

Educational interventions to promote respectful maternity care: A mixed-methods systematic review

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Title: Educational interventions to promote respectful maternity care: A mixed-methods systematic review

Abstract

Aim: This systematic review critiqued the impact of educational interventions for midwives, nurses, or midwifery/nursing students to enhance respectful maternity care.

Background: Treating women with respect during maternity care has gained considerable global attention. Although research has focused on raising awareness about respectful care among health care professionals, the effectiveness of educational interventions remains uncertain.

Methods: A mixed-methods systematic review was conducted according to the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines. This review used a convergent segregated approach, and methodology recommended by Joanna Briggs Institute (JBI) mixed-methods systematic reviews, to synthesise and integrate research findings. Multiple databases were searched. JBI critical appraisal checklists for quasi-experimental studies, cross-sectional, and qualitative studies, as well as a mixed-methods appraisal tool were used.

Findings: Nine educational interventions studies met the inclusion criteria, and most were conducted in Africa. Quantitative evidence supported the effectiveness of interventions to improve knowledge/perceptions of midwives and/or nurses regarding respectful maternity care, and woman-provider communication, and reduce women's experience of disrespect and abuse. However, variation in content, intervention delivery mode, duration, timing of pre and post-test, evaluation methods, and difficulty distilling findings from multi-pronged interventions hindered robust conclusions. Only one study used a valid and reliable tool to measure women's experience of respectful care. Qualitative findings suggest continuous

education rather than one-off interventions and inclusion of other health care providers as well as managerial staff working in maternity care would help promote respectful care.

Conclusion: There is low level evidence that educational interventions can improve midwives', nurses', and students' knowledge and attitudes towards RMC. Outcomes of education and training need to be monitored regularly with valid and reliable tools. There is a need for respectful maternity care education interventions in high as well as middle and low-income countries.

Keywords: Nursing, midwifery, respectful maternity care, disrespect and abuse, mistreatment, education intervention, knowledge, perceptions

Highlights

- Education is one strategy to promote respectful maternity care among care providers in facility-based childbirth.
- Almost all studies were conducted in low- and middle-income African countries.
- Education interventions varied according to teaching methods, content, duration, and evaluation approach.
- There is low level evidence for the effectiveness of educational interventions to enhance midwives', nurses', and midwifery/nursing students' perceptions of respectful maternity care (RMC).

Background

All women deserve to have their dignity, privacy and confidentiality maintained, be free from harm, mistreatment and coercion and receive respectful continuity of care throughout their pregnancy, childbirth, and postpartum period (World Health Organization, 2018). In recent years, considerable attention globally is being given to the increasing prevalence of disrespectful and abusive care towards childbearing women (Bohren et al., 2019; Jolly et al., 2019; World Health Organization, 2018). Disrespect and abuse towards women during labour and birth is also known as ‘obstetric violence’ which includes activities such as not encouraging women to mobilise, eat and drink; not maintaining privacy; performing routine episiotomies; performing episiotomy and suturing tear without anaesthesia; and performing emergency caesarean section without consent Mena-Tudela et al. (2020). Respect for human dignity, compassion and promotion of human rights are underpinning philosophical principles of practice for midwives and nurses (International Confederation of Midwives (ICM), 2014; International Council of Nurses (ICN), 2012). These principles also underwrite global standards for midwifery education which specify the need for graduates to practise respectful one-to-one care (International Confederation of Midwives, 2013). Although a wide variety of methods are used to teach students about RMC there is limited evidence of effectiveness nor guidance about how to best facilitate students’ understanding and practice of dignity and respect (Hall & Mitchell, 2016).

Various education strategies have been used to promote RMC. For example, reproductive health modules in medical curricula in Mozambique were revised to include evidence-based practices such as having a companion during labour and birth, and encouraging alternative childbirth positions (Reis et al., 2012). Similarly, nursing curricula were revised to introduce RMC concepts in Guinea and Mozambique (Reis et al., 2012). Clinical in-service training was

conducted to introduce elements of RMC in Guinea, Mozambique, and India (Reis et al., 2012), and courses on multiculturalism and pregnancy were conducted in Argentina (Reis et al., 2012).

Recently, Downe et al. (2018) conducted a systematic review evaluating the effectiveness of respectful care policies on care. That review included only five studies, all conducted in African countries. Policy-based interventions included value clarification and attitude transformation (VCAT) (Abuya et al., 2015), RMC workshop (Ratcliffe, Sando, Lyatuu, et al., 2016), encouraging the use of birth companions (Brown et al., 2007), and improving communication skills of staff (Umbeli et al., 2014). Included studies were heterogenous with insufficient evidence about which element of an intervention package was effective and if practices/policies were sustained over time. Downe et al. (2018) did not critique any tools used to measure the impact of policies in promoting RMC. Consequently, a systematic review on the quality of tools measuring respectful or disrespectful care among women during labour and birth in low- and middle-income countries was conducted (Dhakal et al., 2021). Although some tools aimed to measure women's experiences of RMC, Dhakal et al. (2021) could not identify tools of sufficient quality to measure the impact of continuing professional development interventions or pre-registration education on clinicians' and/or students' understanding, attitudes, or practices in relation to RMC.

Promoting RMC is complex, and multiple factors are associated with disrespectful care such as organisational culture that normalises disrespect and abuse, lack of standards and accountability, lack of leadership commitment, lack of legal and ethical foundations, provider prejudice, and lack of resources (Bowser & Hill, 2010). Provision of education and training to health care providers has been recommended to enhance RMC (Jolly et al., 2019; Moyer et al., 2021; Orpin et al., 2019). However, no reviews have determined the effectiveness of educational interventions that aim to promote respectful and dignified maternity care. Research

evidence on effectiveness can inform development and implementation of respectful care modules with innovative learning and teaching strategies to enrich care providers' and /or students' learning experiences and practices.

Aim: This mixed-methods systematic review critiqued the impact of educational interventions for midwives, nurses, or midwifery/nursing students to enhance respectful maternity care.

Research questions:

For the quantitative component

- What is the nature of educational interventions (such as content and intervention delivery mode) for midwives, nurses, or students to promote RMC?
- What are the effects of educational interventions on midwives', nurses', or students' knowledge or perceptions towards RMC or disrespect and abuse?
- What are the effects of educational interventions in reducing disrespect and abuse by midwives, nurses, or students towards women during maternity care?

For the qualitative component

- What are the perceptions or experiences of midwives, nurses, or students about educational interventions to promote RMC?

Methods

Protocol and registration

A mixed-methods systematic review was conducted. The Preferred Reporting Items for Systematic Reviews and Meta-Analysis (PRISMA) recommendations (Page et al., 2021) were used for preparing and reporting this systematic review (Supplementary file A). This systematic

review protocol was registered in the International Prospective Register of Systematic Reviews (PROSPERO) (CRD42021268049).

Eligibility Criteria

Studies were selected according to the PICO (Participants/population, Intervention, Comparisons, Outcomes) criteria outlined below (see Table 1).

The qualitative component considered studies that explored participants' experiences of educational interventions on respectful care or mistreatment or obstetric violence or disrespectful and abusive care of woman during maternity care.

Additionally, multiple papers from a single study were considered if the authors used a different method to answer a different aspect of a research question related to the primary outcomes of interest. Information from these other papers was included as appropriate.

Database selection and search strategy

Identification of relevant studies was undertaken by searching the following databases: Cumulative Index to Nursing and Allied Health Literature (CINAHL), Medline (Ovid), Pubmed, and Web of Science. The preliminary search was developed for CINAHL and adapted for searches in other databases (Supplementary file B). PICO model was used to define the search terms (see Table 1). Grey literature was searched on websites of leading organizations promoting respectful care including: the White Ribbon Alliance, World Health Organization, and International Confederation of Midwives. While resources (such as the ICM Respect Toolkit) were identified, none reported outcomes and did meet the inclusion criteria. References lists of previous and adjacent reviews and included papers were screened for relevant studies. The search was conducted between 10 to 20 July 2021.

Table 1**Inclusion and exclusion criteria and search terms**

Population	Midwives, nurses, student nurses, or student midwives
Intervention or phenomena of interest	Educational interventions to improve RMC
Comparison	No intervention, or before and after comparative designs
Outcome	Participants: improved knowledge/perceptions about RMC, obstetric violence, mistreatment or disrespect and abuse of women during labour and birth or maternity care, improved attitudes towards women; improved communication with women. Child-bearing women: self-reported or observed experience of RMC, reduction in disrespect or abuse: reduction in physical abuse, verbal abuse, neglect/abandonment of care, non-confidential care, non-dignified care, detention in facilities, and non-consented care; perceived improved quality of care, satisfaction, and communication with care providers
Setting	Maternity care setting in any country
Design	Randomized controlled trials (RCTs), non-randomized controlled trials (nRCTs), controlled before and after (CBA) studies, interrupted time series studies, and before and after studies, qualitative studies, mixed-methods studies, cross-sectional studies, cohort studies, reviews
Publication type	Peer reviewed; published in English
Search terms	Nurs* OR midw* OR nurs* student OR midwife* student respect* OR disrespect* OR abus* OR mistreatment OR obstetric violence OR dignity OR humanised OR respectful maternity care AND Education OR training OR seminar* OR workshop* OR intervention* intrapartum care OR intrapartum OR intranatal OR labour OR childbirth OR birth OR delivery OR postpartum OR postnatal [Country setting not defined]
Exclusion criteria	Book chapters, opinions, letters, commentary, discussion papers, and editorials

Data management

The bibliographic database Endnote (V.X9.3.3) was used to manage and store details of relevant studies. Document screening and data extraction were conducted by the first author. Database searches were exported to Endnote and labelled 'CINAHL SEARCH' for example. Papers identified through hand searching were manually added to Endnote in a separate file (HAND SEARCH). All files were then combined and labelled 'FULL SEARCH'.

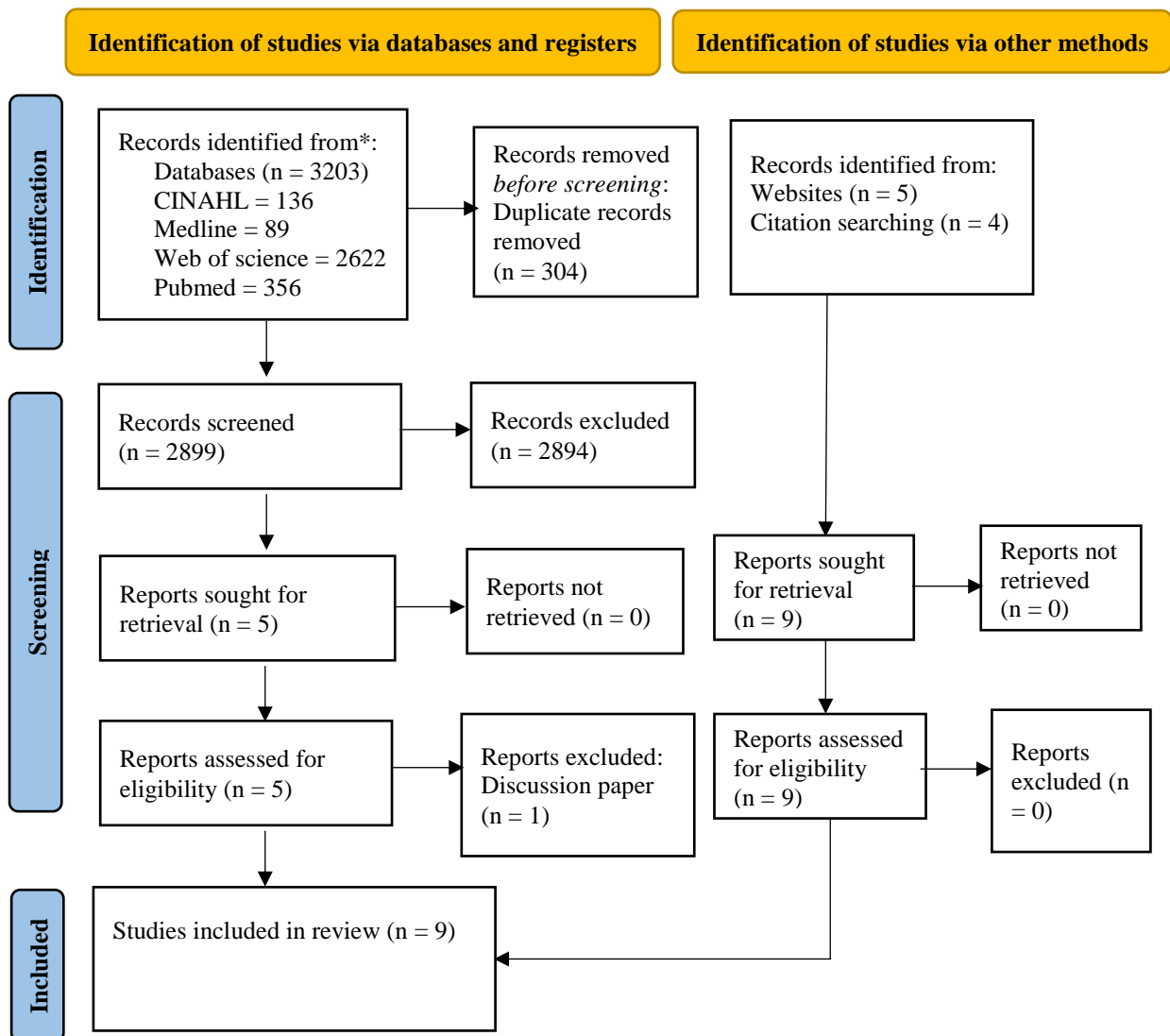
Study selection

Two reviewers (PD, EN) independently assessed the eligibility of studies and full text of potentially relevant articles. Any discrepancies in reviewer selections were resolved with consensus involving a third reviewer (DKC). A final decision on inclusion or exclusion of an article was made based on examination of the full article. Reasons for exclusion was documented for each excluded study. The Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) flow diagram (Figure 1) depicts study selection process (Page et al., 2021).

Methodological Quality Assessment

The Joanna Briggs Institute's (JBI) critical appraisal checklist for quasi-experimental studies (Tufanaru et al., 2020), cross-sectional studies (Moola et al., 2020), and qualitative studies (Lockwood et al., 2015) were used to assess the methodological quality. For mixed-methods studies, the mixed-methods appraisal tool (MMAT) was used (Hong et al., 2018). The first and second authors critically appraised the methodological quality of the selected studies independently and consensus obtained through discussion. The third author verified the methodological quality assessment. The methodological quality of each criterion of different studies is depicted in Supplementary File C.

Figure 1. PRISMA flow diagram



Data extraction

Data were extracted using a standardized template, designed in consultation with team members. It included author name, date and title, study location, article type, population, study design, sample size, educational intervention (content, method of delivery, tools, comparator, and duration), outcomes and conclusions, strengths, and limitations. Data extraction from qualitative components or studies included specific details about the phenomena of interest, populations, study methods and outcomes of significance to the review questions.

The first author extracted data which were independently checked by the second author. Discrepancies in the extracted data were resolved through consultation with other authors. Lastly, all authors read the extracted data and agreed with the content.

Data synthesis and integration

This review followed a convergent segregated approach to synthesise and integrate data according to the JBI's methodology for mixed-methods systematic reviews (Lizarondo et al., 2020). Quantitative studies were synthesized narratively as there were no RCTs to conduct a meta-analysis. Narrative synthesis was also used to present qualitative findings as textual pooling was not possible due to the limited number of qualitative studies. Findings of mixed-methods studies were separated into their respective quantitative and qualitative components. Finally, integration of the evidence from quantitative, qualitative, and mixed-methods studies was done using narrative synthesis.

Findings

The systematic search strategy generated 2899 studies after removing duplicates. One of the five full text assessment papers identified through the database search was removed due to it being a discussion paper. After handsearching and website searching, we identified nine more papers on educational interventions conducted to promote RMC. Data were extracted from 13 papers reporting on nine studies. Although studies were included without any restriction to date of publication, most were recent 2014 to 2021. Almost all studies were from low- and middle-income African countries: Ghana (n = 2), Ethiopia (n = 2), Tanzania (n = 3) and Kenya (n = 1) and one study was from a high-income country (Spain).

Characteristics of included studies

Among the included papers, eight were quantitative, two were qualitative, and three were mixed-methods (see Table 1). Of the quantitative studies, seven were pre-test post-test studies without comparison group (Abuya et al., 2015; Afulani et al., 2019; Asefa, Morgan, Gebremedhin, et al., 2020; Dzomeku et al., 2020; Mena-Tudela et al., 2020; Ratcliffe, Sando, Lyatuu, et al., 2016; Ratcliffe, Sando, Mwanyika-Sando, et al., 2016), and one was cross-sectional (Wilson-Mitchell et al., 2018). Sample sizes ranged from 15 to 278. Most studies included midwives, nurses, and other health care professionals (Abuya et al., 2015; Afulani et al., 2019; Asefa, Morgan, Bohren, et al., 2020; Mihret et al., 2020; Ratcliffe, Sando, Lyatuu, et al., 2016); one study recruited students from nursing and medicine (Mena-Tudela et al., 2020); two studies recruited only midwives (Dzomeku et al., 2021; Wilson-Mitchell et al., 2018); and another only nurses (Webber et al., 2018). Duration of the intervention ranged from eight hours to five days.

Outcomes were predominantly changes in knowledge or perceptions towards RMC, disrespect and abuse, or obstetric violence (Asefa, Morgan, Bohren, et al., 2020; Dzomeku et al., 2020; Mena-Tudela et al., 2020; Ratcliffe, Sando, Lyatuu, et al., 2016; Wilson-Mitchell et al., 2018); changes in occurrence of disrespect and abuse among women (Abuya et al., 2015; Afulani et al., 2019; Asefa, Morgan, Gebremedhin, et al., 2020; Ratcliffe, Sando, Mwanyika-Sando, et al., 2016); changes in clinical practice (Asefa, Morgan, Bohren, et al., 2020; Dzomeku et al., 2021; Mihret et al., 2020); and experiences/perceptions of the intervention (Afulani et al., 2020; Dzomeku et al., 2020; Webber et al., 2018). In addition to a survey, two studies used structured non-participant observations of women from early labour to post childbirth to measure the occurrence of disrespect and abuse (Abuya et al., 2015; Ratcliffe, Sando, Mwanyika-Sando, et al., 2016).

Changes in clinical practices among staff participants were measured at two months (Asefa, Morgan, Bohren, et al., 2020) and four months (Dzomeku et al., 2021) after the intervention

through focus group discussions and in-depth interviews, respectively. One study did not mention when key informant interviews were conducted after the intervention (Mihret et al., 2020).

We critically appraised thirteen papers based on their research questions and methods applied. Quality varied because of design, however no papers were excluded based on their quality. Findings related to educational interventions were organised according to 1) nature of educational interventions and 2) type, quality, and timing of outcome measures

Nature of educational interventions (Content, intervention delivery mode, and duration)

There were variations in content, intervention delivery mode and duration which prevented a useful synthesis of data, therefore, a narrative summary is presented. Most educational interventions were in workshop format (Abuya et al., 2015; Asefa, Morgan, Gebremedhin, et al., 2020; Dzomeku et al., 2021; Ratcliffe, Sando, Lyatuu, et al., 2016; Webber et al., 2018; Wilson-Mitchell et al., 2018), used interactive role play, and were delivered by a range of health professionals. Intervention details are provided in Table 2.

Table 2
Summary of included studies

Author (year)	Objective	Study location, population, sample size	Study design	Educational intervention and content	Comparator and duration	Intervention Evaluation	Outcome and critique	Critical appraisal score
Mena-Tudela et al. (2020)	1) evaluate health science students' perceptions regarding obstetric violence and 2) determine impact of an educational intervention on perceptions.	Spain, Medical (n = 14) and nursing students (n = 93) (Total n = 107), Voluntarily enrolment of students	One group pre-post study design	Seminar on obstetric violence; composed of a one hour theatrical performance; master class on legal aspects presented by a lawyer specializing in health law (2 hrs); a round table discussion of professionals from different fields, sharing their experiences (4 hrs); and four volunteer mothers narrated their experiences of childbirth (1 hr).	Before and after comparison, 8-hour seminar	33 items on obstetric violence practices (before birth, during birth, in case of caesarean section and after birth) on a 5-point Likert scale (1 = strongly disagree to 5 = strongly agree). Items developed by 3 experts based on Clinical Practice of Normal Birth Care Guide of Spain. Cronbach alpha was 0.92 and 0.98 for pre- and post-intervention respectively.	<ul style="list-style-type: none"> - Statistically significant difference between pre and post intervention measures among 28 items on perceptions regarding obstetric violence. - Normalisation of violence by students (higher year of study, those who have personal experience of pregnancy and birth, exposure to obstetric practices during study) - No control group - Convenience sample - Single institute data - Immediate collection of post-test data - No use of replicable tool 	6/9
Paper 1 Dzomeku et al. 2021	To explore midwives' experiences of implementing RMC knowledge in their daily	Ghana, Midwives working in intrapartum facility-based childbirth (n	Qualitative descriptive design	Role play, discussion, brainstorming, demonstration, and case study Program had four modules 1) respect	Before and after comparison, 4-day workshop	In-depth interviews 4 months after training (n = 14).	<ul style="list-style-type: none"> -Perceived positive midwife-women relationship -Effective communication with women -Recognising autonomy of women 	8/10

	maternity care practices.	= 15), tertiary health facility, method of recruitment not stated		and dignity in childbirth; 2) communication; 3) focused antenatal care; and 4) use of alternative birthing positions for birth			-Recommended to provide training to all midwives, student-midwives, management staff.	
Paper 2 Dzomeku et al. 2020 (Preprint)	Feasibility of using four RMC modules in a training program to change the culture of D & A in maternity care.	As above	Pre-post evaluation of pilot project	As above	As above	Study-specific 20-item RMC questionnaire - four domains each containing five questions. Peer-review by two independent experts who provided feedback and suggestions on the content, teaching methods, materials, and duration. Midwives' feedback and recommendations on training program.	Significant increase in knowledge of RMC ($z = -3.43$, $p = 0.001$), effect size ($r = 0.63$). Median score increased by five points. <u>Midwives' evaluation</u> - Satisfied with training. - Role play very effective in understanding the concept of RMC. - Provide training to other health care staff, students, health administrators and managers. - Include psychological effects of D & A and legal implications - Organise training frequently - No control group -No information on method of sample recruitment - No reliable, replicable tool	7/9

							<ul style="list-style-type: none"> - Very small sample size - Single site data - Immediate collection of post-test data 	
Webber et al. (2018)	Experience of workshops based on the “Health Workers for Change” curriculum (Fonn & Xaba, 1995)	Tanzania, nurses (n = 60), health facilities including hospitals, health centres and dispensaries, Method of recruitment not stated.	Pre-post qualitative evaluation	Self-reflective activities included creating an individual “river of life”, role playing and storytelling. “Health workers for change” includes six workshops: ‘Why I am a health worker,’ ‘how do our clients see us?’, ‘women’s status in society’, ‘unmet needs’, ‘overcoming obstacles at work’, and ‘solutions’.	Before and after comparison, 3-day workshops	Open and closed ended survey sought feedback on workshops. Focus group discussions determined participants’ experiences in the workshop and suggestions for future training and improvement in services	<ul style="list-style-type: none"> - Participants more aware that quality of care and their attitudes towards women were poor. - Could identify where the weaknesses in quality of service originated. - Felt the workshop made a significant impact on their on-going care and could influence others to improve care. 	7/10
Abuya et al. (2015)	To measure the effect of interventions to reduce the prevalence of disrespect and abuse (D & A) during labour and childbirth.	Kenya, county health managers, facility and maternity staff (n = 132), facility staff (n = 146), 13 health care	Pre-post study design (multi-level intervention study ‘Heshima Project’)	Multi-prong intervention including workshop. Used interactive presentations, large and small group discussions, individual and group work, hypothetical and	Before and after comparison, 1.5-day workshop for managers and 3 days for care providers	Exit interviews with postpartum women (baseline n = 641 and post-intervention n = 728) - Overall abuse was measured using a 5-point Likert scale (1 = very humiliated and 5 = not humiliated). Six	<ul style="list-style-type: none"> - 7% reduction in prevalence of D & A (20% to 13%) (OR 0.6; 95% CI 0.4 - 0.8) - Reduction in most subcategories of D & A by 40-50%. - No control group - Convenience sample - Outcome based on the multi-level intervention, 	5/9

		<p>facility including public, private and faith-based, Method of recruitment not stated.</p>		<p>real case studies, sensitivity and listening techniques, role play, songs, skits, artwork, games, simulations, personal journals and interviews, self-analysis worksheets. Included: overview D & A on maternal health, human and childbearing rights, Values Clarification and Attitude Transformation (VCAT), psychological debriefing of staff, ethics and code of conduct, role of professional association and regulatory bodies in RMC, rights and responsibilities of clients and providers for mutual accountability.</p>		<p>Yes/No questions for six categories of D & A by Bowser and Hill (2010). Structured non-participant observation of women from early labour to post-childbirth using seven indicators of D & A (3 for initial examination, 3 during birth and 1 for postpartum care). (baseline n = 677, post-intervention n = 523)</p>	<p>not specific to training to nurses/midwives - No reliable, replicable tool - Validity and reliability of tool not mentioned</p>	
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Paper 1 Afulani et al. (2018)	Effect of integrated simulation-based training on provision of RMC.	Ghana, midwives (n = 22), community health nurses (n = 18), medical doctors (n = 2), Anaesthetist (n = 1)	Pre-post study design	Obstetric simulation training with integration of RMC components (dignity and respect, communication with team, respecting women's autonomy, and supporting them) based on methodology developed by PRONTO International (PRONTO international, 2020). Simulation paired with clinical care review including video, interactive activity, reflection of performance after simulation. Included five simulation scenarios and associated case-based learning modules and skills stations capturing seven topics.	Before and after comparison, 2-day training	Interview with women aged 15-49 years given birth in health facility within 8 weeks (baseline n = 215 and post-intervention n = 318) 30 item PCMC scale having 4-point response options initially validated in Kenya and India with high content, construct and criterion validity, and good reliability. Scale was modified to 24 item (Cronbach's alpha 0.9 for total and over 0.7 for subscales).	PCMC score increased from 50 to 72 from baseline to post-intervention with relative increase of 43%. After controlling confounders 18 point higher than baseline scores ($\beta = 17.6$; 95% CI = 15.6 - 19.6) $p = <0.001$. Increase in subscales scores: 15% for dignity and respect; 87% for communication and autonomy; and 45% for supportive care. - No control group - No randomisation - Convenience sample	5/9
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				Simulation was followed by a debrief for self-analysis of the performance in the clinical management of cases, interactions with patient and other medical personnel.				
Paper 2 Afulani et al. (2020)	Effectiveness of an integrated simulation training on providers' knowledge and self-efficacy, and perceptions of the integrated training.	As above	Mixed-methods study	As above	As above	36 multiple choice questions to measure changes in knowledge on key topics covered in the training. Training evaluation with closed and open-ended questions. In-depth Interviews (n = 17) after one week to assess barriers in providing good quality of care and perceptions of training.	Changes in knowledge regarding teamwork and communication from 63.4% to 84.1% (p <0.01) <u>Process evaluation:</u> Positive perceptions of the training. <u>Qualitative:</u> -Enjoyed the training -Refreshed their knowledge on critical skills -Improvement in woman-provider communication and teamwork. -Immediate collection of post-test data - No separate data on midwives'/nurses' outcome - No information about changes in RMC knowledge or practice post-intervention	6/7

Paper 1 Ratcliffe, Sando, Lyatuu, et al. (2016)	To measure D & A, introduce a package of interventions to reduce its incidence, and evaluate their effectiveness.	Tanzania, Maternity ward staff (n = 76, 86% acceptance rate), hospital management team and council health management team (number not stated), a large urban referral hospital, approached all maternity ward staff	Pre-post study design	Used theory of change model. Multi-prong intervention including adaptation of “Health workers for change” curriculum to compare staff’s current practice with professional codes of conduct, reflect on needs and preferences of patients, and discuss the barriers that prevent provision of RMC. At the end participants developed an action plan to address these issues.	Before and after comparison, 2-day workshop	Used self-developed tool to measure provider knowledge (5 items), and attitude (8 items).	Increase in knowledge, and changes in attitude of health care providers. - No control group - No rigorous statistical analysis - No separate data on midwives’/nurses’ outcome - Immediate collection of post-test data - No reliable, replicable tool	6/9
Paper 2 Ratcliffe, Sando, Mwanyika- Sando et al. (2016)	To describe the participatory approach adopted to engage key stakeholders throughout the planning and implementation of the program.	As above	As above	As above	As above	Tools validated in Kenya was adapted for provider interview, community follow-up interview with women at 4-6 weeks after childbirth (baseline n = 64, post-intervention n = 149), and	D & A among women reduced from 70% to 18%. Observation: revealed marked decline in D & A. -Outcome based on the multi-level intervention	4/9

						observation of women from labour to postpartum (baseline n = 208, post-intervention n = 459)		
Paper 1 Asefa, Morgan, Bohren et al. (2020)	To identify health system challenges to the implementation of RMC and potential solutions to address these challenges	Ethiopia, Midwife (n = 51), Nurse (n = 3), general practitioner (n = 4), integrated emergency surgical officer (n = 4), and health officer (n = 2), three public hospitals, all service provider attending labour and birth were invited.	Interventional mixed methods study	Multi-prong intervention including training of service providers. Presentation, role play, demonstrations, case studies, individual readings, videos, hospital visit and meeting with hospital managers, medical directors, and program managers. Module: Overview of maternal health in Ethiopia, rights and law in the context of reproductive health, RMC rights and standards, professional ethics, and	Before and after comparison, 3-day workshop	<p><u>Quantitative</u> Health care provider: Self-developed 10 items questionnaire for observed experience of mistreatment of women 30 days preceding the survey date; and 8 items on perceptions of RMC and mistreatment (n = 64)</p> <p><u>Qualitative</u> Focus group discussions (n = 21) with participants using semi structured interview guide 2 months after training</p>	<p><u>Quantitative</u>: Overall perception positively changed from 21.9% to 35.9% before and after training respectively ($p = 0.08$).</p> <p><u>Qualitative</u>:</p> <ul style="list-style-type: none"> - Gained new knowledge about rights of women. - Change in attitude toward mistreatment. - Motivation towards work increased. - Positively valued the approach of training. - No control group - No randomisation - No use of replicable tool - Immediate collection of post-test data - No information on validity and reliability of tool 	7/7

				continuous quality improvement.				
Paper 2 Asefa, Morgan, Gebremedhin et al. (2020)	To compare the experiences of mistreatment reported by childbearing women before and after implementation of a RMC intervention	As above	Pre-post study without comparison group	As above	As above	Exit interviews with postpartum women using self-developed 25-item yes/no questionnaire divided into six categories (baseline n = 198 and post-intervention n = 190)	Mistreatment to women was reduced by 18% ($A\beta = 0.82$, 95% CI 0.74 - 0.91) - No control group - Convenience sample - No use of replicable tool - Outcome not explicitly based on educational intervention - No information on validity and reliability of tool	5/9
Mihret et al. (2020)	Reducing D & A of mothers during antenatal care and delivery of services	Ethiopia, Midwives, case managers, coordinators porters, medical record unit coordinators and liaison officers (n = 133), Method of recruitment not stated.	Pre-post intervention mixed methods	Multi-prong intervention Module: Person centred care; RMC, planning, monitoring, and implementation of Compassionate Respectful and Caring; client-provider interaction; facilitation of patients' and families' participation in decisions and care; and communication with teams and health care ethics.	Pre-post comparison, 5-day training	<u>Quantitative</u> : self-developed 24-item questionnaire based on category of D & A by Bowser and Hill (2010) used to interview women (randomly selected) from antenatal and labour ward (baseline n = 374 and post-intervention n = 374) <u>Qualitative</u> : Key informant interviews (n= 10; 3 health care provider, 4 women development army leaders, and 3 women with at least 3 antenatal visits)	<u>Quantitative</u> : D & A during pregnancy and childbirth decreased from 71.8% to 15.9% with 55.9% change (mean difference: 0.56, 95% CI: 0.55 - 0.57), p <0.0001 D & A during ANC reduced from 64.7% to 36.2%. D & A during labour reduced from 78.5% to 27.7%. <u>Qualitative</u> : Improvement in respectful care from health care providers. - No control group - Single institute data	3/7

						using semi-structured interview guide.	<ul style="list-style-type: none"> - No reliable, replicable tool - No comparison of knowledge before and after intervention - No information on methods used to deliver module 	
Wilson-Mitchell et al. (2018)	Evaluate a two-day RMC workshop for midwives using Intellectual Partnership Model (IPM) Principles (Bailey et al., 2016)	Tanzania, Midwives (n = 170), Method of recruitment not stated.	Cross-sectional study	Lectures, videos, small group discussions (pair and share; cluster groups), role play Shared decision making with women, conflict resolution, interprofessional collaboration in a workplace characterized by power differentials as well as differences of culture, language, religion, tribal affiliation, and socioeconomic status.	Pre-post comparison, 2-day workshop	10-item multiple choice quiz about understanding of RMC before and after workshop Verbal and written evaluation of workshop	<p>Mean quiz scores increased by 20%. Two-year certificate learners were less prepared for critical thinking, work, and social innovations than those midwives who had 3- or 4-years formal training.</p> <p><u>Evaluation of workshop</u></p> <ul style="list-style-type: none"> -Midwives planned to become patient advocates and share what they have learnt with colleagues. -Midwives more aware of D & A in health facilities after workshop. - No control group -No randomisation - No robust statistical analysis - No reliable, replicable tool -Immediate collection of post-test data 	1/8

D & A: Disrespect and Abuse; RMC: Respectful Maternity care

In Spain, Mena-Tudela et al. (2020) conducted an eight-hour seminar to enhance perceptions of obstetric violence, which included a theatrical performance on obstetric violence common in labour rooms, legal aspects were discussed by a health law specialist, and health professionals and women shared experiences of disrespect and abuse.

Dzomeku et al. (2021) conducted a four-day RMC workshop in Ghana. The four modules included: respect and dignity in childbirth; communication; focused antenatal care; and birthing positions in RMC training. The workshop was facilitated by the authors and two midwifery educators using interactive methods such as role play, discussion, brainstorming, demonstration, and case study. Another two-day obstetric simulation training in Ghana integrated specific components of RMC such as maintaining dignity, communication amongst the team, respecting autonomy, and supporting women (Afulani et al., 2019). The two-day simulation training package was provided in a train-the-trainer approach by external trainers from PRONTO to participants of the first group. Recorded participant sessions were reviewed through interactive activities and reflection. PRONTO is a non-profit organisation that aims to improve quality of care for women and neonates during obstetric emergencies (PRONTO International, 2020).

Two studies in Tanzania adapted the WHO “Health Workers for Change” curriculum (Fonn & Xaba, 1995) which included ‘why I am a health worker,’ ‘how do our clients see us?’, ‘women’s status in society’, ‘unmet needs’, ‘overcoming obstacles at work’, and ‘solutions’ to deliver RMC components (Ratcliffe, Sando, Lyatuu, et al., 2016; Webber et al., 2018). For instance, Ratcliffe, Sando, Lyatuu, et al. (2016) discussed professional code of conduct, ethical practice, reflection on the personal circumstances and birth preferences of women at the facility, and reflection on local barriers that prevent provision of RMC. Participants then developed an action plan to address barriers. The two-day training program was facilitated by medical school professors and experienced quality improvement facilitators who completed a

two-day orientation on the curriculum. In another Tanzanian study, experienced nurses facilitated a three-day workshop that included self-reflection activities such as creating an individual river of life, role play, and storytelling (Webber et al., 2018).

A two-day RMC workshop in Tanzania focused on shared decision making with clients, conflict resolution, interprofessional collaboration in a workplace characterised by power differentials, differences of socioeconomic status, culture, language, religion, and tribal affiliation. The aim was to infuse RMC principles into clinical management of women in this low-resource setting (Wilson-Mitchell et al., 2018). Intervention delivery consisted of lectures, videos, small group discussions, and role play about complex, ethical decisions.

Various multi-prong interventions also included education (Abuya et al., 2015; Asefa, Morgan, Bohren, et al., 2020; Mihret et al., 2020). In Kenya, the Heshima Project investigated the causes of disrespectful and abusive care during facility-based childbirth and developed interventions to mitigate these problems. The three-day workshop addressed RMC; human and childbearing rights; psychological debriefing of health care workers; professional ethics and code of conduct; and rights and responsibilities of clients and providers for mutual accountability. Various interactive methods such as large and small group discussions, group work, case studies, role play, and action planning were used (Abuya et al., 2015).

Similarly, a three-day workshop in Ethiopia included an overview of maternal health, human rights and the law in reproductive health, RMC rights and standards, professional ethics, and continuous quality improvement (Asefa, Morgan, Bohren, et al., 2020). The principal author, a senior maternal health expert, and a senior obstetrician-gynaecologist facilitated the workshop incorporating presentations, role play, demonstrations, case studies, individual readings, videos, and a hospital visit. A five-day program also offered in Ethiopia focused on person centred care; planning, monitoring and implementation of compassionate respectful and

care; woman-provider interaction; facilitation of women's and families' participation in decisions and care; communication with teams and health care ethics (Mihret et al., 2020). However, information on how the training was facilitated and by whom was not provided (Mihret et al., 2020).

One study used a Theory of Change model specifying outcomes to guide the intervention and evaluation (Ratcliffe, Sando, Lyatuu, et al., 2016). Another study used the Intellectual Partnership Model (IPM) (Bailey et al., 2016) to enrich midwives' understanding of RMC where knowledge, solutions, and approaches to learning occurs through co-creation by both learner and facilitator (Wilson-Mitchell et al., 2018).

Nature, quality, and timing of outcome measures

The eight quantitative and three mixed methods studies varied in the nature, quality, and timing of outcome measurement. Outcomes related to changes in knowledge or perceptions towards RMC, disrespect and abuse, or obstetric violence among participants were typically measured using a researcher generated questionnaire immediately after the intervention (Asefa, Morgan, Bohren, et al., 2020; Dzomeku et al., 2020; Mena-Tudela et al., 2020; Ratcliffe, Sando, Lyatuu, et al., 2016; Wilson-Mitchell et al., 2018). Surveys using study-specific questionnaires were used to measure women's experience of disrespect and abuse before their discharge from health facility (Abuya et al., 2015; Asefa, Morgan, Gebremedhin, et al., 2020; Mihret et al., 2020; Ratcliffe, Sando, Mwanyika-Sando, et al., 2016) and four to six weeks after childbirth (Ratcliffe, Sando, Mwanyika-Sando, et al., 2016). Only one study used the 30-item PCMC which was developed and tested in Kenya, validated in India, and modified to 24 items for Ghanaian women (Afulani et al., 2020). There are three subscales (dignity and respect, communication and autonomy, and supportive care). Women aged 15-49 years who had given birth within eight weeks were interviewed before and six months after the intervention and

completed the scale (Afulani et al., 2019). Staff completed 36 multiple choice questions on key topics covered in the training including communication and teamwork immediately before and after intervention (Afulani et al., 2020).

A one group pre-test-post-test study used a new 33-item questionnaire relating to obstetric violence practices immediately before and after the educational intervention (Mena-Tudela et al., 2020). The questionnaire was reviewed by experts and had good internal consistency (>0.90). There were four major practice domains: before childbirth, during childbirth, during caesarean section, and after childbirth.

One multi-prong intervention targeting women and care providers used a study-specific 13-item questionnaire to measure provider knowledge and attitudes immediately before and after the RMC workshop (Ratcliffe, Sando, Lyatuu, et al., 2016). Another multi-prong intervention used a study-specific eight-item questionnaire to measure perceptions of RMC and mistreatment immediately before and after the intervention (Asefa, Morgan, Bohren, et al., 2020). Dzomeku et al. (2020) used another study specific 20-item questionnaire, while Wilson-Mitchell et al. (2018) used a 10-item multiple choice quiz to measure changes in knowledge about RMC immediately following the intervention.

Abuya et al. (2015) conducted independent observations of women from early labour to post birth and exit interviews to determine the prevalence of disrespect and abuse before and after a multi-prong intervention for staff. A key outcome, “were you treated in a way that made you feel humiliated or disrespected?”, was measured on a five-point Likert scale of 1 (very humiliated) to 5 (not humiliated). In addition, six study-specific yes/no questions based on the categories of disrespect and abuse by Bowser and Hill (2010) were used for the exit interviews and seven yes/no questions for observations.

Similarly, Ratcliffe, Sando, Mwanyika-Sando, et al. (2016) observed women from the time of admission to two hours postpartum and interviewed some women in the community at four to six weeks postpartum in their pre-post intervention study. Interviewees also completed a study-specific tool adapted from Abuya et al. (2015) with seven categories of disrespect and abuse. Prevalence of disrespect and abuse was calculated by tallying the number of women who reported “yes” to at least one category.

Two mixed-methods studies interviewed women who gave birth in a health facility before discharge using study-specific questionnaires. Asefa, Morgan, Gebremedhin, et al. (2020) used 25-item yes/no questionnaire based on six categories of mistreatment by Bohren et al. (2015). The number of mistreatment components women experienced were counted as a score out of 25. However, Mihret et al. (2020) developed a 24-item questionnaire based on categories by Bowser and Hill (2010) to determine prevalence.

Outcomes of educational interventions - Quantitative evidence

Changes in knowledge/perceptions towards RMC or disrespect and abuse or obstetric violence

Among five studies that assessed knowledge, two showed significant positive change. Dzomeku et al. (2020) reported a significant increase in knowledge about RMC after the intervention ($z = -3.43$, $p = 0.001$), effect size ($r = 0.63$). Similarly, Mena-Tudela et al. (2020) reported significant increases in mean scores on 25 out of 33 items regarding perceptions of obstetric violence among students.

Ratcliffe, Sando, Lyatuu, et al. (2016) presented changes in percentages of participants who agreed with a correct answer on knowledge and attitude items in the pre- and post-tests. Another study revealed a 20% increase in mean scores about understanding of RMC following a workshop (Wilson-Mitchell et al., 2018). Although the change was not statistically

significant, the number of participants who perceived all eight RMC domains positively changed from 21.9% to 35.9% (Asefa, Morgan, Bohren, et al., 2020).

Reducing disrespect and abuse during maternity care or increasing RMC

Five studies reported changes in women's experience of disrespect and abuse or respectful care. Abuya et al. (2015) reported a 7% reduction in prevalence of feelings of humiliation or disrespect (OR 0.6; 95% CI = 0.4 - 0.8). Overall, there was a 40-50% reduction in experience of disrespect and abuse on four of the six subcategories of disrespect and abuse (Abuya et al., 2015). Likewise, Ratcliffe, Sando, Mwanyika-Sando, et al. (2016) reported a reduction in women's experience of any form of disrespect and abuse from 70% to 18%. Observations of women from admission to post birth revealed a marked reduction in various forms of disrespect and abuse (Abuya et al., 2015; Ratcliffe, Sando, Mwanyika-Sando, et al., 2016).

Mihret et al. (2020) showed a significant decrease in women's experience of disrespect and abuse from 71.8% to 15.9% (mean difference: 0.56, 95% CI = 0.55 - 0.57). Another study showed a reduction in women's experience of mistreatment by 18% ($A\beta = 0.82$, 95% CI = 0.74 - 0.91) (Asefa, Morgan, Gebremedhin, et al., 2020). Afulani et al. (2019) reported a significant increase in women's PCMC scores after staff had completed the intervention ($\beta = 17.6$; 95% CI = 15.6 - 19.6).

Changes in knowledge regarding communication

There was a significant change in scores regarding communication and teamwork from 63.4% to 84.1% ($p < 0.01$) among participants (Afulani et al., 2020). In another study, the median scores for communication increased from three to four among participants (Dzomeku et al., 2020). However, one study reported a slight decrease (4.1%) in knowledge about communication (Ratcliffe, Sando, Lyatuu, et al., 2016).

Changes in maternal satisfaction of care

Ratcliffe, Sando, Lyatuu, et al. (2016) reported that the proportion of women who were very satisfied with their childbirth experience increased from 12.9% to 75.8% post-intervention.

Outcomes of educational interventions - Qualitative evidence

Findings were derived from two qualitative studies, three mixed-methods studies, and two quantitative studies which used in-depth interviews, focus groups, or open-ended survey questions to assess an educational intervention, implementation of practice changes, or as a process evaluation.

Two qualitative studies explored the experience of implementing RMC in clinical practice four months after the intervention (Dzomeku et al., 2021), and perceptions of the RMC workshop upon completion (Webber et al., 2018). In-depth interviews with midwives revealed positive midwife-woman relationships, effective communication with women, and increased recognition of women's autonomy (Dzomeku et al., 2021). During a focus group discussion nurses perceived positive effects of training on their practices, attitudes, and desire to support others to improve care (Webber et al., 2018).

Two mixed-methods studies in Ethiopia conducted focus group discussion with participants (Asefa, Morgan, Bohren, et al., 2020) and key informant interviews with health care providers and supervisors (Mihret et al., 2020) to explore the effects of training. Participants perceived gains in new knowledge about the rights of women, changes in attitude towards mistreatment and increased motivation by staff towards their work (Asefa, Morgan, Bohren, et al., 2020). Similarly, key informants reported more respectful care by midwives (Mihret et al., 2020).

In Ghana, a process evaluation of an obstetric simulation training package revealed positive perceptions towards RMC (Afulani et al., 2020). Participants reported that the training

refreshed their knowledge on critical skills and improved woman-provider communication and teamwork (Afulani et al., 2020).

Feedback surveys revealed that the training was perceived to be effective and satisfying (Asefa, Morgan, Bohren, et al., 2020; Dzomeku et al., 2020; Webber et al., 2018). Participants recommended training for students, other health care staff, management staff, and women and their partners to enhance RMC. In addition, participants emphasised the need for frequent training to sustain positive changes in care (Dzomeku et al., 2020; Webber et al., 2018). In verbal and written evaluations of a workshop, participants reported becoming a patient advocate and sharing their knowledge with colleagues (Wilson-Mitchell et al., 2018).

Integration of qualitative and quantitative evidence

The quantitative and qualitative evidence was integrated according to JBI Mixed Methods Systematic Review (MMSR) methodology (Lizarondo et al., 2020). The independent syntheses of quantitative and qualitative evidence partially supported each other. The narrative synthesis of quantitative evidence indicated that educational interventions improved knowledge, perceptions, or attitudes of participants towards RMC. This is supported by qualitative findings where a RMC intervention improved knowledge about women's rights and enhanced participants' insights about their previously poor care.

Knowledge regarding communication, improvements in woman-provider communication, and increased empathy towards women were reported by quantitative studies. Only one study reported a slight decrease in knowledge about communication among participants post-intervention. In support of these findings, qualitative evidence revealed improved woman-provider communication, woman-provider relationships, and teamwork.

Women reported less disrespect and abuse during labour and birth. Qualitative evidence from women also identified an improvement in respectful care.

Most quantitative studies assessed impact on staff knowledge and perceptions towards RMC immediately after an intervention whereas qualitative studies assessed participants' experience of care after an intervention at two months and four months revealing sustained changed in reported practice.

Discussion

This mixed-methods systematic review is the first to synthesise evidence from qualitative, quantitative and mixed-methods educational intervention studies targeting midwives, nurses, or students in promoting RMC among women during maternity care. Few educational intervention studies have been published, and all were conducted in the last six years predominantly in low-income countries. This is probably not surprising as recognition of disrespect and abuse during childbirth is relatively recent (Downe et al., 2018). Consequently, interventions addressing RMC are just beginning to emerge.

This review identified variation in the content, intervention delivery mode, duration of intervention, timing of pre- and post-testing, and evaluation methods. Variation in content might be due to the context-specific nature of RMC (Hastings, 2015). For example, eye contact and smiling during care in one culture may be perceived as disrespectful in another (Bowser & Hill, 2010). Similarly, various study-specific tools were used to assess knowledge or perceptions making comparisons difficult. Furthermore, only one study used a reliable and valid tool to measure women's experience of RMC (Afulani et al., 2019), even though this tool

was also modified for the local context. Therefore, findings of the review need to be considered in light of these limitations.

Although findings indicated a reduction in women's experience of disrespectful and abusive care during maternity care, the summary measures of disrespect and abuse were not derived in a consistent way. In line with the conclusions of Sando et al. (2017), there was variation in operationalising the construct of disrespect and abuse, study designs, settings, and types of participants which affect generalisability and comparability of outcomes. In addition, education interventions were usually a component of multi-prong strategies making it difficult to determine the true effects of education alone. However, when considering the complex interaction of various factors in the provision of respectful care, multi-component interventions targeting various levels may be a preferred option over a standalone intervention (World Health Organization, 2018). Importantly, to transform the culture of disrespect and abuse, change must start at an individual level (Hall & Mitchell, 2017). Therefore the provision of education which provides new knowledge and addressed attitudes for individuals is important for change.

Our review identified only one study that included nursing students to enhance perceptions of obstetric violence (Mena-Tudela et al., 2020). This finding supports Sen et al. (2018) who reported that training to medical undergraduates regarding disrespectful and abusive care is lacking. Effective interpersonal interactions and communication are often not formally taught and evaluated during undergraduate medical education (Sen et al., 2018). Midwifery and nursing students, as the future workforce, must learn how to maintain client dignity and respect (Matiti, 2015). Importantly, education has the transformative potential to combat the normalisation of disrespect in health care (Moyer et al., 2016; Munoz et al., 2017).

Our review identified a RMC resource package (facilitators' guide) developed and tested as a part of Heshima project to provide training to health care providers (Ndwiga et al., 2014).

Resource packages can be shared across settings to provide support to health care providers, and facility managers and enhance the replication of interventions to promote RMC in future.

Included studies showed improved knowledge/perceptions and attitudes of midwives and/or nurses about RMC, reduction in disrespect and abuse among women during maternity care, and improved woman-provider communication and quality of care. However, we cannot draw robust conclusions, due to the lack of RCTs; lack of control groups; variation in content, duration, intervention delivery mode, and evaluation methods; and lack of standard evaluation tools and rigorous statistical analysis. In addition, inclusion of other health care providers in addition to midwives and nurses in the intervention sometimes meant we could not identify outcomes that related specifically to changes in knowledge/perceptions towards RMC by midwives or nurses. Moreover, few studies assessed the impact of interventions over time. Additional studies are required to assess the long-term effectiveness of educational interventions in enhancing knowledge regarding RMC among midwives and/or nurses for continuity of respectful care among women during maternity care.

This review has some strengths and limitations. First, the search strategy was comprehensive and designed in consultation with a librarian. All possible terms were included in the search strategy using different databases. In addition, date of publication was not restricted, although included studies were recent. Quality of included studies was assessed using recognised tools. However, there was lack of RCT data for meta-analysis. The other limitation was that most studies originated from African countries, limiting the generalisability of findings to other contexts. Lastly, due to the limitation of time and resources, only English papers were reviewed which may have missed important studies conducted in other languages.

Conclusion

Our review suggests positive outcomes of educational interventions for enhancing knowledge/perceptions towards RMC, reducing women's experience of disrespect and abuse during maternity care, enhancing woman-provider communication, and improving quality of care. However, more rigorous educational intervention studies targeting midwives, nurses, and midwifery/nursing students are needed. Rigorous multi-method, longitudinal evaluation approaches are needed to determine how the benefits and impact of such interventions can be maintained over time. Although RMC is a global concern and a WHO priority, most of interventions originated from African countries. Therefore, educational interventions to promote RMC should be developed, tested, and implemented in other countries. Our review indicated that, frequent rather than one-off interventions and inclusion of other health care providers, students, as well as managerial staff, may have greater impact in promoting a culture of respectful care in maternity facilities.

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