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# Promoting respectful maternity care in Nepal: A mixed-methods one-year follow-up of a pilot Forum Play intervention with hospital staff

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ABSTRACT

*Background:* Respectful maternity care promotes dignity, privacy, informed choice, and equitable treatment during childbirth. However, disrespect and abuse remain common, particularly in low- and middle-income countries such as Nepal, where evidence on sustainable interventions is limited. Forum Play is a participatory theatre-based approach using role-play, reflection, and dialogue.

*Aim:* To assess changes over one year in hospital staff's perceptions and self-reported behaviour regarding disrespect and abuse following participation in a pilot Forum Play intervention and to explore its contribution to respectful maternity care.

*Methods:* A mixed-methods follow-up study was conducted in November 2024 among tertiary hospital staff in Kathmandu, one-year post-intervention. Quantitative data were collected through a self-administered questionnaire (n = 30) and analysed across pretest, two-month posttest, and one-year follow-up using descriptive and inferential statistics. Qualitative data were obtained through focus group discussions (n = 22) and in-depth interviews (n = 6) and analysed using inductive qualitative content analysis.

*Findings:* Recognition of disrespect and abuse increased significantly, with greater identification of incidents and regret for not intervening ($p$ = <0.05). Perceptions of respectful maternity care remained positive and stable from pretest to follow-up ($p$ = 0.69). Qualitative findings indicated that disrespect and abuse were often normalised and shaped by hierarchical relationships, medicalized care, and systemic constraints. Forum Play enhanced awareness, empathy, and communication despite ongoing structural barriers.

*Conclusions:* Forum Play showed promise in promoting respectful maternity care by encouraging reflection and strengthening empathy and communication among hospital staff. Sustaining these changes, however, requires broader institutional and health system support.

**Statement of significance**

**What is the issue?**

Disrespect and abuse during facility-based childbirth remain widespread, yet evidence on sustainable interventions to promote respectful maternity care is limited, particularly in low-resource settings like Nepal.

**What is already known?**

Disrespect and abuse during childbirth is driven by complex individual, organisational, and health-system factors. Participatory educational approaches have shown promise for improving awareness of respectful maternity care, but evidence of their long-term effectiveness remains scarce.

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**What does this paper add?**

This study provides novel one-year follow-up evidence on the sustainability of a pilot Forum Play intervention in maternity care. It demonstrates the potential of participatory, experiential learning to improve recognition of disrespect and abuse while highlighting the need for organisational and health-system reforms to achieve sustainable respectful maternity care in low- and middle-income countries.

## 1. Introduction

Respectful maternity care (RMC) is a cornerstone of quality maternal health services, promoting dignity, privacy, informed consent, autonomy, and equitable treatment during childbirth [1]. Although facility-based births have increased globally, improving women's experiences of care remains a major priority [2]. Disrespect and abuse (D&A), widely recognized as mistreatment during childbirth, remain widespread, particularly in low- and middle-income countries. A recent meta-analysis estimated that 54.5% (95% CI: 49.1%–59.9%) of women globally experience some form of mistreatment during childbirth [3]. Common forms include verbal abuse, neglect, non-consented care, discrimination, and denial of companionship, undermining women's rights, trust in health systems, and maternal and neonatal outcomes [4–6].

Various interventions, including provider training, mentorship, community engagement, and health system strengthening, have been implemented to promote RMC. Evidence indicates that these approaches can improve women's experiences and reduce mistreatment. A systematic review from Africa found that RMC interventions significantly increased respectful care (AOR: 3.44; 95% CI 2.45–4.84) and reduced abuse [7]. Pilot Forum Play interventions in Sri Lanka and Sweden have demonstrated improved critical reflection, awareness of D&A, empathy, and communication among healthcare providers [8,9]. Forum Play is a participatory theatre-based approach derived from Augusto Boal's *Theatre of the Oppressed*. It uses role-play, dialogue, and audience participation to explore challenging situations and develop alternative ways of responding. In Forum Play, participants can intervene in a performed scenario, suggest or enact alternative actions, and reflect collectively on possible responses to the situation. In this study, Forum Play was used to facilitate reflection on D&A and to explore more respectful approaches to maternity care. However, evidence remains limited, with few studies assessing long-term sustainability or addressing structural factors [10,11].

Despite substantial progress in maternal and newborn health, Nepal continues to face challenges in ensuring RMC [12–14]. Reflecting global estimates of women experience of mistreatment during childbirth [3], studies in Nepal report widespread D&A, including poor communication, lack of privacy, neglect, and non-consented care [14]. A multicenter study found that 84.3% of women could not discuss their concerns and 80.4% received inadequate information about their care [15]. These practices are shaped by workload pressures, resource constraints, hierarchical structures, and sociocultural norms [4,15–17].

While RMC has received growing attention, evidence on effective, contextually appropriate, and sustainable interventions in Nepal remains limited [18–21]. Participatory approaches such as Forum Play may help address this gap by engaging healthcare providers in experiential learning, critical reflection, and exploration of respectful alternatives to everyday care practices [22,23]. Building on a pilot Forum Play intervention conducted in 2023, this study forms part of a broader programme of research evaluating the intervention. Details of the intervention have been published previously [24]. Briefly, three half-day Forum Play workshops were conducted in November 2023 with doctors, nurses, and administrative staff. Grounded in Freire's *Pedagogy of the Oppressed,* Boal's *Theatre of the Oppressed,* and *Sexual and Reproductive Health and Rights* (*SRHR*) principles [23,25,26], the intervention used participant-generated scenarios of D&A during labour and childbirth to facilitate reflection, audience intervention, and rehearsal of respectful, rights-based approaches to maternity care. The workshops were facilitated by an experienced Swedish drama pedagogue. While previous analyses focused on intervention implementation and short-term outcomes, the present study examines participants' reflections and perceived changes in attitudes and self-reported behaviour one year after the intervention.

## 2. Methodology

### 2.1. Study design and setting

A mixed-methods follow-up study was conducted at a tertiary hospital in Kathmandu, Nepal, embedded within a pilot intervention of Forum Play held in November 2023. The hospital implements Nepal's national Safe Motherhood and Newborn Health programme, which seeks to improve access to equitable, affordable, and quality maternal and newborn health services. As part of this broader programme, the Aama Programme supports access to facility-based childbirth by providing free birth services and transportation incentives [27]. The hospital conducts more than 1500 births annually, including Caesarean section operations.

### 2.2. Population and sampling

The study population comprised doctors, nurses, and administrative staff directly or indirectly involved in providing care to women during labour and childbirth. The nurses did not hold separate midwifery qualifications; however, nursing education in Nepal includes theoretical and clinical training in maternal and newborn care. The doctors comprised obstetricians and gynaecologists, anaesthesiologists, and neonatologists, representing key professional groups involved in the care of women and newborns within the hospital.

Thirty-six participants took part in the pilot Forum Play intervention and were followed over time for this study. Quantitative assessments were conducted at pre-intervention, two months, and one year after the intervention. Qualitative data were collected during the one-year follow-up. Participant attrition occurred primarily because of staff turnover. Accordingly, 35 participants completed the two-month quantitative assessment, 30 completed the one-year quantitative assessment, and 28 participated in the one-year qualitative component. The participant flow for the present study is shown in Fig. 1.

### 2.3. Data collection

Data collection for the one-year follow-up study was conducted in November 2024, one year after implementation of the pilot Forum Play intervention.

#### 2.3.1. Quantitative

Quantitative data were collected using a structured self-administered questionnaire. A self-administered structured questionnaire was used at baseline, two months post-intervention, and one-year follow-up. The questionnaire was developed for the pilot study based on a review of relevant literature and the authors' experience. It comprised sections assessing participants' views and responses to D&A and their perceptions of RMC. The questionnaire was designed to capture outcomes that were conceptually relevant to the Forum Play intervention, particularly participants' awareness and recognition of D&A, their ability to respond to such situations, and their perceptions of RMC. The full questionnaire and further details of its development are provided in Appendix A (Supplementary Material). The questionnaire was not a single previously validated instrument; rather, it comprised items adapted from existing measures and study-specific items. It was translated into Nepali,

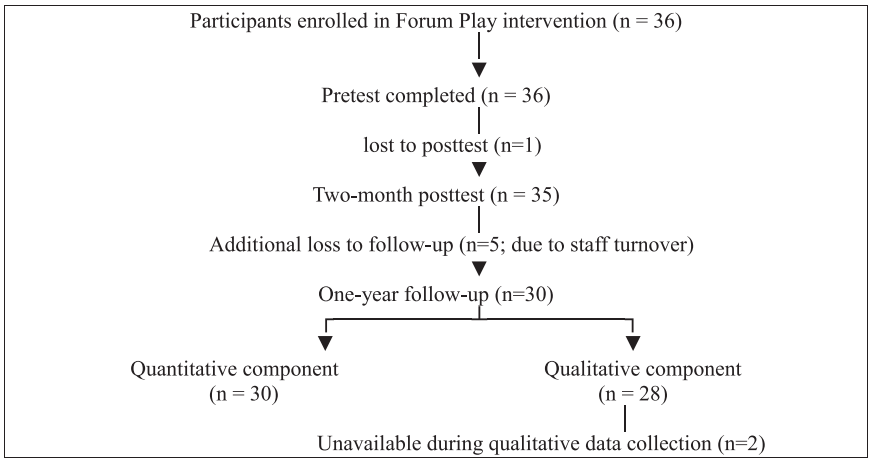


**Fig. 1.** Flow of participants through the Forum Play intervention study from enrolment to one-year follow-up.
Numbers of participants completing the pretest, posttest, and quantitative and qualitative follow-up assessments, together with attrition at each stage, are shown.

back translated into English, and pretested before use. Internal consistency was assessed for the relevant multi-item sections [24]. The response rate was 100% at each assessment point, with all eligible participants completing the questionnaire (pretest: 36/36, two-month posttest: 35/35, one-year follow-up: 30/30).

#### 2.3.2. Qualitative

Qualitative data were collected through three profession-specific focus group discussions (FGDs) with doctors, nurses, and administrative staff (n = 22), followed by six in-depth interviews (IDIs), with two participants selected from each group. A semi-structured interview guide (Appendix A) was used to explore participants' experiences, perceptions, and reflections on the Forum Play intervention and RMC. All FGDs and IDIs were conducted in a private room and moderated by the first author. Sessions were audio-recorded, and two note-takers independently documented non-verbal cues and key observations to enhance data richness.

### 2.4. Data analysis

#### 2.4.1. Quantitative

Quantitative data were analyzed using the Statistical Package for the Social Sciences (IBM SPSS), version 20. Descriptive statistics were used to summarise the background characteristics of the participants, perception and behaviour related to D&A, and perceptions of RMC. Generalized estimating equations (GEE) were used to assess changes in participants' perceptions and actions regarding D&A across the three assessment points (pretest, posttest, and follow-up), accounting for the correlation between repeated observations from the same participants. The pretest assessment was specified as the reference category. GEE estimates represent the population-averaged effect of assessment time on each outcome. The regression coefficient (β) indicates the direction and magnitude of the association between assessment time and the outcome relative to pretest. For categorical outcomes analysed using a logit link, β represents the change in log odds relative to pretest. Positive β values indicate higher log odds of the outcome, whereas negative β values indicate lower log odds compared with pretest. The 95% Wald confidence interval (CI) was used to indicate the precision of the β estimate, and a p-value $< 0.05$ was considered statistically significant. The Friedman test, a non-parametric test for related samples, was used to assess changes in participants' perception of RMC scores across the three assessment points, as the scores were not normally distributed.

#### 2.4.2. Qualitative

Qualitative data from FGDs and IDIs were transcribed verbatim, translated into English, and analysed using inductive qualitative content analysis approach following Graneheim and Lundman [28]. Transcripts were read repeatedly to gain familiarity with the data. Meaning units relevant to the research question were identified, condensed, coded, and grouped into subcategories and broader categories representing shared patterns (Fig. 2). Data from FGDs and IDIs were first compared and then analysed as a single dataset, enabling methodological triangulation and integration of group and individual perspectives. This approach captured participants' experiences of D&A during facility-based births and their reflections on the Forum Play intervention. Illustrative quotations are presented to support the findings.

The qualitative study was underpinned by a constructivist ontological and epistemological perspective, which views reality as socially constructed through interactions and knowledge as co-created between researchers and participants [29]. Accordingly, D&A were understood as socially and contextually constructed practices shaped by institutional, cultural, interpersonal, and resource-related factors. The perspectives of doctors, nurses, and administrative staff were therefore considered important for understanding how D&A were experienced, perceived, and normalized within the institutional context.

The analysis was informed by Freire's *Pedagogy of the Oppressed*, particularly its concepts of power, dialogue, critical reflection, and conscientization [23], which helped examine how hierarchical relationships and normalized practices shaped participants' understanding of D&A and possibilities for change. Together, these perspectives guided the interpretation of participants' accounts while allowing categories to emerge inductively from the data.

## 3. Findings

### 3.1. Quantitative findings

#### 3.1.1. Background characteristics of the participants

Thirty-six participants completed the pretest, 35 the posttest, and 30 the one-year follow-up. Participant characteristics remained largely similar across time points (Table 1). The mean age was approximately 32 years, and most participants were female (75.0% at pretest and 76.7% at follow-up).

Table 2 summarises participants' perceptions, responses, and generalised estimating equation (GEE) estimates regarding the D&A of women across the three study timepoints. At pretest, awareness was limited: 30.6% of participants considered the issue irrelevant, 41.7% reported only general knowledge, and 27.8% recognised workplace cases. Following the intervention, awareness improved progressively; recognition of workplace cases increased to 54.3% at posttest and

| Meaning unit | Condensed meaning unit | Codes | Subcategory | Category |
|---|---|---|---|---|
| Majority of participants, FGD, Admin staff: After attending the Forum Play workshop, we are now better able to recognize abusive behaviour and provide respectful care to patients. | Forum Play workshops improved participants' ability to recognize abuse and deliver respectful care. | Recognition of abusive practices; greater understanding of respectful maternity care | Increased awareness of disrespect and abuse | Awareness and behavioural change through Forum Play |

**Fig. 2.** Example of the qualitative content analysis process.
Illustration of the progression from a meaning unit to a condensed meaning unit, codes, subcategory, and category.

**Table 1**
Background characteristics of the participants.

| Variables | Pretest (n = 36) n (%) | Post test (n = 35) n (%) | Follow-up (n = 30) n (%) |
|---|---|---|---|
| **Mean age** (in years) | 32.2 ± 7.82 | 32.4 ± 7.89 | 34.3 ± 8.09 |
| **Sex** | 9 (25.0) | 8 (22.9) | 7 (23.3) |
| Male | 27 (75.0) | 27 (77.1) | 23 (76.7) |
| Female | | | |
| **Ethnicity** | 17 (47.2) | 16 (45.7) | 12 (40.0) |
| Brahmin/Chhetri | 16 (44.4) | 16 (45.7) | 16 (53.3) |
| Janjati | 3 (8.4) | 3 (8.6) | 2 (6.7) |
| Madhesi | | | |
| **Education level** | 11 (30.6) | 10 (28.6) | 10 (33.3) |
| Up to secondary | 11 (30.6) | 11 (31.4) | 9 (30.0) |
| Bachelor | 14 (38.8) | 14 (40.0) | 11 (36.7) |
| Master | | | |
| **Occupation** | 14 (38.8) | 14 (40.0) | 12 (40.0) |
| Nurses | 11 (30.6) | 11 (31.4) | 9 (30.0) |
| Doctors | 11 (30.6) | 10 (28.6) | 9 (30.0) |
| Administrative staff | | | |
| **Work experience (in years)** | 5 (2–11) | 5 (2–11) | 6 (3–12) |
| Median (IQR) | | | |

IQR=Intra quartile range

reached 70.0% at follow-up. Perceived relevance and awareness of D&A increased significantly from pretest to posttest and remained significantly higher at one-year follow-up, with a stronger effect at follow-up (posttest: β = 0.96, 95% CI: 0.03–1.88, *p* 0.04; follow-up: β = 3.90, 95% CI: 2.38–5.42, $p < 0.001$). Furthermore, sustained recognition was evidenced at follow-up, with 23.3% of participants reporting personal involvement in such cases.

Participants reported significantly greater ability to recall their responses to situations involving D&A at both posttest (β = 1.26, 95% CI: 0.31–2.21, *p* 0.009) and one-year follow-up (β = 1.87, 95% CI: 0.73–3.00, *p* 0.001) compared with pretest. Concurrently, the proportion of participants reporting no clinical encounters with these situations declined steadily from 83.3% at pretest to 57.1% at posttest, dropping to 33.3% at follow-up.

Reported regret significantly increased at both posttest (β = 1.97, 95% CI: 0.99–2.96, $p < 0.001$) and one-year follow-up (β = 3.08, 95% CI: 1.92–4.24, $p < 0.001$) compared with pretest. Specifically, regret over non-intervention rose from a pretest of 2.8–28.6% at posttest and 43.3% at follow-up, while 16.7% reported regret over supporting complicit staff at follow-up. Notably, no participants expressed regret regarding advocating for women at any point. Participants consistently rated the woman's perspective as highly important across all assessments, demonstrating a sustained alignment with woman-centered care frameworks at follow-up.

Table 3 presents participants' item-wise and overall perception scores regarding RMC. Mean scores exceeded 4 for most items across pretest, posttest, and follow-up assessments, indicating generally positive perceptions. However, lower scores (< 4) were observed for allowing a labour companion, maintaining an optimal labour room environment, and supporting women's preferred birthing positions. These findings suggest that, despite overall favorable perceptions of RMC, gaps remained in awareness or implementation of practices related to women's rights and preferences during childbirth.

Overall, the participants demonstrated consistently positive perceptions of RMC across all three assessments. Mean perception scores remained high, increasing only slightly from pretest (79.0 ± 6.33) to posttest (80.33 ± 5.89) and follow-up (80.13 ± 5.22). Consistent with the similar mean ranks, the Friedman test showed no significant change over time ($\chi^2 = 0.73$, p = 0.69), indicating that favorable perceptions were maintained throughout the study period (Table 3).

### 3.2. Qualitative findings

At the one-year follow-up, participants were invited to share their views on D&A during facility-based birth and to reflect on the role of the Forum Play intervention in promoting RMC. Relevant meaning units were identified from the discussions and interviews, condensed, and abstracted into codes, which were subsequently grouped into three overarching categories and nine subcategories (Fig. 3).

#### 3.2.1. Category 1: Persistent drivers of disrespect and abuse

This category describes the multiple interpersonal, structural, and systemic factors that contribute to D&A during childbirth in institutional settings. Participants reported that disrespectful practices are often embedded within routine clinical interactions and shaped by hierarchical relationships between providers and women, medicalized models of care, inequities within the health system, and challenging workplace conditions. These findings reflect gaps in the realization of *SRHR,* particularly women's rights to dignity, autonomy, and equitable care. This category encompasses three interrelated subcategories as described below.

*3.2.1.1. Normalisation of disrespectful maternity care.* Participants described D&A during childbirth as being shaped by interpersonal, structural, and systemic factors. Disrespectful practices were often embedded within routine clinical interactions and reinforced by provider-centered models of care, hierarchical relationships, and challenging workplace conditions. These experiences reflected gaps in the realisation of *SRHR,* particularly women's rights to dignity, autonomy, and equitable care.

Participants reported that disrespectful communication, including verbal scolding, harsh language, blaming, and coercion, was commonly used to ensure women's compliance during labour. Some providers acknowledged the use of fear-based communication and threats to encourage women to follow instructions.

> *"I have observed care* providers *threatening or coercing women during labour. For example, they sometimes say, 'If you do not push properly, your baby will get stuck,' if anything happens, we will not be responsible" (IDI Doctors 2).*

Physical coercion, including forceful positioning and rough handling during labour and childbirth, was also reported. Although such actions were sometimes justified as necessary for labour management, participants recognised their negative impact on women's childbirth

**Table 2**
Perceptions and actions regarding disrespect and abuse of women at three timepoints.

| Questions | Options | Pretest (n = 36) | | | | Posttest (n = 35) | | | | Follow-up (n = 30) | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | n (%) | β | 95% CI | *p*-value | n (%) | β | 95% CI | *p*-value | n (%) | β | 95% CI | *p*-value |
| How relevant is D&A of women to you? | No relevance | 11 (30.6) | Reference | | | 6 (17.1) | 0.96 | 0.03–1.88 | 0.04 | 1 (3.3) | 3.90 | 2.38–5.42 | < 0.001 |
| | Picked up some general aspects about D&A | 15 (41.7) | | | | 10 (28.6) | | | | 1 (3.3) | | | |
| | Heard about cases of D&A at my workplace | 10 (27.8) | | | | 19 (54.3) | | | | 21 (70.0) | | | |
| | Have been involved personally in cases of D&A | - | | | | - | | | | 7 (23.3) | | | |
| Can you recall your response in a situation of D&A women? | Have not been in such a situation | 30 (83.3) | Reference | | | 20 (57.1) | 1.26 | 0.31–2.21 | 0.009 | 10 (33.3) | 1.87 | 0.73–3.00 | 0.001 |
| | I had no possibility to respond in any way | - | | | | 6 (17.1) | | | | 7 (23.3) | | | |
| | I acted supporting my colleagues'/staff's position | 2 (5.6) | | | | 1 (2.9) | | | | 8 (26.7) | | | |
| | I acted supporting the woman's position | 4 (11.1) | | | | 8 (22.9) | | | | 5 (16.7) | | | |
| Have you experienced regret in this situation? | Have not been in such a situation | 31 (86.1) | Reference | | | 16 (45·7) | 1.97 | 0.99–2.96 | 0.01 | 8 (26.7) | 3.08 | 1.92–4.24 | < 0.001 |
| | No | 4 (11.1) | | | | 8 (22.9) | | | | 4 (13·3) | | | |
| | Yes, about not acting against D&A of women | - | | | | 10 (28.6) | | | | 13 (43.3) | | | |
| | Yes, about acting on behalf of the staff. | - | | | | 1 (2.9) | | | | 5 (16.7) | | | |
| | Yes, about acting on behalf of the woman | 1 (2.8) | | | | - | | | | - | | | |
| How important is it to consider the woman's perspective in Obs/Gyn? | Not so important | - | Reference | | | - | -0.06 | −2.91–2.79 | 0.97 | - | | NA | NA |
| | Little important | 1 (2.8) | | | | 1 (2.9) | | | | - | | | |
| | Very important | 35 (97.2) | | | | 34 (97.1) | | | | 30 (100) | | | |

**β** = regression coefficient from the ordinal logistic GEE model; positive values indicate higher cumulative odds of being in a higher outcome category and negative values indicate lower cumulative odds, relative to pretest.
**NA** = not estimable because there was insufficient variability in responses at follow-up.

experiences. Many reflected that these practices had become normalised within maternity settings and were often perceived as routine rather than as forms of D&A.

> *"During labour when women are unable to cooperate, some doctors forcibly separate their legs and threaten them by saying, 'If you cannot tolerate this little pain, how will you handle childbirth later?'" (P7, FGD Admin staff).*

Participants also highlighted significant power imbalances between healthcare providers and women. Maternity care was described as largely provider-centered, with women expected to comply with instructions and rarely consulted about their preferences or care decisions. Limited communication, inadequate explanations of procedures, and inconsistent informed consent often resulted in women's preferences and voices being overlooked.

> "There appears to be a significant gap between care providers and health service users in Nepal. After admission to the labour room, women are rarely asked about their preferences" (IDI Doctors 1).

Participants emphasised that D&A were not solely attributable to individual attitudes but were also influenced by systemic challenges. Heavy workloads, staff shortages, high volumes of women, and stressful labour ward environments limited opportunities for communication, individualised attention, and emotional support, increasing the likelihood of unintentional disrespectful behaviour.

> *"Labour room is often chaotic with providers working under heavy workload and high stress. In such conditions, unintentional disrespectful or abusive behaviour may occur" (P1, FGD Nurses).*

*3.2.1.2. Over medicalised and provider-led care.* Participants described childbirth care as increasingly medicalised and provider-led, with clinical management often prioritizing efficiency and provider control over women's experiences. Many observed frequent use of interventions, including episiotomies and cesarean sections which were sometimes perceived as being performed for provider convenience rather than clear medical indications.

> *"Episiotomy should be* performed *only when clinically indicated, yet in practice, it is often done even when unnecessary. Similarly, cesarean sections are frequently performed for the convenience of healthcare providers" (IDI Nurses 2).*

Participants reported that clinical decisions were largely provider-driven, with limited opportunities for women to participate in discussions about their care. Pain management, emotional reassurance, and comfort during labour were often overlooked, reflecting a strong emphasis on clinical outcomes and procedural management.

> *"During labour, women experience verbal abuse in the form of scolding when they cry or complain of pain from* contractions*; care providers normalise labour pain and they question women's rights to express suffering" (P2, FGD Doctors).*

These practices contributed to a care environment in which women's

**Table 3**
Mean perception score towards respectful maternity care.

| S. N. | Respectful Maternity Care Aspects (Items) | Pretest Mean ± SD | Posttest Mean ± SD | Follow-up Mean ± SD |
|---|---|---|---|---|
| 1 | Care providers should welcome laboring woman warmly and introduce themselves | 4·56 ± 0·77 | 4·63 ± 0·55 | 4·87 ± 0·34 |
| 2 | Establishing a good and friendly relationship is essential for providing respectful maternity care. | 4·61 ± 0·59 | 4·57 ± 0·85 | 4·53 ± 0·81 |
| 3 | The laboring woman should not allow to have companion inside the labor and childbirth room[a] | 3·72 ± 1·08 | 3·57 ± 1·03 | 3·67 ± 1·09 |
| 4 | Unnecessary interventions without medical indication should be eliminated (e.g., oxytocin, episiotomy, CS) | 3·78 ± 1·12 | 4·03 ± 0·82 | 4·03 ± 0·80 |
| 5 | Women need to get information about progress of labor | 4·47 ± 0·56 | 4·66 ± 0·48 | 4·53 ± 0·57 |
| 6 | All interventions should be performed with laboring woman's informed consent. | 4·56 ± 0·60 | 4·60 ± 0·49 | 4·47 ± 0·81 |
| 7 | There should be provision of drug-free comfort and pain relief methods during labor | 4·91 ± 0·58 | 4·20 ± 0·83 | 4·07 ± 0·86 |
| 8 | Care providers should pay attention to laboring women's safety in providing care and doing interventions. | 4·56 ± 0·49 | 4·45 ± 0·45 | 4·73 ± 0·52 |
| 9 | Women should be encouraged to actively participate in their care. | 4·53 ± 0·65 | 4·43 ± 0·50 | 4·33 ± 0·45 |
| 10 | Preserving dignity is preventing any mistreatments with laboring women. | 4·25 ± 0·96 | 4·26 ± 0·61 | 3·80 ± 0·92 |
| 11 | Care providers should keep all medical records of women confidential. | 4·03 ± 0·84 | 4·43 ± 0·73 | 4·47 ± 0·73 |
| 12 | Equal care should be provided to all women, regardless of their ethnicity, culture, religion, etc. | 4·66 ± 0·66 | 4·53 ± 0·56 | 4·70 ± 0·79 |
| 13 | Care providers should be continuously or timely available during labor and childbirth. | 4·69 ± 0·52 | 4·43 ± 0·60 | 4·53 ± 0·56 |
| 14 | It is often hard to keep a clean and calm environment for women during labour[a] | 2·53 ± 1·23 | 2·69 ± 1·13 | 2·73 ± 1·08 |
| 15 | Care providers should try to limit exposing a woman's body when providing care. | 4·19 ± 1·09 | 4·31 ± 0·67 | 4·13 ± 0·81 |
| 16 | Care providers should support laboring woman to be in her desired birthing position. | 3·39 ± 1·12 | 3·69 ± 0·90 | 3·73 ± 0·90 |
| 17 | Care providers may beat the laboring woman if she does not cooperate[a] | 4•13 ± 1•15 | 4·23 ± 1·21 | 4·40 ± 0•81 |
| 18 | Care providers may shout at laboring woman if she does not cooperate[a] | 3•72 ± 1•23 | 4•11 ± 1•10 | 4•13 ± 0•81 |
| 19 | Care providers should provide evidence-based and up-to-date childbirth care | 4•44 ± 0•69 | 4•49 ± 0•50 | 4•40 ± 0•67 |
| **Overall mean score** | | 79•0 ± 6•33 | 80•33 ± 5•89 | 80•13 ± 5•22 |
| **Mean rank** | | 1•90 | 2•12 | 1•98 |
| $\chi^2$ | | 0•73 | | |
| ***p*-value** | | 0•69 | | |

[a] Reversed score, the maximum possible score of each item is 5, mean ≥ 4 implies positive perception $\chi^2$=Friedman test

physical, emotional, and decision-making needs were insufficiently prioritised.

*3.2.1.3. Preferential treatment and compromised privacy.* Participants described inequities in maternity care, particularly preferential treatment based on women's ability to pay or their social connections with healthcare providers or hospital authorities. Such women were perceived to receive more favourable attention and care than those without such connections. *"Preferential treatment is mainly given to those women who pay or who have personal connections with doctors or hospital authorities" (Majority of the participants, all FGDs and all IDIs).*

Participants also raised concerns about women's privacy and confidentiality, particularly in busy maternity wards where maintaining privacy during examinations and procedures was perceived to be challenging. *"In Nepal, women's confidentiality is often not adequately maintained. Women's privacy is often compromised in practice" (IDI, Doctors 1)*

### *3.2.2. Category 2: Awareness and behavioural change through Forum Play*

This category describes how the Forum Play intervention contributed to increased awareness and reflection among healthcare providers regarding RMC practices. Participants reported that the participatory training created opportunities to critically examine routine behaviour, recognise forms of D&A, and consider alternative ways of interacting with women during childbirth. These changes can be understood as the development of critical consciousness, consistent with *Pedagogy of the Oppressed*. Through dialogue and collective reflection, participants appeared to move beyond viewing D&A as routine aspects of maternity care and began to critically examine the social, professional, and institutional factors that sustain such practices. This category comprises two subcategories, which are described below.

*3.2.2.1. Increased recognition of disrespect and abuse.* Participants reported that the Forum Play workshop enhanced their ability to recognise and acknowledge behaviour that could be perceived as disrespectful or abusive in maternity care. Through reenactment of real-life clinical situations, staff gained new perspectives on routine interactions and identified practices that had previously been normalised within their workplace.

> *"After attending the Forum Play workshop, we are now better able to recognise abusive behaviour and provide* respectful *care to women" (Majority of participants, FGD Admin staff).*

The intervention also strengthened participants' understanding of RMC, particularly the importance of protecting women's dignity, privacy, autonomy, and rights during childbirth which are core components of *SRHR*. Participants further described increased empathy for labouring women and greater awareness of how disrespectful communication and neglect could affect women's experiences and well-being.

> *"Through* the *Forum Play workshop, we learned to develop empathy rather than sympathy and understood the importance of respectful maternity care" (IDI Nurses 1).*

*3.2.2.2. Reflective practice and behaviour change.* Participants reported that the intervention encouraged critical reflection on their professional practices and interactions with women. Through Forum Play, staff examined routine behaviour, considered alternative responses, and identified more respectful approaches to care.

> *"Engaging in Forum Play allows participants to explore diverse perspectives and recognise alternative ways of* responding *to situations. This reflective process contributes to meaningful changes in behaviour." (P3, FGD Nurses).*

Several participants described making conscious efforts to improve communication with women during labour by providing clearer explanations, speaking more respectfully, and showing greater empathy. Participants perceived these changes as contributing to more respectful and woman-centered approaches in their own practice. The participatory nature of Forum Play also promoted experiential learning and increased awareness of bystander responsibility. Through role-play and collective discussion, participants explored practical strategies for addressing disrespectful behaviour and improving RMC.

| Codes | Subcategories | Categories |
|---|---|---|
| Verbal abuse and harsh communication; physical coercion and rough handling; fear-based communication and blaming women; threats and shame; provider-dominated communication and decisions; limited explanations and information; lack of informed consent, heavy workload and staffing shortages; stressful work environment and time pressure; health system constraints; work stress contributing to unintentional disrespect | Normalization of disrespectful maternity care | Persistent drivers of disrespect and abuse |
| Rising cesarean section rates; unnecessary interventions and overmedicalization; provider-driven clinical decisions; inadequate pain management; neglect of women's comfort and emotional needs. | Overmedicalized and provider-led care | |
| Preferential treatment and socio-economic bias; discrimination and inequitable; breach of privacy and confidentiality; limited transparency and accountability in care. | Inequities and ethical concerns in care | |
| Recognition of abusive practices; greater understanding of RMC; increased sensitivity to patient rights and dignity | Increased recognition of disrespect and abuse | Awareness and behavioural change through Forum Play |
| Improved communication and empathy toward women; positive attitude and behaviour change among staff; reflective and experiential learning; increased awareness of bystander responsibility | Reflective practice and behaviour change | |
| Experiential and participatory learning approach; real-life simulation and practical problem solving; high engagement and collective reflection among staff; enhanced understanding of RMC. | Forum Play: Experiential learning | Perceived value and implementation of Forum Play |
| High acceptability; perceived relevance to clinical practice; feasibility of workplace-based training; need for institutional support and leadership involvement | Acceptability and feasibility of Forum Play | |
| Workload and time constraints for training; gap between training and real-life practice; limited resources and logistical barriers; difficulty sustaining behavioural change | Implementation challenges and sustainability | |
| Need for regular training and repeated workshops; institutional integration of RMC training; establishment of hospital mechanisms for RMC; scaling up Forum Play and wider staff participation | Future implementation recommendations | |

**Fig. 3.** Overview of the qualitative content analysis.
The figure presents the relationship between codes, subcategories, and three overarching categories derived from participants' experiences and perceptions of Forum Play and respectful maternity care.

*"In each role play, one group acted out the scenario while others acted as bystanders, who could pause the scene and suggest alternative actions. We learned how to respond more effectively in real-life situations" (IDI Doctors 1).*

### 3.2.3. Category 3: Perceived value and implementation of Forum Play

This category explores participants' perceptions of Forum Play as an approach to promoting RMC and the factors influencing its implementation and sustainability. Participants viewed the intervention as a valuable learning experience that encouraged reflection on routine practices. Consistent with the principles of *Theatre of the Oppressed,* Forum Play promoted active participation, role-play, and learning through experience. Participants also identified institutional and logistical considerations that could affect its long-term integration into healthcare settings. This category comprises four subcategories.

*3.2.3.1. Forum Play: Experiential learning.* Participants identified the experiential and participatory nature of Forum Play as a key strength of the intervention. Unlike traditional lecture-based training, it enabled staff to engage with real-life maternity care scenarios through role-play and discussion.

*"Forum Play goes beyond theory; it offers hands-on practice. It brings real-life experiences into the learning process" (P5, FGD Doctors).*

*"We can learn* and *remember many things through the Forum Play because we see them in action, rather than just hearing lectures. I believe it provides more positive insights" (IDI Admin staff 1).*

Through reenactment and role reversal, participants explored alternative responses to challenging situations, reflected on the impact of their behaviour, and gained a deeper understanding of women's experiences during childbirth.

*"During the workshop, the role plays helped us see situations from the woman's perspective. We realized that if we were in their place, we would also feel hurt. That is the change" (P7, FGD Nurses).*

*3.2.3.2. Acceptability and feasibility of Forum Play.* Participants perceived Forum Play as highly acceptable and relevant to their clinical work. The scenarios closely reflected challenges encountered in maternity wards, making the training meaningful and applicable to practice.

*"The acceptability of Forum Play is very high. It reflects the real-life experiences of people at every level, so it is highly acceptable for everyone" (IDI Doctors 1).*

The intervention was also considered a feasible workplace-based training approach because it could be delivered within hospital settings and actively engaged healthcare staff. Participants suggested that conducting sessions close to participants' work units could further enhance feasibility.

*"To increase the* feasibility, *we should organise the Forum Play workshop near working unit of participants" (P6, FGD Doctors).*

Participants emphasised that long-term integration of Forum Play would require institutional commitment, including management support for time, resources, and organisational coordination.

*"For Forum Play to be feasible, strong support from the management and administration is essential" (All participants, FGD Nurses).*

*3.2.3.3. Implementation challenges and sustainability.* Despite the perceived benefits of Forum Play, participants identified challenges to its implementation and sustainability within busy healthcare settings. Heavy workloads, limited time, and the need for trained facilitators were frequently cited as barriers, particularly in maternity wards with high woman volumes.

*"The* feasibility *is somewhat challenging because hospitals are very busy settings, and maternity units are extremely busy. Feasibility challenges may also arise due to the need for trained experts to facilitate the workshop properly" (IDI Nurses 1).*

Participants also noted that translating lessons learned during role-play into routine clinical practice could be difficult in high-pressure work environments. Overall, participants emphasised that sustained implementation would require ongoing support, resources, and repeated workshops to maintain positive changes in awareness and behaviour.

*"There is a big difference between the play and real life. However, the best part of the Forum Play workshop was* that *participants assumed role based on real-life situations and acted out them" (P3, FGD Doctors).*

*3.2.3.4. Future implementation recommendations.* Participants recommended several strategies to strengthen the long-term implementation and sustainability of Forum Play. Regular and repeated training sessions were suggested to reinforce learning and sustain awareness of RMC practices.

*"Workshops like Forum Play are highly beneficial, as they give participants the opportunity to learn through experience and* develop *positive behavioural changes. It would be even more effective if these workshops were conducted periodically and involved a broader range of staff" (P3, FGD Nurses).*

Participants also emphasised integrating Forum Play into institutional training programs and professional development activities to support ongoing learning and behavioural change.

*"If we use Forum Play in Clinicopathological Conference (CPC), sessions won't feel boring, we can learn in an engaging and entertaining way. Through role-play, we can explore solutions to real-life problems using a pedagogical approach" (P6, FGD Doctors).*

Finally, participants recommended expanding the intervention across hospital units and involving a wider range of healthcare staff to promote a shared commitment to RMC.

*"Workshops should be conducted not only in the maternity ward but in all hospital units, and they should be established as a regular part of the hospital system" (IDI Admin staff 2).*

## 3.3. Triangulation of findings

Triangulation involves comparing and integrating findings from different data sources or methods to enhance the credibility and comprehensiveness of the interpretation [30]. In this study, quantitative and qualitative findings were compared to identify areas of convergence and complementarity regarding participants' recognition and understanding of D&A during facility-based childbirth and the perceived effects of Forum Play.

Quantitative results demonstrated increased awareness over time, reflected in greater recognition of workplace cases, improved identification of appropriate responses, and increased regret for not intervening in disrespectful situations. Qualitative findings reinforced these trends, with participants describing disrespectful communication, coercive practices, hierarchical provider–woman relationships, and systemic factors such as heavy workload, staff shortages, and institutional constraints as contributors to D&A. Both data sources indicated that Forum Play enhanced awareness and encouraged critical reflection on professional behaviour and practices. Notably, many participants were able to recall specific Forum Play scenarios, discussions, and lessons one year after the intervention, suggesting that the experience remained salient and continued to shape their understanding of RMC. However,

participants also highlighted persistent structural challenges, including workload pressures and limited institutional support, which may hinder the sustained implementation of RMC.

## 4. Discussion

This mixed-methods study demonstrates that the Forum Play intervention contributed to sustained improvements in hospital staff's awareness, recognition, and responses to D&A during facility-based childbirth at one-year follow-up. There was a notable shift from passive acceptance of routine practices toward more critical reflection and responsiveness to D&A. Participants' responses indicate a growing awareness of ethical concerns and a greater willingness to address issues of D&A in their clinical practice.

The quantitative findings reveal that although overall perceptions of RMC remained largely unchanged, participants became better able to identify subtle and normalised forms of D&A. This finding is consistent with evidence that mistreatment during childbirth is often underrecognised because it is embedded within routine practices and institutional culture [4,21]. The increase in reported cases of D&A likely reflects improved recognition rather than a true rise in occurrence. Similar findings have been reported following Forum Play interventions in Sri Lanka and Sweden, where participants demonstrated enhanced awareness of disrespectful practices through experiential learning [8,9].

At follow-up, approximately one-fourth of participants reported personal involvement in D&A, similar to findings from Sri Lanka [8]. Increased expressions of regret, particularly for failing to intervene, suggest a shift from awareness toward ethical engagement and professional accountability, which are important for behaviour change in healthcare settings [31]. However, persistent challenges related to labour companionship, preferred birthing positions, and supportive labour environments highlight the limitations of individual-level interventions. These findings underscore the need for complementary organisational and system-level strategies, including supportive policies, adequate resources, supervision, and institutional cultures that promote RMC [32–34].

The qualitative findings provide important insight into the complex drivers of D&A, showing that such practices are shaped by interconnected interpersonal, systemic, and structural factors. Participants described how coercive communication, power imbalances, overmedicalisation, and workplace pressures contribute to a provider-centered model of care. These findings align with evidence that mistreatment during childbirth is not solely driven by individual attitudes but is deeply embedded within health system constraints, professional hierarchies, and sociocultural norms [4,32]. The normalisation of these practices within clinical settings highlights the need for interventions that encourage critical reflection and challenge entrenched behaviors.

Within this context, Forum Play appears to be a transformative learning approach that enables healthcare providers to critically examine their practices and explore alternative ways of interacting with women. Its participatory and experiential nature fostered empathy, perspective-taking, and reflective learning, consistent with evidence that interactive approaches are more effective than didactic training in promoting behavior change and improving provider–woman interactions [22,23]. Notably, participants were able to recall specific Forum Play scenarios, discussions, and lessons one year after the intervention, suggesting that the experience remained meaningful and fostered sustained reflection on RMC. The reported increase in bystander awareness and willingness to intervene also highlights the potential of Forum Play to influence team dynamics and collective responsibility within healthcare settings.

The observed changes in awareness, reflection, and responsiveness among participants can be interpreted through the lens of transformative learning processes. The shift from normalisation of disrespectful practices toward critical reflection suggests the emergence of critical consciousness among healthcare providers, as described in Freirean *Pedagogy of the Oppressed* [25]. Similarly, the reported engagement with alternative responses during and after the intervention reflects experiential and embodied learning, where participants were able to rehearse and internalize new ways of interacting in clinical situations, consistent with the principles of *Theatre of the Oppressed* [23]. From the *SRHR* perspective, these changes indicate a gradual movement toward recognizing RMC as a rights-based care grounded in dignity and autonomy of women [26]. Together, these perspectives help explain how Forum Play may have contributed to both cognitive and ethical shifts in provider perception and behaviour over time.

Despite these positive outcomes, participants emphasised ongoing challenges related to implementation and sustainability. Heavy workloads, staffing shortages, and limited institutional support were identified as key barriers to translating learning into consistent practice. These findings reinforce the broader evidence that improving RMC requires not only training interventions but also systemic changes, including supportive policies, adequate resources, and accountability mechanisms [32,35]. Without such structural support, the impact of interventions like Forum Play may be difficult to sustain over time. Overall, findings suggest that, by addressing both individual behaviour and broader structural influences, the Forum Play intervention may offer a theoretically grounded and contextually relevant pathway for advancing respectful, equitable, and woman-centered maternity care in Nepal.

### 4.1. Strengths and limitations

A major strength of this study is its mixed-methods design, which enabled examination of both measurable changes and the underlying factors influencing RMC. The one-year follow-up provided valuable evidence on the sustainability of intervention effects, an aspect often lacking in similar studies. The qualitative component offered in-depth insight into healthcare providers' experiences and the everyday realities of D&A. Furthermore, the study evaluated Forum Play, an innovative experiential intervention grounded in routine workplace situations, enhancing the practical relevance of the findings.

Several limitations should be considered. The study was conducted in a single hospital with a relatively small sample, limiting generalisability. Self-reported data may have been affected by social desirability bias, particularly regarding respectful care practices. The absence of a control group limits the ability to attribute observed changes solely to the intervention, as other contextual factors may have contributed. In addition, women's perspectives were not included, preventing assessment of whether provider-level changes translated into improved care experiences. High baseline RMC scores may also have limited detectable improvements. Future research should include larger, multi-site studies with comparison groups and women-level outcomes.

## 5. Conclusion

This study suggests that the pilot Forum Play intervention improved hospital staff's recognition of disrespect and abuse and fostered more reflective and responsive attitudes at one-year follow-up. However, sustaining these changes in practice remained challenging due to resources and organisational constraints. These findings highlight that sustained improvements in respectful maternity care require both individual-level change and supportive institutional conditions. Further research is needed to evaluate the effectiveness of Forum Play in diverse healthcare settings and its impact on women's experiences of care.

## Abbreviations

| | |
|---|---|
| D&A | Disrespect and Abuse |
| RMC | Respectful Maternity Care |
| SRHR | Sexual and Reproductive Health and Rights |

## Author declaration

The authors declare that the article entitled "Promoting respectful maternity care in Nepal: A mixed-methods one-year follow-up of a pilot Forum Play intervention among hospital staff" is the authors' original work. The article has not received prior publication and is not under consideration for publication elsewhere. All authors have seen and approved the manuscript being submitted. The authors abide by the copyright terms and conditions of Elsevier and the Australian College of Midwives.

## Ethical approval

Ethical approval for the study was obtained prior to data collection from the Institutional Review Committee of the hospital where the study was conducted. The study was conducted in accordance with the principles of the Declaration of Helsinki. All participants received information about the study and provided written informed consent before participation. Participation was voluntary, and participants were informed of their right to withdraw at any time without consequences. FGDs and IDIs were audio-recorded with participants' permission. To ensure confidentiality, the identity of the hospital and participants is not disclosed.

## Ethics declaration

Written informed consent to take part in the study and to publish the article has been obtained from all participants or their legal representatives. The privacy rights of participants have been observed.

This study was performed in compliance with relevant laws, regulatory frameworks and guidelines where the research took place. This study was approved by the Institutional Review Committee, Kathmandu Medical College. (Approval No. 60102024101)

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## Declaration of Generative AI and AI-assisted technologies in the writing process

During the preparation of this manuscript, the authors used ChatGPT (OpenAI) to assist with language editing, improving clarity, refining wording, and enhancing the readability of selected sections of the manuscript. The AI tool was not used for study design, data collection, data analysis, interpretation of findings, or drawing conclusions. All AI-assisted outputs were critically reviewed, revised, and verified by the authors.

## Declaration of Competing Interest

The authors declare no competing interests.

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## Data availability

The data supporting this study is available through the corresponding author upon reasonable request.

## References

[1] WHO, The prevention and elimination of disrespect and abuse during childbirth in health facilities, WHO Statement (2026). Available from: https://apps.who.int/iris/bitstream/handle/10665/134588/WHO_RHR_14.23_eng.pdf.
[2] World Health Organization, Standards for improving quality of maternal and newborn care in health facilities, World Health Organization, Geneva, 2016. Available from: https://www.who.int/publications/i/item/9789241511216.
[3] M. Mirzania, E. Shakibazadeh, A. Maleki, et al., Prevalence of mistreatment during childbirth: a systematic review and meta-analysis, Reprod. Health 22 (2025) 193, https://doi.org/10.1186/s12978-025-02119-6.
[4] M.A. Bohren, J.P. Vogel, E.C. Hunter, et al., The mistreatment of women during childbirth in health facilities globally: a mixed-methods systematic review, PLoS. Med. 12 (6) (2015) e1001847, https://doi.org/10.1371/journal.pmed.1001847.
[5] World Health Organization, New evidence shows significant mistreatment of women during childbirth, WHO, Geneva, 2019. Available from: https://www.who.int/news/item/09-10-2019-new-evidence-shows-significant-mistreatment-of-women-during-childbirth.
[6] D. Sando, H. Ratcliffe, K. McDonald, et al., The prevalence of disrespect and abuse during facility-based childbirth: a systematic review. Trop Med Int Health 21 (9) (2016) 1136–1148, https://doi.org/10.1186/s12884-016-1019-4.
[7] H.E. Rosen, P.F. Lynam, C. Carr, et al., Direct observation of respectful maternity care in five countries: a systematic review of interventions, BMJ Glob. Health (2) (2017) e000274 doi:10.1186/s12884-015-0728-4.
[8] Swahnberg, K. Zbikowski, A. Wijewardene, K. Josephson, P. Khadka, D. Jeyakumaran, et al., Can forum play contribute to counteracting abuse in health care? A pilot intervention study in in Sri Lanka, Int. J. Environ. Res. Public. Health 16 (2019) 1616, https://doi.org/10.3390/ijerph16091616.
[9] A. Zbikowski, A.J. Brüggemann, B. Wijma, K. Swahnberg, Counteracting Abuse in Health Care: Evaluating a One-Year Drama Intervention with Staff in Sweden, Int. J. Environ. Res. Public. Health 17 (2020) 5931, https://doi.org/10.3390/ijerph17165931.
[10] S. Bradley, C. McCourt, J. Rayment, D. Parmar, Disrespectful intrapartum care during facility-based delivery in LMICs: a qualitative evidence synthesis. PLoS Med 13 (2016) e1002014, https://doi.org/10.1016/j.socscimed.2016.09.039.
[11] G. Sen, B. Reddy, A. Iyer, Beyond measurement: the drivers of disrespect and abuse in childbirth, 1, Reprod. Health Matters 26 (53) (2018) 6, https://doi.org/10.1080/09688080.2018.1508173.
[12] R.B. Khatri, J. Durham, Y. Assefa, Utilisation of quality antenatal, delivery and postnatal care services in Nepal: an analysis of service provision assessment, Glob. Health 17 (2021) 102, https://doi.org/10.1186/s12992-021-00752-x.
[13] S. Sharma, O.M.R. Campbell, W.E. Oswald, D. Adhikari, P. Paudel, B. Lal, et al., Increased utilisation and quality: a focus on inequality and a learning health system approach—explaining Nepal's success in reducing maternal and newborn mortality 2000–2020, BMJ Glob. Health 9 (2) (2024) e011836, https://doi.org/10.1136/bmjgh-2023-011836.
[14] A. Kc, D.R. Singh, M.K. Upadhyaya, S.S. Budhathoki, A. Gurung, M. Målqvist, Quality of Care for Maternal and Newborn Health in Health Facilities in Nepal, Matern. Child. Health J. 24 (1) (2020 Feb) 31–38, https://doi.org/10.1007/s10995-019-02846-w.
[15] R. Gurung, M. Moinuddin, A.K. Sunny, et al., Mistreatment during childbirth and postnatal period reported by women in Nepal —a multicentric prevalence study, BMC Pregnancy Childbirth 22 (2022) 319, https://doi.org/10.1186/s12884-022-04639-6.
[16] R. Thapaliya, K. Paudel, S. Shrestha, Disrespect and abuse during facility-based childbirth in Nepal, J. Gandaki Med. Coll. Nepal. (2020), https://doi.org/10.3126/jgmcn.v14i1.30572.
[17] Ministry of Health and Population (Nepal). Safe Motherhood and Newborn Health Roadmap. Kathmandu; 2021. [Accessed April 25, 2026]. Available from: https://fwd.gov.np/site_uploads/2021/08/SMNH-Roadmap-2030-SGOP.pdf.
[18] Patricia Afulani, Tanya A. Sripad, Charlotte E. Warren, et al., Providers' perceptions of disrespect and abuse during childbirth: a mixed-methods study, Health Policy Plan. 35 (5) (2020) 577–586, https://doi.org/10.1093/heapol/czaa009.
[19] D. Bowser, K. Hill, Explor. Evid. disrespect Abus. Facil. -Based Childbirth. Report. a Landsc. Anal. Wash. (DC) USAID (2010). https://content.sph.harvard.edu/wwwhsph/sites/2413/2014/05/Exploring-Evidence-RMC_Bowser_rep_2010.pdf (Available from).
[20] H.H. Habib, J. Mwaisaka, K. Torpey, E.T. Maya, A. Ankomah, Are RMC interventions effective in reducing intrapartum mistreatment against adolescents? A systematic review, Front. Glob. Women's. Health 4 (2023 Mar 1) 1048441, https://doi.org/10.3389/fgwh.2023.1048441.
[21] N. Paudel, Respectful maternity care, J. Kathmandu Med. Coll. 11 (3) (2022) 135–136, https://doi.org/10.3126/jkmc, v11i3.50781.
[22] A. Zbikowski, K. Zeiler, K. Swahnberg, Forum Play as a method for learning ethical practice: A qualitative study among Swedish health-care staff, Clin. Ethics 11 (1) (2016) 9–18, https://doi.org/10.1177/1477750915622032.
[23] A. Boal, Theatre of the oppressed, Pluto Press, London, 2008. Available from: https://www.plutobooks.com/9780745328380/theatre-of-the-oppressed.

[24] N. Paudel Ghimire, P. Dahal, S.K. Joshi, K. Swahnberg, Effectiveness of Forum Play to promote respectful maternity care: A pilot intervention investigating self-reported perception and behaviour among care providers in urban Nepal, PLoS. One 21 (6) (2026) e0349437, https://doi.org/10.1371/journal.pone.0349437.
[25] P. Freire, Pedagogy of the Oppressed, Continuum, New York, 1970.
[26] United Nations Population Fund (UNFPA), Sexual and reproductive health and rights: an essential element of universal health coverage, UNFPA, New York, 2019 (Available from: https://www.unfpa.org/publications/sexual-and-reproductive-health-and-rights-essential-element-universal-health-coverage).
[27] Ministry of Health and Population, Government of Nepal. Nepal Safe Motherhood and Newborn Health Road Map 2030, Ministry of Health and Population, Kathmandu, 2020. Available from: https://publichealthupdate.com/nepal-safe-motherhood-and-newborn-health-road-map-2030/.
[28] U.H. Graneheim, B. Lundman, Qualitative content analysis in nursing research: concepts, procedures, and measures to achieve trustworthiness, Nurse Educ. Today 24 (2) (2004) 105–112, https://doi.org/10.1016/j.nedt.2003.10.001.
[29] K. Charmaz, The power of constructivist grounded theory for critical inquiry, Qual. Inq. 23 (1) (2017) 34–45, https://doi.org/10.1177/1077800416657105.
[30] N. Carter, D. Bryant-Lukosius, A. DiCenso, J. Blythe, A.J. Neville, The use of triangulation in qualitative research, Oncol. Nurs. Forum 41 (5) (2014) 545–547, https://doi.org/10.1188/14.ONF.545-547.
[31] E.H. Bradley, L.A. Curry, L.A. Taylor, S.W. Pallas, K. Talbert-Slagle, C. Yuan, et al., A model for scale up of family health innovations in low-income and middle-income settings: a mixed methods study, BMJ Open. 2 (4) (2012 Aug 24) e000987, https://doi.org/10.1136/bmjopen-2012-000987.
[32] World Health Organization, WHO recommendations: intrapartum care for a positive childbirth experience, WHO, Geneva, 2018. Available from: https://www.ncbi.nlm.nih.gov/books/NBK513802/table/executivesummary.tu1/.
[33] M.A. Bohren, B.O. Berger, H. Munthe-Kaas, Ö. Tunçalp, Perceptions and experiences of labour companionship: a qualitative evidence synthesis, Cochrane Database Syst. Rev. 3 (3) (2019) CD012449, https://doi.org/10.1002/14651858.CD012449.pub2.
[34] M.A. Bohren, G.J. Hofmeyr, C. Sakala, R.K. Fukuzawa, A. Cuthbert, Continuous support for women during childbirth, Cochrane Database Syst. Rev. 7 (7) (2017) CD003766, https://doi.org/10.1002/14651858.CD003766.pub6.
[35] M.E. Kruk, S. Kujawski, C.A. Moyer, R.M. Adanu, K. Afsana, J. Cohen, et al., Next generation maternal health: external shocks and health-system innovations, Lancet 388 (10057) (2016) 2296–2306, https://doi.org/10.1016/S0140-6736(16)31395-2.