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Effect of Educational Intervention to Promote Respectful Maternity Care among Nurses: A Quasi-Experimental Study in a Trust Hospital in Lahore, Pakistan

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ABSTRACT: **Background**: Respectful maternity care (RMC) protects women's dignity, privacy, confidentiality, autonomy, informed choice, and freedom from mistreatment during childbirth. Nurses have a central role in maternity care, and structured education may support respectful-care practices.

Objective: To evaluate the association between a 12-week educational intervention and nurses' self-reported respectful maternity care practice scores.

Methods: A quasi-experimental, two-group pre-test/post-test study included 28 registered nurses from the Obstetric Department of a trust hospital in Lahore, Pakistan (14 per group). Purposive, non-random allocation was by labor room: Labor Room 1 received the intervention and Labor Room 2 served as the control. The adapted 30-item, five-point Likert questionnaire measured self-reported RMC practice. The intervention was delivered over 12 weeks through two sessions per week, each lasting 1–2 hours. Between group change was summarized descriptively; ANCOVA adjusting for baseline score was retained as an adjusted analysis. The small sample and marked baseline imbalance require cautious interpretation.

Results: The intervention group had a lower baseline mean score than the control group (98.64 ± 3.52 vs 114.00 ± 10.25; Welch $t(16.03) = -5.30$, $p < .001$). The intervention group's mean score increased to 137.50 ± 1.70, while the control group's post-test mean was 109.00 ± 8.10. Mean change was +38.86 points in the intervention group and −5.00 points in the control group. The recorded ANCOVA showed a baseline-adjusted group difference of 31.14 points (95% CI 24.61–37.67; $F(1, 25) = 96.57$, $p < .001$, partial $\eta^2 = .794$). These estimates are based on self-reported scores and do not demonstrate observed clinical behavior or patient outcomes.

Conclusion: The educational programme was associated with higher post-intervention self-reported RMC practice scores. Because the study was small, single-site, non-randomized, and affected by substantial baseline imbalance, the findings are preliminary and should not be interpreted as definitive evidence of causation.

1. INTRODUCTION

Respectful maternity care (RMC) is a core dimension of quality intrapartum care that upholds a woman's dignity, privacy, and confidentiality; protects her from harm and mistreatment; and supports her right to informed choice and continuous support throughout labor (World Health Organization [WHO], 2018). Because nurses typically provide the most sustained bedside contact during labor and delivery, their communication style, responsiveness, and attentiveness to a woman's preferences shape her birth experience more directly than institutional policy alone (Aschenbrenner et al., 2016; Hill et al., 2024).

Despite normative and policy consensus around RMC, mistreatment during facility-based childbirth remains widespread. Globally, disrespect and abuse in maternity settings have been described as a persistent, under recognized threat to the quality and safety of intrapartum care, ranging from verbal abuse and physical mistreatment to non-consented procedures and outright neglect (Bohren et al., 2020). The quality of the interpersonal relationship between a laboring woman and her care provider is now considered as consequential for maternal outcomes as the technical competence of the care itself (Souza et al., 2024).

Country level evidence illustrates the scale of the problem. In Iran, nearly all women in one postpartum sample reported non-consented care, and the large majority reported neglect or being left unattended during labor (Hajizadeh et al., 2020). In Pakistan, similarly stark figures have been reported: in Gujrat district, almost all women were judged, on structured observation, to have experienced disrespect or abuse, yet only a minority recognized or reported it themselves (Azhar et al., 2018), and approximately 97% of women delivering in a health facility elsewhere in Pakistan reported at least one form of disrespect or abuse most commonly non-consented care, breaches of confidentiality, verbal abuse, and abandonment (Hameed & Avan, 2018). Such experiences discourage future use of facility based delivery services and contribute to preventable maternal and neonatal morbidity and mortality (Kawish et al., 2023).

Targeted, provider facing interventions can shift this picture. In Sindh, Pakistan, a theory-informed health-system intervention combining provider training with facility level supportive supervision reduced reported mistreatment by more than half and produced marked gains in privacy and confidentiality (Avan et al., 2023). Structured training programmes focused on communication skills, empathy, and patient rights have likewise shown promising results elsewhere (Bohren et al., 2020; Habib et al., 2023). Because nurses' RMC related knowledge and attitudes are shaped by the training they receive and by their working environment, rather than being a fixed trait of individual providers, RMC practice is plausibly modifiable through structured education (Hill et al., 2024).

Nonetheless, most existing RMC research has emphasized systemic or institutional reform rather than the role of individual nurses, and there remains a research gap in understanding how nurse-focused educational interventions affect actual RMC practice, particularly in South Asian tertiary hospital settings (Avan et al., 2023; Jolivet et al., 2021). The present study addresses this gap by evaluating a structured, 12-week, in-service educational intervention delivered to registered nurses in the obstetric department of a tertiary care hospital in Lahore, Pakistan.

The objective of this study was to evaluate the effect of a structured educational intervention on nurses' practices regarding respectful maternity care. It was hypothesized that nurses receiving the intervention would show a significantly greater improvement in RMC practice scores than nurses in a no training control group.

2. METHODS

2.1 Study Design

This was a quasi-experimental, two-group, pre-test/post-test study. Nurses in the two labor rooms were not randomly assigned; Labor Room 1 was the intervention group and Labor Room 2 was the control group. The groups were assessed before and after the 12-week programme.

2.2 Study Setting

The study was conducted in the Obstetric Department of a trust hospital in Lahore, Pakistan. The total bed capacity 518 beds the Department of Gynaecology and Obstetrics comprises 50 beds, encompassing the general gynaecology ward, labour room, and antenatal and postnatal units, with an estimated 2,000 deliveries conducted annually (hospital administrative data).

2.3 Study Population

The study population comprised registered nurses working in the Obstetric Department, responsible for continuous antenatal, intrapartum, and postnatal care of women admitted for maternity services.

2.4 Inclusion and Exclusion Criteria

Eligible nurses were registered nurses currently working in the labor room or gynecology wards, with at least three months of clinical experience in maternity care, who voluntarily consented to participate, were available for the entire training and data collection period, and had not received formal RMC training in the preceding 12 months. Nurses in an administrative role or

who had previously participated in similar training were excluded. The same eligibility criteria applied to both study groups; the only procedural difference was that the intervention group received the educational programme.

The planned sample size was estimated for a two-sided independent-samples t test comparing two means, using $n = 2(Z_{1-\alpha/2} + Z_{1-\beta})^2/d^2$ (Charan & Biswas, 2013). With $\alpha = .05$ ($Z_{1-\alpha/2} = 1.96$), 80% power ($Z_{1-\beta} = 0.84$), and an assumed standardized mean difference of $d = 1.10$, the calculation was $n = 2(1.96 + 0.84)^2/(1.10)^2 = 12.96$, rounded up to 13 nurses per group. The assumed effect was large and was informed by the RMC training study cited in the thesis (Tajvar et al., 2025); it should be regarded as an assumption rather than an effect established in this sample. Allowing approximately 10% attrition, the target was 14 per group (N = 28). Cohen's (1988) conventional benchmark identifies d = 0.80 as a large effect. The final sample was small, and the study's observed baseline imbalance further limits inference.

The dependent variable was respectful maternity care practice "the extent to which nurses demonstrated woman-centered, ethical, and respectful care behaviors"', measured before and after the intervention. The independent variable was the structured 12-week nurse educational intervention. RMC practice was measured with a 30-item questionnaire adapted, with permission, from the 30-item Respectful Maternity Care Practices (RMCP) tool developed by Dhakal et al. (2025) among 100 maternity healthcare providers (nurses, auxiliary nurse midwives and midwives) in Madhesh Province, Nepal. The original tool was developed in nine steps. An initial pool of 58 items was reviewed by eight experts (scale-level content validity index, S-CVI/Ave = 0.895), with item-level content validity ratios and modified kappa values within acceptable ranges. Exploratory factor analysis (principal component analysis with varimax rotation; Kaiser-Meyer-Olkin = 0.801; Bartlett's test $p < .001$) supported a seven-factor structure explaining 74.55% of the variance, corresponding to the seven domains used in the present study. Internal consistency was $\alpha = 0.925$ for the full scale and ranged from 0.704 to 0.818 across the seven subscales.

RMC practice was measured using an adapted 30-item Respectful Maternity Care Practices questionnaire based on the instrument developed by Dhakal et al. (2025). The seven domains were care during admission (4 items), availability of resources (2), care during labor (6), care during childbirth (2), immediate care after childbirth (7), postpartum care (5), and continuity of care (4). Items were rated from 1 (Never) to 5 (Always), giving a total score range of 30–150; higher scores indicate better self-reported practice. The total continuous score was treated as the primary outcome. No externally validated clinical cut-off for "good" practice was available; therefore, sample-mean classifications are not used to infer clinical effectiveness.

The intervention was a 12-week educational programme grounded in the WHO Compendium on Respectful Maternal and Newborn Care (World Health Organization et al., 2025). It was planned as two sessions per week, each lasting 1–2 hours, combining interactive lectures, group discussion, reflective exercises, role-play, and case studies. Thus, the planned dose was 24 sessions and approximately 24–48 contact hours. The 14 intervention nurses in Labor Room 1 were divided into two subgroups of seven: Group A attended morning sessions and Group B attended evening sessions. Both subgroups received the same planned content and duration. The programme covered rights-based care, informed consent, communication, shared decision-making, privacy, companionship, mobility, newborn care, perinatal mental health, bereavement care, and continuity of care. The control group in Labor Room 2 received no additional training during the study. The thesis does not provide individual attendance totals or a formal intervention-fidelity score; these were therefore not inferred.

Formal permission was obtained from the hospital's Chief Operating Officer prior to data collection. The researcher introduced herself to each eligible nurse, explained the study's purpose and procedures, and obtained written informed consent. Data collection proceeded in three phases. In the pre-intervention phase (Week 1), baseline data were collected from both groups using the two-part questionnaire (Part I: socio-demographic characteristics; Part II: 30-item RMC practice scale), self-administered under the researcher's supervision (approximately 30–45 minutes). During the intervention phase (Weeks 2–12), the intervention group received the educational programmed described above, while the control group continued usual duties without additional training. In the post-intervention phase (Week 12), the same questionnaire was re-administered to both groups, with data collection for the control group timed to coincide with that of the intervention group so that the pre-test/post-test interval was equivalent across groups. No independent clinical observation of nurse patient interactions was conducted.

The study was conducted in accordance with the rules and regulations of the Ethical Research Committee, University of Lahore. Written informed consent was obtained from all participants; participation was voluntary, with no reported risks, and participants were free to withdraw at any time. Data were anonymized using coded identifiers and kept confidential.

Data were analyzed in SPSS version 27. Frequencies and percentages summarized participant characteristics; means and standard deviations summarized continuous RMC scores. Shapiro–Wilk tests were used to assess score distributions. Paired-samples t tests summarized within-group pre-test/post-test changes. Because the groups differed substantially at baseline, the primary interpretation emphasizes the group-specific mean changes and their descriptive contrast rather than the unadjusted post-test comparison alone. ANCOVA with post-test score as the dependent variable, group as the factor, and pre-test score as covariate was retained as an adjusted analysis. The ANCOVA estimate is interpreted cautiously because non-random allocation and baseline imbalance may leave residual confounding. Statistical significance was set at $p < .05$.

The groups' baseline imbalance was addressed by reporting the baseline comparison, presenting pre-to-post mean changes for each group, and retaining the recorded baseline adjusted ANCOVA as a sensitivity analysis. Welch's t test was used for between-group comparisons where unequal variances were relevant.

2.5 Group Allocation

Group allocation was non-random and based on the existing labor-room arrangement: nurses working in Labor Room 1 formed the intervention group (n = 14), and nurses working in Labor Room 2 formed the control group (n = 14). The intervention group was split into two subgroups of seven to accommodate morning and evening shifts while maintaining staffing coverage. This ward based approach reduced the need to mix staff across the two study groups during training, but it did not ensure that contamination was absent. The study did not document a formal contamination assessment, and information on the total number of eligible nurses approached or those declining participation.

3. RESULTS

Twenty-eight registered nurses were enrolled and completed the study, 14 in the intervention group and 14 in the control group; no attrition or missing outcome data.

3.1 Participant Characteristics

Table 1 summarizes participants' age, work experience, and educational qualification by group. In the intervention group, most nurses were aged 25–30 years (42.9%); the majority in both groups had more than five years of clinical experience (92.9% intervention; 71.4% control). Post-RN BSN was the most common qualification in the intervention group (42.9%), while BSN was most common in the control group (42.9%). In the intervention group, 6 nurses (42.9%) were single and 8 (57.1%) were married; in the control group, 7 (50.0%) were single and 7 (50.0%) were married.

Table 1. Sociodemographic Characteristics of Participants by Group (N = 28)

	Intervention (n = 14)	**Control (n = 14)**
Age group		
20–25 years	0 (0%)	1 (7.1%)
25–30 years	6 (42.9%)	6 (42.9%)
30–35 years	4 (28.6%)	5 (35.7%)
>35 years	4 (28.6%)	2 (14.3%)
Marital status		
Single	6 (42.9%)	7 (50.0%)
Married	8 (57.1%)	7 (50.0%)

	Intervention (n = 14)	Control (n = 14)
Work experience		
1–3 years	0 (0%)	1 (7.1%)
3–5 years	1 (7.1%)	3 (21.4%)
>5 years	13 (92.9%)	10 (71.4%)
Educational qualification		
Diploma in Nursing	4 (28.6%)	3 (21.4%)
BSN	4 (28.6%)	6 (42.9%)
Post-RN BSN	6 (42.9%)	5 (35.7%)

Note. BSN = Bachelor of Science in Nursing.

3.2 Normality of Distributions

Shapiro Wilk tests indicated that pre-test and post-test RMC practice scores did not differ significantly from a normal distribution in either group (all $p > .05$), supporting the use of parametric tests (Table 2).

Table 2. Shapiro–Wilk Tests of Normality for Pre-test and Post-test RMC Practice Scores (N = 28)

Variable	Group	W	p	Distribution
Pre-test score	Intervention (n = 14)	0.928	.287	Normal
	Control (n = 14)	0.894	.091	Normal
Post-test score	Intervention (n = 14)	0.935	.356	Normal
	Control (n = 14)	0.936	.375	Normal

Note. W = Shapiro–Wilk test statistic.

3.3 Baseline Comparison between Groups

At baseline, the intervention group's mean RMC practice score was significantly lower than the control group's (98.64 ± 3.52 vs 114.00 ± 10.25; Welch $t(16.03) = -5.30$, $p < .001$). The mean difference was 15.36 points in favor of the control group. This imbalance is important: the groups were not comparable on the primary outcome before the intervention, and non-random allocation means measured adjustment cannot exclude unmeasured confounding.

3.4 Post-Intervention Comparison between Groups

At post-test, the intervention group's mean score was 137.50 ± 1.70 and the control group's was 109.00 ± 8.10. The unadjusted difference was 28.50 points (Welch $t(14.14) = 12.89$, $p < .001$; 95% CI 23.76–33.24). Because the intervention group started with a substantially lower score, this post-test comparison should not be interpreted in isolation.

Table3. Pre- and Post-Intervention RMC Practice Scores by Group (N = 28)

Group	n	Pre-test M ± SD	Post-test M ± SD
Intervention	14	98.64 ± 3.52	137.50 ± 1.70
Control	14	114.00 ± 10.25	109.00 ± 8.10
Overall	28	106.32 ± 10.85	123.25 ± 15.61

Note. M = mean; SD = standard deviation.

3.5 Within-Group Change: Comparison of Changes between Groups

The intervention group's mean self-reported RMC practice score increased by 38.86 points, from 98.64 ± 3.52 to 137.50 ± 1.70 (paired $t(13) = -40.24$, $p < .001$, using the pre-test-minus-post-test sign convention in the reported output). The control group's mean score decreased by 5.00 points, from 114.00 ± 10.25 to 109.00 ± 8.10 (paired $t(13) = -1.63$, $p = .128$). The descriptive difference in mean change was 43.86 points in favor of the intervention group. The thesis does not provide participant-level change scores, so no additional change-score test has been independently recalculated for this revision.

The difference in group-specific mean changes is descriptive: +38.86 points in the intervention group and −5.00 points in the control group, a 43.86-point contrast. This contrast should be interpreted alongside the significant baseline imbalance and non-random allocation.

Table 4. Within-Group Pre-test to Post-test Change in RMC Practice Scores

Group	Pre-test M ± SD	Post-test M ± SD	Mean difference	t	df	p
Intervention	98.64 ± 3.52	137.50 ± 1.70	+38.86	−40.24	13	< .001
Control	114.00 ± 10.25	109.00 ± 8.10	−5.00	−1.63	13	.128

3.6 Baseline-Adjusted Analysis

No clinically validated threshold was available for classifying the total score as "good" or "poor"; the continuous score was therefore retained for interpretation.

The recorded ANCOVA compared post-test RMC practice scores between groups while adjusting for pre-test score. The reported group effect was statistically significant, $F(1, 25) = 96.57$, $p < .001$, partial $\eta^2 = .794$. The adjusted mean difference was 31.14 points (95% CI 24.61–37.67; reported $p = .001$). The pre-test covariate was not statistically significant in this model ($F(1, 25) = 1.34$, $p = .259$). The estimate is retained as an adjusted analysis.

Table 5. Analysis of Covariance Comparing Post-test RMC Practice Scores between Groups (N = 28)

Source	df	F	p-value	Partial η^2
Group	1	96.57	< .001	0.794
Pre-test score	1	1.34	0.259	0.051
Error	25	—	—	—

Outcomes	Adjusted mean difference	95% CI	P value
Post-test RMC score	31.14	24.61-37.67	0.001

Note. Dependent variable: post-test RMC Practiced score. Covariate: pre-test RMC Practiced score. Group: intervention versus control.

4. DISCUSSION

The intervention group showed a marked increase in self-reported RMC practice scores over 12 weeks, while the control group's mean score decreased slightly. This pattern is consistent with a possible benefit of structured education, but the design does not establish a definitive causal effect. The primary outcome was self-reported practice, not independently observed clinical behavior, and patient outcomes were not measured.

Although some demographic characteristics were descriptively similar, the groups were not comparable on baseline RMC practice: the intervention group scored 15.36 points lower than the control group (98.64 ± 3.52 vs 114.00 ± 10.25, $p < .001$). This difference could reflect pre-existing differences between the labor rooms, ward culture, supervision, or other unmeasured factors. The post-test difference and adjusted ANCOVA result should therefore be interpreted cautiously rather than attributed solely to the programme.

The substantial baseline difference is a central limitation, not a minor statistical issue. Non-random allocation by labor room may have introduced selection and setting-related confounding. Adjustment for baseline score helps account for the measured initial score but cannot guarantee comparability on other factors.

The direction of change is consistent with the wider literature on education for nurses and midwives. A mixed-methods systematic review of nine studies, most from Africa, reported that educational interventions generally improved providers' knowledge and perceptions of RMC and, in some studies, communication with women and women's reports of disrespect and abuse. The authors rated the evidence as low-level, with studies varying in content, duration and timing of testing, and only one study using a valid and reliable measure of women's experience (Dhakal, Creedy, et al., 2022). Trials in Iranian hospitals (Tajvar et al., 2025) and an Ethiopian workshop evaluation (Asefa et al., 2020) point the same way, with the latter noting that gains in behavior needed ongoing supervisory reinforcement. The size of the change observed here is, however, unusually large for a behavioral training effect, and the reasons for caution are set out below. Self-report and social desirability. The outcome was nurses' self-reported practice, so the findings concern what nurses say they do, not what they do. Self-reports of clinical practice tend to overstate adherence compared with observation or records (Adams et al., 1999), and answers on socially sensitive topics are prone to social desirability bias, in which respondents give the answer they believe is expected or approved (Nederhof, 1985; Krumpal, 2013). Several features of this study increase that risk. The programme explicitly taught which behaviors are desirable, the same instrument was completed immediately after the programme ended, nurses knew which group they were in, and the researcher who delivered the training also supervised data collection. Intervention-group nurses may therefore have learned the "right" answers, or wished to show that the training had worked, and either could raise scores without any change in bedside care. Two features of the data are consistent with this possibility: the intervention group's post-test mean (137.5) sat close to the 150-point maximum with very little spread (SD = 1.70), and the control group, which received no teaching, did not rise. Neither feature proves response bias, and a real change in practice cannot be excluded, but this study cannot tell the two apart. The results are best read as an improvement in nurses' self-reported RMC practice, which may partly reflect greater awareness of RMC norms, and not as evidence that care or women's experiences improved. Observation, record audit, or woman-reported measures collected by assessors blind to group would be needed to test this.. In a quasi-experimental study of an educational intervention for midwives in Iranian teaching hospitals, mistreatment scores fell substantially in intervention hospitals after training, while scores in untrained control hospitals worsened over the same follow-up period (Tajvar et al., 2025). A multi-day RMC workshop for Ethiopian maternity providers similarly improved participants' understanding of women's rights and their confidence in respectful communication, although sustaining this gain in bedside behavior was reported to require ongoing supervisory reinforcement (Asefa et al.,

2020). A mixed-methods systematic review likewise concluded that educational interventions for nurses and midwives generally improve knowledge and perceptions of RMC and reduce reported disrespect and abuse, while cautioning that evidence quality varies and gains are not always sustained without reinforcement (Dhakal, Mohammad, et al., 2022).

These findings align with WHO guidance recommending RMC as a standard component of quality intrapartum care (World Health Organization, 2018) and with foundational work framing disrespect and abuse during childbirth as a global patient-safety and human-rights concern rooted partly in provider knowledge gaps (Bowser & Hill, 2010; Vogel et al., 2015). At the same time, evidence from Pakistan cautions against relying on education alone: a theory-informed health-system intervention in Sindh achieved a substantial reduction in mistreatment only when provider training was combined with structural and managerial change at the facility level (Avan et al., 2023). This suggests that while the present intervention produced a strong short term improvement in individual nurses' self-reported practice, sustaining and scaling this improvement would likely require complementary system-level supports supervision, feedback mechanisms, and institutional commitment to RMC standards rather than education delivered as a stand-alone activity (Kasaye et al., 2023; Kassa et al., 2020).

ANCOVA was retained as an adjusted analysis of post-test score with baseline score as covariate.

5. STRENGTHS AND LIMITATIONS

The study included a control group, repeated measurement, and an adapted instrument whose original validation evidence and local content review are described. However, the small sample (14 nurses per group), single hospital, non-random ward-based allocation, significant baseline outcome imbalance, and self-reported outcome limit the strength and generalizability of the evidence.

Several limitations should be emphasized. First, only 28 nurses from one hospital participated, limiting precision and generalizability. Second, the groups were allocated non-randomly by labor room and differed significantly at baseline, leaving possible confounding by ward environment, supervision, and other unmeasured characteristics. Third, nurses reported their own practices, which may be affected by recall and social desirability bias, especially after education explicitly addressing the behaviors measured. No independent observation of bedside behavior or patient-reported experience was collected; therefore, actual clinical behavior and patient outcomes cannot be inferred.

6. IMPLICATIONS FOR NURSING PRACTICE

For nurses, these findings suggest that structured, reflective, interactive RMC education rather than passive instruction alone may meaningfully strengthen self-reported respectful care practices in the short term. For nurse educators, the results support integrating RMC content, grounded in WHO guidance, into in-service training using formats such as role-play, case discussion, and reflective exercises. For hospital administrators, the findings indicate that in-service RMC training is a feasible, low-infrastructure intervention that can be scheduled around ward staffing needs (as in this study's shift-based subgroup delivery), though evidence from other Pakistani settings suggests that pairing training with supervision, feedback, and institutional accountability mechanisms may be necessary to sustain gains. For maternal health services and RMC policy more broadly, this study offers single site, preliminary evidence that nurse focused education can be a component of efforts to reduce mistreatment during childbirth, complementing rather than replacing system level reform.

The 12-week educational programme was associated with an increase in nurses' self-reported RMC practice scores compared with the control group. However, the small single-site sample, non-random allocation, significant baseline imbalance, self-report measurement, and absence of observed clinical or patient outcomes mean that the findings should be considered preliminary and not definitive evidence of causation. Larger, multi-site studies with stronger allocation methods and objective practice measures are needed.

7. RECOMMENDATIONS

Recommendations for Nursing Practice

- Maternity and labor ward nurses should receive regular, structured RMC education as a routine part of in-service training rather than a one-time activity.
- Ward level RMC champions or mentors should be identified to model and reinforce respectful communication, informed consent, and dignity-preserving care during daily clinical work.

Recommendations for Nursing Education and Training Institutions

- Nursing education institutions should integrate WHO aligned RMC content into pre-service midwifery and maternal child health nursing curricula as a foundational, rather than remedial, competency.
- Simulation, case discussion, and reflective practice exercises similar to those used in this intervention should be adopted to help translate RMC knowledge into durable clinical behavior.

Recommendations for Hospital and Nursing Administration

- Hospital and nursing leadership should pair RMC training with system level supports, including adequate staffing, supportive supervision, and periodic audit and feedback on RMC indicators.
- Administrators should establish patient-facing feedback mechanisms so that women can report their care experience and inform continuous quality improvement.

Recommendations for Future Research

- Future studies should replicate this intervention using larger, multi-site samples and, where feasible, random assignment of participants or facilities to strengthen internal validity.
- Long term follow-up studies are needed to determine whether post-intervention gains in RMC practice are sustained over time or require periodic refresher training.
- Future research should incorporate direct observation of nurse patient interactions and the perspectives of childbearing women themselves, since provider self-report and patient reported experience of respectful care do not always align.
- Further research should examine which specific components of RMC education content, duration, or teaching method contribute most strongly to sustained practice change.

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