Norris, G., Hollins Martin, C.J., Moylan, A., Greig, Y. (2024). A qualitative descriptive training needs analysis of midwives perceived continuous professional development in providing intranatal respectful maternal care. *Nurse Education Today*. 136, 106144. https://doi.org/10.1016/j.nedt.2024.106144.

A qualitative descriptive training needs analysis of midwives perceived continuous professional development in providing intranatal respectful maternal care

Gail Norris [1]

Caroline J. Hollins Martin[2]

Anne Moylan[3]

Yvonne Greig [4]

[1]Gail Norris, Associate Professor in Midwifery, School of Health and Social Care, Edinburgh Napier University (ENU), Sighthill Campus, Edinburgh, Scotland, UK, EH11 4BN, Email: g.norris@napier.ac.uk
Experience & Training: PhD MSc BM RM, RN, Senior Fellow HEA
Gender Female

[2]Caroline J Hollins Martin, Professor in Maternal Health, School of Health and Social Care, Edinburgh Napier University (ENU), Sighthill Campus, Edinburgh, Scotland, UK. Email: c.hollinsmartin@napier.ac.uk
Experience & Training: PhD MPhil BSc RM RGN MBPsS Senior Fellow HEA
Gender Female

[3]Anne Moylan, Advanced Neonatal Practitioner, School of Health and Social Care, Edinburgh Napier University (ENU), Sighthill Campus, Edinburgh, Scotland, UK. Email: A.Moylan@napier.ac.uk
Experience & Training: MSc BSc RM RN Senior Fellow HEA
Gender Female

[4]Yvonne Greig, Midwife Lecturer, School of Health and Social Care, Edinburgh Napier University (ENU), Sighthill Campus, Edinburgh, Scotland, UK. Email: Y.Greig2@napier.ac.uk
Experience & Training: Prof Doc MSc BM RM RN Pg Cert
Gender Female

Corresponding Author
[2]Caroline J Hollins Martin, Professor in Maternal Health, School of Health and Social Care, Edinburgh Napier University (ENU), Sighthill Campus, Edinburgh, Scotland, UK. Email: c.hollinsmartin@napier.ac.uk

A qualitative descriptive training needs analysis of midwives perceived continuous professional development in providing intranatal respectful maternal care

Abstract

Background: The Vietnam midwifery report acknowledges that while health services are available in Vietnam, there is growing need to increase levels of respectful maternal care provided to women in labour.
Objective: In conjunction with newborns Vietnam charity, our objective was to assess the perceived continuous professional development needs of midwives working in Vietnam to inform development of an intranatal respectful maternal care education resource.
Method: A qualitative exploratory descriptive method was used to conduct a training needs analysis, which identified perceived education requirements of midwives in Vietnam in relation to providing respectful maternal care.
Participants: A convenience sample of midwives (n=49) participated in the study.
Data-collection: Eight on-line focus groups were carried out in four hospitals (maternity units) across Vietnam using WebEx, with the interview schedule informed by the World Health Organization guide for delivering intrapartum care for a positive birth experience.
Data-analysis: Data were transcribed into English and analysed using the 6-steps of thematic analysis outlined by Braun and Clark.
Findings: Three themes and 9 sub-themes were developed from the data. The first theme addressed aspects that contribute towards creating a positive birth experience; the second theme observed barriers to changing practice; and the third theme noted that there are a variety of preferred teaching methods.
Conclusions: In response to the training needs analysis, a respectful maternal care education resource has been designed to transform selected areas of intranatal care in Vietnam. Integrating the respectful maternal care educational resource into midwives' continuous professional development in Vietnam is intended to increase women's rights to have safe childbirth, which accommodates choice and control, and promotes a positive birth experience.
Recommendations for practice: Post-completion and evaluation, we hope that the intranatal respectful maternal care educational resource will be rolled out to all practising midwives in Vietnam.

Key words: education, midwives, respectful maternal care, training needs analysis, qualitative, Vietnam

A qualitative descriptive training needs analysis of midwives perceived continuous professional development in providing intranatal respectful maternal care

Introduction

Along with reducing maternal and neonatal mortality, it is a fundamental right for all childbearing women world-wide to receive high-quality intranatal respectful maternal care (Jolivet et al., 2021; Vogel et al., 2016). Internationally in 2020, significant numbers of women (n=800) died from preventable childbearing related causes (WHO, 2023). The focus of the United Nations (UN) *Sustainable Development Goal Three: ensure healthy lives and promote well-being for all at all ages* (UN, 2023) and the *Global strategy for women's, children's, and adolescents' health* (2016-2030)' (WHO, 2015) is to reduce this number. Many of these maternal deaths could have been prevented by provision of high-quality education to relevant health care professionals, with curriculum equipping staff with additional prevention, recognition, and management skills (Graner et al., 2010; WHO, 2023). When maternity care is compromised with disrespect, some women decline to attend clinics (Shakibazadeh et al., 2018). In response and to improve attendance rates, the WHO stipulates that every woman must receive respectful maternal care (WHO, 2018a):

> "*Every woman should receive care organized for and provided to them in a manner that maintains their dignity, privacy, and confidentiality, ensures freedom from harm and mistreatment, and enables informed choice and continuous support during labour and childbirth*" (WHO, 2018a, p.3).

In reply to this WHO (2018a) recommendation, the International Confederation of Midwives (FIGO, 2021), White Ribbon Alliance (2023), International Pediatrics Association (IPA, 2023), and the WHO (2023) launched the '12-steps to safe and respectful mother baby-family maternity care' (ICI, 2023; Lalonde et al., 2019). This 12-step guide (ICI, 2023; Lalonde et al., 2019) outlines the intention of respectful maternal care to reduce abuse and neglect of women who attend childbirth facilities. This document is the 'blueprint for advancing high-quality maternity care through physiologic childbearing' (Avery et al., 2018), with contents aligned to four key policies:

(1) Standards for improving quality of maternal and newborn care in health facilities (WHO, 2016a),

(2) Standards for improving the quality of care for children and young adolescents in health facilities (WHO, 2018b),
(3) WHO recommendations on antenatal care for a positive pregnancy experience (WHO, 2016b).
(4) WHO recommendations: intrapartum care for a positive childbirth experience' (WHO, 2018a).

Background

Vietnam is a lower middle-income country, which has a birth forecast of 7.5 million for 2020-2025 (Stastica Research Department, 2021). Currently 96% of births are assisted by skilled attendants, with maternity care provided at commune, district, provincial, and central levels (UNICEF, 2023). The Vietnam midwifery report (UNPF, MoH, 2016) is the first national document to acknowledge the need for improving levels of respectful maternal care provided in Vietnam. In response, our team were invited to develop an education program for delivery to practising midwives in Vietnam, which clearly defines the term respectful maternal care, how to provide it during labour, and outlines its evidence-based impacts. Our destination was to respond to Steps 1, 3, 4, 5, 6, 7,11,12 (*Table 1*) and produce an intranatal respectful maternal care education resource. To contextualise this development and gain co-operation of practising midwives in Vietnam, our objective was to assess the perceived training needs of midwives working in Vietnam to inform development of an intranatal respectful maternal care education resource.

Method

A qualitative exploratory descriptive method was used to carry out a training needs analysis, which identified practising midwives in Vietnam perceived intranatal respectful maternal care training needs. This method was selected because a training needs analysis establishes the gaps between where participants are and where they want to be (Hicks & Hennessy, 1997; Markaki et al., 2021), with findings used to inform development of the intrantal respectful maternal care education resource.

Participants

A convenience sample of midwives (n=49) took part in the training needs analysis, with this number continuing to study end. Being a current practicing midwife in Vietnam was the only inclusion criteria. Participants were informed of the study via an electronic poster distributed by a named gate keeper at each of the of four Vietnamese hospitals (maternity units). Respondents were invited to participate in the training needs analysis by electronic letter, accompanied by an information sheet that declared personal goals and reasons for the study and a consent form. Anonymity and confidentiality were assured. Ethics approval was granted by the Vietnamese Ethics Council: code: CS/PSHN/DC/21/16 and the United Kingdom university ethics committee. Data were gathered in April-May 2023.

Data-collection

A total of eight on-line focus groups were carried out in the four maternity units in Vietnam using WebEx organised from Scotland (UK):

- *Group A*: Clinical managers (15 females; 5 males):
  (Group A1: n=8); (Group A2: n=3); (Group A3: n=4); (Group A4: n=5).
- *Group B*: Clinical midwives (n=29) (all female):
  (Group B1: n=8); (Group B2: n=4); (Group B3: n=9); (Group B4: n=8).

All on-line focus groups took place during the day. The interview guide was informed by the *WHO intrapartum care for a positive birth experience* report (WHO, 2018a). At time of data-collection, all authors were registered practising midwives and experienced midwifery educators with an interest in methods of delivering quality education that teaches midwives how to provide respectful midwifery care. A face-to-face pilot was carried out in Vietnam in Aug 2022 by the first and second authors in two maternity units in Vietnam (*Table 1*).

TABLE 1

Consent was obtained to record the focus groups. The data collectors (authors one, three, and four) were unknown to the participants and communicated in English, with an independent Vietnamese citizen translating English into Vietnamese and visa-versa. Other than what is reported, no other persons were present at time of data collection. PowerPoint slides were presented in English and translated prior to

delivery into Vietnamese. These slides outlined potential intranatal respectful maternal care related educational topics. Open-ended questions explored participants perceived facilitators and barriers to successful delivery of the respectful maternal care education resource as part of continuous professional development, and ability to implement evidence taught into midwifery practice. During the process, one researcher moderated the focus group, whilst another recorded field notes. The focus groups lasted on average 47-minutes.

Data-analysis

Data were transcribed in English and analysed using the 6-steps of thematic analysis outlined by Braun and Clark (2006):

STEP 1: The first author familiarized themself with data, by reading and re-reading transcripts.

STEP 2: An initial list of interesting codes were identified.

STEP 3: Searching for categories by sorting different codes into potential themes and collating relevant data extracts under those identified.

STEP 4: Reviewing and refining the identified themes by examining and re-examining to determine what aspect of the data had captured.

STEP 5: Defining and naming themes and sub-themes.

STEP 6: Producing a report.

In keeping with the 6-steps of Braun and Clark (2006), transcripts were manually reviewed multiple times by two coders (authors one and two), whilst simultaneously watching and listening to the recordings and considering field notes (STEP 1). Using an exploratory descriptive method, content was explored and charted using codes (STEP 2). Emerging themes were identified, and relevant quotes collated under those recognised to be similar (STEP 3). The three identified themes were further examined, with related subthemes and their connections subdivided into relevant quotes (STEP 4). The next step was to appropriately define and name the identified themes and their related sub-themes (STEP 5) and produce tables and a report that captured the perceived training needs of midwives working in Vietnam to inform development of the intranatal respectful maternal care education resource (STEP 6). Findings were peer reviewed and validated by authors three and four.

Findings

In relation to developing the intranatal respectful maternal care education resource, the clinical managers (Group1) and clinical midwives (Group 2) identified content topics that can be viewed in *Tables 2* and *3.* These tables were reviewed by four participants who confirmed content was both applicable and discussed during data collection.

TABLE 2

TABLE 3

Three themes and seven sub-themes were developed from the data.

(1) *Creating a positive birth experience.*

Childbirth is one of the most challenging psychological events in a woman's life, with 10-34% of women faced with perceptions of a traumatic birth experience (Taheri et al., 2018). Selective use of episiotomy was identified as one approach towards reducing perineal trauma (Franchi et al., 2020).

(1a) *100% Episiotomy Rate*

All groups of the clinical managers and clinical midwives reported that three out of the four maternity units implemented a 100% episiotomy rate, with some stating disbelief that women could give birth without having one.

> "*In their hospital, the episiotomy episode in practice is 100%. Everyone for normal delivery. They would do that. Mmm….if they don't do that it's very hard for them. To to, you know, to help the mother to have the baby out. It can lead to some complexity or something like that. Okay. So, if you give the information, you give me evidence that show them how to do in some case how to not do in some case" (B3).*

Participants appeared eager to learn more about the evidence-base for carrying out an episiotomy. One maternity unit with prior episiotomy training, stated they were now not applying the 100% rule. Also, to change the 100% rule, the other three were required to seek permission from the Vietnamese Ministry of Health. It was unanimously concluded that teaching the evidence-base underpinning episiotomy should be part of the respectful intranatal maternal care education resource. Respectful communication was also considered to be important.

(1b) *Respectful communication skills.*

All groups of clinical managers and clinical midwives agreed that effective communication with women during labour was important.

> "*In my opinion, I think this topic (communication) is very important and necessary….*" *(B2).*

Clinical managers from two maternity units requested training in relationship building and compassionate caring skills.

> "*They want to also take the training, deeper training…… such as communication skill…..and those are the methods of the sharing and talking to the mother, soft skills*" (A2).

Compassionate mind training could be used to help midwives cope with traumatic clinical incidents (Hollins Martin et al., 2021), because it heightens levels of compassion towards self and others (Beaumont & Hollins Martin, 2016). Offering adequate pain relief was also considered to be an important aspect of providing respectful maternal care to women in labour.

(1c) *Pain relief*

All groups of clinical managers and clinical midwives requested that the topic of pain relief be included in the respectful intranatal maternal care education resource. Methods of pain relief offered in first stage of labour was reported to be limited in Vietnam.

> "*For the first stage, no need to include pain relief, just to include natural pain relief for the mother to encourage her relaxed muscles by the medical staff or relatives. The first bit is often they get no medicine" (A2).*

An interest was shown in learning about non-pharmacological methods of pain relief, and approaches that would help women relax and gain control during the first stage of labour. We were informed that epidural is the most common method of pain relief used, with non-pharmacological methods the main alternative.

> "*They prefer learning about the non-pharmacological…to be about massage and other menu skills for pain relief, because in the hospital they are very confident about using medicines like epidural for pain relief" (B4).*

One midwife had read about waterbirth and was keen to introduce this into the curriculum.

> *Also, we like some equipment for the woman during labour. As you can see, she can relax. We would also like to look at the use of water for delivery" (A1).*

Presence of a birth companion was also considered to be an integral part of providing respectful maternal care during labour.

(1d) *Birth companions*

Many participants viewed that accommodating birth companions was a new venture that Vietnam should embrace, with space in the birthing room considered a problem.

> "*It also have a barrier that very difficult to implement because the room, the delivery room sometimes cannot let the companion persons or relative of the mother come in ……. that's a barrier to them. Why is it, because it's too small for them?" (B2).*

One group of clinical managers emphasised that they were attempting to develop a policy that permitted husbands to be present during labour and childbirth. One clinical manager stated that she currently was carrying out a literature review to inform inclusion of a birth companion, with the following literature review currently available (Xue et al., 2018). An interest was also shown in learning the benefits of alternative birth positions.

(1e) *Alternative birth positions*

The supine position was quoted to be the only birth position used in all four maternity units.

> "*Yes. I would like to learn more about the position of the woman and the rationale I was using. They just know one position…the woman laid out on the delivery table" (B1).*

This dearth of adaptability led to an enquiry about barriers and challenges for midwives wanting to access and implement a new evidence-base.

(2) *Barriers to changing practice*

Several factors were stated to limit research evidence being implemented into practice, which included financial restrictions, lack of support from authorities, and environmental constraints.

(2a) *Financial restrictions*

The following quote illustrates that finances were a challenge to implementing new evidence into midwifery practice.

> *Well, she said that is not necessary because they flexibilities cannot afford it for another kind of position (A3).*

The authorities were also reported to be a restrictive barrier.

(2b) *Support from authorities*

Both clinical managers and clinical midwives recognized that midwifery practice requires to be evidence-based, with the Ministry of Health and Board of Directors considered a barrier to implementing any suggested new practice. The following three quotes illustrate this point:

> "*But you know to get the permission from the Ministry of Health, which for Every hospital…… so have very strong ideas to convince the Ministry of Health*" (*A4*).
>
> *She lists three things, the first one is the…it should be suitable with the condition of the hospital where we apply the new practice. And the second one is need to have approval from the Ministry of Health, and the top one is the health department. Also have to like to do that (A3).*
>
> *She said that the most difficult one is getting the approval from the hospital. The Board of Directors (A4).*

A further barrier to change included restrictions within the environment.

(2c) *Environmental constraints*

A further barrier viewed to inhibit changing midwifery practice again included space restriction.

> "*Also, there some new things…. we want to change. But there is some difficulties. For example, the woman with the husband and also family members to come in. But is very over patients (crowded)…. It's also other difficulties that we may look at (A1).*

In addition, participants articulated their preferred teaching methods.

(3) *Variety of preferred teaching methods*

Participants were asked what teaching methods they would prefer, with on-line learning accommodating shift patterns and off-line facilitating real-time hands-on

experience. The following participant stated she would prefer the intranatal respectful maternal care education resource to be delivered off-line.

Offline training will be better results (A3).

The key barrier to face-to-face teaching was midwives shift patterns, with the following participants emphasising the need to incorporate some hands-on clinical teaching.

When you teach using pictures, also demonstrate on model (B2).

Yeah, would like to have a combination (teaching methods). Offline for practising real care, or on the mannequin (B2).

So that would be better for the visual (clinical practice) (B2).

In response to the multiple needs of participants, the team considered that flexible blended teaching methods would be the best way to deliver the intranatal respectful maternal care education resource.

(3a) *Blended learning selected.*
Participants from all four maternity units agreed that there would be benefits from implementing blended teaching methods, with this decision reinforced by three out of the four clinical managers.

Discussion

The objective was to carry out a training needs analysis of practising midwives in Vietnam perceived learning needs to inform development of a intranatal respectful maternal care education resource. From the themes and sub-themes generated, a table of learning outcomes has been produced (*Table 4*).

TABLE 4

The organised intranatal respectful maternal care education resource will be valuable on several counts. Identifying workers training needs in stressful working environments has been shown to positively correlate with willingness to participate, achievement motivation, and job satisfaction (Chien et al., 2022). These

characteristics were evidenced in all of the focus groups in which participants enthusiastically contributed content ideas and narrated barriers that currently restrict introducing the evidence-base into midwifery practice in Vietnam. Underpinning the respectful maternal care education resource with learning that encourages women to have a positive intrapartum experience (WHO, 2018a) will expectantly improve evaluations of intranatal care received (Bohren et al., 2015). Incorporating the themes identified in the training needs analysis (*Table 5*) also invites additional benefits for childbearing women in Vietnam. For example, introducing birth companions should work towards increasing maternal birth satisfaction (Kobayashi et al., 2017), via attendants providing extra information, facilitating communication, and supplying supportive non-pharmacological pain relief (Bohren et al., 2019). Such evidence is not just relevant to Vietnam, with other countries facing similar issues of restricted space and overcrowding in birthing suites (Orpin et., 2019; Housseine et al., 2020). Teaching the evidence-based benefits of women receiving support from a birth companion (Bohren et al., 2019; Kobayashi et al., 2017) should influence the ministry of health to invest in environmental infrastructure and develop up-to-date evidence-based intranatal guidelines.

In addition, introducing alternative birth positions brings benefits, with supine posture currently the only position offered during labour in all four of the participating maternity units. Evidence supports the benefits of childbearing women adopting upright positions (e.g., sitting on an obstetric chair or stool), kneeling, all-fours, squatting, with the acquired advantages of shortening labour (Gupta, et al., 2017), reducing need for episiotomy (Jiang et al., 2017), and reducing risk of requiring assisted delivery (Gupta, et al., 2017). The advantages of adopting upright position to enhance uterine contractions, promote maternal comfort, and widen the pelvic outlet was new information for the majority of participants. Upright positions include flexible sacrum positions (e.g., knee-standing, on all fours, sitting on a birth seat, and lateral), all of which remove sacral pressure and allow the pelvic outlet to expand (Berta et al., 2019; Kibuka & Thornton, 2017). Learning about alternative birth positions and their benefits was repetitively voiced within focus groups, with a range of options available to view in Hollins Martin et al. (2015).

Childbearing women associate respectful maternal care with the midwife being kind, feeling safe and supported, and having their individual needs responded

to (Downe et al., 2018). Quality of care provider interaction is a key influence towards creating perceptions of a positive birth experience (Taheri et al., 2018), and plays a significant role in preventing psychological trauma (Patterson et al., 2019 a&b). Taking a person-centred approach is integral towards providing respectful maternal care, which includes birth planning, informed consent, and accommodating what matters (Downe et al., 2018). Incorporating aspects of compassionate mind training into the intranatal respectful maternal care education resource, is to enhance midwives' ability to provide compassion and cope with emotional demands and organisational pressures within the workplace (Beaumont & Hollins Martin, 2016; Hollins Martin et al., 2021). Aspects of teaching will be delivered through a compassionate connections (2014) model (*Figure 1*).

FIGURE 1

The factors identified that limit research evidence being implemented into practice (i.e., financial restrictions, lack of support from authorities & environmental constraints), were also identified by Alatawiet al. (2020). Emphasis upon these points alone may influence address. Implementation of the evidence-base into practice can be achieved through creating an accepting culture, the right leadership, capability in interpreting and implementing evidence, and engaging staff with referenced guidelines (e.g., NHS England & NHS Improvement, 2020). Embedding research findings into clinical practice also involves putting the learner into a situation where they view themself as the agent responsible for implementing the change (Shirani Bidabadi et al., 2016).

In response to participants comments, each theme will be addressed in the intranatal respectful maternal care education resource using a blended learning approach. Resources will be creatively organised on an electronic platform, which can be flexibly accessed by enrolled learners. To accommodate midwives shift patterns, a digital site will hold education that can be flexibly accessed by the learner. Also, delivering face-to-face simulation will enable learners to practice clinical skills and critically account for decisions they make (Koukourikos et al., 2021). To accommodate this, an additional week of face-to-face activities will also be organized, which embraces seminars, group work, and clinical simulations (*Table 5*).

TABLE 5

A reflection log (*Table 6*) and action plan (*Table 7*) will be issued to midwives who register to undertake the intranatal respectful maternal care education resource.

TABLE 6

TABLE 7

The organized electronic platform will host sequential directed evidence-based materials, and a team of experienced midwifery educators will travel from Scotland to Vietnam to deliver face-to-face components. Post-delivery, the intranatal respectful maternal care education resource will be evaluated for effectiveness, content, consumer satisfaction, and the snag list resolved.

Limitations of study and recommendations

A search of the databases has yielded that this is the first ever training needs analysis that has focused on intranatal respectful maternal care training needs of practising midwives in Vietnam, with our team acknowledging limitations of our study. First, an interpreter was present during the data-collection, who paraphrased English into Vietnamese and visa-versa. Consequently, accurate portrayals may have been somewhat lost in translation. In attempts to reduce this source of error, an independent translator was engaged to confirm results with the first translator. Another limitation of the study is the potential influence of the researchers' western standpoint in terms of childbirth culture. In efforts to avoid imposing our positionality, the focus groups concentrated upon perceived clients' needs contextualised within a Vietnam culture. The risk being that when researchers assign limited and generalized cultural understanding and meanings to an identified ethnic group, they are at risk of glossing over the convoluted within group diversity. To counteract this, the first two authors spent time in the birthing rooms and premises of two Vietnam maternity hospitals. We were acutely aware of the privileged position we had been afforded and were invited by senior maternity care staff in Vietnam to undertake this study. From the outset, this study was focused upon illuminating the midwives' perceptions about what respectful intranatal care should look like, with our team welcomed into the maternity units and our advice sought. We worked with the

participating midwives diligently to provide an educational program that met their contextualised needs, with our team selected for the job because members had previously delivered three very successful neonatal education programs to the same audience.

In keeping with the WHO (2016a&b; 2018a), our recommendation is that maternity care professionals around the world develop contextualised evidence-based teaching plans about how to deliver quality intranatal respectful maternal care. It would also be useful to measure effectiveness of delivering this education through use of validated tools that evaluate women's birth experiences (e.g., the Birth Satisfaction Scale-Revised (Hollins Martin & Martin, 2014) (https://www.bss-r.co.uk/). In addition, legal systems must be designed to support removal of disrespectful and abusive behaviours and environments that degrade the quality of maternity care provided. Our intranatal respectful maternal care education resource is just one guide that can be used to support maternity care providers and societies with promoting sensitive care designed to improve birth outcomes.

Conclusion

This training needs analysis assessed the perceived continuous professional development needs of practising midwives in Vietnam for purpose of informing development of a intranatal respectful maternal care education resource. In response to the themes generated, an evidence-based curriculum has been designed to transform aspects of intranatal care provided in Vietnam, which is in keeping with the WHO request that childbearing women world-wide receive respectful maternal care (WHO, 2018a). Integrating the developed intranatal respectful maternal care education resource into midwives' continuous professional development fundamentally aims to improve women's experiences of childbirth in Vietnam.

References

Alatawi, M., Aljuhani, E., Alsufiany, F., Aleid, K., Rawah, R., Aljanabi, S., Banakhar. M. 2020. Barriers of implementing evidence-based practice in nursing profession: a literature review. American Journal of Nursing Science 9(1), 35-42. doi: 10.11648/j.ajns.20200901.16

Atkins, S,. Murphy, K. 1994. Reflective practice. Nursing Standard 8(39), 49–56.

Avery, M.D., Bell, A.D., Bingham, D., Corry, M.P., Delbanco, S.F., et al. 2018. Blueprint for advancing high-value maternity care through physiologic childbearing. Journal Perinatal Education 27(3), 130-134. doi: 10.1891/1058-1243.27.3.130.

Beaumont, E. Hollins Martin, C.J. 2016. Heightening levels of compassion towards self and others through use of compassionate mind training. British Journal of Midwifery 24(11), 3-12. https://doi.org/10.12968/bjom.2016.24.11.777

Berta, M., Lindgren, H., Christensson, K., Mekonnen, S., Adefris, M. 2019. Effect of maternal birth positions on duration of second stage of labor: systematic review and meta-analysis. BMC Pregnancy Childbirth 19(1), 466. doi: 10.1186/s12884-019-2620-0.

Bohren, M., Berger,B., Munthe-Kaas,H., Tnncalp, O. 2019. Perceptions and experiences of labour companionship: a qualitative evidence synthesis. Cochrane Database of Systematic Reviews. DOI: 10.1002/14651858.CD012449.pub2

Bohren, M.A., Vogel, J.P., Hunter, E.C., Lutsiv, O., Makh, S.K. 2015. The mistreatment of women during childbirth in health facilities globally: a mixed-methods systematic review. PLOS Med 12, e1001847. DOI:10.1371/journal.pmed.1001849

Braun, V., Clarke, V. 2006. Using thematic analysis in psychology. Qualitative research in psychology 3(2), 77-101. DOI: 10.1191/1478088706qp063oa

Chien, Y.A., Lee, Y.H., Chang, Y.P., Lee, D.C., Chow, C.C. 2022. Exploring the relationships among training needs, willingness to participate and job satisfaction in disaster nursing: the mediating effect of achievement motivation. Nurse Education in Practice 61, 103327. doi: 10.1016/j.nepr.2022.103327.

Downe, S., Finlayson, K., Oladapo, O., Bonet, M., Gülmezoglu, A.M. 2018. What matters to women during childbirth: a systematic qualitative review PloS one 13(4), e0194906. https://doi.org/10.1371/journal.pone.0194906

FIGO: International Federation of Gynecology and Obstetrics. 2021. Ethical framework for respectful maternity care during pregnancy and childbirth https://www.figo.org/resources/figo-statements/ethical-framework-respectful-maternity-care-during-pregnancy-and-childbirth

Franchi, M., Parissone, F., Lazzari, C., Garzon, S., Laganà, A.S., et al. 2020. Selective use of episiotomy: what is the impact on perineal trauma? Results from a retrospective cohort study. Arch Gynecol Obstet 301(2), 427-435. doi: 10.1007/s00404-019-05404-5.

Graner, S., Mogren, I., Duong, L.Q., Krantz, G., Klingberg-Allvin, M. 2010. Maternal health care professionals' perspectives on the provision and use of antenatal and delivery care: a qualitative descriptive study in rural Vietnam. BMC Public Health 10, 608. https://doi.org/10.1186/1471-2458-10-608

Gupta, J., Akanksha, S.,Hofmeyr,J., Vogel,J. 2017. Position in the second stage of labour for women without epidural anaesthesia. Cochrane Database of Systematic Reviews. https://doi.org/10.1002/14651858.CD002006.pub4

Hicks C, Hennessy D. 1997. The use of a customized training needs analysis tool for nurse practitioner development. Journal Advanced Nursing, 26(2), 389–98. https:// doi.org/10.1046/j.1365-2648.1997.1997026389.x

Hollins Martin, C.J., Beaumont, E., Norris, G., Cullen, G. 2021. Teaching Compassionate Mind Training (CMT) to help midwives cope with traumatic clinical incidents. British Journal of Midwifery 29(1), 26-35. https://doi.org/10.12968/bjom.2021.29.1.26

Hollins Martin., C.J., Kenney, L., Pratt, T., Granat, M.H. 2015. The development and validation of an activity monitoring system for use in measurement of posture of childbearing women during first stage of labour. Journal of Midwifery & Women's Health 60(2),182-186. 1526-9523/09/$36.00 doi:10.1111/jmwh.12230

Hollins-Martin, C.J., Martin, C. 2014. Development and psychometric properties of the Birth Satisfaction Scale-Revised (BSS-R). Midwifery 30: 610-619 Doi.org/10.1016/j.midw.2013.10.006

Housseine, N., Punt, M.C., Mohamed, A. G., Said, S.M., Maaløe, N., et al. 2020. Quality of intrapartum care: direct observations in a low-resource tertiary hospital. Reproductive Health 17, 36. https://doi.org/10.1186/s12978-020-0849-8

International Childbirth Initiative (ICI). 2023. https://icichildbirth.org/

International Pediatrics Association (IPA). 2023. https://www.ipa-world.org/

Janes, G., Ekpenyong, M.S., Mbeah-Bankas, H., Serrant, L. 2023. An international exploration of blended learning use in pre-registration nursing and midwifery education. Nurse Education in Practice 66, 103514. https://doi.org/10.1016/j.nepr.2022.103514.

Jiang, H., Qian, Xy.,Guillermo, C., Graner, P. 2017. Selective use of episiotomy for vaginal birth. Cochrane Database of Systematic Reviews. https://doi.org/10.1002/14651858.CD000081.pub3

Jolivet, R.R., Gausman, J., Kapoor, N., Langer, A., Sharma, J., Semrau, K.E. 2021. Operationalizing respectful maternity care at the healthcare provider level: a systematic scoping review. Reproductive health 18,194. https://doi.org/10.1186/s12978-021-01241-5

Kibuka, M., Thornton, J.G. 2017. Position in the second stage of labour for women with epidural anaesthesia. Cochrane Database Syst Rev. Cd008070.

Kobayashi, S., Hanada, N., Matsuzaki, M., Takehara, K., Ota, E., et al. 2017. Assessment and support during early labour for improving birth outcomes. Cochrane Database of Systematic Reviews 20, 4(4): CD011516. doi: 10.1002/14651858.CD011516.pub2.

Koukourikos, K., Tsaloglidou, A., Kourkouta, L., Papathanasiou, I.V., Iliadis, C., et al. 2021. Simulation in clinical nursing education. Acta Informatica Medica 29(1),15-20. doi: 10.5455/aim.2021.29.15-20.

Lalonde, A., Herschderfer, K., Pascali-Bonaro, D., Hanson, C., Fuchtner, C., Visser, G.H.A. 2019. The International Childbirth Initiative: 12 steps to safe and respectful mother-baby–

family maternity care. International Journal of Gynecology & Obstetrics 146(1), 65-73. https://doi.org/10.1002/ijgo.12844

Markaki, A., Malhotra, S., Billings, R., Theus, L. 2021. Training needs assessment: tool utilization and global impact. BMC Medical Education 21(1), 310. https://doi.org/10.1186/s12909-021-02748-y

Newborns Vietnam. 2023. https://www.newbornsvietnam.org/

NHS England & NHS Improvement. 2020. Embedding evidence-based practice within the pre-registration midwifery curriculum. https://www.england.nhs.uk/wp-content/uploads/2020/03/leading-the-acceleration-of-evidence-into-practice-guide.pdf

NHS Education for Scotland Compassionate Connections. 2014. Family focused learning resources to support your role in maternal, newborn, and infant health and well-being. https://slideplayer.com/slide/17831354/

Orpin, J., Puthussery, S., Burden, B. 2019. Healthcare providers' perspectives of disrespect and abuse in maternity care facilities in Nigeria: a qualitative study. International journal of public health 64(9), 1291-1299. doi: 10.1007/s00038-019-01306-0.

Patterson, J., Hollins Martin, C.J., Karatzias, T. 2019a. PTSD post-childbirth: a systematic review of women's and midwives' subjective experiences of care provider interaction. Journal of Reproductive and Infant Psychology 37(1), 56-83. DOI: 10.1080/02646838.2018.15042

Patterson, J., Hollins Martin, C.J., Karatzias, T. 2019b. Disempowered midwives and traumatised women: exploring the parallel processes of care provider interaction that contribute to women developing Post Traumatic Stress Disorder (PTSD) Post Childbirth. Midwifery 76, 21-35. Doi: 10.1016/j.midw.2019.05.010.

Shakibazadeh, E., Namadian, M., Bohren, M.A., Vogel, J. P., Rashidian, A., et al. 2018. Respectful care during childbirth in health facilities globally: a qualitative evidence synthesis. BJOG: An International Journal of Obstetrics & Gynaecology 125(8), 932-942. doi: 10.1111/1471-0528.15015.

Shirani Bidabadi, N., Nasr Isfahani, A., Rouhollahi, A., Khalili, R. 2016. Effective teaching methods in higher education: requirements and barriers. Journal of Advances in Medical Education & Professionalism 4(4),170-178.

Stastica Research Department. 2021. The Statistics Portal for Market data, Market research and Market studies. https://www.statista.com/

Taheri, M., Takian, A., Taghizadeh, Z., et al. 2018. Creating a positive perception of childbirth experience: systematic review and meta-analysis of prenatal and intrapartum interventions. Reprod Health. 15,73. https://doi.org/10.1186/s12978-018-0511-x

United Nations (UN). 2023. Sustainable development Goal 3: Ensure healthy lives and promote well-being for all at all ages. https://www.un.org/sustainabledevelopment/health/

United Nations International Children's Emergency Fund. 2023. For Every Child UNICEF data. https://data.unicef.org/topic/maternal-health/antenatal-care/

UNPF, MoH. 2016. United Nations Population Fund, Ministry of Health. Final Report Viet Nam Midwifery Report.
https://vietnam.unfpa.org/sites/default/files/pub-pdf/Web_Midwifery_Eng.pdf

Vogel, J.O., Bohren, M.A., Tuncalp, Ö., Oladapo, O.T., Gutmezoglu, A.M. 2016. Promoting respect and preventing mistreatment during childbirth. BJOG. 123(5), 671-4.
doi: 10.1111/1471-0528.13750.

White Ribbon Alliance. 2023. Every woman and girl should determine the direction of her own life. https://whiteribbonalliance.org/

World Health Organization (WHO). 2023. https://www.who.int/

World Health Organization (WHO). 2023. Maternal mortality: https://www.who.int/news-room/fact-sheets/detail/maternal-mortality

World Health Organization (WHO). 2018a. Recommendations: intrapartum care for a positive childbirth experience'.
https://apps.who.int/iris/bitstream/handle/10665/260178/9789241550215-eng.pdf

World Health Organization (WHO). 2018b. Standards for improving the quality of care for children and young adolescents in health facilities.
https://www.who.int/publications/i/item/9789241565554

World Health Organization (WHO). 2016a. Standards for improving quality of maternal and newborn care in health facilities.
https://cdn.who.int/media/docs/default-source/mca-documents/qoc/quality-of-care/standards-for-improving-quality-of-maternal-and-newborn-care-in-health-facilities.pdf

World Health Organization (WHO). 2016b. WHO recommendations on antenatal care for a positive pregnancy experience.
https://www.who.int/publications/i/item/9789241549912

World Health Organization (WHO). 2015. Global strategy for women's, children's and adolescents' health 2016–2030. Geneva: WHO.
https://www.cgi.org.uk/blog/the-5-essential-qualities-of-a-non-executive-director

Xue, W.L., Shorey, S., Wang, W., He, H.G. 2018. Fathers' involvement during pregnancy and childbirth: an integrative literature review. Midwifery 62,135-145.
DOI: 10.1016/j.midw.2018.04.013.

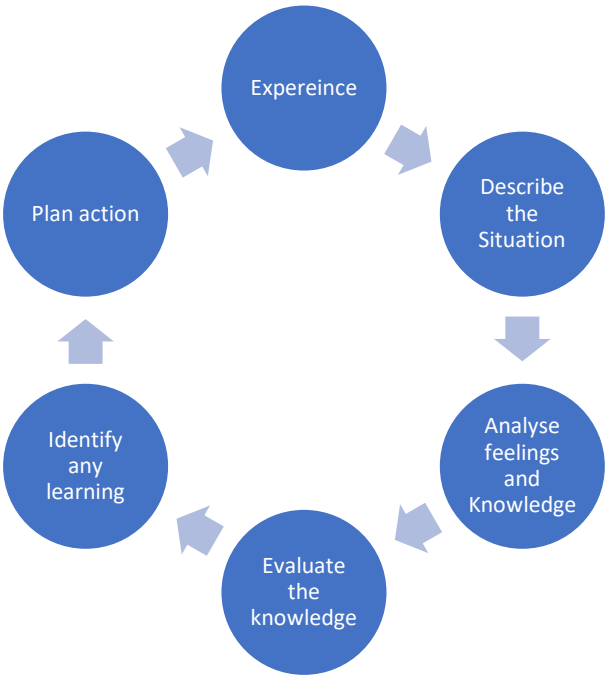

Figure 1: Atkins and Murphy (1994) Reflective Cycle: adapted from the National Health Service education for Scotland compassionate connections (2014)

Table 1: **Interview guide**

Show participants PowerPoint slide: World Health Organization recommendations for intrapartum care for a positive childbirth experience.

- What is the perception of own confidence in providing respectful intrapartum and immediate postnatal care?
- What knowledge and skills do they/others have (how is this demonstrated in the care they provide for women.
- How have they acquired and maintained them?
- What are the gaps/priorities that continuous professional development needs to include?

Training and Education

- How could midwives be supported to build confidence and upskill? - How should this be delivered?
- What would facilitate continuous medical education of midwives?
- What are the barriers to continuous medical education of midwives?
- What are the barriers that they see to implementing change within their clinical practice areas?

Table 2. Clinical managers selected topics	**Group A1** (n=8)	**Group A2** (n=3)	**Group A3** (n= 4)	**Group A4** (n= 5)
Respectful communication skills	X	X	X	X
Birth companion	X	X	X	X
Informed consent	X	X	X	
Review Physiology of 1st stage of labour	X	X	X	X
Evidence-base for oral fluids and light diet during labour	X	X	X	X
Evidence-base for mobility and positioning during labour and birth	X	X	X	X
Pain relief during labour (pharmacological & non-pharmacological)	X	X	X	Non- Pharmacological
Overview of 2nd stage of labour	X	X	X	X
Evidence-base for methods of pushing during 2nd stage of labour	X	X	X	X
Evidence-base for care of the perineum & episiotomy during childbirth	X	X	X	X
Review third stage of labour	X	X	X	X
Delayed cord clamping	X	X	X	X
Immediate postnatal care of childbearing women	X	X	X	X
Care of the new-born and skin to skin contact	X	X	X	
Breastfeeding		X	X	
Haemorrhagic disease prophylaxis and role of vitamin K	X	X	X	
Bathing and other immediate postnatal care of the new-born	X	X		
Importance of relationship building	X	X		
Waterbirth	X			X
Breastfeeding problems (breast massage & breast milk expression)				
Care of woman post cesarean section				
Management of obstetric haemorrhage				X

Table 3. Clinical Midwives selected topics	**Group B1** (n= 8)	**Group B2** (n=4)	**Group B3** (n=9)	**Group B4** (n=8)
Respectful communication skills	X	X	X	X
Birth companion	X	X	X	X
Informed consent	X	X	X	X
Review Physiology of 1st stage of labour	X		X	X
Evidence-base for oral fluids and light diet during labour			X	
Evidence-base for mobility and positioning during labour and birth	X	X		X
Pain relief during labour (pharmacological & non-pharmacological)	X	X	X	Non- pharmacological
Overview of 2nd stage of labour	X	X	X	X
Evidence-base for methods of pushing 2nd stage of labour	X	x	X	X
Evidence-base for care of the perineum & episiotomy during childbirth	X	X	X	X
Review third stage of labour	X	X	X	X
Delayed cord clamping		X	X	X
Immediate postnatal care of the childbearing woman	X	X	X	X
Care of the new-born and skin to skin contact		X	X	
Breastfeeding	X	X	X	
Haemorrhagic disease prophylaxis and role of vitamin K	X	X	X	
Bathing and other immediate postnatal care of the new-born	X	X	X	
Importance of relationship building				
Waterbirth	X	X		
Breastfeeding problems (breast massage & breast milk expression)	X			
Care of woman post cesarean section	X			

Table 4: Learning outcomes for the intranatal respectful maternal care education resource

Revision of first stage of labour	**Revision of second stage of labour**	**Revision of third stage of labour**
• Revise the first stage of labour and explore the normal physiology of labour & midwifery care. • Explore the concept of continuous support by birth companion.	• Revise the basic physiology of transition and the second stage & midwifery care (includes pushing technique).	• Revise the basic physiology of the third stage of labour & midwifery care. • Critically review the evidence base around delayed cord clamping. • Explore the immediate postnatal care following childbirth.
Episiotomy and care of the perineum during childbirth (core)	**Pain relief during childbirth (core)**	**Respectful communication and informed consent (core)**
• Critically review the evidence base to identify factors to reduce the incidence of perineal trauma during childbirth. • Review the evidence base surrounding episiotomy during childbirth. • Assess the need for an episiotomy.	• Explore the physiological aspect of pain processes in labour and its effect on the woman. • Critically review a range of approaches available to support the woman to take control of her childbirth experience.	• Demonstrate knowledge of the impact of health and social circumstances on engagement with services and health and wellbeing outcomes. • Explore the principles of compassionate women centered care and how it relates to the role of the midwife. • Explore the concept of informed choice/ consent during childbirth.
Alternative birth positions (core)	**Pain relief - waterbirth (Optional)**	**Evidence based care respectful maternity care (core)**
• Relate knowledge of anatomy to understand how different positions aid the different physiologic process of childbirth.	• Explore the choice of water immersion during labour and birth - risks and benefits. • Define the criteria for giving birth in water. • Critically review the preparation and care for women birthing in water.	• Critically explore the principles of evidenced based respectful maternal care.
Respectful maternal care: universal right of all childbearing women (Core)	**Reflective midwifery practice (core)**	**Immediate care of the newborn**
• Explore the concept of respectful maternal care. • Outline the status of maternal and newborn health globally and locally.	• Explore the concept of reflective midwifery practice. • Complete a reflection log and action plan.	• Review the holistic assessment of the newborn - well baby and immediate care of the newborn. • Critically review the physiology of lactation. • Oxytocin and attachment. • Responsive feeding (to include evidence base for skin-to-skin contact).

Table 5: Timetable for face-to-face week of the intranatal **respectful maternal care education resource**

	Time 09.00 - 12.00 (Includes coffee break)		**12.00 - 14.00**	**14.00 – 17.00**
Monday	Respectful maternal care: a universal right for all women	Introduction to reflective midwifery practice	Break	Respectful communication & informed consent workshop
Tuesday	Introduction to evidenced-based midwifery practice	Revision of first stage of labour & evidence-based midwifery care	Break	Pain relief during childbirth
Wednesday	Revision of second stage of labour & evidence-based midwifery care	Episiotomy & care of the perineum during childbirth	Break	Alternative birth positions workshop
Thursday	Revision of third stage of labour & immediate postnatal care		Break	Introduction to waterbirth & its evidence-base
Friday	Immediate care of the newborn		Break	Reflective midwifery practice & action planning workshop

Table 6: Reflection log that accompanies the intranatal respectful maternal care education resource

Reflection Log	Notes
What are the most important things that have come up for me?	
What have I learned about myself?	
What have I learned that helps me understand respectful maternal care themes?	
Are there any gaps in my knowledge skills?	
Additional notes	

Table 7: Action plan that accompanies the intranatal respectful maternal care educational resource

Action plan	Notes
What will I start to do to enable my practice to enhance respectful maternal care for women and families?	
What will I stop doing to enable my practice to improve respectful maternal care for women and families?	
What support do I need by way of additional skills, knowledge, or feedback from clinical managers or colleagues?	