

**Midwifery and nursing students' perceptions of respectful maternity care and witnessing of disrespect and abuse: A comparative study from Nepal and Jordan**

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Published

2022

Journal Title

Midwifery

Version

Accepted Manuscript (AM)

DOI

[10.1016/j.midw.2022.103426](https://doi.org/10.1016/j.midw.2022.103426)

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## **Midwifery and nursing students' perceptions of respectful maternity care and witnessing of disrespect and abuse: A comparative study from Nepal and Jordan**

### **Abstract**

*Objectives:* To compare Nepalese and Jordanian midwifery and nursing students' perceptions of respectful maternity care (RMC) and witnessing of disrespect and abuse; and determine factors that predict scores on a scale measuring perceptions of RMC.

*Design:* A descriptive, comparative design was used.

*Setting:* Recruitment took place from two medical colleges in Nepal and one University in Jordan.

*Methods:* A convenience sample of students ( $n = 276$ ) enrolled in a Bachelor or Diploma level midwifery or nursing degree who were undertaking or had recently completed their midwifery clinical placement were recruited. The online or hard copy survey included the Students' Perceptions of Respectful Maternity Care (SPRMC) Scale and nine questions on witnessing different types of disrespect and abuse.

*Findings:* Nepalese students were slightly older (mean = 23.68 years) than Jordanian students (mean = 21.36). Mean duration of clinical placement was longer for Jordanian students (11.24 compared to 6.28 weeks). However, mean number of births observed was higher among Nepalese students (19.6 compared to 18.62). Overall, perceptions of RMC were more positive among Jordanian students ( $t(199.97) = 6.68, p < 0.001$ ). A multiple regression analysis found that duration of clinical placement ( $\beta = .22, p < 0.001$ ), witnessing disrespect and abuse ( $\beta = .11, p = 0.08$ ) and age ( $\beta = -0.14, p = 0.03$ ) explained 12.2% of variance in SPRMC scores. Compared to students in Nepal, all Jordanian students had observed non-consented care during their clinical practicum. However, Nepalese students were more likely to observe poor adherence to women's privacy and confidentiality.

*Key conclusion and implications for practice:* This is the first study to compare midwifery and nursing students' perceptions of RMC across two middle-income countries. Although

Jordanian students held more positive perceptions of RMC than those in Nepal, more had witnessed different forms of disrespect and abuse. Variations in students' perceptions of RMC and witnessing of abuse across countries highlight the need for assessment of workplace cultures to inform the development of tailored education and practice interventions for students, clinicians, and managers. Future research needs to explore how to best support students to consistently offer RMC and how to improve the experiences of childbearing women.

**Keywords:** Student, nursing, midwifery, perceptions, respectful maternity care, disrespect, abuse, middle-income countries, survey

### **Highlights**

- There is relatively little research on students' understanding of RMC and witnessing of disrespect and abuse.
- Generally, students from Nepal and Jordan reported positive perceptions of respectful maternity care.
- All Jordanian students had observed non-consented care during their clinical practicum.
- Nepalese students reported witnessing poor adherence to women's privacy and confidentiality during labour and birth.
- Findings suggest that changes to clinical practice rather than student awareness is needed to promote RMC.
- Ensuring consent, confidentiality and privacy are modifiable practice issues.

## **Introduction**

Respectful Maternity Care (RMC) is defined as “care organized for and provided to all women in a manner that maintains their dignity, privacy and confidentiality, ensures freedom from harm and mistreatment, and enables informed choice and continuous support during labour and childbirth” (World Health Organization, 2018, p. 3). Respectful and dignified care underpins the philosophy of care for both the International Council of Nurses (ICN) (2012) and International Confederation of Midwives (ICM) (2014). RMC is included in the global standards for midwifery education (International Confederation of Midwives, 2021) and essential competencies for midwifery practice (International Confederation of Midwives, 2019). However, women continue to experience different forms of disrespect and abuse during labour and childbirth globally (World Health Organization, 2015).

Researchers often measure RMC, in part, by the absence of disrespect and abuse even though a lack of abuse does not guarantee respectful care (Afulani et al., 2020). The occurrence of disrespect and abuse during childbirth is a violation of a woman’s human rights (White Ribbon Alliance, 2011) and an indicator of poor quality of care (Kujawski et al., 2015). Since 2015, WHO has called for the prevention and elimination of disrespectful and abusive practices, included RMC in its vision of quality of care (World Health Organization, 2016), and recommended RMC in their positive childbirth guidelines (World Health Organization, 2018). In low- and middle-income countries (LMICs), disrespectful care is a barrier to achieving better maternity outcomes because it is associated with low uptake of childbirth care in health facilities (Bohren et al., 2014). The presence of disrespect and abuse in LMICs also hinders efforts to address preventable maternal and neonatal mortality (Kruk, Gage, et al., 2018; Sharma et al., 2015; Tuncalp et al., 2015).

The only international comparison of RMC was conducted by Bohren and colleagues (2019) who observed a 41.6% prevalence of mistreatment of childbearing women in Nigeria,

Ghana, Myanmar, and India (Bohren et al., 2019). Countries such as Nepal and Jordan are rarely included in such comparisons. According to the World Bank (2021) Nepal and Jordan are middle-income countries. Culturally, there is gender-related bias, restrictive social norms, and disempowerment of women in the medically dominated maternity care systems of both countries. Undergraduate midwifery programs were introduced in Jordan in 2002 but only recently in Nepal where most maternity care is offered by obstetric nurses and nursing students.

In October 2018, the Government of Nepal incorporated RMC in the Safe Motherhood and Reproductive Health Rights Act paving the way for the provision of quality and respectful care to women and newborns in public and private health facilities (Health Policy Plus, 2019). Despite this, a recent study in Nepal reported women's experiences of physical abuse (including biting, slapping), non-confidential care, verbal abuse (talking impolitely), inadequate anaesthesia during episiotomies and suturing, discrimination based on sociocultural characteristics, neglectful care, and excluding husbands against the woman's wishes (Ghimire et al., 2021).

Similarly, there are reports of disrespectful care practices during labour and childbirth in Jordan where women have reported experiences of verbal abuse and neglect during labour (Alzyoud et al., 2018), lack of emotional support, privacy, and respect for choices (Khresheh et al., 2019). Care providers, including midwives, blamed women for not being involved in decision making, and lacking knowledge about childbirth (Hussein et al., 2016). Four years later, Hussein et al. (2020) continued to highlight the urgent need to promote RMC in the Jordanian health care system.

Various qualitative studies have described midwives' perspectives of disrespect and abuse (Afulani et al., 2020; Burrowes et al., 2017; Dzomeku et al., 2020b) and RMC (Dzomeku et al., 2020a; Moridi et al., 2020) but there is little research with students. One qualitative study from Ghana reported that midwifery students witnessed high levels of disrespectful and abusive

care during their clinical practicum (Rominski, 2015). One of the few quantitative studies was conducted with undergraduate nursing students placed in maternity services in Nepal. While students reported generally positive perceptions of RMC, around 44% had witnessed some form of disrespectful care (Dhakal et al., 2022).

While disrespectful and abusive care towards women during labour and birth is a global issue, students from different countries or cultures may have different perceptions about RMC (Hastings, 2015). Midwifery and nursing students' perceptions of RMC and witnessing of disrespectful care to women during labour and birth may impact on their future practice. Surveys of students placed in maternity care settings in various countries can provide evidence about the extent of RMC in practice. Comparisons of perceptions about RMC by students may also inform educational gaps within programs, and between programs offered in different countries/cultures so educational responses/interventions can be tailored. Regular assessment of RMC in practice (by students as observers) can also be an indicator of practice changes over time and potential impact of professional development and governance initiatives.

### **Aims**

1. To compare Nepalese and Jordanian midwifery and nursing students' perceptions of respectful maternity care and witnessing of disrespect and abuse.
2. To determine factors that predict scores on a scale measuring perceptions of RMC.

### **Methods**

#### **Study design**

A descriptive, comparative survey design was used.

#### **Study participants and sampling**

Convenience sampling is a suitable approach when recruiting participants from a particular clinical setting or organisation (Polit & Beck, 2017). All students studying in the second or third year of Bachelor of Nursing Science (BNS) and third or fourth year of Bachelor of Science in Nursing (BSN) from two colleges in Nepal were invited to participate. Similarly,

all students studying in the third year Diploma of Midwifery and third- or fourth-year Bachelor of Midwifery in a university in Jordan were invited to participate. Students were eligible if they were undertaking or had recently completed their midwifery clinical placement. A G\* power calculation using a 0.05 two-tailed level of significance, an effect size of 0.5 and a power of 0.8 using the mean differences between two groups with an independent *t*-test revealed that a sample of 64 students in each group was required. Altogether 268 students from Nepal and 127 students from Jordan were approached as a large, diverse sample may better reflect students' experiences.

### **Measurement**

The survey consisted of a participant information sheet and questions related to students' sociodemographic characteristics (age, name of college, year of study); clinical placement details (duration of clinical placement, number of births observed and assisted, type of facility for childbirth); extent to which students witnessed nine forms of disrespect and abuse (0 = no, never to 4 = yes, all the time) adapted from Afulani et al. (2020); and the Student Perceptions of RMC (SPRMC) scale (Dhakal et al., 2022). The list of disrespectful and abusive practices was originally developed for use by maternity care providers (Afulani et al., 2020). When necessary, we adapted items for students who may witness disrespectful and abusive care practices towards women. The SPRMC scale was validated in Nepal and consists of 18 items with three subscales namely: Respectful care (10 items), Safety and comfort (5 items), and Supportive care (3 items) with reliability coefficient value ( $\alpha$ ) 0.81. Each item of SPRMC scale is scored on 5-point Likert scale ranging from 1 (strongly disagree) to 5 (strongly agree). Higher perception scores represent the student's cognitive ability to 'make sense of' or better understand the concept of RMC. In Jordan, the SPRMC was translated from English into Arabic and back translated to English by bilingual experts in the fields of midwifery and maternal health nursing.

## **Data collection procedure**

Human Research Ethics approval was obtained in both countries (Nepal Health Research Council Ref. 2170; Institutional Review Board at Jordan University of Science and Technology and Jordan Ministry of Health Ref. 71/140/2021). In Nepal, the survey was conducted using LimeSurvey software. Program convenors from participating colleges sent an email to students that included a survey link. Completing the survey implied consent. A follow-up reminder email was sent one week later. In Jordan, permission of the Dean of the participating institute was obtained for the researcher to speak with course instructors and briefly meet with students during their lecture to provide verbal and written information about the study. Students willing to participate collected an envelope containing an information sheet and translated questionnaire. Participants completed the questionnaire in their own time, placed it in a sealed envelope and returned it to a locked box near the course instructor's office. Completed forms were collected after one week by one of the authors (KM). An identification number was assigned to completed forms. Confidentiality was assured as names and other identifiable information were not required. Data were collected between May and November 2021.

## **Data analysis**

Data from the online survey were downloaded in Microsoft Excel and imported into the Statistical Package for the Social Sciences (SPSS) for Windows version 28. Whereas data from completed paper-based questionnaires were directly entered into SPSS.

Sociodemographic characteristics, clinical placement variables, observed disrespect and abuse, and SPRMC scores were analysed using mean, standard deviation, frequency, and percentages. Differences in observed disrespectful and abusive care between Nepalese and Jordanian students were analysed using Chi square test and differences in SPRMC scale scores were analysed using independent t-test. Preliminary analyses were conducted to ensure no

violation of assumptions regarding normality, linearity, multicollinearity, and homoscedasticity. Standard multiple regression analysis was performed to explore the relationship between independent variables (age, duration of clinical placement and total scores on witnessing disrespect and abuse) and total SPRMC scores.

## Results

### *Socio-demographic and Clinical Placement Information*

Altogether 171 students from Nepal (response rate 63.8%) and 105 students from Jordan (response rate 82.7%) completed the survey. Nepalese students were slightly older than Jordanian students (see Table 1). Although the average duration of clinical placement was higher among Jordanian students (mean = 11.24 weeks compared to 6.28 weeks), the number of childbirths observed during clinical placement was higher among Nepalese students (mean = 19.6 births compared to 18.6). All but one student had assisted at a birth during their clinical placement at the time of the survey. Nepalese students attended childbirth in various settings whereas Jordanian students were only placed in district or teaching hospitals.

**Table 1**

Participants' Socio-demographic and Clinical Placement Information

<b>Characteristics</b>	<b>Nepal (n = 171) n (%)</b>	<b>Jordan (n = 105) n (%)</b>	<b>t/p</b>
<b>Age (years)</b>	Mean = 23.68 SD = 2.44 range = 20 - 34	Mean = 21.36 SD = 0.48 range = 20 - 21	-12.05*
<b>Course</b>			
Diploma of Midwifery	-	24 (22.9)	
Bachelor of Midwifery	-	81 (77.1)	
Bachelor of Nursing Science	81 (47.4) 90 (52.6)	-	
Bachelor of Science in Nursing			
<b>Year level</b>			
Second year	33 (19.3)	-	
Third year	82 (48.0)	67 (63.8)	
Fourth year	56 (32.7)	38 (36.2)	

<b>Clinical placement duration (weeks)</b>	Mean $\pm$ SD = 6.28 $\pm$ 4.04 range = 2 – 20	Mean $\pm$ SD = 11.24 $\pm$ 2.36 range = 8 - 15	12.86*
<b>Number of births observed</b>	Mean $\pm$ SD = 19.6 $\pm$ 12.03 range = 2 – 50	Mean $\pm$ SD = 11.24 $\pm$ 2.36 range = 8 -15	-0.99
<b>Assisted birth during clinical placement</b>			
Yes	170 (99.4)	105 (100)	
No	1 (0.6)	-	
<b>Clinical practicum<sup>#</sup></b>			
District hospital	103 (60.2)	54 (51.4)	
Teaching hospital	84 (49.1)	51 (48.6)	
Private health facility	17 (9.9)	-	
Home	3 (1.8)	-	
Other	6 (3.5)	-	

<sup>#</sup> Multiple responses possible, *t*= independent *t*-test, \**p* <0.001

### *Students' Perceptions of Respectful Maternity Care*

Table 2 shows responses on the SPRMC scale. Scores on the 'Safety and comfort' subscale, 'Supportive care' subscale and total SPRMC scale were significantly higher among Jordanian students (total mean = 75.2 out of a possible 90) compared to Nepalese students (total mean = 71.2) (*p* < 0.001).

**Table 2**

Responses on the Students' Perceptions of Respectful Maternity Care Scale

Items	Mean $\pm$ SD		<i>t/p</i>
	Nepal (n = 171)	Jordan (n = 105)	
<b>Respectful care subscale</b>	<b>36.5 <math>\pm</math> 6.0</b>	<b>36.6 <math>\pm</math> 1.5</b>	<b>0.17</b>
Scolding a woman is necessary if she does not cooperate. (R)	3.9 $\pm$ 1.0	4.7 $\pm$ 0.5	
Women should "leave their dignity at the door" as there is nothing private about giving birth. (R)	3.6 $\pm$ 1.1	3.1 $\pm$ 1.0	
Confidentiality is hard to maintain in maternity care. (R)	3.5 $\pm$ 1.1	5.0 $\pm$ 0.0	
I am too busy to greet every woman with a smile. (R)	3.9 $\pm$ 1.0	1.0 $\pm$ 0.0	

Routine procedures like vaginal examination and abdominal palpation do not require permission. (R)	4.5 ± 0.9	5.0 ± 0.0	
Women's cultural beliefs are so varied that staff cannot be expected to accommodate them all. (R)	3.4 ± 1.0	4.2 ± 0.7	
There is no point providing all the details about birth procedures because some women will not understand. (R)	3.9 ± 0.9	4.9 ± 0.4	
I am often too busy to provide birth options to women. (R)	3.9 ± 0.9	1.8 ± 0.4	
It is often hard to keep a calm environment for women during labour. (R)	2.5 ± 1.0	2.1 ± 0.5	
If women do not look after their own health, they should not expect the same treatment as others. (R)	3.5 ± 1.1	4.9 ± 0.4	
<b>Safety and comfort subscale</b>	<b>21.6 ± 2.3</b>	<b>24.0 ± 0.9</b>	<b>12.27*</b>
Labouring women need a birth space free from unnecessary disturbance by others.	4.2 ± 0.8	4.7 ± 0.4	
I have a responsibility to help women feel safe during labour and birth.	4.6 ± 0.6	5.0 ± 0.0	
I try to limit exposing a woman's body when providing care.	4.4 ± 0.6	5.0 ± 0.0	
Actively listening to women's stories values their experiences.	4.1 ± 0.7	4.8 ± 0.5	
I explain benefits and risks to a woman before any procedure.	4.3 ± 0.7	4.4 ± 0.5	
<b>Supportive care</b>	<b>13.1 ± 1.4</b>	<b>14.6 ± 0.6</b>	<b>13.01*</b>
Women should be encouraged to actively participate in their care.	4.5 ± 0.6	4.8 ± 0.4	
Every woman should receive support she needs with breastfeeding.	4.4 ± 0.7	4.9 ± 0.3	
Women should be encouraged to talk to postpartum women about their experiences.	4.3 ± 0.6	4.9 ± 0.3	
<b>Total SPRMC scale</b>	<b>71.2 ± 7.5</b>	<b>75.2 ± 1.8</b>	<b>6.68*</b>

\* $p < 0.001$ ,  $t =$  independent  $t$ -test,  $R =$  reverse scored (negative statement); refer to Dhakal et al. (2022) for exact item wording

### *Students' Witnessing of Disrespect and Abuse*

Students reported if they had witnessed any of the nine examples of disrespect and abuse towards women during their clinical placement (see Table 3). Varying proportions of

students from both countries had observed all forms of disrespect and abuse except “physical restraint”, which was only witnessed in Nepal. The prevalence of observing disrespectful care was significantly different for seven items. Non-consented care was observed by all Jordanian students, whereas observation of non-confidential care such as ‘allowing other people not involved in a woman’s care to be present at birth’ was significantly higher among Nepalese students.

**Table 3**

Students Witnessing Disrespect and/or Abuse During Clinical Placement

Items	Nepal (n = 171) n (%)	Jordan (n = 105) n (%)	$\chi^2/p$
<b>During my clinical placement I have seen staff-</b>			
1. treat women in an unfriendly manner.	73 (42.7)	91 (86.7)	50.37**
2. shout at, scold, insult, threaten, or be rude to women.	58 (33.9)	86 (81.9)	58.13**
3. push, slap, or pinch women if they did not co-operate.	40 (23.4)	49 (46.7)	15.08**
4. physically restrain or gag women when giving birth.	11 (6.4)	-	-
5. perform a procedure without consent.	17 (9.9)	105 (100)	210.29**
6. leave women exposed.	40 (23.4)	102 (97.41)	138.72**
7. allow other people not involved in a woman’s care to be present at the birth.	75 (43.9)	26 (24.8)	9.42*
8. talk about a woman's health information with others not directly involved in her care.	58 (33.9)	27 (25.7)	1.69
9. treat women differently because of their personal attributes (age, ethnicity).	42 (24.6)	39 (32.1)	4.39*

\* =  $p < 0.05$ , \*\* =  $p < 0.001$

**Table 4**

Multiple Regression Analysis of Variables Related to Total SPRMC Scores

	B	SE B	$\beta$	t	CI
Duration of clinical placement	0.32	0.92	0.22	3.47 **	0.14-0.50
Age	-0.43	2.00	-0.14	-2.14*	-0.82- -0.03

Score on witnessing disrespect and abuse	0.21	0.12	0.11	1.75	-0.03- 0.44
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$R^2 = 0.122$ , \*\* =  $p < 0.001$ , \* =  $p < 0.05$ , SE = Standard Error, CI = Confidence Interval

A multiple regression analysis was run to predict SPRMC scores from age, duration of clinical placement and total scores on witnessing disrespect and abuse (see Table 4). All three variables significantly predicted SPRMC score [ $F(3, 267) = 12.41, p < 0.001, R^2 = 0.122$ ]. Two variables were statistically significant, with duration of clinical placement recording a higher beta value (beta = .22,  $p < 0.001$ ), than age (beta = -0.14,  $p = 0.03$ ). However, total scores on witnessing disrespect and abuse had a non-significant unique contribution (beta = 0.11,  $p = 0.08$ ).

## Discussion

This is the first study to compare students' perceptions of RMC in two middle-income countries. The findings inform our understanding of students' perceptions of RMC during labour and birth and the extent to which they witness disrespectful and or abusive care. While there were similarities in student's experiences, differences may be explained by university/college pathways, characteristics of students, nature of the practicum, the practice context and wider cultural context.

The mean age was higher among Nepalese students which may be because students need to complete qualifying programs before entering Bachelor level programs. In Nepal, BNS students are eligible for admission into the three-year program after completing their diploma in nursing and with a minimum of one year experience as a registered nurse. In contrast, students in Jordan enter directly into diploma or degree programs. The mean duration of clinical placement was higher in Jordan than Nepal, however, the average number of births observed was slightly higher among Nepalese students. This might be due to Jordanian students completing two to three days per week of placement compared to five to six days among Nepalese students. Furthermore, high number of childbirths in the health facility where

Nepalese students practised or a program specific requirement for observing births might be the reason. For instance, in Nepal, BSN students need to observe at least five births before assisting with childbirth.

According to SPMRC scores, perceptions of RMC were more positive amongst Jordanian than Nepalese students. These differences were explained by higher mean age and less duration of clinical placement among Nepalese students. The reasons why age (a non-modifiable variable) is associated with lower perceptions of RMC are not readily apparent. It could be that the life experiences of older students contributed to a disregard of RMC and requires further investigation. Higher perceptions of RMC by Jordanian students may relate to supervision during their longer clinical placement which shaped their understanding. The influence of supervision reported in a Tanzanian study revealed that supportive supervision to new midwives/nurses decreased the incidence of disrespectful and abusive behaviours (Shimoda et al., 2020). Decrease in disrespectful behaviours might be due to increase understanding of RMC through supportive supervision. In addition, differences in the program of study might be another factor for the differences in SPRMC scores. The Bachelor of Midwifery is a separate four-year speciality program in Jordan whereas in Nepal, midwifery theory and practicum are integrated in the third year of the BSN program and second year of the BNS program. As such RMC may receive less attention and reinforcement when content is integrated.

Nepalese and Jordanian students' overall scores on the 'Respectful care' subscale were similar but there was variation among the items. All Jordanian students had high perceptions about maintaining confidentiality. Privacy and confidentiality in maternity care are essential and any breach of health-related data contravenes universal health rights (Hartigan et al., 2018). Conversely, all Jordanian students had observed non-consented care. This finding is supported by other studies where women were not always asked for consent before any medical procedure

(Al-Maharma et al., 2020; Hussein et al., 2018). Furthermore, Jordanian students more often reported being too busy to smile at women when greeting them or provide birth options to women. These findings are supported by a study in Jordan where women described their midwives as “cold and expressionless” (Khresheh et al., 2019). Another study with health care professionals that included midwives reported high workloads and staff shortages as the reasons for poor care (Abuidhail et al., 2021). In Jordan, midwives are often required to care for ten women per shift making it difficult to provide individualised quality of care (Mohammad et al., 2020). Consequently, Jordanian students might have perceived difficulty in creating a calm and welcoming environment for women during labour.

Jordanian students had higher scores on all items of the ‘Safety and comfort’ and ‘Supportive care’ subscales than Nepalese students. All Jordanian students had higher scores on such as statements ‘I have a responsibility to make women feel safe during labour and birth’, and ‘I try to limit exposing a woman’s body while providing care’. Jordanian students who study only midwifery are likely to have a better understanding and respect the importance of privacy for women. Supportive intrapartum care improves women’s perceptions of support and control during birth, lowers pain scores, and shortens the duration of labour (Isbir & Serçekus, 2017). Furthermore, continuous supportive care has been shown to promote positive adaptation to motherhood and reduce the risk of perinatal mental health problems (Ross-Davie & Cheyne, 2014).

This study revealed that compared to Nepalese students, a higher proportion of Jordanian students had observed different forms of disrespectful and abusive care during their clinical placement which was at odds with their SPRMC scores. We had theorized that observing more disrespect would be associated with poorer SPRMC scores, however, Jordanian students witnessed more disrespect than Nepalese students and yet had higher SPRMC scores. Multiple regression analysis also confirmed witnessing disrespect and abuse

did not influence SPRMC scores. This finding suggests that education about RMC improves students' awareness, but other strategies are needed to improve clinical practice. In Jordan, disrespectful and abusive practices have been documented in several studies. For instance, women reported a lack of support in managing pain, repeated vaginal examinations, birth in the lithotomy position, and allowing unwanted persons to attend the birth (Mohammad et al., 2014). Women reported feeling 'dehumanised' during childbirth (Hatamleh et al., 2012) and abused (Alzyoud et al., 2018; Khresheh et al., 2019).

In Nepal, women's experience of disrespectful care has only recently been documented. A study in eastern Nepal revealed various forms of disrespect and abuse among women such as non-consented care, verbal and physical abuse, non-confidential care, and discriminatory care (Ghimire et al., 2021). Conversely, three studies from central and western parts of Nepal found high prevalence of RMC practices (Gurung et al., 2021; Munikar et al., 2021; Pathak & Ghimire, 2020). Two studies reported that although women received care that was friendly, abuse free, and non-discriminatory, they wanted more timely care (Munikar et al., 2021; Pathak & Ghimire, 2020).

Although participating students reported generally positive perceptions of RMC, creating a supportive clinical environment for the consistent provision of RMC is needed. Although care providers may have adequate understanding of RMC, various factors in their work environment such as staff shortages, high workloads, inadequate supplies, lack of policy guidelines, lack of support from management may hinder RMC. For instance, midwives in a study in Ghana reported that despite having knowledge about RMC approaches, the lack of policy and health facility infrastructure restricted them to practice RMC (Dzomeku et al., 2021). Interventions that may enable midwives to provide RMC include improving the quality of the work environment for midwives, implementing a healthcare charter of women's reproductive rights at the service level, strengthening accountability through robust complaints

systems and processes, participation by women from the community on health service governance structures (e.g., boards) (Kruk, Kujawski, et al., 2018). Strengthening midwifery leadership and governance, implementing midwife-led models of care, and optimising the roles for midwives will further contribute to quality maternity care (Nove et al., 2021).

Further research is required to better understand factors associated with disrespectful and abusive care towards women during labour and birth in these two countries/cultures. Such research is needed to develop tailored interventions. Although RMC is explicitly addressed in midwifery curricula in Jordan, this is not the case in Nepal. Findings suggest inclusion of RMC content in Nepalese curricula needs to be a priority. Strategies to encourage peer-review and reflective practice amongst midwives and nurses in Jordan and Nepal may help to promote respectful care.

### **Strengths and limitations**

This study applied a tool validated in Nepal to another middle-income country. The English version of the tool has now been successfully translated into Arabic and items were understood by students in two different cultures. However, other researchers should ensure relevancy when using the tool in their context. The study revealed variation in response rates among students from Jordan and Nepal. The paper-based survey in Jordan yielded a 18.9% higher response rate compared to the online survey conducted in Nepal. Response rates to online surveys are reported to be lower than those for paper-based surveys (Sue & Ritter, 2012). A recent meta-analysis shows a 12% difference in response rate between web-surveys and other modes (Daikeler et al., 2020). This difference in response rate might have influenced the results which needs further testing.

Results are likely to have been influenced by the different content of the midwifery and nursing degrees, however, the similarity in total scores between countries suggests this influence may have been minimal. Students' self-reports may have been influenced by social

desirability bias. To minimise this, no identifiable information was asked to encourage openness and honesty. We don't know the extent to which students' responses reflect their practice. Future studies could provide an independent observation of students' practice and encourage reflection to improve RMC practices. Future research is required to explore and address workplace issues such as being too busy to greet women or provide birth options to women, maintaining privacy and confidentiality, and enhancing safety and comfort.

## **Conclusion**

To the best of our knowledge this is the first study to compare perceptions of RMC by midwifery and nursing students in two middle-income countries. Although Jordanian students reported higher scores on the SPRMC scale, all students reported positive perceptions of RMC. Clearly, participating students understood RMC, but their experiences in the practice context revealed differences. Higher proportions of Jordanian students witnessed various forms of disrespect and abuse compared to their Nepalese counterparts. Importantly, non-consented care was observed by all Jordanian students but only ten percent of Nepalese students. The clinical setting has a powerful influence on students' practice and may negate their learning and awareness of RMC. The extent to which students will be able to consistently implement RMC after graduation requires further investigation. Findings indicate that students are practicing in the contexts where disrespect and abuse are routine. Variations in students' perceptions of RMC and witnessing of abuse across countries highlight the need to assess workplace cultures to inform the development of tailored education and practice interventions for students, clinicians, managers, and policy makers. Future research needs to explore how to improve practice and the experience of childbearing women.

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