ethiopia	Ethiopia	Maternal health	Quantitative	Childbirth	Patient	As an aspect of disrespect and abuse	Involvement, privacy, respect,	HCW factors	Infrastructure	Culture and structure	Health policy - No companion		Infrastructure (PHC)		
Asefa et al. 2020	Imagining maternity care as a complex adaptive system: understanding health system constraints to the promotion of respectful maternity care	Ethiopia	Maternal health	Qualitative	Childbirth	Patient	Asan aspect of respectful maternity care	Respect, privacy, confidentiality, equality, informed consent, autonomy		Infrastructure Staffing	Professional dignity Culture and structure Accountability Policy	Health policy - user fee National context - delayed payment, political will		Staffing	Informal policy Policy	International policy
Asefa et al. 2020	Lessons learned through respectful maternity care training and its implementation in Ethiopia: an interventional mixed methods study	Ethiopia	Maternal health	Mixed methods	Childbirth	Patient	As an aspect of quality of care	Communication, involvement, privacy, consent, discrimination	Patient factors - SES, age, marriage, ethnicity HCW factors	Infrastructure Staffing	Culture and structure Professional dignity Accountability Policy			Staffing	Structure and culture	International policy Health policy
Asefa et al. 2018	Service providers' experiences of disrespectful and abusive behaviour towards women during facility-based childbirth in Addis Ababa, Ethiopia	Ethiopia	Maternal health	Quantitative	Childbirth	Patient	As an aspect of disrespect and abuse	Involvement, privacy, communication, confidentiality	Chew factors	Staffing	Culture and structure Professional dignity Informal policy					Health policy
Asefa et al. 2020	Mitigating the mistreatment of childbearing women: Evaluation of respectful maternity care intervention in Ethiopian hospitals	Ethiopia	Maternal health	Quantitative	Childbirth	Patient	As an aspect of disrespect and abuse	Involvement, discrimination, friendliness	HCW factors	Staffing	Culture and structure Accountability		Patient factors	Staffing		International policy Health policy

Asrese 2020	Quality of intrapartum care at health centres in Jabi Tehinan district, Northwest Ethiopia: clients' perspective	Ethiopia	Maternal health	Mixed methods	Childbirth		As an aspect of quality of care	Privacy, communication, cleanliness, crowdedness, humaneness (or cognition)	HCW Factors Patient factors - SES	Infrastructure	Culture and structure Accountability Policy		Patient factors - high SES HCW factors		Structure and culture Accountability	International policy Health policy - guidelines
Atinga et al. 2016	Some patients are more equal than others': Patient-centred care differential in two-tier inpatient ward hospitals in Ghana	Ghana	Quality of care	Quantitative	General health services	Patient	As one dimensions of patient centred care	Discrimination, involvement, communication, friendliness	HCW factors Patient factors - SES		Structure and culture		HCW factors (private) Patient factors - High SES, older age (private)		Structure and culture (private)	National context - Social, respect elderly
Atukunda et al. 2020	When Women Deliver at Home Without a Skilled Birth Attendant: A Qualitative Study on the Role of Health Care Systems in the Increasing Home Births Among Rural Women in Southwestern Uganda	Uganda	Maternal health	Qualitative	Childbirth	Patient	As an aspect of quality of care	Embarrassment, privacy, humaneness, communication, friendliness’	HCW factors	Infrastructure Staffing	Culture and structure Accountability Informal policy	Health policy - user fee	HCW factors (TBA)		Structure and culture (TBA)	
Banks et al. 2017	Jeopardizing quality at the frontline of healthcare: prevalence and risk factors for disrespect and abuse during facility-based childbirth in Ethiopia	Ethiopia	Maternal health	Quantitative	Childbirth	Patient	As an aspect of disrespect and abuse	Confidentiality, privacy, detention, non-consented care	HCW factors	Infrastructure	Accountability Culture and structure	Health policy - user fee				International policy Health policy - PHC
Baum et al. 2021	Abortion quality of care from the client perspective: a qualitative study in India and Kenya	Kenya	Quality of care	Qualitative	Abortion	Patient	As an aspect of quality of care	Involvement, communication	HCW factors		Structure and culture (Kenya)	National context - Social, abortion (Kenya)	HCW factors (Kenya)		Structure and culture (Kenya)	International policy
Birhanu et al. 2021	Patients' healthcare, education, engagement, and empowerment rights' framework: Patients', caretakers' and health care workers' perspectives from Oromia, Ethiopia	Ethiopia	Health and human rights	Qualitative	General health services	Patient	As a right	Human- centred, friendliness, communication, respect,	HCW factors Patient factors - SES, ethnic group	Infrastructure Staffing	Policy Informal policy Culture and structure Accountability	National context - National accountability	HCW Factors	Staffing	Structure and culture Policy	International policy National context - Constitution Health policy - Patient rights
Bohren et al. 2017	Defining quality of care during childbirth from the perspectives of Nigerian and Ugandan women: A qualitative study	Nigeria and Uganda	Maternal health	Qualitative	Childbirth	Patient	As an aspect of quality care:	Communication, involvement, privacy, consent, humanness, discrimination	HCW factors (all) Patient factors - SES, marriage (Uganda)	Infrastructure (all) Staffing (all)	Informal policy (Uganda) Policy (all) Accountability (all) Structure		HCW factors (all)	Staffing (all) Infrastructure (all)	Structure and culture (all) Accoutnablity (all)	International policy

											and culture (all)					
Bulto et al. 2020	Respectful maternity care during labour and childbirth and associated factors among women who gave birth at health institutions in the West Shewa zone, Oromia region, Central Ethiopia	Ethiopia	Maternal health	Quantitative	Childbirth	Patient	As an aspect of disrespect and abuse	Consent, privacy, involvement	HCW factors	Staffing Infrastructure	Accountability Culture and structure		Patient factors - Increased health knowledge	Staffing (PHC) Infrastructure (PHC)		International context Health policy - guidelines
Busser et al. 2020	Cultural beliefs and health-seeking practices: Rural Zambians' views on maternal-newborn care	Zambia	Maternal health	Qualitative	Maternal health	Patient	As an aspect of quality of care	Privacy, discrimination		Infrastructure		National context - Social Health policy - Mandating HIV test				
Chigwenembe, 2011	Dignity in maternal health service delivery: Cross sectional survey on factors that promote or compromise dignity in maternal health service delivery: Perspectives of Women and Midwives from Southern Malawi	Malawi	Maternal health	Mixed methods	Childbirth	Patient	As an aspect of quality mineral care	Privacy, shame, cleanliness, communication, involvement, friendliness, respect	HCW factors Patient factors - SES	Infrastructure Staffing	Policy Accountability Structure and culture Professional dignity	Health policy - Not adequate	HCW factors		Informal policy - Resiliency Structure and culture Accountability	International policy
Coenen, Doorenbos, and Wilson, 2007	Nursing interventions to promote dignified dying in four countries	Ethiopia, Kenya, India, and USA	Palliative care	Mixed methods	Palliative care	Patient	Based on International Classification for Nursing Practice Dignified Dying Survey	Individualized care, comfort, respect, friendliness, communication, and involvement.					HCW factors (Kenya, Ethiopia)	Staffing (Kenya, Ethiopia) Infrastructure (Kenya, Ethiopia)	Structure and culture (Kenya, Ethiopia)	
Combrinck, van Wyk, and Mogale, 2020	Nurses' professional dignity in private health care: a descriptive phenomenological study	South Africa	Professional dignity	Qualitative	Professional dignity	Professional	In relation to professional dignity	Communication, respect, involvement, care environment, humanness, trust, recognition, pride		Staffing	Structure and culture Professional dignity				Structure and culture Professional dignity	
Combrinck, Van Wyk, and Mogale, 2020	Preserving nurses' professional dignity: Six evidence-based strategies	South Africa	Professional dignity	Qualitative	Professional dignity	Professional	In relation to professional dignity	Respect, autonomy, trust, personness, motivation, pride		Infrastructure	Structure and culture Professional dignity Accountability			Staffing (training) Infrastructure	Policy Structure and culture Professional dignity Accountability	

Dagnaw et al. 2020	Determinants of person-centred maternity care at the selected health facilities of Dessie town, North-eastern, Ethiopia: community-based cross-sectional study	Ethiopia	Maternal health	Quantitative	Childbirth	Patient	As an aspect of person-centred maternity care	Communication, autonomy, respect, privacy	Patient factors - SES HCW factors	Infrastructure Staffing	Structure and culture Accountability		Patient factors - High SES	Infrastructure (private)	Structure and culture	International policy
Duby et al. 2018	'Scared of going to the clinic': Contextualizing healthcare access for men who have sex with men, female sex workers and people who use drugs in two South African cities	South Africa	Vulnerable populations: LGBTQI, sex workers	Qualitative	General health services	Patient	As an aspect of quality of care	Shame, discrimination, humiliation, communication, confidentiality	HCW factors Patient Factors - LGBTQI	Staffing	Structure and culture Policy Informal policy Accountability	National context - Criminalization sex workers, Social - sex workers and LGBT	HCW factors	Staffing (CBO, private)	Accountability (private)	National context - Constitution
Dynes et al. 2018	Patient and provider determinants for receipt of three dimensions of respectful maternity care in Kigoma Region, Tanzania-April-July, 2016	Tanzania	Maternal health	Quantitative	Childbirth	Patient	As an aspect of respectful maternity care	Consent, privacy, involvement, friendliness, humaneness, discrimination,	Patient factors - Age HCW factors	Staffing	Professional dignity Structure and culture		HCW factors Patient factors - Older		Structure and culture Professional dignity Accountability Policy	International policy
Dzomeku et al. 2021	Midwives' experiences of implementing respectful maternity care knowledge in daily maternity care practices after participating in a four-day RMC training	Ghana	Maternal health	Qualitative	Childbirth	Patient	As an aspect of respectful maternal care	Communication, involvement, privacy, respect, friendliness		Infrastructure Staffing	Structure and culture Policy		HCW factors	Staffing		International policy
Ehlers et al. 2001	The well-being of gays, lesbians, and bisexuals in Botswana	Botswana	Vulnerable populations: LGBTQI	Quantitative	General health services	Patient	As an aspect of quality care in	Discrimination, confidentiality, trust	HCW factors Patient factors - LGBTQI	Infrastructure (Public) Staffing (Public)	Structure and culture (Public)	National context - Social LGBT Health policy - Heteronormative		Staffing (NGO) Infrastructure (NGO)		
Fassin, 2008	The elementary forms of care: An empirical approach to ethics in a South African Hospital	South Africa	Ethics and nursing	Qualitative	General health services	Patient	In describing medical ethics and understanding elementary forms of care	Involvement, communication, trust, humanness, recognition	HCW factors Patient factors - SES	Infrastructure Staffing	Structure and culture Policy Professional dignity		HCW Factors	Infrastructure		National context Health policy - Patient rights

Freedman et al. 2018	Eye of the beholder? Observation versus self-report in the measurement of disrespect and abuse during facility-based childbirth	Tanzania	Maternal health	Mixed methods	Childbirth	Patient	As an aspect of disrespect and abuse	Confidentiality, privacy, detention, non-consented care	HCW factors	Infrastructure	Structure and culture Informal policy Accoutnablity					International policy
Froneman et al. 2019	Enhancing the professional dignity of midwives: A phenomenological study	South Africa	Professional dignity	Qualitative	Professional dignity:	Professional	In relation to professional dignity	Value, recognition, autonomy, communication, respect		Staffing Infrastructure	Professional dignity Structure and culture	Health policy - Contradiction				
Fujita et al. 2012	Humanized care and a change in practice in a hospital in Benin	Benin	Maternal health	Qualitative	Childbirth	Patient	As an aspect of humanized care	Humanness, privacy, involvement, confidentiality		Staffing	Culture and structure			Staffing	Structure and culture Professional dignity Policy	International policy
Galle et al. 2020	A qualitative study on midwives' identity and perspectives on the occurrence of disrespect and abuse in Maputo city	Mozambique	Maternal health	Qualitative	Childbirth	Patient	As disrespect and abuse	Pride, respect, recognition, autonomy, communication	HCW factors Patient factors - SES	Staffing Infrastructure	Professional dignity Accountability				Structure and culture Professional dignity Accountability	
Ganle et al. 2016	Addressing health system barriers to access to and use of skilled delivery services: perspectives from Ghana	Ghana	Maternal health	Qualitative	Childbirth	Patient	As an aspect of quality of care	Respect, autonomy, choice, involvement, communication,	HCW factors	Staffing Infrastructure	Professional dignity Structure and culture Policy	Health policy - user fee	HCW factors		Structure and culture	International policy Health policy - guidelines
Gebremichael et al. 2018	Women suffer more from disrespectful and abusive care than from the labour pain itself: a qualitative study from Women's perspective	Ethiopia	Maternal health	Qualitative	Childbirth	Patient	As an aspect of disrespect and abuse	Autonomy, respect, communication, support, privacy	HCW factors	Infrastructure Staffing	Accountability Structure and culture Informal policy		HCW factors			International policy
Grant et al. 2011	Palliative care making a difference in rural Uganda, Kenya, and Malawi: three rapid evaluation field studies	Uganda & Kenya & Malawi	Palliative care	Qualitative	Palliative care	Patient	As an experience of quality palliative care	Respect, hopeless, not worthy of life					HCW factors (CBO/ NGO all)	Staffing (CBO/ NGO all) Infrastructure (CBO/ NGO all)	Structure and culture (CBO/ NGO, all)	International context

Gray et al. 2018	'When Ebola enters a home, a family, a community': A qualitative study of population perspectives on Ebola control measures in rural and urban areas of Sierra Leone	Sierra Leon	Ebola	Qualitative	Policy related, death	Patient	As a "quality of human interaction"	Respect, friendliness, compassion, humility, cultural respect, involvement			Structure and culture	Health policy - underdeveloped			Structure and culture	Health policy - developed and cultural relevant
Gwacham-Anisiobi and Banke-Thomas, 2020	There is no ideal place, but it is best to deliver in a hospital: expectations and experiences of health facility-based childbirth in Imo State, Nigeria	Nigeria	Maternal health	Qualitative	Childbirth	Patient	As an aspect of quality of care	Friendliness, respect, communication, privacy, support		Infrastructure (public) Staffing (public)	Accountability (public) Structure and culture (public)	National context - HCW strike	Patient factors - compliant		Structure and culture (private) Accountability (private) Policy (public) Informal policy (public)	International policy
Haricharan et al. 2013	Can we talk about the right to healthcare without language? A critique of key international human rights law, drawing on the experiences of a Deaf woman in Cape Town, South Africa	South Africa	Vulnerable populations: Deaf	Qualitative	General health services	Patient	As a right and as an experience of quality of care	Communication, respect, discrimination,		Staffing	Structure and culture	International policy - loop holes		Staffing	Structure and culture	National context - Constitution
Hazel et al. 2021	Disrespectful care in family planning services among youth and adult simulated clients in public sector facilities in Malawi	Malawi	Quality of care	Quantitative	Sexual reproductive	Patient	As an aspect disrespectful SRHR care	Discrimination, communication, respect, privacy, humiliation	HCW factors Patient factors - Gender, age	Infrastructure	Structure and culture Accountability Informal policy	National context -				International policy
Ijadunola et al. 2019	Lifting the veil on disrespect and abuse in facility-based childbirth care: findings from Southwest Nigeria	Nigeria	Maternal health	Quantitative	Childbirth	Patient	As aspect of disrespect and abuse	Communication, respect, discrimination	HCW factors Patient factors - SES, marital status, HIV		Structure and culture Accoutnablity					International policy National context - medical malpractice
Jolly et al. 2019	We are the ones who should make the decision - knowledge and understanding of the rights-based approach to maternity care among women and healthcare providers	Malawi	Maternal health	Qualitative	Childbirth	Patient	As an aspect of respectful maternal care	Respect, communication, involvement, privacy, confidentiality, kindness	HCW factors	Infrastructure Staffing			HCW factors		Structure and culture Accountability	International policy

Kane et al. 2018	Too afraid to go: fears of dignity violations as reasons for non-use of maternal health services in South Sudan	South Sudan	Maternal health	Qualitative	Childbirth	Patient	As an aspect of quality of care	Embarrassment, shame, belittled, pride, discrimination	HCW factors Patient factors - SES	Infrastructure Staffing	Accountability Policy Structure and culture	National context - social marriage, HCW shortage, accountability Health policy - user fee			Structure and culture (TBA) Policy (TBA)	International policy Health policy - guidelines
Kapologwe et al. 2020	Assessing health system responsiveness in primary health care facilities in Tanzania	Tanzania	Responsiveness	Quantitative	General health services	Patient	As an aspect of responsiveness	Communication, confidentiality, and privacy		Infrastructure (Dispensaries)				Infrastructure (PHC)		Health policy - guidelines, PHC, RBF
Kennedy et al. 2013	They are human beings, they are Swazi: intersecting stigmas and the positive health, dignity and prevention needs of HIV-positive men who have sex with men in Swaziland	Eswatini	Vulnerable populations: LGBTQI (MSM)	Qualitative	General health services	Patient	As an aspect of quality of care	Shame, discrimination, humiliation, communication, confidentiality, humanness	Patient factors - MSM HCW factors	Infrastructure Staffing	Structure and culture Policy Accountability	National context - social, law LGBTQI Health policy - heteronormative	HCW factors (NGO)	Staffing (NGO)		International policy
Kigenyi et al. 2013	Quality of intrapartum care at Mulago national referral hospital, Uganda: clients' perspective	Uganda	Maternal health	Quantitative	Childbirth	Patient	As an aspect of quality care	Involvement, communication, respect, privacy, confidentiality	Patient factors - SES HCW factors	Infrastructure Staffing	Professional dignity Culture and structure Accountability		Patient - Rural			International policy Health policy - guideline, imitative
Kruk et al. 2014	Disrespectful and abusive treatment during facility delivery in Tanzania: a facility and community survey	Tanzania	Maternal health	Quantitative	Childbirth	Patient	As an aspect of disrespect and abuse	Privacy, respect, neglect, bribe	Patient factor - SES HCW factors	Infrastructure	Structure and culture Accountability Informal policy				Accountability	International policy
Kujawski et al. 2017	Community and health system intervention to reduce disrespect and abuse during childbirth in Tanga Region, Tanzania: A comparative before-and-after study	Tanzania	Maternal health	Quantitative	Childbirth	Patient	As an aspect of disrespect and abuse	Communication, discrimination						Staffing Infrastructure	Policy Structure and culture	International policy

Kyaddondo et al. 2017	Expectations and needs of Ugandan women for improved quality of childbirth care in health facilities: A qualitative study	Uganda	Maternal health	Qualitative	Childbirth	Patient	As an aspect of quality of care and as an expectation or need during childbirth.	Friendly, respect, communication, involvement, humiliation, humanness	HCW factors	Infrastructure	Structure and culture Accountability Policy		HCW factors	Infrastructure (private)	Structure and culture	International policy Health policy - UHC
Larson et al. 2019	Disrespectful treatment in primary care in rural Tanzania: beyond any single health issue	Tanzania	Quality of care	Quantitative	General health services	Patient	As an aspect of quality of care	Respect, discrimination, communication, involvement	HCW factors		Structure and culture				Accoutnablity	
Lavender et al. 2021	Respectful care an added extra: a grounded theory study exploring intrapartum experiences in Zambia and Tanzania	Tanzania and Zambia	Maternal health	Qualitative	Childbirth	Patient	As an aspect of respectful maternity care	Discrimination, communication, respect, privacy	Patient factors - SES, tribe HCW factors	Infrastructure Staffing	Structure and culture Accountability Informal and formal policy Professional dignity				Accountability (Tanzania)	International context (all) National context - Political will (Tanzania) Health policy - Guidelines (all), HCW accountability (Tanzania)
Liambila and Kuria, 2014	Birth attendance and magnitude of obstetric complications in Western Kenya: a retrospective case-control study	Kenya	Maternal health	Quantitative	Childbirth	Patient	As an aspect of disrespect and abuse	Communication	HCW factors	Infrastructure	Structure and culture Accountability		HCW factors (TBA)		Culture and structure (TBA)	International policy Health policy - guidelines
Lonnie et al. 2021	Exploring patient-provider interactions and the health system's responsiveness to street-connected children and youth in Kenya: a qualitative study	Kenya	Responsiveness	Qualitative	General health services	Patient	As an aspect of responsiveness	Respect, discrimination, communication	Patient factor - SES HCW factors		Structure and culture Policy	Health policy - user fee, weak implementation of UHC National context - social SES	Patient factors - Empowerment HCW factors			National policy - Constitution, right to health
Lusambili et al. 2020	Deliver on Your Own: Disrespectful Maternity Care in rural Kenya	Kenya	Maternal health	Qualitative	Childbirth	Patient	As an aspect of disrespect and abuse	Respect, humiliation, humanness, communication, involvement, and discrimination.	HCW factors Patient factors - Disability, SES	Infrastructure	Professional dignity Structure and culture Accountability	National context - pregnancy, marriage, age Health policy	HCW factors			International policy Health policy - guidelines

Lusambili et al. 2020	Health Care Workers' Perspectives of the Influences of Disrespectful Maternity Care in Rural Kenya	Kenya	Maternal health	Qualitative	Childbirth	Patient	As an aspect of respectful maternity care	Privacy, discrimination, involvement, respect	Patient factors - Age, disability, religion, SES	Infrastructure Staffing	Structure and culture Policy Accountability	National context - HCW shortage				International policy
Mafuta et al. 2018	Factors influencing the capacity of women to voice their concerns about maternal health services in the Muanda and Bolenge Health Zones, Democratic Republic of the Congo: a multi-method study	Democratic Republic of Congo	Maternal health	Mixed methods	Maternal health	Patient	As a human right	Respect, discrimination, involvement	Patient factors - SES HCW factors		Accountability Structure and culture Informal policy					International policy National context - Constitution Health policy - Patient rights
Malatji and Madiba, 2020	Disrespect and Abuse Experienced by Women during Childbirth in Midwife-Led Obstetric Units in Tshwane District, South Africa: A Qualitative Study	South Africa	Maternal health	Qualitative	Childbirth	Patient	As an aspect of disrespect and abuse	Consent, discrimination, respect, humaneness, involvement	Patient factors - SES HCW factors	Infrastructure	Policy Informal policy Structure and culture Accountability				Accountability	International policy National context - Constitution Health policy - guidelines, initiative
Manu et al. 2021	Respectful maternity care delivered within health facilities in Bangladesh, Ghana, and Tanzania: a cross-sectional assessment preceding a quality improvement intervention	Ghana & Tanzania	Maternal health	Quantitative	Childbirth	Patient	As an aspect of respectful maternity care	Autonomy, respect, communication, support, privacy	HCW factors (Ghana, Tanzania)	Staffing (Ghana, Tanzania) Infrastructure (Ghana, Tanzania)	Policy (Ghana, Tanzania) Informal policy (Ghana, Tanzania) Accountability (Ghana, Tanzania)				Accountability (all)	International policy (all) National policy - Complaint framework (Ghana)
Mayers et al. 2010	Mental health service users' perceptions and experiences of sedation, seclusion, and restraint	South Africa	Vulnerable populations: Mental health	Mixed methods	Mental health services	Patient	As an aspect of quality of care and rights violation	Humiliation, discrimination, respect	Patient factors - Illness HCW factors	Staffing	Structure and culture Accountability					National context Health policy - Mental health policy
Mbugua et al. 2021	Family and provider perceptions of quality of care in the management of sick young infants in primary healthcare settings in four counties of Kenya	Kenya	Maternal and child health	Qualitative	Childcare	Patient	As an aspect of quality of care	Respect, communication, involvement, discrimination	HCW factors (country not specified)	Staffing Infrastructure	Culture and structure Professional dignity Policy				Structure and culture Professional dignity	International policy National context - political will Health policy - guidelines

McMahon et al. 2014	Experiences of and responses to disrespectful maternity care and abuse during childbirth; a qualitative study with women and men in Morogoro Region, Tanzania	Tanzania	Maternal health	Qualitative	Childbirth	Patient	As an aspect disrespect and abuse	Respect, communication, involvement, discrimination	Patient factors - SES HCW factors	Staffing	Accountability Informal policy Structure and culture		HCW factors (TBA)		Accountability	International policy
Mengistu et al. 2021	An innovative intervention to improve respectful maternity care in three Districts in Ethiopia	Ethiopia	Maternal health	Quantitative	Maternal health services	Patient	As an aspect of disrespect and abuse	Respect, discrimination, privacy, confidentiality		Staffing				Staffing Infrastructure	Structure and culture Informal Policy - resiliency Accountability	International policy National context - political will Health policy - guidelines
Mihret et al. 2020	Reducing Disrespect and Abuse of Women During Antenatal Care and Delivery Services at Injibara General Hospital, Northwest Ethiopia: A Pre-Post Interventional Study	Ethiopia	Maternal health	Mixed methods	Childbirth	Patient	As an aspect of disrespect and abuse	Privacy, communication, respect	HCW factors Patient factors - SES, tribe, age	Staffing	Accountability Structure and culture	Health policy - user fee		Staffing Infrastructure	Accountability Professional dignity	International policy National context - political will
Mihret, 2019	Obstetric violence and its associated factors among postnatal women in a Specialized Comprehensive Hospital, Amhara Region, Northwest Ethiopia	Ethiopia	Maternal health	Quantitative	Childbirth	Patient	As an aspect of disrespect and abuse (called obstetric violence)	Respect, discrimination, privacy, confidentiality	HCW factors Patient factors - Urban and high SES		Structure and culture Accountability					International policy
Mohammed et al. 2013	Assessing responsiveness of health care services within a health insurance scheme in Nigeria: users' perspectives	Nigeria	Responsiveness	Quantitative	General health services	Patient	As an aspect of responsiveness	Communication, respect, privacy	Patient factors - SES (public) HCW factors (public)	Staffing (public)	Structure and culture (public)			Infrastructure - (private)		Health policy - National health insurance scheme
Moyer et al. 2014	'They treat you like you are not a human being': maltreatment during labour and delivery in rural northern Ghana	Ghana	Maternal health	Qualitative	Childbirth	Patient	As an aspect of disrespect and abuse	Discrimination, respect, humanness, humiliation, communication	Patient factors - SES HCW factors		Accountability Structure and culture		HCW factors		Structure and culture	International policy
Mselle et al. 2018	Barriers and facilitators to humanizing birth care in Tanzania: findings from semi-structured interviews with midwives and obstetricians	Tanzania	Maternal health	Qualitative	Childbirth	Patient	As an aspect of quality care	Privacy, discrimination, involvement, respect, humanness		Infrastructure Staffing	Structure and culture			Staffing	Structure and culture	International policy

Mthombeni, Maputle, and Khoza, 2018	Perceptions of Postpartum Mothers towards the Care Provided by Male Student Midwives at Labour Units in Limpopo Province, South Africa	South Africa	Maternal health	Qualitative	Childbirth	Patient	As an aspect of quality of care	Caring, respectful, communication, privacy					HCW factors			Health policy - Guidelines
Mukamurigo, 2017	The meaning of a poor childbirth experience - A qualitative phenomenological study with women in Rwanda	Rwanda	Maternal health	Mixed methods	Childbirth	Patient	As an aspect of quality of care	Involvement, communication, discrimination, respect, humiliation, and humanness	HCW factors Patient factors - HIV	Infrastructure	Structure and culture Accountability Policy					
Nara et al. 2020	A Multi-Methods Qualitative Study of the Delivery Care Experiences of Congolese Refugees in Uganda	Uganda	Maternal health	Mixed methods	Childbirth	Patient	As an experience of receiving care	Privacy, discrimination, humanness, respect	HCW factors Patient factors - Refugee	Infrastructure Staffing	Structure and culture Policy					
Ndwiga et al. 2017	Exploring provider perspectives on respectful maternity care in Kenya: "Work with what you have"	Kenya	Maternal health	Mixed methods	Childbirth	Patient	As an aspect of respectful maternity care	Involvement, communication, respect, privacy, confidentiality,		Staffing	Professional dignity Structure and culture Accountability			Staffing Infrastructure	Structure and culture Accountability	International policy National context - political will
Oduenyi et al. 2021	Gender discrimination as a barrier to high-quality maternal and newborn health care in Nigeria: findings from a cross-sectional quality of care assessment	Nigeria	Maternal health	Quantitative	Maternal and child health	Patient	As an aspect of respectful maternity care	Respect, discrimination, privacy, involvement, friendliness	Patient factors - gender HCW factors	Infrastructure Staffing	Structure and culture Accountability Professional dignity Policy	National context - Gender norms, patriarchal				International policy
Ogbuabor and Nwankwor, 2021	Perception of Person-Centred Maternity Care and Its Associated Factors Among Post-Partum Women: Evidence from a Cross-Sectional Study in Enugu State, Nigeria	Nigeria	Maternal health	Quantitative	Childbirth	Patient	As an aspect of person-centred maternity care	Respect, privacy, confidentiality, discrimination	HCW factors Patient factors - SES, unmarried	Staffing Infrastructure	Structure and culture Accountability		Patient factors - Empowerment HCW factors	Infrastructure (private, PHC) Staffing (private, PHC)	Structure and culture (private, PHC)	
Ojwang et al. 2010	Nurses' impoliteness as an impediment to patients' rights in selected Kenyan hospitals	Kenya	Health and human rights	Qualitative	General health services	Patient	As an aspect of quality of care	Friendliness, respect, involvement, communication, discrimination, humiliation, humanness	HCW Factors Patients Factors - SES, ethnicity	Infrastructure staffing	Structure and Culture Professional dignity Policy Accountability	National context - Soc heighted expectation age	HCW factors Patient factors - Compliance		Structure and culture	International policy - Human rights National context - Constitution Health policy - Nursing Charter,

																Patient Charter
Okafor et al. 2015	Disrespect and abuse during facility-based childbirth in a low-income country	Nigeria	Maternal health	Quantitative	Childbirth	Patient	As an aspect of disrespect and abuse	Discrimination, confidentiality, respect, and consent	Patient factors - SES, tribe HCW factors	Infrastructure	Structure and culture Informal policy Accountability	National policy - Medical malpractice				
Okedo-Alex et al. 2021	Does it happen and why? Lived and shared experiences of mistreatment and respectful care during childbirth among maternal health providers in a tertiary hospital in Nigeria	Nigeria	Maternal health	Mixed methods	Childbirth	Patient	As an aspect of disrespect and abuse	Privacy, communication, confidentiality, discrimination	HCW factors	Infrastructure Staffing	Professional dignity Structure and culture				Accountability	Enabling international policy
Oluoch-Aridi et al. 2021	Exploring women's childbirth experiences and perceptions of delivery care in peri-urban settings in Nairobi, Kenya	Kenya	Maternal health	Qualitative	Childbirth	Patient	As an aspect of quality of care	Responsiveness, communication, privacy	HCW factors	Staffing Infrastructure	Structure and culture Professional dignity Accountability Policy	Health policy - user fee	HCW factors	Infrastructure	Structure and culture Accountability	
Oosthuizen et al. 2017	It does matter where you come from: mothers' experiences of childbirth in midwife obstetric units, Tshwane, South Africa	South Africa	Maternal health	Quantitative	Childbirth	Patient	As an aspect of quality of care	Respect, communication, consent	HCW factors Patient factors - Age, cultural		Structure and culture Accountability					International policy National context - political will Health policy - guidelines
Peltzer and Phaswana-Mafuya, 2012	Patient experiences and health system responsiveness among older adults in South Africa	South Africa	Responsiveness	Quantitative	General health services	Patient	As an aspect of health system responsiveness	Dignity, communication, confidentiality, communication, prompt attention, quality of basic amenities, access to external support (these are the domains of HS responsiveness)	Patient factors - Race		Structure and culture		Patient factors - Older	Infrastructure - (Private) higher score	NA	

Peters, 2016	'They wrote "gay" on her file': transgender Ugandans in HIV prevention and treatment	Uganda	Vulnerable populations: LGBTQI	Qualitative	General health services	Patient	As an experience during care	Discrimination, respect	HCW factors Patient factors - LGBTQI	Staffing	Structure and culture	National context - social LGBTQI, law LGBTQI Health policy - No LGBTQI				
Pinehas, van Wyk and Leech, 2016	Healthcare needs of displaced women: Osire refugee camp, Namibia	Namibia	Vulnerable populations: Displaced women	Qualitative	General health services	Patient	As an aspect of quality of care	Discrimination, autonomy, involvement, and respect	HCW factors Patient factors - SES, HIV, marriage, refugee	Infrastructure	Structure and culture Accountability	National context - refugee setting				
Raphalalani et al. 2021	The role of Mental Health Care Act status in dignity-related complaints by psychiatric inpatients: A cross-sectional analytical study	South Africa	Vulnerable populations: Mental health	Quantitative	Mental health services	Patient	As a nature of a compliant	Discrimination, autonomy, communication, involvement, humiliation, humanness			Accountability Policy		Patient factors - autonomy		Structure and culture	National context - Constitution Health policy - Mental Health Act, guidelines
Rosen et al. 2015	Direct observation of respectful maternity care in five countries: a cross-sectional study of health facilities in East and Southern Africa	Ethiopia, Kenya, Madagascar, Rwanda, Tanzania	Maternal health	Quantitative	Childbirth	Patient	As an aspect of respectful maternity care	Friendliness, respect, communication, privacy, and involvement, privacy, confidentiality	HCW factors (all) Patient factors - SES (all)	Infrastructure (all) Staffing (all)	Structure and culture (all) Policy (all)				Structure and culture (all)	International policy (all)
Rucell, 2017	Obstetric violence & colonial conditioning in South Africa's reproductive health system	South Africa	Maternal health	Qualitative	Childbirth	Patient	As an aspect of disrespect and abuse	Discrimination, privacy, human ness, respect	HCW factors Patient factors - SES	Infrastructure Staffing	Professional dignity Policy Structure and culture Accountability	National context - High discrimination (apartheid), political will Health policy - HCW villainization			Informal policy and resiliency	Health policy - Guidelines, accountability frameworks
Sando et al. 2014	Disrespect and Abuse During Childbirth in Tanzania: Are Women Living with HIV More Vulnerable?	Tanzania	Maternal health	Mixed methods	Childbirth	Patient	As an aspect of disrespect and abuse	Respect, privacy, confidentiality, humiliation	HCW factors	Infrastructure	Structure and culture Accountability			Staffing	Structure and culture	National context - political will Health policy - non-discrimination on HIV

Sando et al. 2016	The prevalence of disrespect and abuse during facility-based childbirth in urban Tanzania	Tanzania	Maternal health	Quantitative	Childbirth	Patient	As an aspect of disrespect and abuse	Privacy, confidentiality, communication, respect, and discrimination	HCW factors	Infrastructure Staffing	Structure and culture Accountability Professional dignity Informal policy					International policy
Scorgie et al. 2013	'We are despised in the hospitals': sex workers' experiences of accessing health care in four African countries	Kenya, Zimbabwe, Uganda, South Africa	Vulnerable populations: sex workers, LGBTQI	Qualitative	General health services	Patient	As an aspect of desired treatment	Discrimination, privacy, humanness, respect,	HCW factors (all) Patient factors and discrimination - LGBTQI, sex worker (all)		Structure and culture (all) Informal policy (Uganda, Zimbabwe) Accountability (all)	National policy - Criminalization, social context - discrimination (all)	HCW factors (NGO, Private) (South Africa, Zimbabwe)	Staffing (NGO, Private) (South Africa, Zimbabwe)	Structure culture (NGO, Private, South Africa, Zimbabwe)	
Sendo, Chauke, and Ganga-Limando, 2021	Women's perspectives on the measures that need to be taken to increase the use of health-care facility delivery service among slums women, Addis Ababa, Ethiopia: a qualitative study	Ethiopia	Maternal health	Qualitative	Childbirth	Patient	As a measure necessary to increase uptake of facility delivery	Communication, respect, privacy, humanness, and friendliness	HCW factors Patient factors - SES	Infrastructure Staffing	Structure and culture Policy	Health policy - payment require, user fee		Staffing Infrastructure	Policy	International policy National context - political will
Sethi et al. 2017	The prevalence of disrespect and abuse during facility-based maternity care in Malawi: evidence from direct observations of labour and delivery	Malawi	Maternal health	Quantitative	Childbirth	Patient	As an aspect of disrespect and abuse	Friendliness, respect, privacy and involvement	HCW factors Patient factors - HIV	Infrastructure	Structure and culture Accountability		HCW factors	Staffing Infrastructure	Structure and culture (PHC)	Health policy - guidelines, SOC
Sewpaul et al. 2021	A mixed reception: perceptions of pregnant adolescents' experiences with health care workers in Cape Town, South Africa	South Africa	Maternal health	Qualitative	Maternal health: ANC	Patient	As an experience of care	Discrimination, communication, involvement, humaneness	HCW factors Patient factors - Age	Infrastructure	Accountability Structure and culture Informal policy	National context - age pregnancy	HCW factors		Structure and culture	Health policy - SOC, guidelines
Sheferaw et al. 2017	Respectful maternity care in Ethiopian public health facilities	Ethiopia	Maternal health	Quantitative	Childbirth	Patient	As an aspect of respectful maternity care	Privacy, respect, friendliness, involvement, communication	HCW factors	Infrastructure Staffing	Structure and culture Accountability Professional dignity		HCW factors	Infrastructure Staffing	Structure and culture (PHC) Policy (PHC) Accountability (PHC)	International policy National context - political will Health policy - guidelines, report

Shimoda et al. 2018	Midwives' respect and disrespect of women during facility-based childbirth in urban Tanzania: a qualitative study	Tanzania	Maternal health	Qualitative	Childbirth	Patient	As an aspect of disrespect and abuse	Privacy, respect, confidentiality, communication, humiliation	HCW factors	Infrastructure	Structure and culture Accountability			Infrastructure	Structure and culture	International policy
Shimoda et al. 2020	Self-reported disrespect and abuse by nurses and midwives during childbirth in Tanzania: a cross-sectional study	Tanzania	Maternal health	Quantitative	Childbirth	Patient	As an aspect of disrespect and abuse	Respect, humanness, pride, confidentiality, privacy, communication, and friendliness	HCW factors	Staffing Infrastructure Privacy	Structure and culture Professional dignity Accountability				Professional dignity Accountability	
Sudhinaraset et al, 2019	Providers and women's perspectives on person-centred maternity care: a mixed methods study in Kenya	Kenya	Maternal health	Mixed methods	Childbirth	Patient	As an aspect of person-centred maternity care	Privacy, confidentiality, communication, involvement, respect, and humanness	HCW factors Patient factors - SES	Infrastructure Staffing	Professional dignity Accountability Structure and culture		HCW factors		Structure and culture	Health policy - (report) National context - political will
Tato Nyirenda et al. 2020	Abuse and disrespectful care on women during access to antenatal care services and its implications in Ndola and Kitwe health facilities	Zambia	Maternal health	Quantitative	Maternal health: ANC	Patient	As an aspect of disrespect and abuse	Privacy, respect, involvement	HCW factors Patient factors - SES	Infrastructure Staffing	Accountability Structure and culture					International policy Health policy - guidelines
Tekle Bobo et al. 2019	Disrespect and abuse during childbirth in Western Ethiopia: Should women continue to tolerate?	Ethiopia	Maternal health	Quantitative	Childbirth	Patient	As an aspect of disrespect and abuse	Respect, confidentiality, privacy,	HCW factors Patient factors - SES, age	Infrastructure (hospital) Staffing (hospital)	Accountability Professional dignity Informal policy	National policy - medical malpractice	Patient factors - High SES	Infrastructure (PHC) Staffing (PHC)	Accountability	Health policy - Guidelines National context - Political will
Ughasoro et al. 2017	An exploratory study of patients' perceptions of responsiveness of tertiary health-care services in Southeast Nigeria: A hospital-based cross-sectional study	Nigeria	Responsiveness	Quantitative	General health services	Patient	As an aspect of responsiveness	Autonomy, communication, confidentiality, privacy	HCW factors		Structure and culture Policy	Health policy - uncomprehensive		Infrastructure	Structure and culture Accountability	International policy
Ukke et al. 2019	Disrespect and abuse of women during childbirth in public health facilities in Arba Minch town, south Ethiopia - a cross-sectional study	Ethiopia	Maternal health	Quantitative	Childbirth	Patient	As an aspect of disrespect and abuse	Involvement, confidentiality, privacy, discrimination, communication, and respect	HCW factors Patient factors - SES	Infrastructure (hospital) Staffing (hospital)	Accountability Structure and culture			Infrastructure (PHC) Staffing (PHC)		

Umar et al.2019	Understanding mistreatment during institutional delivery in Northeast Nigeria: a mixed-method study	Nigeria	Mate rnal healt h	Mixed methods	Childbirth	Patient	As an aspect of disrespect and abuse	Privacy, respect, communication, humiliation	HCW factors Patient factors - SES	Infrastructur e Staffing	Accountabili ty Structure and culture Informal policy		HCW factors		Structure and culture	
Vivian et al. 2011	Medical students' experiences of professional lapses and patient rights abuses in a South African health sciences faculty	South Africa	Healt h and huma n rights	Mixed methods	General health services	Patient	As an abuse and rights violation	Privacy, respect, humiliation, involvement, confidently	HCW factors Patient factors - SES, age	Staffing Infrastructur e	Culture and structure Accountabili ty					National context - Social justice Health policy - Patient Rights
Warren et al. 2017	Manifestations and drivers of mistreatment of women during childbirth in Kenya: implications for measurement and developing interventions	Kenya	Mate rnal healt h	Qualitative	Childbirth	Patient	As an aspect of disrespect and abuse	Privacy, respect, humiliation, involvement, friendliness, discrimination.	HCW factors Patient factors - SES, Tribe	Infrastructur e	Structure and culture Accountabili ty Informal policy	National context - social, gender, tribal lection violence, accountabili ty medical malpractice			Informal policy	
Warren et al. 2015	Nègènègèn: Sweet talk, disrespect, and abuse among rural auxiliary midwives in Mali	Mali	Mate rnal healt h	Mixed methods	Childbirth	Patient	As an aspect of quality of care	Friendliness, respect, communication,	HCW factors	Infrastructur e Staffing	Structure and culture Professional dignity		HCW factors		Informal policy - Resiliency Structure and culture	Internationa l policy Health policy - Guidelines, additional HCW National context - Political will
Warren et al. 2017	Sowing the seeds of transformative practice to actualize women's rights to respectful maternity care: reflections from Kenya using the consolidated framework for implementation research	Kenya	Mate rnal healt h	Mixed methods	Childbirth	Patient	As an aspect of respectful maternity care	Communication, respect, involvement, privacy		Infrastructur e Staffing	Accoutnablit y Policy Structure and culture	National context - political will Health policy - User fee		Staffing	Accountabili ty Structure and culture Professional dignity	Internationa l policy National context - Political will Health policy - Guidelines
Wassihun and Zeleke, 2018	Compassionate and respectful maternity care during facility-based childbirth and women's intent to use maternity service in Bahir Dar, Ethiopia	Ethiopia	Mate rnal healt h	Quantitative	Childbirth	Patient	As an aspect of respectful maternity care	Discrimination, respect, and abuse	HCW factors Patient factors - SES	Staffing	Professional dignity Structure and culture Accountabili ty					Internationa l policy

Appendix 3: Health Policy and Planning Journal Guidelines

"*Health Policy and Planning* improves the design, implementation and evaluation of health policies in low- and middle-income countries through providing a forum for publishing high quality research and original ideas, for an audience of policy and public health researchers and practitioners. *HPP* is published 10 times a year.

HPP has a double-blinded peer-review policy. This means the identity of the authors is anonymous to the reviewers and vice-versa. All types of papers are peer reviewed and all article abstracts from each issue are translated into French, Spanish and Chinese.

Before you submit please make sure you have followed all the relevant instructions. A checklist for authors is available on the *HPP* webpage.

Please submit your paper to the most appropriate section. Read our Section Summaries.

Please note that submission of a paper implies that it reports unpublished work and that it is not under consideration for publication elsewhere. Plagiarism, including duplicate publication of the author's own work, in whole or in part without proper citation is not tolerated by *HPP*. Submitted manuscripts are screened with iThenticate software, as part of the CrossCheck initiative to detect and prevent plagiarism.

- Guidance
    i. Improving chances of publication
    ii. Manuscript format and style for all articles
    iii. Prior publication guidelines
- Types of papers
- Submission process

Guidance

Improving chances of publication

As well as the high overall quality required for publication in an international journal, authors should take into consideration:

- Addressing *HPP*'s readership: national and international policy makers, practitioners, academics and general readers with a particular interest in health policy issues and debates.
- Manuscripts that fail to set out the international debates to which the paper contributes, and to draw out policy lessons and conclusions, are more likely to be rejected, returned to the authors for redrafting prior to being reviewed, or undergo a slower acceptance process.
- Economists should note that papers accepted for publication in HPP will consider the broad policy implications of an economic analysis rather than focusing primarily on the methodological or theoretical aspects of the study.
- Public health specialists writing about a specific health problem or service should discuss the relevance of the analysis for the broader health system. Those submitting health policy analyses should draw on relevant bodies of theory in their analysis, or justify why they have not, rather than only presenting a narrative based on empirical data.
- Primarily focus on one or more low- or middle-income countries.

The editors cannot enter into correspondence about papers considered unsuitable for publication and their decision is final. Neither the editors nor the publishers accept responsibility for the views of authors expressed in their contributions. The editors reserve the right to make amendments to the papers submitted although, whenever possible, they will seek the authors' consent to any significant changes made. The manuscript will not be returned to authors following submission unless specifically requested.

Should you require any assistance in submitting your article or have any queries, please do not hesitate to contact the editorial office at hpp.editorialoffice@oup.com.

Should your manuscript require any English language editing, we recommend contacting AuthorAid, a free network which provides free mentoring and English-language editing for researchers in low-and middle-income countries.

Manuscript format and style for all articles

Only articles in English are considered for publication.

The journal follows Oxford SCIMED style. Please refer to these requirements when preparing your manuscript. More information on preparing your manuscript is available. Oxford English spelling style should be used consistently throughout your manuscript. (-ize/-ization), except in quotations and in references.

Prepare your manuscript, including tables, using a word processing program and save it as a *.doc, .rtf* or *.ps* file. Use a minimum font size of 11, double-spaced and paginated throughout including references and tables, with margins of at least 2.5 cm. The text should be left justified and not hyphenated.

Authorship: Please note there should be a LMIC (lower-middle-income) named author from the region of the paper included in the paper. If all named authors are from HICs' (high-income countries) please clarify the reason for this on the Title Page. In addition, a contributorship statement is required - please note as follows on the Title Page:

Please clarify how each author has contributed to the paper. You need to create a list assigning a person's name against the following roles or tasks:

- Conception or design of the work
- Data collection
- Data analysis and interpretation
- Drafting the article
- Critical revision of the article
- Final approval of the version to be submitted - all named authors should approve the paper prior to submission.

The Title Page should be uploaded as a separate file type "Title Page" and contain the following information:

1. Title
2. Corresponding authors name,address,country,e-mail address, ORCID details
3. Each authors affiliation and qualification (BSc, MA, PhD...)
4. Keywords and an abbreviated running title
5. 2-4 Key messages, detailing the main points made in the paper
6. A word count of the full article:Word Limits do not include Abstract, References, Figure/Table legends.
7. Ethical Approval
    - if no ethical approval was required for the research, please note the reason:
        - Example A: Ethical approval for this type of study is not required by our institute.
        - Example B: Ethical approval for this research was waived by the authors institute/s IRB.
    - Ethical Approval Received-Please note the institute/s which approved the research with reference number.

Original Articles-word limit 6000
Review Articles- word limit 10000
Commentaries: Word limit 1200
How to do...or not to do - word limit 3000
Methodological Musings-word limit 3000
Innovation and practice reports: word limit 2000

Funding/Acknowledgements/Conflicts of interest/Ethical approval should be noted on the title page.

In the acknowledgements, all contributors who do not meet the criteria for authorship should be listed. Sources of funding for research must be explicitly stated, including grant numbers if appropriate. Other financial and material support, specifying the nature of the support, should be acknowledged as well.

Figures should be designed using a well-known software package for standard personal computers. If a figure has been published earlier, acknowledge the original source and submit written permission from the copyright holder to reproduce the material.

Please be aware that the requirements for online submission and for reproduction in the journal are different: (i) for online submission and peer review, please upload your figures separately as low-resolution images (.jpg, .tif, .gif or. eps); (ii) for

reproduction in the journal, you will be required after acceptance to supply high-resolution .tif files. Minimum resolutions are 300 d.p.i. for colour or tone images, and 600 d.p.i. for line drawings. We advise that you create your high-resolution images first as these can be easily converted into low-resolution images for online submission.

Figures will not be relettered by the publisher. The journal reserves the right to reduce the size of illustrative material. Any photomicrographs, electron micrographs or radiographs must be of high quality. Wherever possible, photographs should fit within the print area or within a column width. Photomicrographs should provide details of staining technique and a scale bar. Patients shown in photographs should have their identity concealed or should have given their written consent to publication. When creating figures, please make sure any embedded text is large enough to read. Many figures contain miniscule characters such as numbers on a chart or graph. If these characters are not easily readable, they will most likely be illegible in the final version.

Certain image formats such as .jpg and .gif do not have high resolutions, so you may elect to save your figures and insert them as .tif instead.

For useful information on preparing your figures for publication, go to the Digital Art Support page.

All measures should be reported in SI units, followed (where necessary) by the traditional units in parentheses. There are two exceptions: blood pressure should be expressed in mmHg and haemoglobin in g/dl. For general guidance on the International System of Units, and some useful conversion factors, see 'The SI for the Health Professions' (WHO 1977).

Manuscript file must include text body. Title Page, Figures and Tables should be uploaded separately.

Prior Publication Policy

[Based on a statement developed by a group of editors of journals that publish articles on health, health services, and health policy. Journals currently using this statement include: Health Affairs, Health Services Research, Inquiry, Journal of Health Politics, Policy and Law, Journal of Health Services Research & Policy, Medical Care, and the Milbank Quarterly.]

Background

The policy of the journals subscribing to this statement is to consider for publication only original work that has not previously been published. Questions about what constitutes previous publication are arising with increasing frequency because of the growth of electronic publishing and the increasing number of reports and papers being produced by organizations and agencies. This statement provides guidance on this issue.

There are legitimate reasons why research may be disseminated before submission to a journal. Active communication among researchers about preliminary findings or the circulation of draft reports for discussion and critique contributes to the eventual quality of published work. In addition, organizations that support or carry our research have an understandable interest in disseminating their work. From the perspective of journals, these reasons for dissemination must be balanced against two considerations. The first is the value of the peer review process. The rules against prior publication are intended to add some assurance of the credibility of published research.

Papers are often improved during the peer review process, with findings, conclusions, and recommendations sometimes changed in response to reviewers' comments. The public and policymakers might be confused or misled if there were multiple versions of a paper in the public domain. Second, from a more parochial viewpoint, journal space is limited, and much time and expense are involved in the evaluation, publication, and distribution of journal articles. Journals must make difficult choices about what to include; there is less value in publishing papers that have already been disseminated to their target audiences.

We discuss here several types of dissemination and provide guidelines with respect to the prior publication question. This discussion is essentially an elaboration of two rules, the first emphasizing previous dissemination of the material, the second stressing disclosure.

- Rule One: If the material in a paper has already been disseminated to a journal's audience, particularly in a format that appears to be a final product, then it is unlikely that a second version will be worth publishing in the journal.
- Rule Two: It is the responsibility of authors to let editors know at the time of submission whether a paper's contents have been previously disseminated in any manner so that the editors can determine whether to proceed with the review process.

Previous Presentations at Meetings

Presentation of a paper at conferences or seminars usually does not jeopardize the possibility of publication.

Working Papers

Dissemination of "working papers" to a limited audience will not ordinarily jeopardize publication. Working paper series are used by

many organizations as a means of enabling researchers to obtain critiques from fellow researchers. Working papers covered by this policy are those that are released by the author or an organization rather than by a publisher, are not advertised to the public, and are marked as drafts that are subject to future revision. HPP will not publish papers for which a similar working paper is already available in the public domain.

Internet Postings

Release via the Internet may jeopardize journal publication under some circumstances. Presentation of the work as a final report is a marker of an attempt to reach a wide audience, particularly when combined with efforts to direct traffic to the work (e.g., via links on other sites) and efforts to attract attention (e.g., press releases). In contrast, if a document is posted on the Internet only to facilitate communication among colleagues with the aim of getting feedback, and if there has been no attempt to otherwise attract the attention of journalists, the public, or the broader research community to the document, then this is unlikely to preclude journal publication.
In general, when posting on the Internet serves similar functions as presentation at professional meetings - facilitating the development of papers and the improvement of the research, influencing future revisions, and not constituting a "finished" product - it would not be considered prior publication. On the other hand, when the Web site posting functions as a virtual version of a conventional publication, which may even be copyrighted by the posting organization, the benefit of an additional publication in the journal will be scrutinized carefully.

In cases where there has been little to no exposure at the time that a paper has been submitted to the journal, but the circumstances surrounding the posting make it likely that a high level of exposure (press coverage, etc.) might occur, then the author should remove a posting as a condition for further consideration of the manuscript.
Authors who post papers on a Web site and do not want it to constitute prior publication should also post a disclosure statement such as: "This draft paper is intended for review and comments only. It is not intended for citation, quotation, or other use in any form." This statement should be kept on the Web site throughout the review process and until the paper is actually accepted for publication in a journal. Once accepted, authors should post a message to the effect that: "A revised final version of this paper will appear in (Journal Name), volume, issue." Authors also should include this statement as a header or footer on every page of the paper.

Formal Reports from Foundations, Academic Institutions, Institutes, Trade Associations, and Government Agencies

The dissemination efforts of foundations, government agencies, research institutes, and other organizations that support or carry out research can complement publication in peer-reviewed journals. If publication in one of our peer-reviewed journals is desired, organizational publications should be timed to coincide with or follow journal publication, with appropriate copyright permissions having been obtained. This sequence ensures that the peer-review process will have an opportunity to correct deficiencies of method or presentation.
Formal, published reports that have gone through an editorial process, that have been intended to reach a wide audience, and that are publicized and available to any interested party (whether free or not) usually will not be considered for journal publication. A paper that is based on such a report might be considered for publication if it were sufficiently different in emphasis or intent. In such instances, the author should explain at the time of submission (or before) how the paper differs from the previously released report and why its publication would represent a distinct and important contribution beyond that version.

Policy briefs

If the findings of a piece of research have been published locally (i.e. in a specific country) with the aim of influencing policy debates in that country then even if the brief is available on the web we may consider publishing an article so long as (i) the brief has not had wide circulation outside the country and (ii) the brief is clearly targeted at policy-making audiences, and hence does not include the detailed discussion of methods and perhaps findings that one might expect in a journal article.

Media Publicity

If results reported in a working paper have become widely known as a result of media exposure (or even if the potential for widespread exposure remains during review), and that working paper is readily available to interested readers (e.g., through a Web site), an editorial judgment will be made whether journal publication would be appropriate. Authors can help protect their work from unwanted media exposure by making clear on working drafts, copies presented at conferences, and other versions that it is a draft that has not yet undergone peer review for publication and that findings and conclusions are subject to change. Authors also should request that any "stories" derived from interviews with the media be embargoed until the work is published or released by the publisher (see, for example, Fontanarosa, P.B., and C.D. DeAngelis. 2002. The Importance of the Journal Embargo. Journal of the American Medical Association 288: 748-750). Any accepted manuscript released to the media should contain the statement: "A revised final version of this paper will appear in (Journal Name), volume, issue." Journal policies involving author contact with members of the media may vary, depending on the issue or journal. Thus, authors should check with the editor before speaking with or distributing papers to members of the media.

Importance of Disclosure

In contrast to the editors' decision whether a certain paper has been disseminated too widely to warrant journal publication, there is very little judgment involved in whether an author should disclose previous dissemination. Prior to, or at the time of, submission of a paper that has been disseminated in any of the ways discussed previously, authors should bring this to the attention of the editor so that a determination can be made before the paper goes into the peer-review process. In so doing, authors should describe in what form and how the work was previously disseminated and how the submitted manuscript differs from previously disseminated versions. Editors might be receptive to a modified version of a paper that has been widely disseminated if the submitted version has a different focus (e.g., more emphasis on methods, more sophisticated analytic approach, or discussion of developments that have transpired since the initial dissemination). The key point is to let editors know about any dissemination that will have, or is likely to have, occurred before the journal article is published rather than have it discovered during or after the review or editorial process. As part of the submittal, authors should include copies of other related papers that might be seen as covering the same material.

Failure to disclose could preclude publication in the journal or, if already published, could result in a notice in the journal about the failure and may result in a retraction of the article.

Manuscript Preparation

Page 1: *Title Page* – as above.

Page 2: *Abstract.* The abstract should be prepared in one paragraph, no headings are required. It should describe the purpose, materials and methods, results, and conclusion in a single paragraph no longer than 300 words without line feeds.

Page 3: *Introduction.* The Introduction should state the purpose of the investigation and give a short review of the pertinent literature, and be followed by:

Materials and methods. The Materials and methods section should follow the Introduction and should provide enough information to permit repetition of the experimental work. For particular chemicals or equipment, the name and location of the supplier should be given in parentheses.

Results. The Results section should describe the outcome of the study. Data should be presented as concisely as possible, if appropriate in the form of tables or figures, although very large tables should be avoided.

Discussion. The Discussion should be an interpretation of the results and their significance with reference to work by other authors.

Abbreviations. Non-standard abbreviations should be defined at the first occurrence and introduced only where multiple use is made. Authors should not use abbreviations in headings.

All *measures* should be reported in SI units, followed (where necessary) by the traditional units in parentheses. There are two exceptions: blood pressure should be expressed in mmHg and haemoglobin in g/dl. For general guidance on the International System of Units, and some useful conversion factors, see 'The SI for the Health Professions' (WHO 1977).

References. References must follow the Harvard system and must be cited as follows:

Baker and Watts (1993) found...

In an earlier study (Baker and Watts 1993), it...

Where works by more than two authors are cited, only the first author is named followed by 'et al.' and the year. The reference list must be typed double-spaced in alphabetical order and include the full title of both paper (or chapter) and journal (or book), thus:

Baker S, Watts P. 1993. Paper/chapter title in normal script. Journal/book title in italics *Volume number in bold* : page numbers.

Baker S, Watts P. 1993. Chapter title in normal script. In: Smith B (ed). *Book title in italics*. 2nd edn. Place of publication: Publisher's name, page numbers.

Tables All tables should be on separate pages and accompanied by a title - and footnotes where necessary. The tables should be numbered consecutively using Arabic numerals. Units in which results are expressed should be given in parentheses at the top of each column and not repeated in each line of the table. Ditto signs are not used. Avoid overcrowding the tables and the excessive use of words. The format of tables should be in keeping with that normally used by the journal; in particular, vertical lines, coloured text and shading should not be used. Please be certain that the data given in tables are correct. Tables should be provided as Word or Excel files.

Availability of Data and Materials

Where ethically feasible, *Health Policy and Planning* strongly encourages authors to make all data and software code on which the conclusions of the paper rely available to readers. Authors are required to include a Data Availability Statement in their article.

We suggest that data be presented in the main manuscript or additional supporting files, or deposited in a public repository whenever possible. For information on general repositories for all data types, and a list of recommended repositories by subject area, please see Choosing where to archive your data.

Data Availability Statement
The inclusion of a Data Availability Statement is a requirement for articles published in *Health Policy and Planning*. Data Availability Statements provide a standardised format for readers to understand the availability of data underlying the research results described in the article. The statement may refer to original data generated in the course of the study or to third-party data analysed in the article. The statement should describe and provide means of access, where possible, by linking to the data or providing the required unique identifier.

The Data Availability Statement should be included in the endmatter of your article under the heading 'Data availability'.

More information and examples of Data Availability Statements.

Data Citation
Family Practice supports the Force 11 Data Citation Principles and requires that all publicly available datasets be fully referenced in the reference list with an accession number or unique identifier such as a digital object identifier (DOI). Data citations should include the minimum information recommended by DataCite:

- [dataset]* Authors, Year, Title, Publisher (repository or archive name), Identifier

*The inclusion of the [dataset] tag at the beginning of the citation helps us to correctly identify and tag the citation. This tag will be removed from the citation published in the reference list.

Preprint policy

Authors retain the right to make an Author's Original Version (preprint) available through various channels, and this does not prevent submission to the journal. For further information see our Online Licensing, Copyright and Permissions policies. If accepted, the authors are required to update the status of any preprint, including your published paper's DOI, as described on our Author Self-Archiving policy page.

Types of papers

Health Policy and Planning welcomes submissions of the following article types:

- Original research
- Review articles
- Methodological musings
- Innovation and practice reports
- Commentaries
- 'How to do (or not to do)...' [for example, see Hutton & Baltussen, HPP, 20(4): 252-9] and
- '10 best resources' [for example, see David & Haberlen, HPP, 20(4): 260-3].

Original Research

Manuscripts should preferably be a *maximum* of *6,000* words, excluding tables and figures/diagrams.

The manuscript will generally follow through sections: Title page, Abstract (no more than 300 words), Introduction, Methods, Results, Discussion, Conclusion, Acknowledgements, References. However, it may be appropriate to combine the results and discussion sections in some papers. Tables and Figures should not be placed within the text, rather provided in separate file/s.

For the reporting of statistical analyses please consider the following additional points:

- Focus the statistical analysis at the research question.
- Provide information about participation and missing data.
- As much as possible, describe results using meaningful phrases (e.g., do not say "beta" or "regression coefficient", but "mean change in Y per unit of X"). Provide 95% confidence intervals for estimates.
- Report the proportions as *N* (%), not just %.

- Report *P* values with 2 digits after the decimal, 3 if <0.01 or near 0.05 (e.g., 0.54, 0.03, 0.007, <0.001, 0.048). Do not report *P* values greater than 0.05 as "NS".
- Always include a leading zero before the decimal point (e.g., 0.32 not .32).
- Do not report tests statistics (such as chi-2, T, F, etc.)."

For acknowledgements, figures and measures see above.

Review Articles

Manuscripts should preferably be a *maximum of 10,000 words*, excluding tables, figures/diagrams and references.

Reviews may be invited. They generally address recent advances in health policy, health systems and implementation. *Systematic reviews are particularly welcomed,* but may not be appropriate for every topic. If authors are submitting a review article that is not a systematic review then the paper should explain why a systematic review was not feasible/desirable, and the review methods should be described in a way that is as clear and as replicable as possible.

The manuscript will generally follow through sections: Abstract (no more than 300 words), Introduction, Methods, Results, Discussion, Conclusion, References. However, it may be appropriate to combine the results and discussion sections in some papers. Tables and Figures should not be placed within the text, rather provided in separate file/s.

Checklists have been developed for a number of study designs, including randomized controlled trials (CONSORT), systematic reviews (PRISMA), observational studies (STROBE), diagnostic accuracy studies (STARD) and qualitative studies (COREQ, RATS). We recommend authors refer to the EQUATOR Network website for further information on the available reporting guidelines for health research, and the MIBBI Portal for prescriptive checklists for reporting biological and biomedical research where applicable. Authors are requested to make use of these when drafting their manuscript and peer reviewers will also be asked to refer to these checklists when evaluating these studies.

Commentaries

Short commentaries on topical issues in health systems are welcomed - *please email the editorial office prior to submission*. Most such commentaries are commissioned by the editors, but the journal will also consider unsolicited submissions. Commentaries should of broad interest to readers of *Health Policy and Planning*, and while they are not research papers, they should be well substantiated. Manuscripts should preferably be a *maximum of 1,200 words*, excluding tables, figures/diagrams and references.

The manuscript will generally contain a short set of key take-home messages. Tables and Figures should not be placed within the text, rather provided in separate file/s.

How To Do...Or Not To Do

This series is meant to explain how to use a particular research or analytical method (e.g. social network analysis, discrete choice experiment etc.). The research or analytical methods discussed should be well accepted and clearly defined: this category of paper is not meant to address methodological debates but rather to help disseminate and promote the use of well-accepted methodologies.

Manuscripts should preferably be a *maximum of 3,000 words* excluding tables, figures/diagrams and references.

- The sections must be arranged as follows: i) Title page, ii) Abstract, iii) Introduction, iv) Body of the paper, and v) References. Main sections should be coordinated by the author, and inserted between Introduction and Reference sessions. Please contact our office before submitting a manuscript in this category.

Tables and Figures should not be placed within the text, rather provided in separate file/s.

10 Best Resources

This 10 best is a series of articles that identify and outline the 10 most useful resources from a range of sources to help facilitate a better understanding of a particular issue in global health.

We often commission these articles but we also hear unsolicited suggestions.

For acknowledgements, figures and measures see Title page.

Methodological Musings

This series is meant to address methodological issues in health policy and systems research, where there is currently a lack of clarity about accepted research methods. This series is intended to support the development of the health policy and systems research field, through supporting methodological discussion.

Manuscripts should preferably be a *maximum of 3,000 words*, excluding tables, figures/diagrams and references.

- The sections must be arranged as follows: i) Title page, ii) Abstract, iii) Introduction, iv) Body of the paper, and v) References. Main sections should be coordinated by the author, and inserted between Introduction and Reference sessions. Please contact our office before submitting a manuscript in this category.
- For acknowledgements, figures and measures see Title page.

Innovation and Practice Reports

These short reports are narratives and/or reflections/experiences from the perspective of health leaders, managers and practitioners operating at the national or sub-national level which focus on innovative approaches to strengthen health systems. They do not need to report a completely new activity or practice but could consider an adaptation or modification to an existing one. Papers should highlight the experience of health system practitioners in taking action to strengthen health systems through innovative activities. These activities might address governance or human resource management approaches, for example, rather than having a health care focus. Other relevant activities include practices to build capacity, develop new partnerships, new approaches to management, or restructuring relationships within health systems implemented at scale with the intention of promoting changes in practice. The innovations should preferably have been implemented for sufficient time to allow authors to demonstrate their potential system benefits, including sustained improvement over time. We encourage authors to think how the experience they report adds to existing work in their own setting, as well as other settings - but this is not essential.

We will not consider clinical and pharmaceutical innovations and practices.

Manuscripts should be a *maximum* of *2,000 words*. The manuscript will generally present the following sections:

- *Key Messages* (2-4 key messages or lessons for consideration in other settings)
- *Abstract* (no more than 300 words)
    - *Introduction* – outline the background to and context of the activity or practice: what is it and why does it matter in your health system? Please also clarify how you generated the reflections presented in this report: who was involved, what did you do, what forms of evidence are used?
    - *Implementation* – how was the activity or practice developed and implemented? was it adapted over time and if so, how and why? how was it scaled up, and to what level was it scaled?
    - *Achievements/Challenges* – what benefits have been seen in the health system? at what scale? What challenges were faced?
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