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Review

Curriculum Resources for Integrating Respectful Maternity Care Into Health Professions Education: A Rapid Scoping Review

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Introduction: Respectful maternity care (RMC) ensures that every childbearing woman is treated with dignity, safety, and respect. Health care professionals play a critical role in RMC but can also contribute to disrespectful and abusive practices, inflicting lasting trauma. Educating pre-service health care learners is one promising strategy for change. As part of our larger Mothering and Albinism research project, we sought timely evidence to develop educational resources supporting RMC for people impacted by albinism.

Methods: Our international team conducted a rapid scoping review to answer the question, "What curriculum resources are available for integrating RMC into the education of nursing, midwifery, medical, and other health care students, and what are their key pedagogical components and contextual factors shaping implementation?" We searched key databases and online sources for qualitative, quantitative, and mixed-methods studies of RMC education initiatives and curriculum resources relevant to teaching RMC to pre-service learners. Two reviewers screened abstracts/full texts, and data were charted and synthesized using descriptive statistics and content analysis. Our diverse author network was consulted to ensure rigor and relevance for a range of populations.

Results: Our analysis of 25 research reports and 8 curriculum resources produced 5 synthesized categories. The first 4 categories illuminate how RMC education initiatives are conceptualized, their core content, effective pedagogical strategies, and how researchers studied the impact of RMC education. The fifth category addresses contextual influences and the need for taking a systems perspective within RMC education initiatives. Significant gaps remain with few initiatives addressing the unique needs of structurally disadvantaged groups or including trauma-informed, violence-informed, or equity-oriented approaches.

Discussion: RMC education has potential, but it must be paired with systemic change and attention to equity for meaningful change. These findings lay the groundwork for developing context-specific, effective educational resources to support RMC for all women, including those impacted by albinism.

Keywords: childbirth, education, maternal health services, medicine, midwifery, nursing, quality of health care, respect, scoping review, social justice

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INTRODUCTION

Maternal health is a widely recognized global health priority, yet disrespect during the perinatal period remains rampant across high, mid, and low-income countries.[1,2] Research reveals that 17.3% of women in North America and 44% in sub-Saharan Africa experience mistreatment during childbirth.[3] In response, respectful maternity care (RMC) has gained traction as a key policy agenda championed by the World Health Organization (WHO) and other global institutions.[4–6] RMC asserts the universal human right to dignity, autonomy, and safety during childbirth and reduces maternal mortality and morbidity.[7] To implement RMC, coordinated and multisectoral initiatives are needed, with the education of pre-service health care learners as one promising strategy for change.[1,8,9]

Background: Review of Relevant Literature

Pregnancy, childbirth, and early parenting encompass a remarkable life stage that can be marked by joyful transitions

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Quick Points

- Our international team conducted a rapid scoping review of curriculum resources for integrating RMC into the education of pre-service health care learners.
- Our synthesis of the theoretical perspectives, content, and learning activities provides educators with a flexible "menu" of approaches that can be adapted to diverse learning goals, contexts, and barriers.
- Researchers studied the impact of RMC educational initiatives on participants' understanding, attitudes, skills, motivation and empowerment, and patient experiences.
- There were significant contextual factors, such as discrimination, power dynamics, poor working conditions, and limited resources, which revealed the necessity of taking a systems perspective within RMC education.
- We propose that RMC education initiatives should integrate trauma-informed and violence-informed principles, equity-oriented content, and systems-strengthening strategies to effectively promote respectful care.

and, for some, by vulnerability and trauma.[3,10,11] High-quality, equitable perinatal care is essential to improve maternal and neonatal outcomes, which contributes to broader societal well-being.[6,11] There are, however, alarming instances of disrespectful care, including abuse, neglect, and unconsented procedures.[12,13] While these instances often occur during interactions between women and their providers, they are symptomatic of deeper system failures.[1,14] The United Nations refers to such mistreatment as "obstetrical violence,"[15 (p 1013)] which has serious consequences for women's physical and psychological health.[12,16,17]

A human rights–based approach to mistreatment is urgently needed.[13] In 2011, the White Ribbon Alliance—a people-led movement advocating for women's voices to be heard by those in power—convened a global, multisectoral community to develop RMC principles. These principles affirm the universal human right of every woman to care that safeguards dignity, privacy, and confidentiality; protects against harm and mistreatment; and ensures the conditions for informed decision-making and continuous support throughout childbirth.[5] In 2014, the WHO issued a landmark statement calling for global action to eliminate abuses. They highlighted the need for research on effective RMC implementation strategies in different contexts to address the lack of change and provide guidance to governments and health care providers on how to best enact RMC.[18]

Health care providers have a powerful influence on the birthing experience, but they can also perpetuate harm; for example, disrespectful attitudes and behaviors are often shaped by deeper systemic and cultural factors, including implicit and explicit biases that negatively effect women. One strategy for change is to instill RMC into health care learners' education. Research on RMC education has expanded in recent years, including primary studies and systematic reviews evaluating the effectiveness of RMC interventions.[3,8] No reviews have been conducted on RMC education for health care learners regarding available curriculum resources, which was important to the creation of curriculum resources we were about to undertake. To address this gap, we conducted a rapid scoping review of existing RMC curriculum resources for pre-service health care learners.

A rapid scoping review aligned with the timeline of our larger project on the human rights of women impacted by albinism (The Mothering and Albinism international research-advocacy-policy network: www.motheringandalbinism.com).[19–21] Albinism is a rare genetic condition, considered a disability, in which people lack melanin, a pigmentation in their skin, hair, and eyes. Due to deeply rooted beliefs about the evil, misfortunes, and curses that cause albinism, people often experience stigma and discrimination, inequitable health/social services, and human rights atrocities such as mutilation and murder (predominantly in sub-Saharan Africa and Asia).[20,21] Our research suggests that RMC may offer a promising approach to address the gender-based violence experienced by women impacted by disabilities such as albinism.[20,21] One objective of our current study ("A Human Rights and Equity-Oriented Response to the Birth Stories of Families Impacted by Albinism in sub-Saharan Africa: Intersectoral Partnerships for Enhanced Health Professions' Education"; CIHR #481405) is to develop effective educational resources to support the provision of respectful perinatal care. Our team is comprised of people with lived experience, practitioners, advocates, and scholars from the Global South and Global North who brought important and diverse perspectives to our work.

METHODS

Our review question was "What curriculum resources are available for integrating RMC into the education of nursing, midwifery, medical, and other health care students, and what are their key pedagogical components and contextual factors shaping implementation?" We conducted a rapid scoping review[22] to map the current landscape of RMC educational initiatives and their curriculum resources and identify gaps and challenges. The review protocol was registered with Open Science Framework (https://doi.org/10.17605/OSF.IO/FE93X), and the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) extension for scoping reviews guided this review report (Appendix S1).[23] Of note in this review, we use the term *women* to reflect the terminology most commonly used in the included literature as well as the language in RMC frameworks. We acknowledge, however, that not all people who give birth identify as women. Transgender, nonbinary, and gender-diverse people may also

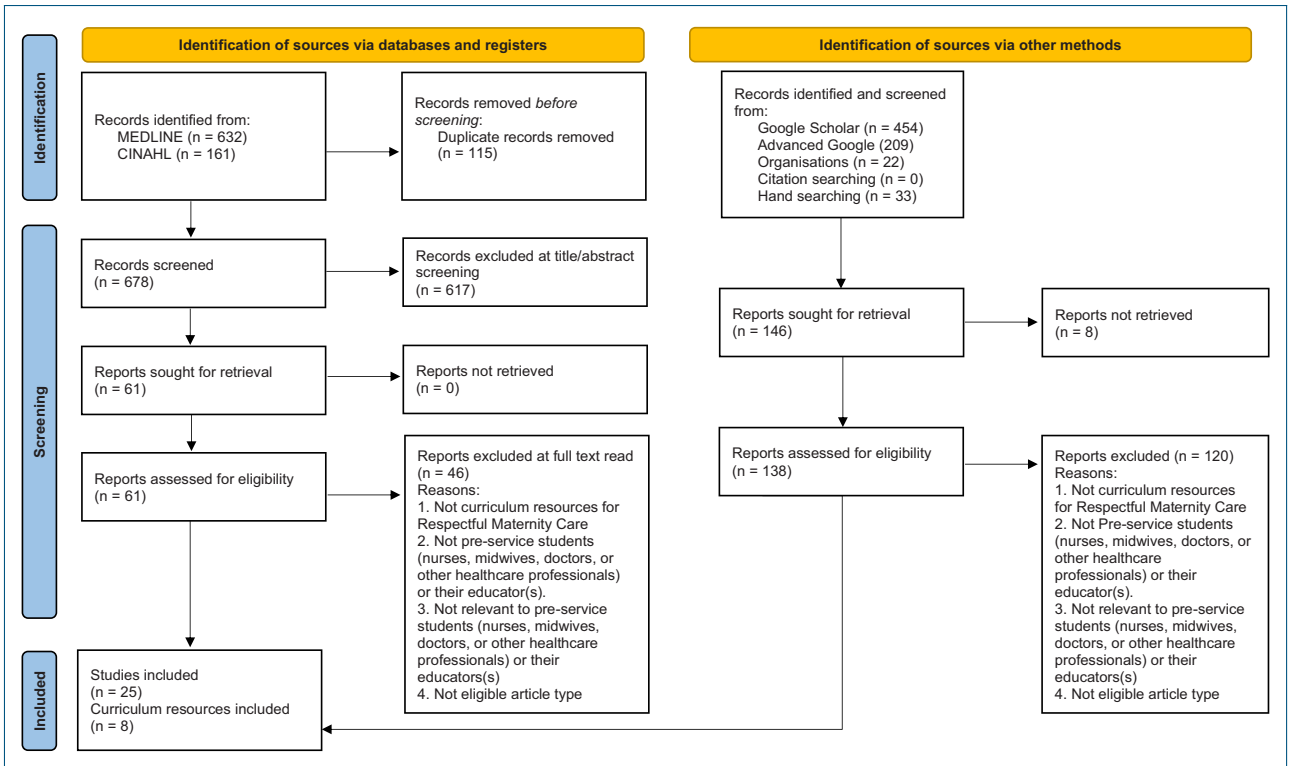

Figure 1. PRISMA Flow Diagram of This Rapid Scoping Review

Source: Page et al.[26]

experience pregnancy and childbirth, and they face distinct forms of marginalization and disrespect within perinatal care settings.

Identifying and Selecting Relevant Sources

The systematic search was developed by an academic librarian with input from our international team and subject-matter experts. Keyword search terms were mapped to MeSH terms and CINAHL headings. EBSCO host MEDLINE with Full Text and CINAHL Complete were searched from 2011 to 2024 to align with the seminal 2011 RMC charter (see Appendix S2 for search strategies). We conducted a gray literature search of Google Scholar, Google, and relevant organizations (eg, midwifery organizations and the WHO). All results were exported to Covidence[24] and deduplicated. Two reviewers independently screened titles/abstracts and full texts against inclusion criteria (Appendix S3). Articles were included if they related to an educational initiative or curriculum resource focused on teaching RMC and were relevant to pre-service health profession learners or their educators in any educational context or geographical area. We included qualitative, quantitative, mixed-methods, and report-based articles, as well as curriculum resources published by government, nongovernmental organizations, nonprofit organizations, or civil society organizations. Discrepancies were resolved through discussion or with a third reviewer. The included research articles were critically appraised using the Mixed Methods Appraisal Tool.[25] Articles were not excluded based on quality assessments; however, assessments were analyzed to guide future research.

Extracting and Synthesizing the Data and Reporting Results

Data were extracted from articles by one reviewer and verified by another using a data extraction matrix (see Appendix S4 for data extraction matrix items). The data extraction matrix was informed by our review question, RMC frameworks, critical perspectives, and scoping review methods. We piloted the matrix with 5 included articles and revised it in consultation with team members. Data were synthesized using descriptive statistics and content analysis.[22] This analysis approach incorporated both deductive and inductive analysis processes, as predefined matrix categories guided the analysis, while patterns were identified through iterative examination of the extracted data.[22]

RESULTS

Description of Included Studies

Following duplicate removal, 678 titles/abstracts and 138 gray literature results were screened, and a final sample of 25 articles from 21 studies (because 4 of the included studies had 2 published reports each) and 8 educational curriculum resources were included (Figure 1).[26] There has been a growing interest in RMC, with 19% of research articles published between 2015 and 2019 and 81% since 2020 (see Table 1 and Appendix S5 for individual sources of evidence). The recent increase may be due to the White Ribbon Alliance's[5] publication in 2011 and the time it takes for literature to be applied. Most education initiatives took place in Africa (71%) and Asia (19%). Notably, 85% of the studies were conducted in lower-middle- or low-income countries. There has been less uptake

Table 1. Characteristics of Included Research Articles

Category and Characteristics	Studies, n (%)
Year of publication (n = 21)[a]	
2020-2024	17 (81%)
2015-2019	4 (19%)
Continents (n = 21)[b]	
Africa	15 (71%)
Asia	4 (19%)
North America	3 (14%)
Income classification by country (n = 21)[b]	
Low income	4 (19%)
Lower-middle income	14 (66%)
Upper-middle income	2 (10%)
High income	2 (10%)
Lead author's discipline (n = 21)[b]	
Nursing and/or midwifery	10 (48%)
Public health	4 (19%)
Medicine	2 (10%)
Health sciences	2 (10%)
Maternity	1 (5%)
Other (eg, global health, epidemiology)	5 (25%)
Primary authors geographical location (n = 21)[a]	
North America	8 (38%)
Africa	8 (38%)
Europe	2 (10%)
Asia	2 (10%)
Oceania	1 (4%)
Congruence of geographical location (n = 21)[a]	
Congruency between author and country of study	13 (62%)
Incongruency between author and country of study	8 (38%)
Educational context (n = 21)[b]	
General/specialized/tertiary hospital	10 (48%)
Clinic/health center	2 (10%)
Birthing center	1 (5%)
Training center	1 (5%)
Higher education setting	1 (5%)
University-affiliated teaching hospital	1 (5%)
Online	1 (5%)
Not described	5 (24%)
Profession of participants (n = 25)[a]	
Registered nurse/midwife/physician	9 (36%)
Registered nurse	6 (24%)
Midwife	4 (16%)
Registered nurse/midwife	2 (8%)
Physician	0
Other single professions	2 (8%)
Other mixed professions	2 (8%)
Research design (n = 25)[a]	
Qualitative	7 (28%)
Quantitative: quasi-experiment	9 (36%)
Quantitative: descriptive	2 (8%)
Mixed methods	7 (28%)
Research participants (n = 25)[a]	
1-49 participants	11 (44%)
50-99 participants	9 (36%)
Over 100 participants	5 (20%)

[a]Exclusive categories.
[b]Nonexclusive categories.

in high-income (10%) and upper-middle-income (10%) countries. There was a range of first authors' disciplines, with the majority being in nursing and midwifery (48%). The primary authors predominantly resided in North America (38%) and Africa (38%). In most studies (62%), there was congruency between the primary author's geographical location and the country of study.

Most RMC education initiatives took place in health care institutions (71%; eg, hospitals). Although the predominant focus was on nursing (24%) or midwifery (16%) professionals, more than half the studies (68%) were interprofessional. For example, 9 studies (36%) included nurses, midwives, and doctors as participants. The studies all investigated the effectiveness, meaningfulness, and/or evaluation of RMC educational initiatives for learners or patients. As for design, 28% used qualitative methods, 44% used quantitative methods, and 28% used mixed methods. Notably, no studies used a more critical methodology, such as critical ethnography.

Using the Mixed Methods Appraisal Tool,[25] most qualitative articles (85.7%) met 4 or 5 of the 5 criteria, while one met only 2 (see Appendix S6 for quality appraisals). Among the quantitative nonrandomized studies, 44.4% met 4 criteria and 55.6% met all 5. The 2 quantitative descriptive studies met 4 and 5 of the 5 criteria, respectively, and all mixed-methods studies (100.0%) met 4 or 5 of the 5 criteria.

Description of Curriculum Resources Found in The Gray Literature

The 8 gray literature sources provide relevant RMC curriculum resources for educators, with publication dates ranging from 2013 to 2022 (Table 2). They were published by nonprofit organizations (62%), government agencies (25%), and a consortium (13%); and originated in Africa (50%), North America (25%), Asia (12.5%), and Europe (12.5%). They primarily focused on health care providers (88%), with policy makers/decision-makers (38%) and managers (25%) receiving more attention than in academic sources. Addressing a gap in the academic sources, communities were the focus in one (13%) resource.[27]

(*Continued*)

Table 2. Characteristics of Included Gray Literature Curriculum Resources (n = 8)

Category and Characteristics	Sources, n (%)
Year of publication[a]	
2020-2024	3 (38%)
2013-2019	5 (62%)
Type of organization[a]	
Nonprofit organization or association	5 (62%)
Government agency or ministry	2 (25%)
Consortium	1 (13%)
Geographical location[a]	
Africa	4 (50%)
Asia	1 (12.5%)
North America	2 (25%)
Europe	1 (12.5%)
Target audience[b]	
Health care providers	7 (88%)
Trainers and/or educators	3 (38%)
Policy makers, supervisors, or stakeholders	3 (38%)
Managers and/or supervisors	2 (25%)
Communities	1 (13%)

[a]Exclusive categories.
[b]Nonexclusive categories.

Table 3. Synthesized Categories and Subcategories

Category	Subcategories
Category 1: Framing of Educational Initiatives	Purpose across sources
	Philosophical or theoretical framing of initiatives
	Key RMC documents informing initiatives
Category 2: Content of Educational Initiatives	Substantive focus: RMC fundamentals, professional practice, systems thinking, and broader policy arenas
	RMC principles
	Equity-oriented content
Category 3: Learning Processes and Activities	Structure of educational initiatives
	Learning activities and exemplars
	Valued pedagogical practices and suggestions
Category 4: Investigating Learning and Practice Outcomes	Investigating impact on learners
	Investigating impact on patients' experiences
	Contextual variation in the educational impact
Category 5: Contextual Influences and the Necessity of Taking a Systems View	The complexity of disrespectful practices
	Structural factors associated with disrespect
	A systems view within educational initiatives

Abbreviation: RMC, respectful maternity care.

Synthesis of Included Studies

In this section, we synthesize the research studies and curriculum resources with a content analysis, resulting in a narrative synthesis. Five synthesized categories provide insights into the framing, content, learning processes, and the investigation of the impact of the RMC educational initiatives, as well as the contextual influences shaping them (Table 3).

Framing of Educational Initiatives

Purpose Across Sources

The stated purposes of the educational initiatives varied (N = 29; Appendix S7), with the most common being to improve the quality of care and mitigate disrespect (48%). A significant portion (41%) aimed to train and empower learners. About one-quarter of the initiatives (24%) focused on increasing learners' knowledge of RMC.

Philosophical or Theoretical Framing of Initiatives

Some authors clearly depicted how philosophical/theoretical perspectives shaped their work, often drawing on several complementary perspectives. Others only briefly mentioned a philosophy or theory, and some had no discernible guiding lens (Table 4). The most common perspective (72%) was a human rights–based lens, which was even more predominant in the African context. Nearly half (45%) of the articles adopted a person-centered, woman-centered, or family-centered perspective, reflecting a commitment to individual needs, although the depth of integration varied. Trauma and/or violence–informed perspectives were present in 34% of articles, indicating a growing sensitivity to the impact of trauma on maternal experiences, and 31% reported using equity-oriented approaches. As can be seen in Table 4, researchers were less likely to use a human rights or equity approach compared with the gray literature curriculum resources. Of note, 14% of the sources advocated for moving from a biomedical model to a midwifery or social model of childbirth. A range of specific theories were identified in 34% of sources, such as Hildegard Peplau's interpersonal relations theory,[28] a theory of change,[29] or Tuckman's stages of group development.[30]

Key RMC Documents Informing Initiatives

Most authors drew on one or more RMC documents (Appendix S8), while 2 sources[28,31] only mentioned RMC documents without indicating how they informed their work. The White Ribbon Alliance RMC charter, *Respectful Maternity Care: The Universal Rights of Women and Newborns*,[5] was the most frequently cited document (70%). Some initiatives referenced *WHO Recommendations: Intrapartum Care for a Positive Childbirth Experience*[6] (42%). Several initiatives drew upon key RMC syntheses/reports: Bohren et al's[17] review on

Table 4. Philosophical or Theoretical Framing of the RMC Educational Initiatives (N = 29)

Theoretical Framing as Described in Evidence Source	Total n = 29	Research Articles n = 21	Curriculum Resources n = 8
Human rights–based lens	21 (72%)	14 (67%)	7 (88%)
Person/woman/family-centered care	13 (45%)	10 (48%)	3 (38%)
Trauma and/or violence–informed care	10 (34%)	8 (38%)	2 (25%)
Equity-oriented approaches and equity, diversity, and inclusion considerations	9 (31%)	6 (29%)	3 (38%)
Midwifery/social model of childbirth	4 (14%)	3 (14%)	1 (13%)
Relational care	2 (7%)	1 (5%)	1 (13%)
Not stated	1 (3%)		1 (13%)
Other specific theories/frameworks	10 (34%)	9 (43%)	1 (13%)

Abbreviation: RMC, respectful maternity care.

the mistreatment of women during childbirth (39%), Bowser and Hill's[32] United States Agency for International Development report on disrespect and abuse in health care (33%), Shakibazadeh et al's[33] review on respectful care during childbirth (21%), and Miller et al's[34] review of evidence-based practice guidelines and RMC (15%).

Content of Educational Initiatives

Substantive Focus: RMC Fundamentals, Professional Practice, Systems Thinking, and Broader Policy Arenas

The substantive content included fundamentals of RMC, professional practice and clinical knowledge, organizational systems thinking, and change in broader policy and systems (Table 5). The predominant focus was on fundamentals of RMC and professional practice, with fewer articles including content relevant to organizations and systems. This lack of emphasis on broader systems may hinder sustainable, large-scale improvements with RMC. We also mapped the content topics according to the perinatal timeline: 64% of the content was threaded across the perinatal period (eg, human rights), and 42% focused on the intrapartum period (eg, privacy during labor). There was minimal content (8%) focused on the antenatal period and none on the postpartum period. The authors provided additional resources to support their RMC content, which can be found in Appendix S9.

RMC Principles

Many authors (44%) did not clearly specify which RMC principles[5] they focused on, often stating they were focusing on RMC in general. When RMC principles were specified, 2 were particularly well covered: "Everyone has the right to information, informed consent, and respect for their choices and preferences" (67%), and "Everyone is their own person from the moment of birth and has the right to be treated with dignity and respect" (61%; Appendix S10). There was a notable lack of focus (0%) on structurally oriented principles regarding the rights to an identity and nationality from birth and to adequate nutrition and clean water.

Equity-Oriented Content

We looked for content on equity-oriented perinatal care that emphasized the problematic differences in RMC across diverse population groups and the importance of social determinants of health in shaping maternal experiences.[35] Although initiatives addressed women's rights, ethics, human rights, attitudes, and the consequences of disrespect, most did not specifically address avoidable and unjust differences in care resulting from social identity factors such as gender, disability, poverty, education level, ethnicity, religion, or caste. Although many findings have significant implications

Table 5. Content of the Educational Initiatives

Content	Content Topics and Numbers of Sources Addressing Topic
Fundamentals of RMC	Perinatal care topics and RMC (n = 19)
	Disrespectful practices (n = 19)
	RMC rights and standards (n = 16)
	RMC history and definition (n = 11)
Professional Practice and Clinical Knowledge	Intra/interpersonal factors and RMC (n = 15)
	Reflection on practice (n = 14)
	Communication skills (n = 11)
	Advocacy (n = 8)
	Professional ethics (n = 8)
	Self-care (n = 3)
	Trauma and violence–informed care (n = 3)
Organizational Systems Thinking	Organizational policies and practice guidelines (n = 13)
	Organizational factors and RMC (n = 12)
	Quality improvement and monitoring (n = 8)
	Organizational action plans (n = 7)
	Dispute resolution processes (n = 6)
Bringing About Change in Broader Policy and Systems	Human rights and the law (n = 12)
	Systems-level factors and RMC (n = 8)
	Intersectional approaches (n = 6)
	Community action plans (n = 5)

Abbreviation: RMC, respectful maternity care.

for a woman impacted by disability, no studies have specifically focused on disabilities in general, or albinism specifically. Wilson-Mitchell et al[36] was one of the few that addressed equity in their content on differences in culture, language, religion, tribal affiliation, and socioeconomic status that exist in a postcolonial, neoliberal Global South. Additionally, Actis Danna et al[37] reported that the RMC game *Dignity* helped nurse-midwifery students recognize discriminatory attitudes toward women of low socioeconomic or education status.

Learning Processes and Activities

The third category synthesizes the pedagogical approaches and suggestions for improvement.

Structure of Educational Initiatives

Most initiatives were delivered via in-person, multisession formats to support meaningful learning, with 30% done as a series of sessions over time, 30% conducted over 2 or more consecutive days, and 27% offered as single-session workshops (Appendix S11). Online, multisession formats were less common (6%), with none relying solely on single-session formats. In an online initiative, most learners found online delivery more convenient than face-to-face (60%) and thought the learning was equivalent to that in traditional classes (87.5%).[9] One curriculum resource (3%) did not specify a format. Some initiatives had unique structures. For example, Watt and colleagues[38] held a half-day refresher on a clinical unit after their initiative. Many (48%) adopted a participatory approach, such as action cycles or a community of practice.

Learning Activities and Exemplars

We extracted data about the learning activities and categorized them to align with domains of contemporary learning theories: cognitive (83%), social and transformative (76%), and experiential/embodied (52%); 3 sources did not specify learning activities.[31,39,40] See a breakdown of learning activity categories in Table 6.[7-12,16,27-30,36-38,41-56] Notably, activities across various categories were often integrated into a single initiative.

Valued Pedagogical Practices and Suggestions

Learners valued pedagogical approaches that were participatory, clinically relevant, and reflective. They highlighted participatory, experiential approaches including group discussions, testimonial videos, game-based learning, simulation, role playing, case scenarios, and skill stations.[7,9–12,37,41] In one study, a game-based activity made learning fun, accessible, and interactive.[37] Relevance to clinical practice was critical for learner engagement.[9,11,12,37] For example, Afulani and colleagues[11] found participants appreciated simulation and debriefing to reinforce clinical management practices. Critical reflection was also valued[7,9,12] for enabling participants to recognize previously unacknowledged discriminatory practices and begin considering corrective action.[37]

Several studies reported suggestions for improvement.[7,9,11,39,41] Participants requested more contextually specific training materials, such as videos and scenarios,[9,41] and more experiential activities to translate theory into practice.[9,39] They also recommended including a broader range of providers to support system-level change[11] and expanding RMC content beyond uncomplicated births.[11] Feedback about online initiatives indicated the desire for hybrid formats and improved technical support.[9]

Investigating Learning and Practice Outcomes

Researchers investigated the impact of RMC education on a range of learner outcomes and patient experiences using quantitative and qualitative approaches, and they reported notable contextual variation in outcomes.

Investigating Impact on Learners

Studies described the impact of RMC educational initiatives on participants' understanding, attitudes, and skills following completion of training.[7,11,28,29,36,37,39,42] Quantitative[11,28,29,37,42] and qualitative[11,37,39] studies reported on changes in RMC knowledge. For instance, Ratcliffe et al[29] noted improved knowledge of patient rights, ethics, and RMC principles. Attitudinal shifts to RMC were also reported in the quantitative and qualitative data,[7,8,11,29,36,37,39,42,51] and findings revealed a nuanced impact. For example, participants began problematizing normalized disrespectful practices, such as failing to maintain privacy.[7] However, in the same study, the belief that it is sometimes necessary for service providers to yell at a woman during labor did not change.[7] Researchers also looked at the impact on job satisfaction following training[9] as well as motivation for work and enacting change.[7,29] Both qualitative[9,55] and quantitative[11,29,36,38] research studied the impact on self-efficacy, agency, and the participants' sense of empowerment in their ability to lead change. Across multiple studies, researchers investigated whether or how RMC education transformed participants' practice to be more respectful.[7,9,11,31,37–39,52,55] For example, some qualitative findings highlighted a shift toward more respectful care, including respectful communication, actively seeking informed consent, and discontinuing demeaning language.[37,52] Quantitative findings confirmed increased implementation of RMC practices, evidence-based pain management, reduced stigma, and improved communication.[11,31,38] Researchers discussed how these changes strengthened provider-patient relationships[52] and women-centered care.[55]

Investigating Impact on Patients' Experiences

Several qualitative[14] and quantitative[10,12,16,31,43,53] studies investigated whether initiatives impacted patient experiences of RMC. For example, Asefa and colleagues[43] found decreases in the number of women reporting nonconsented care, physical abuse, and ignored preferences. However, other indicators, such as harsh language, gagging women, or prolonged neglect, showed no significant change in the same study. Interestingly, some studies revealed a disconnect between provider-reported improvements and patient-reported outcomes. For example, Ratcliffe et al[29] and Watt et al[38] found increased provider scores but no significant differences in patient-reported dignity, autonomy, or respect.

Contextual Variation in Educational Impact

RMC education outcomes varied across local contexts, learner backgrounds, and facility characteristics.[12,16,36,37] In a multicountry study, overall improvements in provider performance were observed. However, a subanalysis in Malawi found no knowledge gains, possibly due to higher pretest scores. These findings suggest that baseline knowledge and context effect

Table 6. Learning Activities and Exemplars

Learning Activity	Exemplar
Cognitive learning activities (83% of sources)	
Presentations and lectures[7,8,12,27,28,36,41–50]	Learners engaged in an interactive lecture with a PPT as a visual aid. Learners were encouraged to ask questions at the end of the module.[42]
Engaging with practice guidelines, policies, or position statements[28,30,44,51]	Learners received guidance on implementing RMC based on the RMC Framework and evidence-based Clinical Practice Guideline published by AWHONN in 2022.[28]
Scenario or problem based[7,8,10,11,28,38,43,44,52,53]	Learners worked in small groups to engage with a real-life scenario and discuss issues in practice. This scenario was constructed by one of the facilitators based on a clinical case.[44]
Learning modules[9,29,38]	Learners engaged in 3 learning modules (2 hours each): (1) introducing RMC domains and the relationship between RMC and quality of care, (2) addressing common disrespectful practices, and (3) consequences of disrespectful care and RMC strategies.[9]
Q-sort to order priorities[54]	Learners were provided a Q-sort template (16 squares) and 16 communication skills cards fitting the squares and then sorted these skills in order of their priorities.[54]
Readings and printed materials[7–9,29,30,43,49,54]	Learners were given a set of pocket cards with communication skills. These cards were held together with a metal ring and fit the average uniform pocket.[54]
Social constructivist and/or transformative learning activities (76% of sources)	
Guided discussions[8,10–12,27,28,36,42,44,46–52,54,55]	Learners engaged in a group discussion of current issues in practice. They nominated a facilitator and a notetaker.[44]
Journal club[30,51]	Learners participated in a virtual journal club to discuss the RMC guideline, clarify recommendations, and ensure it is being used in practice.[51]
Reflective writing[8,9,27,49,55]	Learners wrote reflections based on the Bass Model of Holistic Reflection.[8,56]
Video testimonials[7,8,10,12,30,36,43,44,46,48,51]	Learners watched testimonials of disrespect videos during a learning session, which elicited participants' feelings and allowed them to be "in someone else's shoes" and empathize.[12]

(*Continued*)

Table 6. (Continued)

Learning Activity	Exemplar
Infographics and visual aids[7,30,43]	Learners observed 5 wall posters (4 in English, 1 in Amharic) on display after RMC training. One English poster showed childbearing women's rights (White Ribbon Alliance); 3 were WHO intrapartum care infographics. The Amharic poster covered mistreatment/rights, endorsed by Ethiopia's Ministry of Health.[43]
Arts-based pedagogy[27,30,46]	Learners participated in action theater to explore issues that participants face in practice, aiming to unpack the issues and underlying drivers of disrespectful maternity care.[46]
Client feedback[16]	Learners solicited client feedback and used the feedback to improve performance and quality.[16]
Experiential and/or embodied learning activities (52% of sources)	
Simulation[10,11,27,38,50,53]	Learners engaged in the MAMA training, based on the PRONTO International simulation model, which uses low-technology, low-cost tools to create highly realistic birth simulations.
Role playing[7,27,36,43,46,48–50,52–54]	Learners participated in a semiscripted role play that mirrored a perinatal interaction with a range of interpersonal skills. A likely scenario was provided to the group with core roles identified, and learners acted out the role play.[54]
Gaming[27,37,48,50]	Learners played a game to understand RMC in the context of a woman's childbirth experience.[37]
Breathing technique[27,54]	Learners used a breathing technique to disrupt negative thinking as a way of coping and being present in clinical experiences.[54]
Skill stations and demonstrations[7,10,11,43,47,52,53]	Learners used skill stations to teach priority topics (eg, normal birth practices that were identified during a stakeholder meeting).[10,11]
Hospital visits[29,43,49]	Learners attended hospital visits designed to facilitate communication between women and providers, clarify what women should expect when arriving at the hospital and what to bring, and empower women to advocate for quality care. Learners toured the hospital, including all areas women might encounter during childbirth.[29]

Abbreviations: AWHONN, Association of Women's Health, Obstetric and Neonatal Nurses; MAMA, Mradi wa Afya ya Mama Mzazi; PPT, PowerPoint; PRONTO, Programa de Rescate Obstétrico y Neonatal: Tratamiento Óptimo y Oportuno; RMC, respectful maternity care; WHO, World Health Organization.

educational impact.[37] Similarly, Manu et al[16] observed that facilities in Ghana reported more substantial improvements than those in other countries, potentially due to the greater proportion of midwives in the Ghanaian cohort and infrastructure to support midwifery. These findings suggest that staffing patterns and national health system configurations may influence outcomes. Learner background was another factor. Wilson-Mitchell et al[36] found that advanced midwifery learners were more likely to develop self-directed and creative solutions. There is a need for flexible, adaptive strategies accounting for learner and contextual heterogeneity.

Contextual Influences and the Necessity of Taking a Systems View

Concerning structural and contextual factors impacting RMC came out in the learning, shedding light on the deeply entrenched nature of disrespect and abuse. The complexity of practice change revealed the need to take a systems view in education initiatives.

The Complexity of Disrespectful Practices

Several studies revealed the extent and complexity of mistreatment that students observed. One study[8] reported that 41.6% of students observed at least one form of disrespectful care; another[42] found the rate to be 88.5%. Reports included verbal/physical abuse, breaches of confidentiality, nonconsented care, refusal to follow patient preferences, negligence, beating/slapping/pinching, poor communication, lack of information, and denial of birth companionship.[42–44] These accounts highlighted how pervasive disrespect is within the learning contexts. Authors also offered insights into the complexity of these harms. Smith et al[31] explained that in low-income settings, some women accepted abuse if the outcome was medically successful, as a safe birth often overshadowed concerns about dignity. In some environments, abusive behaviors were normalized and reinforced by unit culture.[37] One junior midwife recounted that a senior colleague "almost beat me because I supported a mother to go through labor politely. She yelled and slapped the mother and also attempted to slap me."[44(p 6)] Such incidents show how both cultural norms and power dynamics make mistreatment resistant to change through education alone.

Structural Factors Associated With Disrespect

Authors stressed that educational initiatives have the potential to address individual resistance and foster respectful care practices but are insufficient without addressing the structural drivers shaping health care providers' behaviors[7,43]; these included structural violence and discrimination based on race and gender.[28,54] Entrenched hierarchies and power imbalances within systems also constrained the ability of nurses and midwives to provide RMC,[37,51] diminishing their self-efficacy and autonomy.[55] Further, the rights and well-being of health care providers were often neglected,[7] leaving them vulnerable to the same systemic failures that undermine patient care. Poor working conditions[44,54] (including staff shortages),[54] violence against providers,[7,37] and lack of supervisor support[54] severely hindered providers' ability to offer RMC. Resource limitations were particularly acute in lower-income countries,[10,44,54] where basic supplies such as clean linens, privacy screens, laboring beds for respectful positioning, and water in bathrooms were often lacking, violating RMC principles. Inadequate physical infrastructure, such as limited space for labor companions or multiple patients in a single room, created physical environments that made RMC difficult to achieve.[7,10,37,43,44,52]

Systems View Within Educational Initiatives

To address the drivers of disrespectful care, educators need to pay close attention to systematic factors within RMC educational initiatives. Authors highlighted the importance of cultivating systems-level thinking through encouraging learners to examine how individual, interpersonal, and institutional forces intersect to shape perinatal experiences.[9,11,37] Several authors emphasized how critical it is to codesign education programs with local stakeholders to develop culturally and contextually relevant initiatives[10,16] and identify acceptable, feasible, and sustainable actions for addressing disrespect.[29] A key recommendation was the adoption of a midwifery or social model of childbirth, which recognizes birth as a normal physiologic process and supports women trusting their bodies and preferences, reinforcing RMC.[52,57]

The considerable structural issues have implications for selecting content and learning activities. One approach was to include critical reflection and dialogue on structural changes needed to enact RMC,[9] as well as patriarchal language,[9] structural violence,[54] and discrimination.[28] Attending to the rights and emotional well-being of health care providers was also vital to sustainable RMC practices.[7,54] Educational activities should empower providers by supporting autonomy, advocacy skills, and leadership capacities.[52,55] Multidisciplinary initiatives mitigated and addressed power differentials between disciplines and empowered all members of the health care team to change practices.[37,51]

Authors offered recommendations to health systems and policymakers regarding RMC education. Authors argued that educational initiatives need to be embedded within broader health systems–strengthening strategies[43,52,53] that promote a rights-based approach to maternal care.[7] Multilevel RMC educational initiatives are needed that target not only health institutions but also communities.[7,9] Collaboration with educational institutions was encouraged to integrate RMC into the curriculum.[7,42,45] Some authors recommended establishing quality improvement processes to promote RMC practices and address the violation of patients' and service providers' rights.[12,16] However, most policy recommendations remained focused on the revision of existing policies that hinder RMC,[16,28,52] and there was a need for expanded capacity building regarding broader policy engagement.

Several exemplary RMC educational initiatives[12,14,16,29] not only taught providers about RMC but also focused on addressing structural issues and systems strengthening (Appendix S12). These initiatives involved participatory, multipronged, and contextually relevant approaches with social/transformational or experiential learning activities. When embedded within broader systems strengthening, RMC education initiatives contributed to positive changes in organizational culture and structures.[12,14,16] A key mechanism was learning activities that encouraged participants to imagine possibilities and envision context-sensitive solutions to seemingly entrenched problems, thereby disrupting inequities

within the health care system. One initiative generated 23 new ideas to enhance RMC, which were included in a formal change package for testing by quality improvement teams.[12] Ratcliffe et al[14] concluded that disrespectful care is not an intractable problem and that "a visible, sustained, and participatory intervention process; committed facility leadership; management support; and staff engagement throughout the project contributed to a marked change in the culture of the hospital."(p 1)

DISCUSSION

To our knowledge, this is the first rapid scoping review of RMC education initiatives to identify curriculum resources for health care students across empirical studies and gray literature sources and to take a systems view of RMC education. Our findings illuminate how RMC educational initiatives are framed, what content they emphasize, the pedagogical strategies used, and the impacts that were studied. While previous research has highlighted how multilevel factors shape RMC practices,[1,58] we outlined how educators can attend to these factors within RMC educational initiatives through integrating broader health systems–strengthening efforts. This review aimed to inform our larger Mothering and Albinism project's educational knowledge translation strategies but found limited attention to RMC and disability or albinism, highlighting concerning gaps.

We identified promising pedagogical approaches that could inform the design of future RMC educational initiatives, both within our larger project and more broadly. Authors argued for a shift in pedagogical emphasis, from knowledge transmission alone to the transformation of values, attitudes, and professional ethics.[37,44] Our synthesis of the substantive content and learning activities offers educators a flexible "menu" of topics and activities to tailor to their learning goals, context, and organizational and structural barriers. Like Yargawa and colleagues'[59] review of RMC training packages in sub-Saharan Africa, we also found that initiatives benefited from their interprofessional nature, which disrupted traditional hierarchies. The educational impact focus echoed other similar reviews,[60] which investigated learners' RMC knowledge and attitudes and patients' experiences of RMC. However, our review was the first to highlight that it may be important to study how RMC education can motivate and empower providers as well as foster professional agency and leadership.

We identified several critical gaps in the RMC education initiatives. They largely failed to address the role of trauma in shaping RMC. There is a need for explicit integration of trauma-and-violence–informed care principles in education initiatives, given the prevalence of trauma and the intimate nature of perinatal care.[61] These principles focus on patient autonomy, safety, trust, and the avoidance of trauma/retraumatization,[62] making them particularly relevant to RMC. Overall, there was also a gap in RMC education initiatives accounting for system-level influences. As Yargawa et al[59] observed, most RMC training lacked a well-developed focus on social justice and equity. This omission is problematic, as 2 major drivers of disrespect are intersecting social and economic inequalities and institutional structures and processes.[58] Further, there was a lack of tailored education about structurally disadvantaged populations. Most education initiatives were generalized to all women, without attending to intersecting axes of gender, disability, poverty, education level, ethnicity, religion, or caste. Yet, these factors have contributed significantly to discriminatory practices and identity-related disrespect and abuse.[20,58,63,64] Reimer-Kirkham et al[20] noted that women birthing newborns with albinism in sub-Saharan Africa often endured violence and stigma due to pervasive discrimination. They argued that RMC holds particular promise for these women, but only if it explicitly addresses this discrimination.

Our review offered insights into the strengths and limitations of the RMC framework itself. RMC resonates with students and health care providers because it is grounded in compassion, dignity, and respect.[65] Sen et al[58] commended the RMC framework for addressing long-neglected issues in a way that is actionable for health care providers. Importantly, RMC does not merely call for the absence of mistreatment; it also advocates for women's human rights. At the same time, critiques of RMC reveal ways to expand it. Scholars are calling for socially grounded and decolonizing RMC approaches.[65,66] While disrespect becomes visible in clinical actions, it primarily has social roots, such as barriers to RMC for those with disabilities.[20] For example, a disability rights approach could foreground individual, lived experiences in RMC and focus on creating accommodating environments and societies.[67] A decolonial lens is also crucial when working with structurally disadvantaged communities,[21,58,65,68–71] because colonial systems have medicalized birth and suppressed Indigenous knowledges and midwifery care, perpetuating inequities.[58,65,69]

Our inclusion criteria required the use of an explicit RMC framework, a requirement that may have excluded equity-oriented[72,73] or family-centered maternity and newborn care[74] frameworks that do not use the same terminology but nonetheless could contribute to respectful practice. For example, Effland et al[75] discuss a conceptual model in the *Equity Agenda Guideline* and associated website resources (https://www.equitymidwifery.org/facultystafftraining) that offer a roadmap for infusing equity and social justice into health professions education.[72] Similarly, De Ornelas and colleagues[76] developed "Beloved Birth Black Centering," a community-centered and antiracist model of whole-person perinatal care, which supports group perinatal care, racially-concordant care, wrap-around support, childbirth education, and doula services. Additionally, many professional organizations have put forward curriculum resources related to RMC, such as American College of Nurse-Midwives resources[77] and the Accreditation Commission for Midwifery Education's education standards,[78] which have relevance for equity-oriented perinatal care.

As with all reviews, this rapid scoping review has several limitations. Despite efforts to ensure a comprehensive search, it is possible that relevant articles were missed due to the lack of controlled vocabulary, the restriction to English-language sources, and streamlined rapid review procedures. Further, a review of westernized research is inherently colonial and obscures Indigenous cultural practices and ways of knowing, doing, and being. In addition, quality appraisals revealed methodological limitations in some studies, which should be

kept in mind when interpreting findings. Although we sought to focus on pre-service education, published literature addressing RMC education exclusively for pre-service learners was limited. In response, we expanded our scope to include studies with content relevant to pre-service curricula to identify potential resources for our project.

Our findings highlight key directions for the development of RMC education and future research. Integrating RMC education with broader systems-strengthening strategies is particularly promising. Research using critical methodologies could deepen insights into how structural and institutional factors shape RMC education and its impact. There is a need for RMC research that focuses on trauma-informed and equity-oriented approaches for diverse groups of people. Aligning with our larger project, future research should explore how RMC education might improve maternal experiences surrounding the birth of a newborn with albinism. Additionally, more rigorous evaluations of the outcomes identified in this review are needed. Research efforts are also needed to decolonize RMC education so it is attuned to the historical and sociopolitical realities of local territories.[65,79] Given the geographic skew in the literature, there is a need for all countries to investigate disrespect and RMC interventions.[80,81] Finally, research is needed to develop RMC education initiatives that extend beyond intrapartum care to the entire perinatal period.

CONCLUSION

Our findings offer timely insights into how RMC can be meaningfully integrated into the curriculum of pre-service health care learners. When educational initiatives are aligned with trauma-and-violence–informed principles, equity-oriented content, and systems-strengthening efforts, they can become a vital mechanism for fostering more respectful and dignified perinatal care for women and their families. Attending to this pivotal stage of life is critical for advancing the health and well-being of women worldwide and for the purposes of our research focus: the human rights of women who give birth to a newborn with albinism. Ultimately, embedding RMC into education and practice represents not only a clinical imperative but also a societal commitment to valuing women's lives.

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CONFLICT OF INTEREST

The authors have no conflicts of interests to disclose.

SUPPORTING INFORMATION

Additional supporting information may be found online in the Supporting Information section at the end of the article.

Appendix S1: Preferred Reporting Items for Systematic reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR) Checklist

Appendix S2: Literature Search Strategy

Appendix S3: Inclusion and Exclusion Criteria

Appendix S4: Data Extraction Matrix Items

Appendix S5: Individual Sources of Evidence

Appendix S6: Quality Appraisals of Included Research Articles

Appendix S7: RMC Educational Initiative Purpose Across Sources

Appendix S8: Key RMC Documents Informing Initiatives

Appendix S9: Additional Curriculum Resources for Educators

Appendix S10: Specific RMC Principles Within the Content of the Educational Initiatives

Appendix S11: Structure of Educational Initiatives Across Sources

Appendix S12: Exemplary RMC Educational Initiatives for Systems Strengthening

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