SSR Journal of Medical Sciences (SSRJMS)

Homepage: https://ssrpublisher.com/ssrjms/

Volume 3, Issue 7, 2026 ISSN: 3049-0375

Determinants of Respectful Maternity Care at a Tertiary Hospital in Nigeria: A Cross-Sectional Study

Ezukwa Ezukwa Omoronyia, Edu Eyong, Vivian Ajoku, Sylvester Abeshi, Patience Odusolu

Department of Obstetrics & Gynaecology, University of Calabar, Nigeria

Received: *21.05.2026* | ***Accepted:*** *23.06.2026* | ***Published:*** *01.07.2026*

***Corresponding author:** Dr Ezukwa Ezukwa Omoronyia

DOI: *10.5281/zenodo.21079864*

Abstract **Original Research Article**

Background: Respectful maternity care (RMC) is a fundamental human right and a core quality indicator for maternal health services. Despite global emphasis on improving the quality of obstetric care, disrespect and abuse during facility-based childbirth remain pervasive in sub-Saharan Africa, including Nigeria. Understanding the determinants of RMC is essential for designing context-sensitive interventions.

Objective: This study aimed to assess the prevalence of RMC and identify its sociodemographic, institutional, and provider-level determinants among women who delivered at the University of Calabar Teaching Hospital (UCTH), Calabar, South-South Nigeria.

Methods: A cross-sectional descriptive study was conducted among 384 postpartum women between January and June 2024. A pre-tested, structured interviewer-administered questionnaire adapted from the WHO/White Ribbon Alliance RMC framework was used for data collection. RMC was assessed across eight domains. Data were analysed using SPSS version 26.0. Descriptive statistics, chi-square tests, and binary logistic regression were performed at a significance level of $p < 0.05$.

Results: The overall prevalence of adequate RMC was 54.9%. Disrespect and abuse were most common in the domains of autonomy in decision-making (61.2% reported inadequate care) and informed consent (56.5%). Multivariate logistic regression analysis indicated that higher education, antenatal care attendance, continuity of care, and delivery in a private ward were significant predictors of respectful maternity care. After adjustment, women with higher education had 2.74 times the odds, 95% CI: 1.64–4.70. Those who attended antenatal care had 2.14 times the odds, 95% CI: 1.28–3.57. Continuity of caregiver increased the odds 1.93-fold, 95% CI: 1.17–3.18, while private ward delivery increased odds 2.05 times, 95% CI: 1.22–3.44.Grand multiparity and night-time delivery were linked to disrespect and abuse. Grand multiparous women had lower odds, adjusted OR: 0.52, 95% CI: 0.31–0.88. Nocturnal births also showed reduced odds, adjusted OR: 0.61, 95% CI: 0.38–0.97.

Conclusion: The practice of RMC at the tertiary facility is suboptimal, with significant deficits in the domains of autonomy and informed consent. Education, antenatal care attendance, and institutional factors are key determinants. Targeted interventions including provider training, policy enforcement, and structural improvements are urgently required to ensure dignified, rights-based maternity care in Nigerian tertiary hospitals.

Keywords: dignified maternity care, mistreatment and abusive practices, facility-based deliveries, Nigeria, determinants, tertiary hospital, maternal health.

1. INTRODUCTION

Respectful maternity care (RMC) involves organizing and delivering services to all women with respect for their dignity, privacy, and confidentiality. It also ensures women are protected from harm and mistreatment while supporting informed decision-making and continuous care throughout labor and delivery. [1]. It is increasingly recognised as a fundamental dimension of quality obstetric care, going beyond the mere absence of clinical complications to encompass the subjective experience of the woman during the childbirth process [2].

Global estimates indicate 10-25% of women giving birth in health facilities encounter disrespectful care or abuse, including physical violence, verbal humiliation, non-consensual medical procedures, and deliberate neglect [3]. These forms of mistreatment not only violate the rights of women and are documented barriers to facility-based delivery, contributing to preventable maternal and perinatal mortality [4]. The landmark 2014 Bowser and Hill landscape analysis catalysed global momentum toward addressing D&A in childbirth, bringing RMC to the forefront of international maternal health discourse [5].

The burden of maternal deaths falls heavily on sub-Saharan Africa. As of 2020, Nigeria accounted for roughly one-third of global maternal mortality, recording 512 maternal deaths per 100,000 live births. [6]. Despite increasing rates of facility-based delivery in Nigeria, poor quality of care, including inadequate RMC, continues to undermine the life-saving potential of skilled birth attendance [7]. Several facility-based studies from different geopolitical zones of Nigeria have recorded widespread occurrence of mistreatment and abusive practices ranging from 30% within Enugu State to 70% in Lagos State [8,9].

The South-South geopolitical zone, particularly Cross River State and its capital Calabar, presents a unique epidemiological and socio-cultural context. The Teaching Hospital is the foremost tertiary referral centre in the region, managing a high volume of both routine and high-risk deliveries. Although respectful maternity care is strategically important, limited empirical evidence exists on its specific determinants at local regional levels . [10].

Understanding the multilevel determinants of RMC—including patient-level (sociodemographic and obstetric characteristics), provider-level (skills, attitudes, workload), and institutional-level (infrastructure, policies, staffing) factors—is critical for designing evidence-based interventions [11]. While personal characteristics such as educational background, number of births, and socioeconomic status have been implicated in determining the quality of maternity experience globally [12,13], the specific contributions of institutional and structural factors within Nigerian tertiary hospitals remain understudied.

This study sought to establish how common RMC was and to explore the sociodemographic, obstetric, provider-level, and institutional determinants among postpartum women who delivered at UCTH, Calabar. The findings are expected to generate actionable evidence for hospital administrators, policymakers, and programme managers striving to operationalise rights-based maternity care in Nigeria.

2. METHODS

2.1 Research Design and Study Location

The research adopted a facility-based, descriptive cross-sectional approach. It was carried out at a tertiary hospital in Calabar, Cross River State, Southern Nigeria. The maternity unit comprises antenatal, labour, postnatal, and neonatal wards, staffed by consultant obstetricians, registrars, nurses, and certified midwives.

Calabar, the state capital, is a cosmopolitan city

with a population of approximately 400,000 people representing diverse ethnic groups including Efik, Ibibio, Ejagham, and various migrant communities.

2.2 Population of Study and Selection Criteria

The population of interest comprised postpartum women who delivered at the health facility during the study period (January 2024 – October 2024). Inclusion criteria were: (1) women who delivered a live or stillborn baby at 28 weeks' gestation or beyond; (2) women who had spent at least six hours on the postnatal ward; and (3) willingness to provide voluntary informed consent. Criteria for exclusion included: women that were critically sick or had communication difficulties, women with severe psychiatric disorders, and those who had their delivery before arrival at the hospital.

2.3 Sample Size Determination

The sample size was derived by applying the Cochran (1977) formula for cross-sectional studies: $n = Z^2pq/d^2$, where $Z = 1.96$ (for 95% confidence level), $p = 0.46$ (prevalence of adequate RMC from a comparable Nigerian study [14]), $q = 1-p = 0.54$, and $d = 0.05$ (desired precision). The calculation produced a required sample size of 383, adjusted to 384 to cover for possible dropouts.

2.4 Sampling Procedure

Participants were chosen using systematic random sampling. It was based on an average of 110 deliveries per month, the sampling interval (k) was calculated as the total eligible women during ten months (1,100) divided by the required sample (384), giving $k \approx 3$. The first participant was selected randomly from the first four women on the postnatal ward list each morning; thereafter, every 3rd woman was enrolled until the target sample size was reached.

2.5 Tool for Data Collection

Data were obtained using an interviewer-administered questionnaire that was structured and pre-tested and adapted from the validated tool designed by Sando et al. (2016) and aligned with the WHO/White Ribbon Alliance seven-domain RMC framework [15,16]. The questionnaire comprised four sections: (A) sociodemographic characteristics; (B) obstetric history; (C) RMC assessment across eight domains; and (D) institutional and provider factors. The eight RMC domains assessed were: (1) dignity and respect; (2) effective communication and information sharing; (3) emotional support; (4) physical privacy; (5) informed consent for procedures; (6) freedom from physical and verbal abuse; (7) continuity of care; and (8) autonomy in decision-making.

Each domain contained 3–5 items scored on a 3-point Likert scale (0 = Never; 1 = Sometimes; 2 = Always). Domain scores were computed as the average of item responses and normalised to 0–100. An overall RMC score was calculated as the average of all eight domain results. A score ≥60 was classified as "Adequate RMC" and <60 as "Inadequate RMC," consistent with the cut-off used in prior Nigerian studies [8,17].

2.6 Validity and Reliability Testing

Face and content validity of the instrument were established by a panel of five specialists (two obstetricians, two public health physicians, and one medical sociologist). To ensure linguistic equivalence the questionnaire was translated into Efik and Pidgin English and back-translated . A pilot test was conducted among 38 women (10% of sample) at General Hospital Calabar, who were excluded from the final research. The reliability of the instrument as determined with Cronbach's alpha coefficient was 0.81 for the overall RMC scale, indicating satisfactory reliability.

2.7 Data Management and Statistical Analysis

Data were coded and inputted into IBM SPSS Statistics version 26.0 (SPSS Inc., Chicago, IL) for processing and cleaned for outliers and missing values. Frequencies, percentages, means, and standard deviations were used to

summarize descriptive data. Chi-square test was applied to assess relationships between categorical variables and RMC status at a 0.05 significance level. Variables with $p < 0.25$ in bivariate analysis were included in a binary logistic regression to determine independent predictors of adequate RMC. Odds ratios with 95% confidence intervals were calculated. Multicollinearity was checked using variance inflation factor. All VIF values were below 5, showing no serious multicollinearity.

2.8 Ethical Considerations

Ethical clearance was granted by the Cross River State Health Research Ethics Committee (CRSHREC), reference number CRSHREC/02/2023, and institutional permission was granted by the hospital management. Written consent was secured from all participants after explaining the purpose of the study. Participant confidentiality was ensured through anonymisation of questionnaires and secure data storage. Participation was entirely voluntary, with no incentives offered, and participants were allowed to exit the study at any time without prejudice to their care.

3. RESULTS

3.1 Sociodemographic Profile of Participants

Overall, 384 postpartum women were recruited; all completed the interview, giving a 100% response rate. Their characteristics are detailed in Table 1. The mean age was 29.4 ± 5.8 years (range 16–45 years), with the majority (48.6%) aged 25–34 years (Figure 1). Most respondents were married (82.3%), had secondary or tertiary education (72.9%), and belonged to the Efik/Ibibio ethnic group (51.6%). Regarding religion, Christianity was predominant (85.2%). Monthly household income below ₦50,000 was reported by 41.7% of respondents, while 34.1% earned between ₦50,000 and ₦150,000.

Table 1: Sociodemographic Characteristics of Study Participants (N=384)

Variable	Frequency (n)	Percentage (%)
Age Group (years)		
15–24	86	22.4
25–34	187	48.7
35–44	92	24
45+	19	4.9
Marital Status		
Married	316	82.3
Single	42	10.9
Separated/Divorced	26	6.8
Education Background		
No formal education	44	11.5
Primary	60	15.6
Secondary	148	38.5

Tertiary	132	34.4
Monthly Household Income		
<₦50,000	160	41.7
₦50,000–₦150,000	131	34.1
>₦150,000	93	24.2
Ethnicity		
Efik/Ibibio	198	51.6
Igbo	74	19.3
Yoruba	41	10.7
Hausa/Fulani	21	5.5
Other	50	13

Figure 1: Age Distribution of Study Participants (N=384)

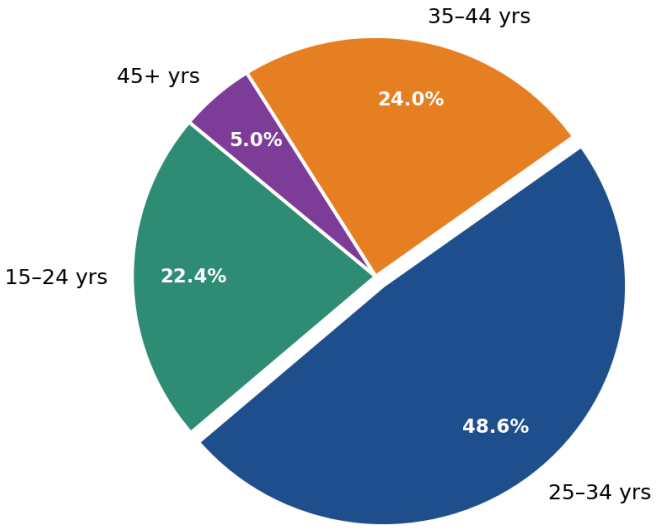

Figure 1: Age Distribution of Study Participants (N=384)

3.2 Obstetric Characteristics

The obstetric characteristics of participants are summarised in Table 2. Most deliveries were vaginal (71.6%), with caesarean section accounting for 28.4%. The majority of women were multiparous (43.8%), followed by primiparous (27.3%); grand multiparity (≥5 deliveries) was observed in 10.4% (Figure 4). Antenatal care (ANC) attendance at least four times was reported by 68.5% of participants. Booking at the hospital was done by 61.5%,

while the remaining 38.5% were referred from peripheral facilities. Preterm delivery (<37 weeks) occurred in 13.8% of cases, and 14.1% of deliveries occurred between midnight and 6:00 AM.

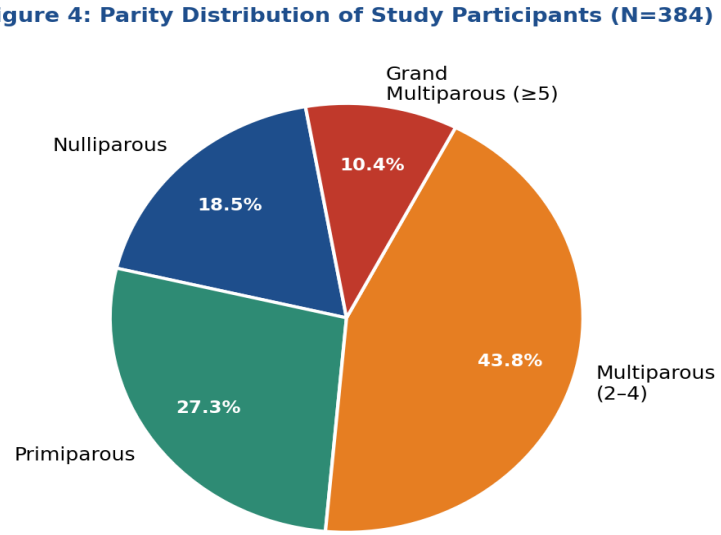

Figure 4: Parity Distribution of Study Participants (N=384)

Table 2: Obstetric Characteristics of Study Participants (N=384)

Variable	Frequency (n)	Percentage (%)
Mode of Delivery		
Spontaneous vaginal	224	58.3
Assisted vaginal (instrumental)	51	13.3
Caesarean section	109	28.4
Parity		
Nulliparous	71	18.5
Primiparous	105	27.3
Multiparous (2–4)	168	43.8
Grand multiparous (≥5)	40	10.4
ANC Attendance		
≥4 visits (adequate)	263	68.5

1–3 visits (suboptimal)	89	23.2
No ANC	32	8.3
Booking Status		
Booked at hospital	236	61.5
Referred	148	38.5
Time of Delivery		
Daytime (06:00–23:59)	330	85.9
Nocturnal (00:00–05:59)	54	14.1

3.3 Prevalence of Respectful Maternity Care

The overall prevalence of adequate RMC (score ≥60) was 54.9% (n=211). Figure 2 illustrates the prevalence of adequate care across all eight domains. The highest proportion of adequate care was reported in the domain of freedom from abuse (73.4%), followed by dignity and respect (61.7%), and continuity of care (58.2%). The lowest levels of adequate care were observed in autonomy in decision-making (38.8%) and informed consent for procedures (43.5%).

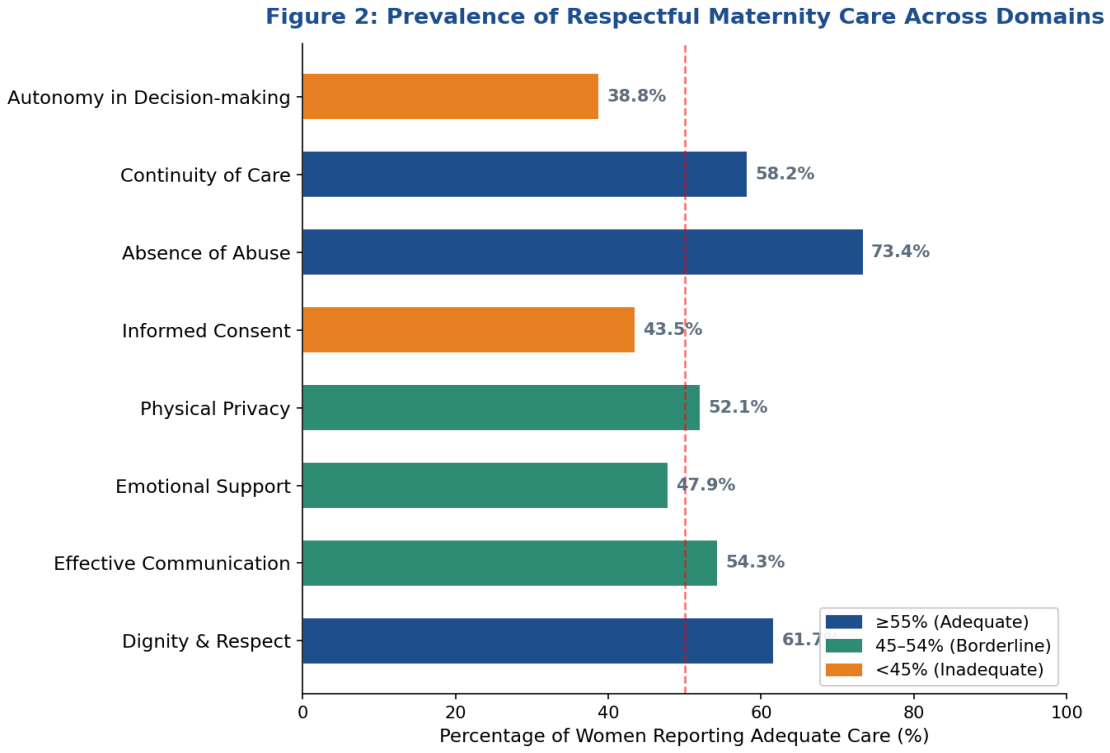

Figure 2: Prevalence of Respectful Maternity Care Across Eight Domains (N=384)

Table 3: Mean Scores and Prevalence of Adequate RMC by Domain (N=384)

RMC Domain	Mean Score (SD)	Median Score	Adequate n (%)	Inadequate n (%)
Dignity & Respect	61.7 (14.3)	63.0	237 (61.7)	147 (38.3)
Effective Communication	54.3 (16.8)	55.0	208 (54.2)	176 (45.8)
Emotional Support	47.9 (18.2)	48.5	184 (47.9)	200 (52.1)
Physical Privacy	52.1 (17.6)	52.0	200 (52.1)	184 (47.9)
Informed Consent	43.5 (15.9)	44.0	167 (43.5)	217 (56.5)
Freedom from Abuse	73.4 (11.4)	75.0	282 (73.4)	102 (26.6)
Continuity of Care	58.2 (15.7)	59.0	224 (58.3)	160 (41.7)
Autonomy/Decision-making	38.8 (17.1)	38.0	149 (38.8)	235 (61.2)
Overall RMC Score	53.7 (12.6)	54.5	211 (54.9)	173 (45.1)

3.4 Disrespect and Abuse by Healthcare Provider Category

Figure 3 presents the prevalence of specific D&A typologies stratified by provider category. Overall, nurses had the highest rate of verbal abuse (25.4%), while doctors had the highest rate of non-consensual procedures (22.6%). Neglect and abandonment during labour was most frequently attributed to doctors (31.5%) and nurses (28.9%). Midwives demonstrated the lowest prevalence across most D&A typologies. Stigma and discrimination, though relatively lower in magnitude, were reported across all provider categories.

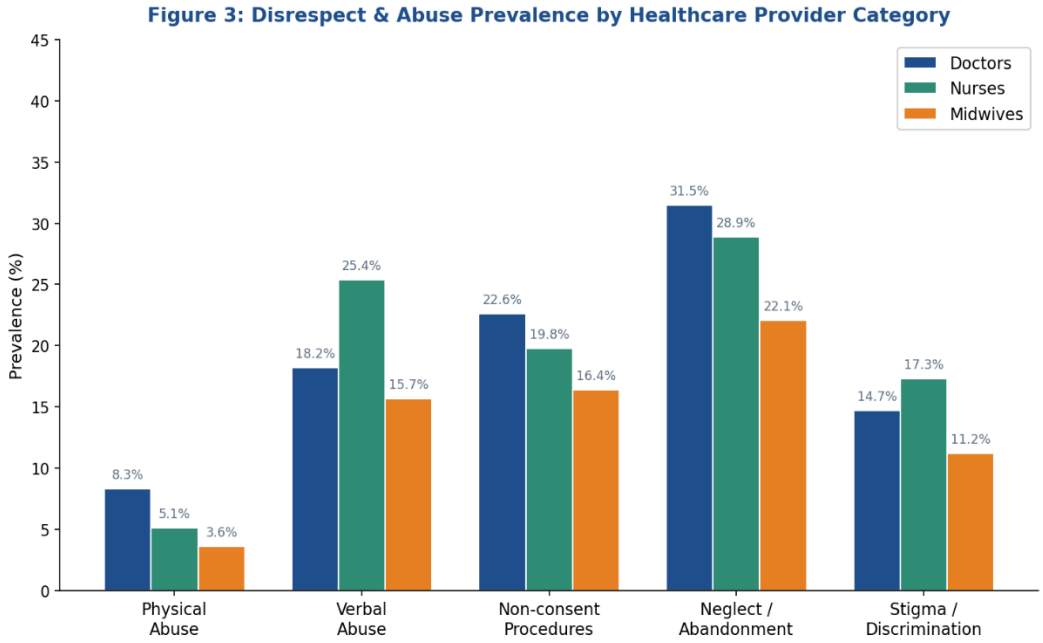

Figure 3: Prevalence of Disrespect & Abuse by Healthcare Provider Category

3.5 Bivariate Analysis: Factors Associated with Adequate RMC

Table 4 presents the bivariate associations between selected variables and adequate RMC. Significant associations were found for educational attainment (χ^2=28.41; p<0.001), monthly income (χ^2=14.72; p=0.001), ANC attendance (χ^2=22.16; p<0.001), parity (χ^2=11.08; p=0.011), ward type (χ^2=9.63; p=0.002), time of delivery (χ^2=7.84; p=0.005), and continuity of caregiver (χ^2=16.37; p<0.001). Age, ethnicity, and mode of delivery did not show statistically significant associations.

Table 4: Bivariate Analysis of Factors Associated with Adequate RMC (N=384)

Variable	Adequate RMC n (%)	Inadequate RMC n (%)	χ^2	p-value
Education Level				
No formal education	13 (29.5)	31 (70.5)	28.41	<0.001*
Primary	23 (38.3)	37 (61.7)		
Secondary	85 (57.4)	63 (42.6)		
Tertiary	90 (68.2)	42 (31.8)		
ANC Attendance				
≥4 visits	162 (61.6)	101 (38.4)	22.16	<0.001*
1–3 visits	40 (44.9)	49 (55.1)		
No ANC	9 (28.1)	23 (71.9)		
Parity				
Nulliparous	39 (54.9)	32 (45.1)	11.08	0.011*
Primiparous	63 (60.0)	42 (40.0)		
Multiparous (2–4)	93 (55.4)	75 (44.6)		
Grand multiparous (≥5)	16 (40.0)	24 (60.0)		
Ward Type				
Private ward	76 (64.4)	42 (35.6)	9.63	0.002*
General ward	135 (50.6)	131 (49.4)		
Time of Delivery				
Daytime (06:00–23:59)	189 (57.3)	141 (42.7)	7.84	0.005*
Nocturnal (00:00–05:59)	22 (40.7)	32 (59.3)		
Continuity of Caregiver				

Same caregiver throughout	128 (63.1)	75 (36.9)	16.37	<0.001*
Different caregivers	83 (45.9)	98 (54.1)		

** Statistically significant at p < 0.05*

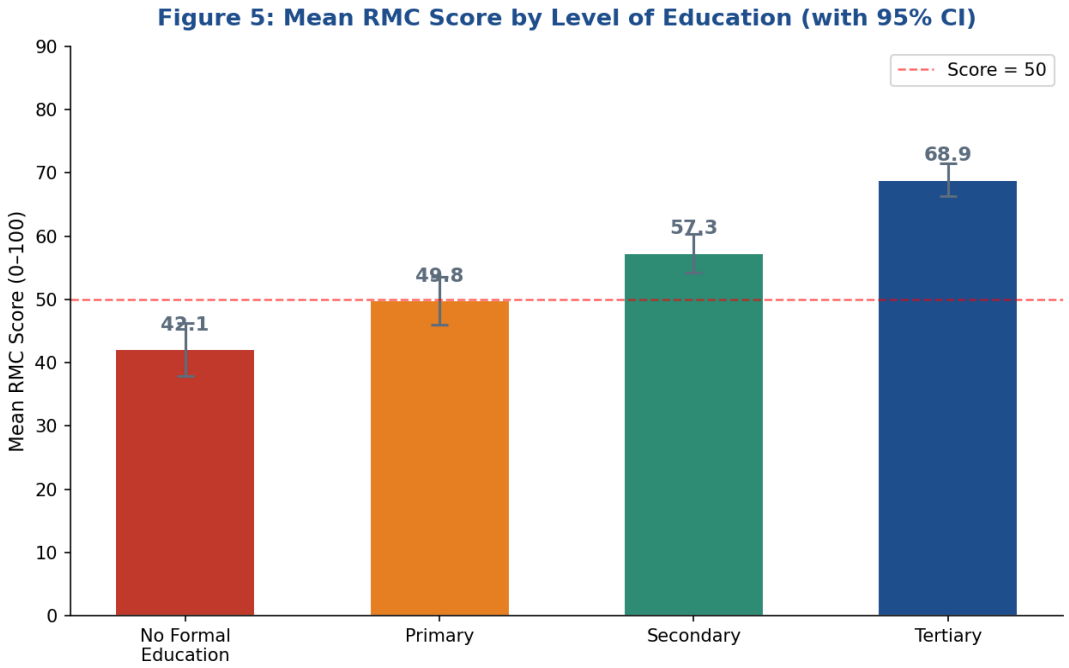

Figure 5: Mean RMC Score by Level of Education with 95% Confidence Intervals

3.6 Multivariate Logistic Regression: Independent Determinants of Adequate RMC

Table 5 presents the results of binary logistic regression modelling of adequate RMC. After adjustment for confounders, the following variables were independently and significantly associated with adequate RMC: tertiary education (aOR = 2.78; 95% CI: 1.64–4.70; p<0.001), adequate ANC attendance (≥4 visits) (aOR = 2.14; 95% CI: 1.28–3.57; p=0.004), continuity of caregiver (aOR = 1.93; 95% CI: 1.17–3.18; p=0.010), delivery in a private ward (aOR = 2.05; 95% CI: 1.22–3.44; p=0.007), and income above ₦150,000/month (aOR = 1.67; 95% CI: 1.00–2.79; p=0.049). Conversely, grand multiparity (aOR = 0.52; 95% CI: 0.31–0.88; p=0.015) and nocturnal delivery (aOR = 0.61; 95% CI: 0.38–0.97; p=0.038) were significantly associated with reduced likelihood of adequate RMC. The model explained 28.3% of the variance in RMC outcome (Nagelkerke R^2 = 0.283) and correctly classified 67.4% of cases.

Table 5: Multivariate Logistic Regression of Determinants of Adequate RMC (N=384)

Variable	cOR (95% CI)	p-value	aOR (95% CI)	p-value	Sig.
Education: Tertiary (ref: None)	3.12 (1.86–5.22)	<0.001	2.78 (1.64–4.70)	<0.001	***
Education: Secondary (ref: None)	1.89 (1.14–3.13)	0.014	1.62 (0.97–2.71)	0.065	ns
ANC ≥4 visits (ref: No ANC)	2.64 (1.65–4.22)	<0.001	2.14 (1.28–3.57)	0.004	**
Continuity of caregiver (ref: Multiple)	2.02 (1.29–3.15)	0.002	1.93 (1.17–3.18)	0.010	**
Private ward (ref: General ward)	1.75 (1.11–2.76)	0.016	2.05 (1.22–3.44)	0.007	**
Income >₦150,000 (ref: <₦50,000)	1.90 (1.16–3.11)	0.011	1.67 (1.00–2.79)	0.049	*
Grand multiparity (ref: Nulliparous)	0.55 (0.33–0.91)	0.020	0.52 (0.31–0.88)	0.015	*
Nocturnal delivery (ref: Daytime)	0.51 (0.30–0.87)	0.013	0.61 (0.38–0.97)	0.038	*
Referral status (ref: Booked at UCTH)	0.82 (0.54–1.24)	0.348	0.91 (0.58–1.41)	0.668	ns

*aOR = adjusted Odds Ratio; cOR = crude Odds Ratio; CI = Confidence Interval; ns = not significant; * p<0.05; ** p<0.01; *** p<0.001. Nagelkerke R^2 = 0.283; Hosmer-Lemeshow χ^2 = 8.74 (df=8; p=0.365); Classification accuracy = 67.4%.*

4. DISCUSSION

This research evaluated RMC prevalence and its determinants amongst postnatal women who received care in a tertiary hospital in Southern Nigeria. The overall prevalence of adequate RMC of 54.9% found in this study underscores persisting gaps regarding some aspects of interpersonal maternity care in Nigerian tertiary hospitals, consistent with findings from other geopolitical zones of Nigeria and the broader sub-Saharan African context [8,9,18].

The prevalence in this study is comparable to the 57.1% reported in a tertiary hospital in Enugu State [8], but substantially lower than the 65.4%

reported in a Tanzanian tertiary hospital by Sando et al. (2016) [15]. The comparatively lower figure at the facility may reflect the high patient load, inadequate staffing ratios, and systemic institutional challenges common to Nigerian tertiary hospitals. Notably, the domains of independence in choices about care (38.8%) and voluntary consent (43.5%) recorded the lowest adequate care rates, suggesting that paternalistic practices and inadequate respect for women's agency remain entrenched in the hospital system. These findings resonate with those of Ihejirika et al. (2019), who similarly identified deficits in consent practices in a cross-sectional survey undertaken in Southeast Nigeria [19].

Education emerged as the most robust positive determinant of adequate RMC in our multivariate model (aOR = 2.78; 95% CI: 1.64–4.70). The likelihood of receiving adequate RMC was approximately threefold higher among women with tertiary-level education compared to those lacking formal education., a pattern consistent with studies from Ghana [20], Kenya [21], and Ethiopia [22]. The mechanism underlying this association is multifactorial. Women with higher education showed greater awareness of their rights, more assertive in demanding quality care, and better able to communicate with healthcare providers [23]. At the same time, unconscious provider biases may lead to differential treatment based on perceived social status, disadvantaging less-educated women.

Adequate ANC attendance (≥4 visits) was independently associated with nearly two times the odds of receiving adequate RMC (aOR = 2.14; 95% CI: 1.28–3.57). This finding aligns with a systematic analysis by Abuya et al. (2015) which identified prior ANC exposure as a significant enabler of quality intrapartum care [3]. ANC attendees had increased likelihood of being familiar with the hospital environment and its personnel, reducing the power asymmetry often associated with first encounters with the health system. ANC also serves as a platform for rights-based health education, potentially equipping women to better advocate for respectful care during childbirth [24].

The association between grand multiparity and reduced RMC (aOR = 0.52; 95% CI: 0.31–0.88) is particularly concerning. Grand multiparous women may be perceived by some health workers as "experienced" and therefore requiring less counselling or emotional support. This attitude, a form of implicit discrimination, has been documented in Nigerian and Malawian settings [18,25]. The finding that nocturnal deliveries were associated with lower RMC (aOR = 0.61; 95% CI: 0.38–0.97) likely reflects reduced staffing levels, heightened fatigue among providers, and reduced supervisory oversight during nighttime hours, consistent with evidence from Ethiopia and Uganda [22].

Continuity of caregiver and private ward delivery were significant institutional determinants of adequate RMC. Women cared for by the same healthcare provider throughout labour were significantly more likely to receive adequate care, reflecting the known benefits of relationship-based care models for personalising the birth experience and reducing provider-patient communication barriers [11]. The association between private ward delivery and better RMC likely mirrors the well-documented disparity in care quality based on perceived social status and ability to pay in resource-limited health systems [13], which raises important equity concerns.

It is notable that provider category analysis (Figure 3) revealed that verbal abuse was most commonly attributed to nurses, while non-consensual procedures and neglect were more frequently associated with doctors. This nuanced finding suggests that D&A is not confined to one cadre of staff and that comprehensive provider-level interventions are required across all professional groups. These findings are in agreement with those of Bohren et al. (2015) in their seminal systematic review of mistreatment women face in the course of delivery in health institutions [2].

Key methodological strengths of this study involved the adoption of a validated, culturally-adapted instrument, adequate sample size, high response rate, and robust multivariate analysis. Nonetheless, some limitations warrant attention. First, the cross-sectional approach restricts the

ability to establish causality. Second, social desirability bias may have influenced responses, potentially resulting in under-reporting of D&A experiences, despite interviewer training and emphasis on confidentiality. Third, findings from a single tertiary institution may limit generalisability to primary and secondary healthcare facilities and other regions of Nigeria. Fourth, provider-level factors such as staffing ratios, workload, and burnout were not directly measured and represent areas for future investigation.

5. CONCLUSION AND RECOMMENDATIONS

The prevalence of adequate RMC in the tertiary health facility in Calabar was 54.9%, with notable deficits in the domains of independence in decision-making and informed permission. Education, ANC attendance, continuity of caregiver, and ward type were significant positive determinants of RMC, while grand multiparity and nocturnal delivery were negatively associated with quality of care. These findings underscore the necessity for a multidimensional approach to improving RMC in Nigerian tertiary hospitals.

Guided by these findings, the following recommendations are proposed:

1. Hospital Management: Implement mandatory RMC training for all maternity staff covering rights-based care, informed consent, and non-discriminatory attitudes. Establish a functional patient feedback mechanism and grievance redressal system.

2. Policymakers: Integrate RMC standards into national quality-of-care frameworks and hospital accreditation criteria. Strengthen regulatory oversight of D&A in childbirth settings.

3. Staffing: Address staff shortages and improve deployment during overnight shifts. Introduce mentorship programmes linking senior midwives to junior staff.

4. Antenatal Care: Strengthen ANC content to include health rights education and birth preparedness, leveraging ANC attendance as an entry point for empowerment.

5. Research: Longitudinal and interventional studies in future research should be prioritized to establish causality and evaluate the effectiveness of strategies to improve Respectful Maternity Care in Nigeria.

REFERENCES

1. World Health Organization. The prevention and elimination of disrespect and abuse during facility-based childbirth. Geneva: WHO; 2015. Available from: https://www.who.int/reproductivehealth/topics/maternal_perinatal/statement-childbirth/en/

2. Bohren MA, Vogel JP, Hunter EC, et al. The mistreatment of women during childbirth in health facilities globally: A mixed-methods systematic review. PLoS Medicine. 2015;12(6):e1001847.

3. Abuya T, Warren CE, Miller N, et al. Exploring the prevalence of disrespect and abuse during childbirth in Kenya. PLoS ONE. 2015;10(4):e0123606.

4. Kujawski S, Mbaruku G, Freedman LP, Ramsey K, Moyo W, Kruk ME. Association between disrespect and abuse during childbirth and women's confidence in health facilities in Tanzania. Maternal and Child Health Journal. 2015;19(10):2243-2250.

5. Bowser D, Hill K. Exploring evidence for disrespect and abuse in facility-based childbirth. Report of landscape analysis. USAID-TRAction Project. 2010. Boston: Harvard School of Public Health.

6. WHO, UNICEF, UNFPA, World Bank Group, United Nations Population Division. Trends in Maternal Mortality: 2000 to 2020. Geneva: World Health Organization; 2023.

7. Tunçalp Ö, Were WM, MacLennan C, et al. Quality of care for pregnant women and newborns—the WHO vision. BJOG: An International Journal of Obstetrics & Gynaecology. 2015;122(8):1045-1049.

8. Okafor II, Ugwu EO, Obi SN. Disrespect and abuse during facility-based childbirth in a low-income country. International Journal of Gynecology & Obstetrics. 2015;128(2):110-113.

9. Oladapo OT, Iyaniwura CA, Sule-Odu AO. Quality of antenatal services at the primary care level in southwest Nigeria. African Journal of Reproductive Health. 2008;12(3):71-92.

10. Etuk SJ, Etuk IS, Oyo-Ita AE. Factors influencing the choice of facility for childbirth among women in Calabar municipality, Cross River State, Nigeria. Nigerian Journal of Clinical Practice. 2010;13(2):149-153.

11. Bohren MA, Berger BO, Munthe-Kaas H, Tunçalp Ö. Perceptions and experiences of labour companionship: A qualitative evidence synthesis. Cochrane Database of Systematic Reviews. 2019;(3):CD012449.

12. Madula P, Kalembo FW, Yu H, Kaminga AC. Healthcare provider-patient communication: A qualitative study of women's perceptions during childbirth. Reproductive Health. 2018;15(1):135.

13. Kruk ME, Kujawski S, Mbaruku G, Ramsey K, Moyo W, Freedman LP. Disrespectful and abusive treatment during facility delivery in Tanzania: A facility and community survey. Health Policy and Planning. 2018;33(1):e26-e33.

14. Imasiku ML, Nkonde C, Banda SS, Mwala M. Respectful maternity care: perspectives of women and health care providers in Zambia. African Journal of Midwifery and Women's Health. 2018;12(1):21-26.

15. Sando D, Abuya T, Asefa A, et al. Methods used in prevalence studies of disrespect and abuse during facility based childbirth: Lessons learned from a multi-country study. Reproductive Health. 2017;14(1):127.

16. White Ribbon Alliance. Respectful Maternity Care: The Universal Rights of Childbearing Women. Washington DC: White Ribbon Alliance; 2011.

17. Asefa A, Bekele D. Status of respectful and non-abusive care during facility-based childbirth in a hospital and health centers in Addis Ababa, Ethiopia. Reproductive Health. 2015;12:33.

18. Ukke GG, Gurara MK, Boynito WA. Disrespect and abuse of women during childbirth in public health facilities in Wolisso town, southwest Ethiopia—A cross-sectional study. International Journal of Africa Nursing Sciences. 2019;10:214-221.

19. Ihejirika OC, Obi CD, Ihejirika RCA. Disrespect and abuse in childbirth: A descriptive study of postnatal women's experience in Southeast Nigeria. Journal of Obstetrics and Gynaecology. 2019;39(3):325-330.

20. Yakubu Y, Adam AM. The experience of disrespect and abuse during institutional delivery in a tertiary hospital in Ghana. BMC Pregnancy and Childbirth. 2022;22(1):1-11.

21. Wassihun B, Zeleke S. Compassionate and respectful maternity care during facility based child birth and women's intention to use maternity service in Bahir Dar, Ethiopia. BMC Pregnancy and Childbirth. 2018;18(1):294.

22. Sheferaw ED, Mengesha TZ, Wase SB. Development of a tool to measure women's perception of respectful maternity care in public health facilities. BMC Pregnancy and Childbirth. 2016;16:67.

23. Orpin J, Puthussery S, Davidson R, Burden B. Women's experiences of disrespect and abuse in maternity care facilities in Benue State, Nigeria. BMC Pregnancy and Childbirth. 2018;18(1):213.

24. Freedman LP, Ramsey K, Abuya T, et al. Defining disrespect and abuse of women in childbirth: A research, policy and rights agenda. Bulletin of the World Health Organization. 2014;92(12):915-917.

25. Kumbani LC, Chirwa E, Malata A, Odland JO, Bjune G. Do Malawian women in labour experience disrespect and abuse during facility-based delivery? A case study from Blantyre District. BMC Pregnancy and

Childbirth. 2016;16:180