ASSESSMENT OF RESPECTFUL MATERNITY CARE EXPERIENCES AMONG POSTNATAL MOTHERS IN BENIN CITY, EDO STATE, NIGERIA

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CERTIFICATION

This is to certify that this research work titled "ASSESSMENT OF RESPECTFUL MATERNITY CARE (RMC) AMONG POSTNATAL MOTHERS IN BENIN CITY, NIGERIA" will be conducted by AWUDU AYIBATONBRA EBISINTEI with matriculation number MED1706186 and OLUWATOSIN OGHENEFEJIRO LADOKUN with matriculation number MED1706228 under the supervision of PROF. E.O OGBOGHODO in the Department of Community Health, College of Medicine, University of Benin as part of the requirements for the award for Bachelor of Medicine, Bachelor of Surgery (MBBS).

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We hereby declare that this project work titled “Assessment of Respectful Maternity Care (RMC) among Postnatal Mothers in Benin City, Nigeria” will be conducted under supervision and has not been submitted in part or in full for any purpose.

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DEDICATION

We dedicate this project to Almighty God for his grace towards us which sustained us and enabled us to successfully complete this project. We also dedicate this project to our respective families who relentlessly supported us spiritually, financially and morally. This work is also dedicated to our teacher who guided us throughout the course of this project, Prof. (Mrs.) E.O. Ogboghodo.

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LIST OF ABBREVIATION

CHEWs: Community Health Extension Workers

D&A: Disrespect and Abuse

IBM SPSS: Statistical Product and Service Solutions

ILO: International Labour Organization

LMICs: Low- and Middle-Income Countries

MORi: Mother on Respect Index

MOUs: Midwife Obstetric Units

NDHS: Nigeria Demographic and Health Survey

NPHCDA: National Primary Health Care Development Agency

NURHI: Nigerian Urban Reproductive Health Initiative

PCMC: Person Centred Maternity Care

PHCs: Primary Health Centres

RMC: Respectful Maternity Care

SARA: Service Availability and Readiness Assessment

UBTH: University of Benin Teaching Hospital

WHO: World Health Organization

DEFINITION OF TERMS

Attitude: A person's predisposition or tendency to respond positively or negatively towards respectful maternity care, often reflected in behaviour or communication with patients.

Autonomy: A woman's ability to make independent decisions about her body and childbirth, including her right to participate actively in choices regarding her care.

Dignity: The right of every woman to be treated with honour, courtesy, and respect during childbirth, without humiliation, judgment, or any form of degrading behaviour.

Disrespect and Abuse: Any form of mistreatment that violates a woman's dignity during childbirth, including verbal or physical abuse, neglect, discrimination, non-consented care, and denial of privacy or confidentiality.

Facility-level Factors: Structural and organizational conditions within a health facility, such as staffing levels, supervision, equipment, and privacy arrangements, that affect the quality of respectful maternity care.

Knowledge: The understanding or awareness women or providers have about the principles, rights, and practices that constitute respectful maternity care.

Maternal Health Outcome: The result of the health services provided to a woman during pregnancy, labour, and the postnatal period, measured through indicators such as survival, recovery, satisfaction, and well-being.

Maternal Mortality Ratio: The number of maternal deaths per 100,000 live births within a specific time period, used as a key indicator of the quality and effectiveness of maternal healthcare in a population.

Postnatal Care: Healthcare services provided to a mother and her newborn immediately after childbirth and during the six weeks following delivery, focusing on recovery, emotional well-being, and prevention of complications.

Postnatal Mother: A woman who has recently given birth, typically within six weeks after delivery, and who may still be receiving care and support related to her childbirth experience.

Provider-level Factors: Characteristics or behaviours of healthcare workers, such as their knowledge, training, attitude, and communication style, which influence how women experience maternity care.

Respectful Maternity Care: This refers to care provided to all women during pregnancy, labour, and childbirth in a manner that preserves their dignity, privacy, and confidentiality, ensures freedom from harm and mistreatment, and upholds their right to make informed choices and receive continuous support throughout the process.

ABSTRACT

Background: Respectful maternity care (RMC) is defined by the World Health Organization as care organized and provided to all women in a manner that maintains their dignity, privacy, and confidentiality, ensures freedom from harm and mistreatment, and enables informed choice and continuous support during labour and childbirth. Despite global recognition of its importance, violations of RMC remain widespread in low- and middle-income countries, including Nigeria, where disrespect and abuse during childbirth have been linked to reduced facility utilization, poor maternal satisfaction, and adverse psychological outcomes. Nigeria accounts for nearly 20% of global maternal deaths, with a maternal mortality ratio of 512 per 100,000 live births. In Benin City, Edo State, there is limited comprehensive data on postnatal mothers' experiences, knowledge, and attitudes toward RMC, creating a significant gap in evidence needed to inform policy and clinical interventions.

Objectives: This study aimed to assess the extent, determinants, and implications of respectful maternity care experiences among postnatal mothers in Benin City, Edo State. Specific objectives included assessing knowledge and attitudes toward RMC, documenting experiences of respectful and disrespectful maternity care during childbirth, identifying provider- and facility-level determinants of RMC violations, determining predictors of respectful care experiences, and advocating for institutional policy changes promoting RMC.

Methods: A descriptive cross-sectional study was conducted between April 2025 and April 2026 among postnatal women in Ugbowo community, Egor Local Government Area, Benin City. A sample size of 418 respondents was determined using Cochran's formula, with a 10% non-response adjustment. A multistage sampling technique was employed: Egor LGA and Ugbowo ward were selected by simple random sampling (balloting), and five communities within the ward served as clusters from which all eligible postnatal women were recruited. Inclusion criteria were women aged 18 years and above who had delivered a live birth within the preceding year and were resident in Edo State. Data were collected using a structured, interviewer-administered questionnaire comprising six sections covering sociodemographic characteristics, knowledge of RMC, attitudes toward RMC, childbirth experiences, facility- and provider-level factors, and overall satisfaction. Data were analysed using IBM SPSS; univariate analysis described sociodemographic characteristics, chi-square tests assessed bivariate associations, and binary logistic regression identified independent predictors of respectful care experience.

Results: The majority of respondents were married women in their late twenties to mid-thirties with tertiary education, predominantly Christian, and most had attended antenatal care during their last pregnancy. Most delivered in public health facilities and settled bills out of pocket. Formal awareness of RMC as a concept was poor, with only 19.6% of respondents having heard of it; among these, fewer than four in ten demonstrated good overall knowledge, with particular weaknesses in domains relating to supportive care, informed consent, autonomy, and non-discriminatory treatment. Despite low conceptual awareness, the overwhelming majority of respondents held strongly positive attitudes toward the underlying principles of respectful care, with formal education being the only statistically significant predictor of positive attitude. Reported childbirth experiences were broadly positive for dignity, empathetic communication, and non-discriminatory treatment; however, serious violations persisted: more than one in five women reported being shouted at during labour, more than one in ten reported being physically struck, and the near-universal suppression of cultural practices during labour was documented. Perceived provider overwork, overcrowding, and intimidation by birth attendants were identified as facility- and provider-level factors compromising care quality, with nurses and midwives disproportionately identified as responsible for mistreatment. In multivariate analysis, positive attitude toward RMC (adjusted OR approximately 3.0) and delivery in a private facility were the only statistically significant independent predictors of a respectful childbirth experience; women who delivered in public facilities had significantly lower odds of respectful care.

Conclusion: Formal awareness and comprehensive knowledge of RMC remain critically low among postnatal mothers in Benin City, despite largely positive attitudes toward its principles. Serious violations, including verbal and physical abuse, financial gatekeeping, and suppression of cultural practices, persist alongside generally favourable overall experience ratings, pointing to a system-level underestimation of mistreatment. A significant public-private quality gap was confirmed, with public facility delivery associated with lower odds of respectful care. These findings underscore the urgent need for rights-based maternal health education integrated into routine antenatal care, mandatory RMC training for maternity staff, improved accountability mechanisms within public health facilities, and the development of a national RMC standard with enforceable facility-level indicators.

Keywords: Respectful maternity care, postnatal mothers, disrespect and abuse, childbirth experience, Benin City, Nigeria, maternal health.

CHAPTER ONE

INTRODUCTION

1.1 BACKGROUND OF THE STUDY

The quality of maternal healthcare is increasingly being assessed not only by the availability of skilled birth attendants or the physical outcomes of delivery, but by the human experience surrounding childbirth. Over the past decade, there has been a global shift toward understanding how respectful maternity care (RMC), or its absence, shapes health outcomes, healthcare utilization, and the overall well-being of mothers and newborns.[1] RMC is defined by the World Health Organization (WHO) as "care that is organized and provided to all women in a manner that maintains their dignity, privacy and confidentiality, ensures freedom from harm and mistreatment, and enables informed choice and continuous support during labour and childbirth".[2]

Respectful maternity care is understood through a set of core domains: communication, privacy, confidentiality, informed consent, emotional support, and freedom from mistreatment, each of which is rooted in global health frameworks such as the WHO Quality of Care initiative and the Respectful Maternity Care Charter.[1,2] These domains represent the non-negotiable elements of dignified maternity care, and evidence from Nigeria and other low- and middle-income countries (LMICs) shows that violations across these domains are common, with consequences for maternal satisfaction, healthcare utilization, and psychological well-being.[5]

Globally, efforts to promote RMC have gained traction due to increasing evidence that disrespect and abuse (D&A) are widespread in maternity settings, especially in low- and middle-income countries. These include verbal insults, physical abuse, neglect, non-consented procedures, discrimination, and detention for inability to pay.[3] Such violations occur even in facilities that offer skilled birth attendance, showing that clinical competence alone is insufficient to guarantee safe and satisfactory childbirth experiences.[4] Respectful care is now recognized as a core element of quality

care. In 2016, the WHO published a framework outlining the components of quality maternal and newborn healthcare, where experience of care, including dignity, communication, and emotional support, is placed alongside clinical effectiveness.[5] This marked a turning point in global health policy, reframing respectful treatment not as an optional luxury but as a fundamental right.

Numerous international studies support this, and this includes a 2019 observational study in Kenya which found that 42% of women experienced at least one form of mistreatment during labour, with physical and verbal abuse being the most common.[6] Similar findings were reported in Ghana, Tanzania, and India, where health worker shortages, burnout, and systemic inefficiencies were linked to high rates of disrespect and abuse. Yet, despite increased awareness, many women still avoid or delay facility-based births due to previous experiences of disrespect.[7-9] This delay is known as the third delay in the "Three Delays" model; the delay in receiving adequate and respectful care upon reaching the facility, and it has been shown to significantly contribute to maternal deaths.[10]

In Nigeria, the problem is particularly acute. The country accounted for nearly 20% of global maternal deaths in 2020, with an estimated maternal mortality ratio of 512 per 100,000 live births.[11] While skilled birth attendance has improved in urban areas, the quality of interaction between mothers and providers is still troubling. Studies from different parts of Nigeria show that a significant number of women are verbally abused, ignored, or coerced into procedures during childbirth.[12] In Nigeria, childbirth is not just a medical event; it is deeply embedded in cultural, emotional, and social dimensions. Unfortunately, the birthing experience for many women is often flawed by mistreatment in health facilities. Findings from a multi-state study conducted by the Nigerian Urban Reproductive Health Initiative (NURHI) revealed that over 60% of women had experienced at least one form of disrespect or abuse during delivery, ranging from scolding and shaming to being left unattended during labour.[13]

This issue persists despite Nigeria's adoption of global reproductive health strategies, such as the Safe Motherhood Initiative and the National Reproductive Health Policy, both of which emphasize women's rights to quality care.[14] The lack of accountability, limited provider training in patient-centred communication, and deep-rooted systemic issues continue to drive the persistence of disrespectful care.[15] Research has shown that many healthcare providers normalize abusive practices, often justifying them as necessary to control patients or speed up labour.[16] This mindset, coupled with workplace stress, understaffing, and inadequate infrastructure, leads to a healthcare environment where respectful treatment becomes the exception rather than the norm.[17]

In urban centres like Benin City, where more women are opting for institutional deliveries, the pressure on health facilities has intensified. Studies conducted in Edo State reveal that although maternal healthcare coverage has improved, qualitative assessments show significant dissatisfaction among postpartum women regarding how they were treated during childbirth.[18] Also, a cross-sectional study involving 302 women in public health facilities in Benin City found that over 45% of them were not asked for their consent before procedures, and 39% reported being shouted at or scolded.[19] These experiences have consequences. Disrespectful maternity care not only causes emotional trauma and psychological stress for mothers but also affects their willingness to return for postnatal care, take up family planning, or recommend facility delivery to others.[20] In many cases, women who had experienced verbal or physical abuse during their first delivery opted for home births or unregulated traditional birth attendants for subsequent pregnancies, putting their lives at greater risk.[21]

Another important dimension is the gap in women's awareness and understanding of RMC. Many women in Benin City and other parts of Nigeria are unaware that they have a right to dignified, respectful care. This lack of awareness often results in underreporting of violations, limited demand for accountability, and little pressure for health systems to change.[22] These realities signal the urgent need to assess the knowledge, experiences, and perceptions of women who have recently

given birth. The postnatal period, particularly within six weeks of delivery, presents a critical window when women can meaningfully reflect on their childbirth experiences and provide informed accounts of how they were treated.[3]

Understanding the determinants of respectful or disrespectful maternity care requires looking closely at both the provider-level and facility-level factors. At the provider level, studies have shown that healthcare workers' attitudes, training, and working conditions heavily influence how women are treated during labour and childbirth.[6] A recent study in Lagos State, Nigeria, found that midwives who had received training on respectful care were significantly more likely to obtain consent before procedures and communicate empathetically with labouring women.[18]

However, not all providers are adequately trained in this regard. Most medical and nursing curricula in Nigeria still emphasize clinical skills over soft skills like communication, empathy, and shared decision-making.[15] This leaves a gap in the competency of healthcare providers to deliver not just technically sound care, but care that aligns with human rights and patient dignity. Moreover, burnout among maternity staff, due to high workload, inadequate staffing, and limited support, is another major factor contributing to the use of harsh or dismissive behaviours during childbirth.[21]

On the facility level, infrastructure, policies, and leadership style also matter. Facilities that are overcrowded, underfunded, or poorly managed are more likely to foster environments where disrespectful care thrives.[16] For instance, where privacy is not structurally possible, such as wards lacking curtains or individual delivery rooms, women may be exposed to shame and embarrassment during childbirth. Similarly, in facilities without clear accountability mechanisms, women who are mistreated may have no clear pathway to report abuse, further establishing the problem.[18] Additionally, cultural norms and societal expectations around childbirth and gender roles shape both how women perceive disrespect and how providers justify their actions. In some settings, loud expressions of pain are seen as unacceptable or uncooperative, and some providers believe that

shouting at or restraining women is necessary to ensure compliance. These beliefs are not only harmful but also reinforce power imbalances that leave women vulnerable in moments of physical and emotional vulnerability.[17]

Recent advocacy efforts have aimed to push for institutional and policy changes to address these gaps. For instance, the White Ribbon Alliance's What Women Want campaign collected over one million voices from women in over 100 countries, including Nigeria, calling for respectful maternity care as a top demand.[3] In Nigeria, this led to renewed discussion on incorporating RMC into the National Health Strategic Plans, but challenges remain in implementation and monitoring. Despite these initiatives, there is still no national standard or enforcement mechanism specifically for respectful maternity care in Nigeria.[25] Some hospitals and professional bodies have adopted guidelines, but uptake is inconsistent and largely depends on local leadership.

This growing concern makes it crucial to advocate for policy changes that promote RMC across all levels of the health system, from training institutions to facility protocols and monitoring systems. Furthermore, community-level education and empowerment are essential to ensure that women are aware of their rights and can demand accountability where violations occur.[26]

One critical but often underutilized entry point for improving maternity care is the postnatal period. It offers a unique opportunity for health systems to gather feedback from women about their childbirth experiences while their memories are still fresh. Postnatal clinic attendees are often in a better psychological and physical state to reflect on whether their dignity was preserved, if they felt listened to, and whether they were treated with respect. Unfortunately, this potential is not being maximized.[27] In many Nigerian health facilities, postnatal visits focus mostly on infant immunizations and maternal complications, with little or no attention paid to psychosocial well-being or emotional experiences during delivery. Yet evidence shows that women who suffer

disrespectful maternity care are more likely to report postpartum depression, anxiety, or post-traumatic stress symptoms, conditions that can affect both mother and child.[22]

More so, postnatal feedback loops can drive quality improvement, especially when they are formalized into the health system. Some countries have integrated birth satisfaction tools and experience of care surveys into their maternal care systems, helping providers reflect and improve on their practices. In Nigeria, these tools are not widely available or used, which limits insight into how women truly perceive the care they receive.[27] This lack of feedback perpetuates a cycle where women remain silent, providers lack self-awareness, and systems fail to learn and evolve. For women who have experienced verbal insults, non-consented procedures, or neglect during delivery, the silence becomes a form of trauma, a reminder that their pain was invisible to the system.[28] Another dimension that makes postnatal engagement vital is that many RMC violations occur during active labour, a time when women may be too overwhelmed to speak up. By the time they attend postnatal care, they are better positioned to give clearer accounts and evaluate how their dignity, autonomy, and rights were respected or violated.[29] Importantly, maternal satisfaction is closely linked to future health-seeking behaviour. Research in Edo and Delta States showed that women who felt disrespected during childbirth were 3.5 times less likely to return to the same facility for postnatal services or subsequent deliveries. This poses a risk to efforts aimed at increasing skilled birth attendance and reducing maternal mortality in Nigeria.[26]

Benin City, the capital of Edo State, represents a dynamic urban centre that reflects the evolving patterns of maternal healthcare in southern Nigeria. The city hosts a mix of public and private maternity facilities that cater to women from diverse educational, cultural, and socioeconomic backgrounds. These facilities vary widely in structure, staffing, and patient volume, offering a microcosm of the challenges and opportunities within Nigeria's maternal health system. Existing studies from Benin City have shown that while access to skilled birth attendance is improving, women's experiences of care remain uneven, with reports of both supportive and disrespectful

treatment during childbirth.[18,19] Understanding the realities within such a diverse healthcare environment provides valuable insight into how respectful maternity care is practiced and perceived in urban Nigeria. Furthermore, exploring women's postnatal observations helps to emphasize a broader social and systemic factors that shape their experiences during labour, delivery, and the immediate postpartum period.[25,26]

Globally, the demand for respectful maternity care is no longer seen as optional but as a fundamental human right. The World Health Organization (WHO) has emphasized that all women have the right to dignified, respectful care during pregnancy and childbirth, free from discrimination, coercion, or abuse. Yet, in practice, this principle is still far from being fully realized, especially in low- and middle-income countries (LMICs) like Nigeria.[1] A critical gap exists between policy and practice. While Nigeria has endorsed the WHO's vision for RMC and integrated aspects of it into its reproductive health policies, actual implementation at the facility level remains fragmented. Guidelines and agreements exist, but few facilities have functioning regulatory controls, clear protocols for reporting abuse, or mandatory training for staff on women-centred care. In addition, societal power dynamics continue to influence the quality of maternal healthcare. Patriarchal norms, low autonomy for women in health-related decisions, and a general mistrust of health systems create an environment where many women suffer in silence. Even where women are educated or empowered, the hierarchical structure within health facilities often makes it difficult for them to question or challenge their treatment during labour.[1, 3]

Recent global efforts such as the Global Respectful Maternity Care Council, the WHO Quality of Care Framework, and Every Woman Every Child initiative have brought renewed attention to the issue. These frameworks not only emphasize the ethical obligation of providing RMC but also emphasize its link to improved maternal and newborn outcomes, including increased satisfaction, higher facility delivery rates, and reduced maternal complications. In Nigeria, studies conducted in

various states, including Enugu, Ogun, Lagos, and emerging data from Edo State, reveal that respectful maternity care is not yet established across most health facilities. Many healthcare providers admit that they are not fully familiar with the principles of respectful maternity care and often work in settings where institutional support for practicing it consistently is limited. Within Benin City, a diverse urban centre with a high volume of institutional deliveries, postnatal clinics, and maternity wards provide an important setting for examining how women experience maternity care. Exploring their knowledge, attitudes, and reported experiences helps reveal gaps between existing policies and the actual quality of care received. By placing the issue within both global and local frameworks, this study contributes to the growing discourse on improving maternal health through dignity-centred, compassionate, and equitable maternity care practices.[1,3,26,30]

1.2 STATEMENT OF THE PROBLEM

Maternal mortality remains a significant public health challenge globally. According to the World Health Organization, approximately 295,000 women die each year due to complications related to pregnancy and childbirth. Despite global efforts to improve healthcare services, disparities between developed and developing countries persist. Sub-Saharan Africa bears the highest burden, with a maternal mortality ratio estimated at 542 deaths per 100,000 live births, significantly higher than the global average of 211 per 100,000 live births.[1] These figures emphasize the persistent gaps in access to quality maternal healthcare, skilled birth attendance, and respectful maternity care.

Respectful maternity care, which includes dignity, privacy, confidentiality, freedom from harm and mistreatment, and informed consent, is important in improving maternal health outcomes.[2] Women who receive respectful care during childbirth are more likely to utilize health facilities for delivery, leading to reductions in maternal and neonatal morbidity and mortality.[55] Equally, disrespect and abuse during childbirth, such as verbal abuse, neglect, physical mistreatment, and non-consented

care, discourage women from seeking institutional care.[24] Studies have shown that over 30% of women in countries like Tanzania, Kenya, and Nigeria have experienced some form of disrespect or abuse during labour and delivery, resulting in low satisfaction and poor utilization of skilled birth attendants.[5]

In Nigeria, the maternal mortality ratio remains unacceptably high at 512 deaths per 100,000 live births, as reported in the 2018 Nigeria Demographic and Health Survey (NDHS).[25] Contributing factors include inadequate healthcare infrastructure, socio-economic barriers, and suboptimal quality of care.[26] Among these, disrespectful and abusive care during childbirth has emerged as a significant barrier to maternal healthcare utilization.[27] Many women report experiencing verbal abuse, neglect, denial of pain relief, and other forms of mistreatment during delivery, discouraging them from seeking institutional care and increasing their vulnerability to complications and death.[28]

Disrespect and abuse during childbirth persist as a significant challenge in Nigeria and other low- and middle-income countries, undermining trust in healthcare systems and prompting many women to opt for home births or traditional birth attendants.[16,17] These choices, though often driven by fear of mistreatment, carry significant risks. Systemic issues, such as overcrowding, understaffing, and lack of training in respectful care, further worsen this problem[31]. Healthcare workers, strained by heavy workloads and institutional constraints, may exhibit dismissive or harsh behaviours, intensifying the challenge and sustaining women's distrust in formal healthcare systems.[32]

Postnatal care services are important for monitoring the health of both mother and newborn, which are often overlooked in the discussion on respectful maternity care. Many women report feeling neglected, rushed, or emotionally unsupported during postnatal visits.[32] Such neglect not only affects postpartum recovery and breastfeeding success but also undermines long-term maternal health. Without ensuring respectful care during the postnatal period, maternity healthcare services remain incomplete and less effective.[20]

In Benin City, Edo State, evidence suggests that despite the availability of postnatal clinics, many mothers report dissatisfaction with maternity care due to disrespectful treatment by healthcare providers. Women attending public health facilities frequently report feeling ignored, humiliated, or subjected to non-consensual medical procedures.[29] While some studies have addressed respectful maternity care in Benin City, comprehensive assessments, particularly among mothers attending postnatal clinics, remain limited. The lack of comprehensive data on respectful maternity care in Benin City hinders the ability of healthcare planners and policymakers to design effective, evidence-based interventions. Existing research has largely focused on general maternity care, leaving gaps in understanding the socio-demographic and institutional factors that influence women's experiences, especially during the postnatal period. This research gap limits the development of policies and training programs that are contextually appropriate for the region.[2,30]

Cultural beliefs and provider attitudes also complicate the delivery of respectful maternity care. Misconceptions about women's behaviour during labour often lead to negative or judgmental attitudes from healthcare workers.[5,26] Combined with systemic issues such as burnout and insufficient training, these factors contribute to a pattern of mistreatment that discourages women from seeking institutional maternity care.[31] Even in Edo State, where urban advantages exist, maternal deaths are often linked to delays in seeking care due to fears of disrespect and abuse. These fears are not baseless and are frequently confirmed by experiences of poor treatment in healthcare facilities.[33] Such patterns highlight the urgent need for interventions that address both the human and infrastructural deficiencies in maternity care.

Given Nigeria's persistently high rates of maternal morbidity and mortality, strengthening respectful maternity care, especially within postnatal clinics, is vital.[34] Improving the quality of care can enhance women's satisfaction, promote early postnatal attendance, and encourage healthy maternal behaviors.[35] However, the scarcity of targeted research in Benin City presents a significant barrier. Addressing this knowledge gap through focused investigation will inform effective

strategies and support the development of policies that ensure every woman receives dignified and compassionate care throughout her childbirth journey.[2]

1.3 JUSTIFICATION OF STUDY

Respectful maternity care (RMC) plays a vital role in ensuring the well-being of both mothers and new-borns. Beyond its contribution to improved health outcomes, RMC upholds women's autonomy, dignity, and fundamental human rights during childbirth. However, despite its significance, RMC continues to face challenges in many regions, including Nigeria. In Benin City, Edo State, limited research exists on the experiences of women attending postnatal clinics, particularly in relation to how they were treated during childbirth. While a few studies have been conducted, they do not fully capture the scope of RMC in this region. This study, therefore, seeks to examine the extent of respectful and disrespectful maternity care, assess mothers' awareness levels, and identify the factors that shape their childbirth experiences in Benin City.

A key motivation for undertaking this research is the scarcity of comprehensive and recent data on the quality of maternity care from the perspective of mothers themselves. Existing studies have documented cases of disrespect and abuse during childbirth in various Nigerian states, but data specifically related to Benin City remain insufficient. This study aims to bridge that gap by providing insights into the real-life experiences of mothers during labour and delivery and highlighting areas that require improvement in maternity care services. By focusing on postnatal women, those who have recently given birth, the study captures first-hand accounts, offering valuable evidence for policy formulation and clinical interventions.

Furthermore, this research aligns with Nigeria’s ongoing initiatives to reduce maternal mortality and enhance maternal health outcomes. Despite the existence of national policies such as the National Strategic Health Development Plan and various guidelines supporting RMC,

implementation remains inadequate across multiple levels. Consequently, disrespectful care, including verbal abuse, physical mistreatment, neglect, non-consensual procedures, and discrimination, continues to be reported in healthcare facilities. Investigating the scope and nature of such practices in Benin City will provide critical data to support advocacy efforts and institutional reforms aimed at making respectful care a standard practice rather than an exception.

Another crucial justification for this study is its potential to uncover underlying systemic issues within healthcare facilities and among providers that contribute to violations of RMC. Factors such as poor provider attitudes, understaffing, overcrowded healthcare settings, inadequate infrastructure, lack of proper training, and weak accountability mechanisms often worsen the prevalence of disrespectful care. By identifying these facility- and provider-level determinants in Benin City, this research will enable stakeholders in the health sector to design targeted interventions that address the root causes of disrespect and abuse. This study, therefore, extends beyond merely identifying the problems, it proposes meaningful and sustainable solutions.

The psychological and emotional consequences of disrespectful maternity care cannot be overlooked. Research has indicated that women subjected to mistreatment during childbirth may experience lasting trauma, postpartum depression, and a deep-rooted distrust in the healthcare system. Some may even choose to avoid skilled birth attendance in subsequent pregnancies due to fears of mistreatment, thereby increasing their risk of maternal and neonatal complications. By drawing attention to these critical concerns within the context of Benin City, this study promotes a necessary shift in the perception and delivery of maternal healthcare, emphasizing empathy, respect, and patient-centred approaches. Additionally, this research aims to empower women by increasing awareness of their rights during childbirth and equipping them with the knowledge to demand better maternity care. RMC is not solely about provider attitudes; it encompasses establishing systems where women are valued, heard, and treated with dignity. By documenting and sharing mothers'

experiences, this study will contribute to community-level advocacy initiatives and facilitate public discussions that promote accountability within the healthcare system.

Beyond local impact, the findings of this research have the potential to contribute meaningfully to broader global discussions on maternal healthcare quality and human rights. As Nigeria continues to face one of the highest maternal mortality rates worldwide, studies stressing respectful care extend beyond service delivery; they address a global concern for women's dignity and autonomy during childbirth. By documenting the experiences of women in Benin City, this study adds to the global evidence base promoted by the World Health Organization's framework for quality maternal and newborn care, which stresses that every woman has the right to dignified, respectful treatment. Awareness from this research can therefore inform global maternal healthcare strategies and comparative studies across Sub-Saharan Africa and other low- and middle-income regions, where similar challenges persist.

In conclusion, this study is highly justifiable as it will generate awareness of the experiences of postnatal women in Benin City. The findings will empower policymakers, healthcare professionals, and the community to address the root causes of RMC violations. Ultimately, this research will contribute to the advancement of maternal healthcare by fostering a culture rooted in respect, dignity, and equality.

1.4 RESEARCH QUESTIONS

This study is guided by the following research questions:

1. What is the level of knowledge and attitude towards respectful maternity care (RMC) among postnatal mothers in Benin City?
2. What are the experiences of mothers regarding respectful or disrespectful maternity care during childbirth in Benin City?
3. What provider-related factors contribute to violations of respectful maternity care in health facilities in Benin City?
4. What facility-level factors are associated with the delivery or denial of respectful maternity care in Benin City?
5. What are the determinants of receiving respectful maternity care among women attending postnatal clinics in Benin City?
6. What institutional policy changes can be recommended to promote respectful maternity care in Benin City?

1.5 AIM AND OBJECTIVES OF THE STUDY

General Objective:

To assess the extent, determinants, and implications of respectful maternity care experiences among mothers attending postnatal mothers in Benin City, Edo State.

Specific Objectives:

1. To assess the knowledge and attitude of RMC among postnatal mothers in Benin City.
2. To assess postnatal mothers experiences of respectful or disrespectful maternity care during childbirth in Benin City.
3. To identify provider and facility-level determinants of RMC violations affecting postnatal mothers in Benin City.
4. To assess the determinants of RMC among postnatal mothers in Benin City.
5. To advocate for institutional policy changes promoting RMC in maternity services for postnatal mothers in Benin City.

CHAPTER TWO

LITERATURE REVIEW

2.1 CONCEPTUAL FRAMEWORK

Respectful Maternity Care (RMC) is a rights-based approach that emphasizes dignity, informed consent, privacy, non-discrimination, and freedom from mistreatment during childbirth. It is rooted in the World Health Organization's framework for quality maternal and new born care, which highlights the need for care that is not only clinically effective but also compassionate and respectful[1]. Based on insights from the literature, this conceptual framework illustrates how the experiences of respectful or disrespectful maternity care among postnatal women are influenced by a combination of individual, provider, and facility-level factors[2,53].

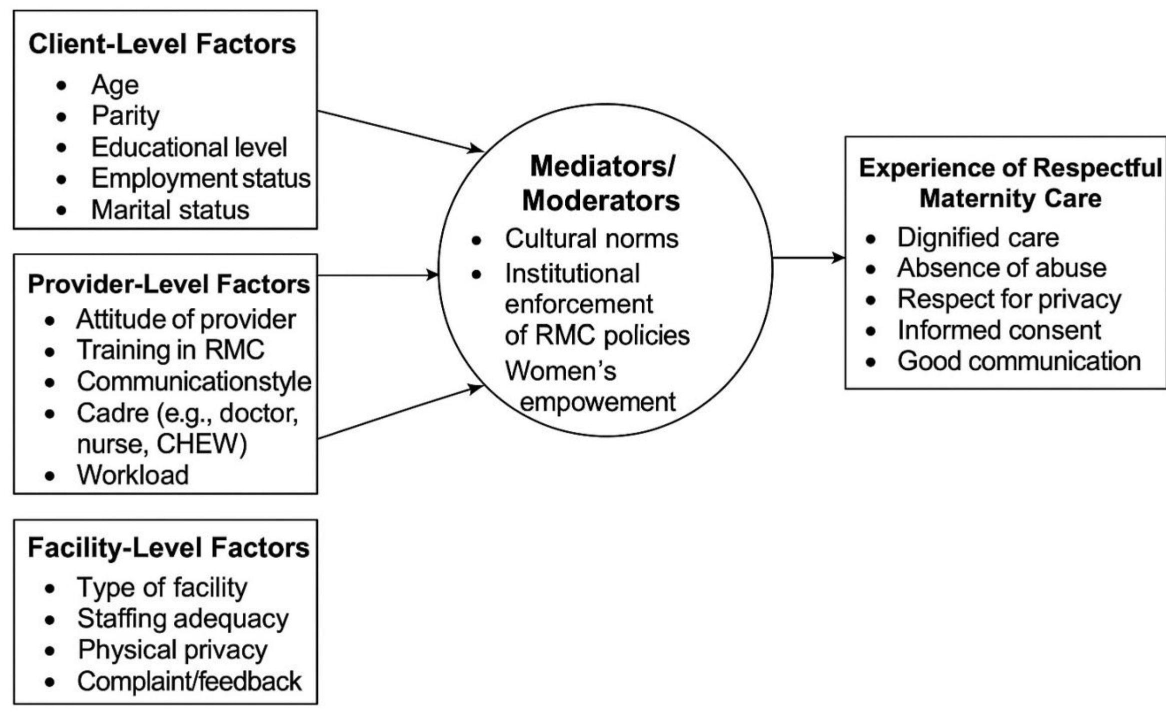

Figure 1: World Health Organization's framework for quality maternal and newborn care[1, 2].

The dependent variable in this model is the experience of respectful maternity care during childbirth, which may be measured by indicators such as dignified care, absence of abuse, respect for privacy,

informed consent, and positive provider–client communication[1,2,59]. This model serves as the foundation for understanding the multiple, interrelated factors that contribute to respectful or disrespectful maternity care. It guides the development of research questions, data collection instruments, and interpretation of results in this study[53].

2.2 ASSESSMENT OF THE KNOWLEDGE AND ATTITUDE OF RMC AMONG POSTNATAL ATTENDEES IN BENIN CITY.

Understanding the knowledge and attitudes of postnatal women toward respectful maternity care (RMC) is essential for designing interventions that promote dignified childbirth experiences. A descriptive cross-sectional study was conducted in 2019 in the United Kingdom, involving 500 postpartum women selected through stratified random sampling. Their findings revealed that women's knowledge of their maternity rights and expectations of respectful care were positively associated with higher satisfaction during childbirth. However, gaps existed in awareness, particularly among first-time mothers, emphasizing the need for targeted education programs during antenatal visits [35].

A community-based survey conducted in 2021 in Zimbabwe examined knowledge and attitudes toward RMC among 450 postnatal women. Using cluster sampling, the study showed that although most women valued respectful treatment, many lacked a clear understanding of what respectful care required. Cultural norms influenced attitudes, with some women accepting disrespectful behaviours as part of childbirth. The study recommended culturally sensitive education to empower women to demand respectful care[36].

A descriptive study carried out in 2024, evaluated respectful maternity care among 310 postpartum women attending selected hospitals in Benin City, Edo State. The study, conducted between January and June 2024, employed a mixed-methods cross-sectional design and used purposive sampling to select participants. Findings revealed that while 65.2% of the respondents rated the

overall respectful maternity care they received as satisfactory, several gaps remained in areas such as informed consent, privacy, and emotional support during labour. The researchers observed that younger women and those with higher levels of education were more likely to report positive experiences. They recommended strengthening healthcare worker training and incorporating respectful maternity care into antenatal and delivery protocols to address these gaps[37]. However, the use of purposive sampling may limit how broadly the findings can be applied.

A descriptive cross-sectional study conducted in 2022 in Ibadan, assessed the knowledge and experience of respectful maternity care among 151 postnatal women using simple random sampling with a structured self-administered questionnaire. They found that 74.2% of respondents reported experiencing respectful care, and 67.5% were highly satisfied with the care received. However, despite their satisfaction, knowledge and experience didn't correlate significantly, suggesting that women's perception of respectful care may not equate to actual awareness. The authors concluded that improving RMC provision is essential to boost facility childbirth uptake, but noted the limitation that the sample was quite small and conducted only in urban public hospitals[38].

A cross-sectional study conducted in 2021 in Enugu assessed the perception of person-centred maternity care (PCMC), which encompasses respectful maternity care principles, among 450 postpartum women. The study took place across five public health facilities using multistage sampling and a structured 22-item questionnaire adapted from the PCMC scale. Participants were recruited within six weeks postpartum. The findings revealed that only 25% of respondents experienced high levels of person-centred care, with low scores reported in areas related to dignity, communication, and autonomy. While most women believed in the importance of respectful treatment, many accepted being denied information or decision-making as normal, suggesting underlying misconceptions. Factors associated with better care perception included tertiary education, earlier antenatal care registration, and facility type[39]. A noted limitation was that the study did not include women who delivered in private or traditional birth settings.

A descriptive cross-sectional design was carried out in 2020, to assess attitudes and experiences of respectful maternity care among 83 postnatal women in two public hospitals in Calabar. Using purposive sampling and an RMC checklist during exit interviews, they found that 69.9% of women reported respectful care, while 30.1% experienced disrespect, such as lack of privacy, denial of information, disrespect for childbirth preferences, verbal abuse, and detention for unpaid bills. Notably, some women considered being scolded or restricted the usual fate of childbirth, pointing to normalized misconceptions[40]. However, the limited sample size and focus on only two facilities may affect the broader applicability of results.

Collectively, these studies show that while attitudes toward respectful maternity care are often positive, knowledge gaps remain a significant barrier to achieving universal respectful care. Addressing these gaps through culturally appropriate education and empowering women during antenatal visits is critical for fostering demand for dignified childbirth experiences.

2.3 ASSESSING POSTNATAL ATTENDEES' EXPERIENCES OF RESPECTFUL OR DISRESPECTFUL MATERNITY CARE DURING CHILDBIRTH IN BENIN CITY.

Mothers' experiences of respectful or disrespectful maternity care (RMC) during childbirth profoundly shape their overall satisfaction and health outcomes. A qualitative meta-synthesis was conducted in 2019, including over 2000 women across various countries such as the United States and Australia. The study revealed that many women experienced both respectful care marked by empathy and support and disrespectful practices, including verbal abuse and neglect. The authors stressed that women's experiences are influenced by provider behaviour, facility environment, and systemic issues like understaffing, highlighting the urgent need for health systems to prioritize respectful treatment during childbirth[2].

A cross-sectional survey was conducted in 2017 in the Tshwane District of South Africa, involving 653 postpartum women who attended midwife obstetric units (MOUs) for routine postnatal visits between three days and six weeks after childbirth. The study aimed to assess mothers' experiences of respectful or disrespectful maternity care during childbirth. Using an anonymous, structured questionnaire that captured elements of communication, clinical care, and interpersonal treatment, the authors found that only 48% of women felt they were treated with "a lot of respect," while about 55% expressed general satisfaction with their childbirth experience. Notably, disrespectful care was more commonly reported among vulnerable groups such as adolescents, women with lower educational levels, non-dominant language speakers, and recent migrants to the district. The authors observed that some women came to accept disrespect and saw it as a normal part of giving birth in public health settings[41]. A key limitation of the study was its reliance on self-reported data, which may have been influenced by recall bias or social desirability bias, especially given the postnatal timing and facility-based setting of the interviews.

A cross-sectional survey was conducted in 2022, Abakaliki, Southeast Nigeria, involving 268 postpartum women at a tertiary hospital to assess experiences of disrespect and abuse during childbirth. The structured interviewer-administered questionnaire revealed that 47.6% of participants experienced at least one type of mistreatment, including facility detention due to unpaid fees (40.2%), physical abuse (34.1%), and non-dignified treatment (37.2%). Other forms included non-consented care (20.1%), abandonment during labour (18.9%), breach of confidentiality (25%), and discrimination (15.2%). Multivariate analysis identified a lack of birth companionship, unbooked pregnancies, and rural residence as significant predictors[42]. A limitation noted was potential social desirability bias in self-reporting and the study's confinement to a single tertiary hospital, which may make it harder to apply the findings to other settings or communities.

A cross-sectional study conducted in 2021, Ebonyi State, Nigeria, investigated the prevalence and forms of disrespect and abuse (D&A) experienced by women during childbirth. The study compared experiences in a public teaching hospital and a private faith-based hospital. A total of 620 women who had delivered within 14 weeks were recruited using systematic random sampling, 310 women from each facility. The study employed interviewer-administered questionnaires based on the Bowser and Hill framework. Findings revealed that 61.6% of respondents from the public facility and 50.3% from the private facility experienced at least one form of disrespect and abuse during childbirth. The most frequently reported types were denial of companionship, non-consented care, and abandonment. The study also showed that women who lived in rural areas were less likely to experience disrespect and abuse. Although the study highlights that disrespect and abuse occurs in both public and private settings, it also confirms that women using public facilities are more vulnerable to disrespectful treatment[43]. A limitation, however, is that it covered only two hospitals, which may not reflect broader trends across the country.

A descriptive cross-sectional study was conducted in 2019 at Murtala Muhammad Specialist Hospital in Kano State, Nigeria, to assess the prevalence, patterns, and determinants of disrespect

and abuse during childbirth. A total of 306 postnatal women (mean age 27.7 ± 6.3 years) were systematically sampled from those attending immunization and postnatal services. Data were collected using a structured, interviewer-administered questionnaire adapted from established disrespect-and-abuse frameworks. The study revealed that 55.9% of women experienced at least one form of disrespect or abuse. The most common forms included abandonment or neglect (84.5%) and non-confidential care (67.9%), with nurses and midwives responsible in 83% of cases. Multivariate analysis showed that formal education, delivering in the facility, and obstetric complications significantly increased the likelihood of mistreatment[44]. The study highlights that disrespect and abuse are prevalent in urban tertiary facilities in Northern Nigeria, though the ability to apply these findings more broadly may be limited by its single-site design and reliance on self-reporting.

A descriptive cross-sectional study carried out in 2023, assessed the prevalence and associated factors of disrespect and abuse during childbirth in a tertiary hospital in Southern Nigeria. The study was carried out at the University of Benin Teaching Hospital (UBTH) located in Benin City, Edo State. It recruited 200 women who presented for their routine six-week postnatal clinic visit. Participants were selected using convenience sampling. Data were collected using structured interviewer-administered questionnaires, which were adapted from the Respectful Maternity Care (RMC) Charter. The findings showed that 36.5% of respondents experienced at least one form of disrespect or abuse during labour and delivery. The most frequently reported forms included verbal abuse (15.5%) and delays in receiving care (untimely care), also reported by 15.5% of the women. Other forms included non-consented care and neglect. The study also identified that most of the mistreatment was performed by nursing staff. The authors concluded that while the overall prevalence of mistreatment was lower than in some other settings, it remains a concern that must be addressed even in tertiary hospitals[45]. A limitation of the study was its use of a single institution and non-probability sampling, which may limit how widely the findings can be applied.

These studies collectively demonstrate that while some women receive respectful maternity care, many still face significant disrespect and abuse during childbirth. Addressing provider attitudes, improving facility conditions, and enforcing respectful care policies are critical steps toward ensuring positive childbirth experiences for all women.

2.4 IDENTIFYING PROVIDER AND FACILITY-LEVEL DETERMINANTS OF RMC VIOLATIONS AFFECTING POSTNATAL ATTENDEES IN BENIN CITY.

Identifying the factors at the provider and facility levels that contribute to violations of respectful maternity care (RMC) is essential for targeted interventions. A cross-sectional study was conducted in 2022 in six public health facilities across Assam, Telangana, and Maharashtra, India, to explore the determinants of disrespect and abuse during childbirth. The study included 401 women, all within two months postpartum, selected through systematic random sampling. Data were collected using a structured, pretested tool informed by the WHO respectful maternity care framework. Findings showed that lower socioeconomic status, food insecurity, and lack of antenatal care at the delivery facility were significantly associated with mistreatment. From a facility perspective, overcrowding, poor infrastructure, shortages of staff, and inadequate privacy were key contributors. At the provider level, fatigue, low motivation, and weak supervision structures emerged as factors that fostered disrespectful care[46]. A limitation of the study was its cross-sectional design, which does not establish causation, though it provides relevant insight into structural contributors to RMC violations.

A qualitative descriptive study carried out in 2021 in two public hospitals in Oromia Region, Ethiopia, explored the provider and facility-level causes of disrespect and abuse during childbirth. A total of 20 maternity care providers, including midwives, nurses, and medical doctors, were selected through purposive sampling and interviewed using semi-structured interview guides. Thematic analysis revealed that providers often engaged in behaviors such as verbal scolding,

neglect, and performing procedures without consent, many of which were normalized under stressful working conditions. Major provider-level determinants included emotional exhaustion, low motivation, inadequate respectful maternity care training, and internalized negative attitudes toward certain patients. At the facility level, contributors included chronic staff shortages, lack of privacy-enhancing infrastructure, inadequate equipment, and absence of effective supervision and feedback systems. Many providers admitted to unintentionally disrespecting patients due to overload and pressure to manage large volumes with minimal support[47]. One limitation noted was the restricted geographic scope, which may not reflect broader variations across other Ethiopian regions or facility types.

A cross-sectional study conducted in 2025, across four public healthcare facilities in Lagos State, assessed the prevalence and determinants of disrespect and abuse during childbirth by interviewing 261 postnatal women within 14 weeks after delivery. A semi-structured questionnaire based on the seven categories of disrespect and abuse by Bowser and Hill was used, and participants were selected through systematic sampling. The study found a high prevalence of disrespect and abuse, with 82% of respondents reporting at least one form of mistreatment. The most commonly reported were non-consented care (86.8%), abandonment and neglect (45.6%), and verbal abuse (35.6%). The findings identified significant provider-level factors such as insufficient training, work overload, and poor attitudes, especially towards women with complications or lower educational backgrounds. At the facility level, staff shortages, ineffective consent procedures, and weak supervision mechanisms were major contributors to the poor quality of maternity care. The study also revealed that women who had vaginal births were more than twice as likely to experience disrespect compared to those who had caesarean deliveries, and those with complicated pregnancies were nearly five times more likely to experience abuse[48]. One limitation of the study was that it only included public facilities, which may make it difficult to extend the findings to the private sector.

A cross-sectional study conducted in 2022 in Abia State, Nigeria, investigated the magnitude and determinants of disrespect and abuse during childbirth among 312 postnatal women attending clinics at Federal Medical Centre Umuahia and Nigerian Christian Hospital Nlagu, representing both urban and rural settings. Women were recruited using systematic sampling and interviewed with a structured questionnaire based on common categories of mistreatment during childbirth. The study found that 54.5% of the respondents had experienced at least one form of disrespect or abuse, with non-confidential care (22.9%) and lack of privacy (18.3%) being the most frequently reported violations. Notably, women who delivered in the rural secondary facility reported higher levels of mistreatment (63.5%) compared to those in the urban tertiary hospital (50%), with the difference being statistically significant ($p = 0.03$). The study identified several provider-level determinants, such as poor communication, failure to obtain consent, and disregard for patients' emotional needs, while facility-level determinants included insufficient staff, overcrowding, and the absence of physical structures ensuring privacy during labour[49]. A limitation of the study was that it only included two facilities, which may not represent the situation across other regions in Nigeria.

A descriptive cross-sectional study conducted in 2022 in Benin City, Edo State, investigated the experiences and predictors of respectful maternity care among 300 postnatal women who delivered in public health facilities within the preceding three months. The study utilized a two-stage sampling technique and administered a 15-item RMC scale covering four domains: communication, dignity, autonomy, and supportive care. Findings revealed that only 38% of respondents reported receiving fully respectful maternity care. Multivariate logistic regression showed that having formal education was associated with lower odds of RMC, while primiparous and multiparous women were less likely to receive full RMC compared to nulliparous women. Importantly, women delivering in public health facilities were significantly more likely to receive respectful care than those in private facilities. The study highlighted key provider- and facility-level determinants, including deficits in effective communication, engagement of women in decision-making, staffing

adequacy, and provider empathy[50]. A limitation noted was reliance on self-reported data, which may be affected by recall bias.

A cross-sectional study carried out in 2019 in Ile-Ife, Southwest Nigeria, assessed the prevalence and institutional factors contributing to disrespect and abuse during childbirth were assessed among 384 postnatal women attending immunization and postnatal clinics within six weeks of delivery. Participants were recruited consecutively from both primary and tertiary health facilities, and data were collected using a structured questionnaire based on the seven domains of mistreatment outlined by Bowser and Hill. The study revealed that although 98.4% of the women believed respectful maternity care to be their right, 19% reported experiencing at least one form of disrespect or abuse during childbirth. The most common forms reported were non-dignified care (12.8%), discrimination (8.1%), and abandonment or detention (6%). Key provider-level determinants included negative staff attitudes, lack of empathy, and poor communication, while facility-level factors involved inadequate supervision, limited accountability structures, and excessive workload on care providers. The study also noted that only a small fraction of the women offered feedback or complaints, which may reflect how mistreatment has been normalized or a fear of possible retaliation[51]. A limitation was the potential underreporting of abuse due to social desirability bias or internalized expectations of mistreatment.

These studies collectively show that both provider-related factors, such as burnout, training gaps, and motivation, and facility-related challenges like overcrowding, poor infrastructure, and weak supervision contribute to violations of respectful maternity care. Addressing these determinants requires comprehensive interventions targeting both human resources and health system strengthening.

2.5 ASSESS THE DETERMINANTS OF RMC AMONG POSTNATAL ATTENDEES IN BENIN CITY

Determining what influences respectful maternity care is vital for designing effective interventions that improve maternal experiences during childbirth. A cross-sectional study conducted in 2023 in Saudi Arabia, assessed determinants of respectful maternity care among 586 postnatal women who had delivered within the past five years. The study used an adapted version of the validated Mother on Respect Index (MORi), administered via an online survey across public and private hospitals in different regions of the country. The findings revealed inconsistencies in respectful maternity care based on the type of health facility. Women who gave birth in public hospitals reported lower levels of respectful care compared to those who delivered in private hospitals. Among all participants, 21.8% reported experiencing at least one form of physical mistreatment during childbirth, and many highlighted a lack of informed consent and emotional support. The study identified both provider-level and facility-level determinants. On the provider side, negative staff attitudes, poor communication, and lack of empathy were frequently cited, particularly in the public sector. Facility-related factors included overcrowding, limited accountability systems, and fewer privacy safeguards in government hospitals[52]. A key limitation was the retrospective design, relying on self-reported experiences up to five years after delivery, which may have introduced recall bias.

A cross-sectional study conducted in 2018, across 61 health facilities in Kigoma Region, Tanzania, linked data from 935 post-delivery clients and 249 providers using multilevel surveys. The study assessed three dimensions of respectful maternity care: Friendliness/Comfort/Attention, Information and Consent, and Non-abuse/Kindness, through both client interviews and facility observations. Multilevel regression analysis revealed key provider-level determinants: providers' perception of fair pay, their age, and the number of deliveries attended significantly influenced women's experiences in the first domain. Use of birth companions and provider electronic mentoring were strong predictors of better outcomes in Information/Consent and Non-abuse/Kindness, while

facility-level determinants (such as staff management systems and mentorship support) also played a role. Clients with delivery complications, younger women, and those with higher education levels reported differential experiences across these RMC dimensions. The authors recommended institutional changes such as fair compensation, structured mentoring, birth companionship policies, and provisions for short-term staff respite to enhance respectful care and boost facility delivery uptake[53].

A cross-sectional study conducted in 2021, across two districts in Enugu State, Nigeria, assessed the determinants of respectful maternity care among 450 postnatal women within nine weeks of delivery. The researchers used a culturally adapted 30-item Person-Centred Maternity Care (PCMC) scale to assess women's experiences of maternity care and applied generalized linear modelling to explore influencing factors. The findings revealed that only 25% of respondents received high levels of respectful care. Significant determinants at the individual level included age at marriage, employment status, and timing of antenatal care, experience of pregnancy complications, involvement in decision-making, and the presence of domestic violence. Facility-level differences were also prominent: women who delivered at health centres scored 18.10 points higher on the PCMC scale compared to those at tertiary hospitals, and those who used private or mission hospitals scored 4.01 points higher. On the other hand, the use of unskilled attendants and late ANC initiation were associated with lower scores. The authors concluded that respectful maternity care is influenced by both provider interactions and institutional characteristics, and they recommended targeted staff training, improved facility environments, and empowerment strategies for women[54]. A limitation of the study was its focus on only two districts in one state, which may make it more difficult to apply these findings to other regions in Nigeria.

A cross-sectional study conducted in 2019, at one primary and one tertiary facility in Ile-Ife, Southwest Nigeria, assessed the prevalence and facility-related determinants of disrespect and abuse during childbirth among 384 postnatal women attending immunization and postnatal clinics within

six weeks post-delivery. Using a validated 30-item questionnaire based on Bowser–Hill's categories of mistreatment, women were interviewed consecutively. While nearly all participants (98.4%) acknowledged respectful care as their right, 19% reported experiencing disrespect during their last delivery. Most frequently cited were non-dignified care (12.8%), discrimination (8.1%), and abandonment or detention (6.0%). The study found that facility-level factors, including inadequate supervision, low provider accountability, and insufficient privacy, were key factors contributing to mistreatment. While explicit provider-level determinants were not statistically modelled, qualitative responses emphasized provider attitudes, lack of empathy, and communication failures as core issues affecting women's experiences[55]. Limitations included the potential for under-reporting due to women normalizing mistreatment or fearing reprisal, and the limited geographic scope of two facilities in one town.

A cross-sectional study conducted in 2018, across multiple maternity facilities in Benue State, Nigeria, surveyed 610 postnatal women using exit interviews shortly after delivery to explore disrespect and abuse during childbirth. The study applied a structured questionnaire adapted from Bowser & Hill's seven domains of disrespect and abuse. Overall, 35% of women reported experiencing at least one mistreatment, including non-consented care (21%), non-confidential care (15%), physical abuse (8%), and detainment for inability to pay (5%). Regression analysis identified key provider-level determinants: provider disrespect was significantly higher in situations involving emotional stress and high patient volumes. Facility-level determinants included lack of privacy, weak accountability systems, and inadequate staffing protocols, particularly during busy shifts[56]. Limitations include potential underreporting due to the study's self-report design and the possibility of social desirability bias.

A cross-sectional discrete choice experiment was conducted in 2020, in Gombe State, Northeast Nigeria, with 425 postnatal women who had recently delivered in primary and secondary health facilities. The study aimed to determine how specific features of facility-based childbirth care, such

as the absence of sexual, physical, or verbal abuse, privacy during labour, facility cleanliness, and transparent fee structures, shaped women's stated preferences for future delivery sites. Participants were presented with hypothetical comparisons between two facility scenarios or home birth, and their choices were analysed using multinomial and mixed logit models. The findings showed that women placed the highest importance on the absence of sexual abuse and non-coercive care, while unclean environments and lack of privacy were strong discouraging factors. These points on the importance of postnatal women's perceptions of respectful care, including their awareness of unacceptable behaviours, are essential motivators for facility childbirth uptake. The authors suggested strengthening health system conditions, ensuring privacy, and enforcing zero-tolerance policies against mistreatment[57]. A noted limitation was that the study assessed stated preferences rather than actual lived experiences.

Together, these studies emphasize that respectful maternity care is influenced by a complex interplay of provider knowledge and attitudes, workload, training, facility resources, and organizational support. Addressing these determinants at multiple levels is crucial for improving respectful care and maternal satisfaction during childbirth.

2.6 ADVOCACY FOR INSTITUTIONAL POLICY CHANGES PROMOTING RMC IN MATERNITY SERVICES FOR POSTNATAL ATTENDEES IN BENIN CITY.

Advocacy for institutional policy changes is critical in ensuring respectful maternity care is not only encouraged but systematically integrated into maternity services. An explanatory sequential mixed-methods study was conducted in 2022, in Addis Ababa, Ethiopia, across 50 health centres, involving 500 postpartum women interviewed using structured questionnaires, followed by in-depth interviews with 20 midwives and 13 health centre managers. The study assessed the quality of respectful maternity care practices and institutional readiness for change. Results showed only 24.6% of women reported receiving fully respectful care. Key gaps included poor communication

(46%), lack of emotional support (9.6%), and low use of birth companions (22.4%). The researchers concluded that without strong policy directives, training programs for caregivers, public education on maternal rights, and regular monitoring, respectful maternity care cannot be sustained[58]. A limitation noted was that the gestational context was limited to immediate postpartum recall.

In a systematic review carried out in 2018, the effectiveness of introducing respectful maternity care (RMC) policies into routine intrapartum services was assessed across five African countries: Kenya, Tanzania, South Africa, Sudan, and Ethiopia. The review included five intervention studies, two cluster-randomized trials, and three before-and-after designs, involving more than 8,000 women at baseline and 7,500 women at follow-up. The analysis revealed that RMC-focused institutional policy interventions significantly improved women's reported experiences of respectful care. These policies also contributed to a decrease in physical abuse and overall mistreatment. However, evidence was weaker for reductions in verbal abuse, neglect, and privacy violations. The authors emphasized that multi-component institutional changes, including policy reform, provider training, and systemic monitoring, are essential for sustaining respectful care[59]. A limitation noted was the diversity of interventions and uncertainty about long-term sustainability.

A large-scale facility-based study conducted in 2021, in Gombe, involved 700 postnatal women across ten high-volume primary health centres. Using structured clinical observations in conjunction with exit interviews, the researchers assessed the prevalence of respectful maternity care and the validity of patient-reported experiences as monitoring tools. They found that 32% of women experienced verbal abuse, 28% reported a lack of privacy, and 22% underwent non-consented procedures. Only 41% felt their rights were fully respected. Based on these findings, the study strongly advocated for institutional reforms, recommending the integration of exit interviews as routine monitoring tools, alongside policy-backed provider training, patient rights education, and facility-level complaint systems to enhance accountability and respectful care. While it did not test a specific policy intervention, the study's conclusions offered a clear evidence-based push for

policy development and institutional change to uphold respectful maternity care[60]. A limitation was that the study focused only on government PHCs and did not include private health facilities.

A qualitative study conducted in 2023 in Jos, Plateau State, Nigeria, explored the experiences of respectful and disrespectful maternity care among women who had recently delivered in two secondary-level public hospitals. The aim was to document women's voices and identify elements that influenced their perceptions of care. Using a lived-experience-based approach, the researchers conducted in-depth interviews with 13 postnatal women, selected through purposive sampling to ensure diverse experiences. The findings revealed that respectful care was closely linked to being treated with dignity, adequate pain management, clear communication, and emotional support. However, several women reported negative experiences, including verbal abuse, lack of privacy, neglect, and being shouted at during labour. The study emphasized that these experiences are not only upsetting but also wear away trust in the health system. In response, the authors advocated for facility-level policy reforms, including the reorganisation of labour wards to enhance privacy, integration of birth companionship policies, and mandatory compassion-focused training for maternity care providers. These recommendations directly support institutional policy change aimed at embedding respectful maternity care in routine practice[61]. A key limitation of the study was its small sample size, which may limit the application of these findings in a broader setting; however, the rich qualitative data offers valuable awareness for policy reform and service improvement.

A mixed-methods facility-based evaluation was conducted in 2022, in Ibadan, Southwest Nigeria, to assess observed versus self-reported experiences of respectful maternity care among 269 postnatal women in nine public health facilities. Using a 29-item observational checklist during labour and a 15-item exit interview scale, the study found that no woman received 100% of respectful care. Observed deficiencies were notable in information sharing and consent (14%), privacy (28%), and pain management, while 28% of women were observed being hit, and only 8.2% received pain relief. Inconsistencies between observed and reported care emphasized

underreporting of mistreatment. Multivariate analysis identified employment and higher education as predictors of better care. The authors concluded that relying solely on exit interviews risks overlooking actual abuses and recommended institutional policy reforms such as routine clinical observation audits, provider accountability, and standardized pain management and consent protocols. This study provided practical, policy-oriented guidance for publicly accountable, respectful maternity care programs[62]. A limitation was geographic confinement to Ibadan's public facilities.

A mixed-method study was conducted in 2020, in Ebonyi State, Southeast Nigeria, across two urban cities to explore multi-stakeholder perspectives, including postpartum women, providers, facility managers, policymakers, and community leaders, on the drivers and solutions for disrespectful maternity care. Data were collected using semi-structured questionnaires with 200 participants, six focus group discussions, and key informant interviews framed around a Context Mechanism Outcome evaluation model. The study identified key institutional barriers to respectful care: poorly designed wards lacking privacy, absence of formal accountability systems, inadequate provider training, and normalization of mistreatment. Importantly, participants emphasized the need for policy-level changes, such as integration of RMC standards into facility SOPs, implementation of routine community feedback mechanisms, and periodic in-service compassionate care training. The authors concluded that establishing respectful maternity care through governance frameworks, stakeholder collaboration, and supportive infrastructure is essential for sustained improvement[63]. Limitation included its focus on public tertiary hospitals only, which may limit broader applicability.

These studies collectively show that advocacy for institutional policy changes requires sustained, multi-level efforts involving healthcare providers, administrators, policymakers, and communities. Effective policy implementation can institutionalize respectful maternity care and improve maternal health outcomes significantly.

CHAPTER THREE

METHODOLOGY

3.1 STUDY AREA

The study was carried out in Benin City, Edo state Nigeria. Edo state is one of the 36 States in Nigeria. Edo state covers about 17,802 square miles. It is in the South-South geopolitical zone of Nigeria and the country's central gateway to the North, East and Western regions, it came to existence in 1991 from the old Bendel state with Benin City as the state capital town. Its geographic region include Latitude 5° 44' to 07 34' N and longitude 5° 4' and 06 45'E, with 19,794km square as land mass. The state is bounded by Delta State to the Southeast and South, Kogi State to the North-east and East, Ondo State to the West and Northwest, Anambra to the East and the River Niger flows along the Eastern border. Edo state lies at elevations between 500 feet (150metres) in the south and 1800 feet (550metres) in the North. Tropical rain forest covers most of the area.[(64,65)]

The state is inhabited largely by the Edo people who are linked to the historic Benin kingdom. Major tribes in the state are Benin, Afemais, Edos, Owan, Akoko Edo, Esan, Etsako and Auchi. Agriculture is the mainstay of the economy; Yams, cassava, oil palm produce, rice and corn are the major food crops while rubber, timber, palm oil and kernel are the cash crops. Mineral resources include limestone and lignite. Industries produce pharmaceuticals, rubber, plywood, beer, sawn wood and furniture.[66,]

Benin City comprises three Local Government Areas (LGAs) namely, Egor, Oredo and Ikpoba-Okha. The projected population of Benin City for 2019 at a growth rate of 3.99% per annum was 1,495,800,21 with a male/female ratio of nearly 1:1, Egor LGA is divided into several political wards such as Ugbowo, Uselu, Ogida, Evbareke and Okhoro.[50] The population of Egor LGA is projected to be over 500,000 in recent years, Estimated Women (49.5%) putting the estimated number of women in Egor LGA as approximately 272,654

Ugbowo is a prominent urban community located within Benin City, under Egor Local Government Area (LGA) of Edo State, Nigeria. It is situated along the Ugbowo Lagos Road axis and is recognized as one of the most densely populated and socioeconomically active parts of the city, the community accommodates a mixed population of traders, students, civil servants, artisans, and professionals, reflecting the broader demographic profile of Benin City.[67] A key distinguishing feature of Ugbowo is the presence of the University of Benin Teaching Hospital (UBTH**)**, one of Nigeria's major tertiary healthcare institutions. UBTH attracts patients from within Edo State and from neighbouring states, significantly influencing healthcare-seeking behaviour within the community. The area also hosts numerous private clinics, maternity homes, pharmacies, and traditional birth attendants, making it a strategic location for maternal and child health research, including studies on Respectful Maternity Care (RMC)**.**[67]

The settlement pattern in Ugbowo is predominantly urban, comprising family residences, student hostels, rental apartments, and informal settlements. The area is well-connected through public transport routes and has access to essential facilities such as markets, schools, and worship centres, which support daily socioeconomic activities.[64,68] The demographic structure of Ugbowo is dominated by young adults between the ages of 18 and 35, primarily students and young workers. The communal environment is highly diverse, drawing individuals from all parts of Nigeria, which contributes to a vibrant social culture. While the indigenous Edo people remain the primary landowners, the influx of non-indigenes has created a lively cultural mix with various languages and lifestyles coexisting and population estimates for Ugbowo range from 30,000 to 50,000, with seasonal increases due to the academic calendar of the University of Benin[50,69,70)]

Women of reproductive age account for a substantial proportion of the population in this area is consistent with national demographic trends where females constitute nearly half of the population ,given its urban structure, proximity to UBTH, and mix of healthcare providers, Ugbowo provides a suitable setting for assessing Respectful Maternal Care (RMC) experiences among

postpartum women. The wide range of educational levels and socioeconomic statuses among the residents makes it possible to obtain different views on the maternity care experienced during pregnancy, labour, and childbirth[50]

3.2 STUDY DESIGN

A descriptive cross-sectional study design was be used for this study.

3.3 STUDY DURATION

The study was conducted between April 2025 and April 2026.

3.4 STUDY POPULATION

The study was carried out among postnatal women in Ugbowo community, Benin City, Edo State.

3.5 SELECTION CRITERIA

3.5.1 Inclusion Criteria

The selection criteria include:

- Women aged ≥ 18 years (or emancipated minors) who delivered a live birth within 1 year prior to the survey.

3.5.2 Exclusion Criteria

- Women who are critically ill or in obvious distress at the time of recruitment.
- Women with cognitive impairment that precludes reliable consent/ response.
- Non-residents who received maternity care outside Edo State and cannot reliably report on their childbirth experience.

3.6 SAMPLE SIZE DETERMINATION

Sample size was calculated using the Cochran's formula for a descriptive study[71].

$$n = \frac{Z^2pq}{d^2}$$

Where;

n = minimum sample size

Z = standard normal deviate = 1.96 at 95% confidence interval

p = prevalence of the characteristic of interest

q = 1-p

d = degree of precision desired set at 0.05

The p-value was set at 57% based on a descriptive cross-sectional study conducted in several public health institutions of South Gondar Zone, Northern Ethiopia[72].

q = 1 – p

= 1- 0.57

= 0.43

$$n = \frac{1.96^2 \; x \, 0.57 \; x \, 0.43}{0.05^2}$$

n = 376.6

Non-Response rate: A 10% non-response rate was added to the sample size, utilizing the formula of the non-response rate

$$nf = \frac{n}{1 - nr}$$

Where;

n_f = Final Minimum Sample Size

n = Minimum Sample Size

nr = non-response rate at 10% = 0.1

Thus;

$$nf = \frac{376.6}{1 - 0.1}$$

= 418.44 ~ 418

3.7. SAMPLING TECHNIQUE

A multistage sampling technique comprising of three stages was employed to recruit respondents from the selected community. The selection process was conducted as follows:

Stage 1: Selection of Local Government Area

Benin City comprises three Local Government Areas: Oredo, Ikpoba-Okha and Egor.

At this stage, Egor LGA was selected using simple random sampling by balloting. The selected LGA formed the sampling frame for the next stage.

Stage 2: Selection of Ward

Egor LGA is divided into 10 wards, which include Otubu, Oliha, Ogida/Use, Egor, Uwelu, Evbakere, Uselu I, Uselu II, Okhoro, and Ugbowo. A complete list of wards within the selected LGA was obtained from the Local Government Authority. From this list, Ugbowo ward was selected using simple random sampling (balloting without replacement).

Stage 3: Selection of Communities (Clusters)

Ugbowo ward comprises 9 communities which include Ugbowo I, Ugbowo II, BDPA estate, Adolor, UBTH/UNIBEN environs, Osasogie, Uwasota, which served as clusters. A complete list of

all communities within the selected ward was obtained with the assistance of community leaders. Using simple random sampling (balloting), 5 communities was selected from the list.

Five (5) communities served as the clusters for the study. Within these selected communities, all eligible postnatal women who met the inclusion criteria (within one year postpartum) was recruited into the study. This recruitment process continued across the selected communities until the required sample size of 418 respondents was attained.

3.8. DATA MANAGEMENT

3.8.1 Tools for Data Collection

A structured interviewer-administered questionnaire with closed-ended and open-ended questions was the tool used for data collection. The questionnaire was standardized based on the research objectives. The questionnaire was adapted from WHO Standards for Quality of Maternal and Newborn Care, previous studies on patients' knowledge and experiences of respectful maternity care and patient centred maternal care scale[28,50,73-76]. Each questionnaire contains six sections.

SECTION A: contains questions that aimed to obtain the socio-demographic data of the respondents. It included the respondents' age, religion, occupation, place of residence, marital status, level of education, parity, antenatal care attendance, mode of delivery, time of delivery, and planned pregnancy. This section had a total of 16 questions.

SECTION B: contains questions that aimed to assess the knowledge towards respectful maternity. It included the respondents' awareness of rights, consent, dignity, and autonomy. This section had 15 questions.

SECTION C: contains questions adapted from the Person Centred Maternity Care Scale (PCMC)[77] that aimed to assess the attitude towards respectful maternity. It explored their beliefs and value orientation regarding the treatment of women during labour and childbirth. The items reflected

domains such as dignity, privacy, informed consent, empathy, communication, and non-discrimination. This section had 12 questions.

SECTION D: contains questions that aimed to assess experiences of respectful maternity care during childbirth. It included respondents' dignity, privacy, verbal/physical abuse, and emotional support. This section contained 15 questions.

SECTION E: contains questions that aimed to assess the facility and provider-level factors influencing respectful care. It included knowledge on staffing, environment, communication, and confidence. This section had 5 questions.

SECTION F: contains questions that aimed to assess the overall satisfaction of respondents and suggestions for improvement. It included the satisfaction rating and facility recommendations. This section had 3 questions.

3.8.2 Methods of Data Collection

Data was collected using pretested semi-structured questionnaires. The questionnaire was modified by the authors using information from literature reviews and previous studies on patients' knowledge and satisfaction with respectful maternity care practices and experiences.

3.8.3 Research Assistant

Prior to data collection, five 500-level medical students were recruited and trained over a three-day period. The training covered the study objectives, ethical principles governing human research, and standardized procedures for questionnaire administration. Emphasis was placed on maintaining confidentiality, managing sensitive topics appropriately, and establishing rapport with participants to ensure accurate and respectful data collection.

3.8.4. Pretesting

The questionnaire was pre-tested in Uselu community. Ten percent of our sample size (42) will be used for pretesting.

3.9 DATA ANALYSIS

SCORING

Socio-demographic characteristics

Univariate analysis was carried out on socio-demographic data of the respondents. Categorical variables such as age group, marital status, education level, occupation, parity, and mode of delivery was summarized using frequencies and percentages[82].

Occupation:

The occupation of respondents were grouped using the modified ILO classification into skill levels 0-4[78];

Skill level 0: includes retirees, housewives, the unemployed and students

Skill level 1: includes labourers, cleaners

Skill level 2: includes traders, police officers, electricians, mechanic civil servants, bus drivers, farmers, tailors

Skill level 3: includes technicians, other health workers

Skill level 4: includes doctors, lawyers, engineers, teachers, nurses, accountants, managers

Knowledge of Respectful Maternity Care

The knowledge of was assessed using 13 questions, using various domain such as informed consent, dignity and respect, privacy and confidentiality, discrimination and equity, quality care, support and companionship Each correct response was scored one and incorrect response was scored 0. The scores were summed up and converted to percentages. Respondents who score 70%

or higher were categorised as having good knowledge, while those scoring below 70% were categorised as having poor knowledge. Knowledge of RMC was analysed as a categorical variable.[79]

Attitude towards Respectful Maternity Care

This section assessed respondents' attitudes towards RMC using 13 questions on a 5-point Likert scale: Strongly agree = 5, Agree = 4, Neutral = 3, Disagree = 2, Strongly disagree = 1. Negative questions was coded reversely. Data was recorded into correct and incorrect responses. Each correct response was scored one and incorrect response was scored 0. The total score was summed and converted into a percentage of the maximum score.[80] The score interpretation was as follows:

0%–69.9%: Negative attitude.

70%–100%: Positive attitude.

Experience during Childbirth

The section was assessed using 14 binary items on respectful maternity care. Positive responses were scored as 1 and negative responses as 0, with reverse coding applied to negatively worded items. A composite score was generated and categorized into good and poor experience based on a 70% cutoff.[50]

Provider and Facility Factors

This section was assessed using 5 questions to determine provider and facility factors affecting RMC. Provider- and facility-level factors affecting respectful maternity care was assessed using structured questions. Positive responses were scored as 1 and negative responses as 0, with reverse coding applied to negatively worded items. A composite score was generated and categorized into ready and not ready based on a 60% cutoff. These variables were treated as categorical variables

and summarized using frequencies and percentages. Associations between provider/facility factors and respectful maternity care were assessed using the Chi-square test.

Overall Satisfaction on Respectful Maternity Care

Respondents' overall satisfaction and willingness to recommend the health facility was analysed descriptively using frequencies and percentages. Associations between overall satisfaction and knowledge, attitude, and experience of respectful maternity care was assessed using the Chi-square test.

The filled questionnaires was thoroughly checked for any inconsistencies. Data coding, entry and cleaning was done. Data was analysed using the IBM SPSS (Statistical Package for Social Sciences) version 27.0 software to determine the frequency, percentage, and mean of the parameters. Categorical data was presented as frequencies and proportions. Continuous data was presented as means and standard deviations if normally distributed and as medians and modes if skewed. Univariate analysis was done to assess the distribution of the variables. Bivariate analysis was done to determine the association between clients' socio-demographic characteristics and their level of satisfaction. Multivariate analysis was done to identify the determinants of satisfaction using binary logistic regression. Results of data analysis was presented using tables, charts, and graphs. A p value of < 0.05 was considered statistically significant.

3.10. ETHICAL CONSIDERATION

Ethical approval for this study was sought and obtained from the Health Research Ethics Committee of the University of Benin Teaching Hospital before the commencement of data collection. Ethical approval protocol number: ADM/E 22/A/VOL. VII/1486549127281. All participants were informed about the purpose, procedures, and potential risks and benefits of the study. Participation was entirely voluntary, and participants were assured of their right to withdraw from the study at

any point without penalty. Written informed consent was obtained from each participant. To ensure confidentiality, all collected data was anonymised, and personal identifiers was not be recorded. The results of the study were presented in a way that protects the privacy of all participants.

3.11. LIMITATIONS OF STUDY

Data to be collected from the respondents may be subject to recall bias; however, this was avoided using timelines to aid recall. Enrolees may also be reluctant to report bad experiences from fear that it might cause them to be denied services. This was overcome by assuring the respondents of the confidentiality of the study.

CHAPTER FOUR

RESULTS

Four hundred and thirty (430) questionnaires were distributed, out of which four hundred and eighteen (418) were retrieved, giving a response rate of 97.2%.

The result was represented in the following sections:

Section A: Sociodemographic characteristics of postnatal mothers.

Section B: Knowledge of respectful maternity care among postnatal mothers

Section C: Attitude towards respectful maternity care among postnatal mothers

Section D: Experience during childbirth among postnatal mothers

Section E: Provider and facility-level factors influencing respectful maternity care

Section F: Overall satisfaction and policy suggestion towards respectful maternity care

SECTION A: SOCIODEMOGRAPHIC CHARACTERISTICS

Table 1A: Sociodemographic characteristics of respondents

Variables	Frequency (n = 418)	Percent
Age (years)		
18-25	65	15.6
26-35	236	56.5
36-45	103	24.6
>45	14	3.3
Mean ± SD	**32.42± 6.47**	
Ethnicity		
Benin	181	43.3
Igbo	77	18.4
Esan	46	11.0
Urhobo	27	6.5
Yoruba	26	6.2
Etsako	17	4.1
Ibibio	12	2.9
Owan	7	1.7
Hausa	5	1.2
Ijaw	5	1.2
Efik	4	1.0
Isoko	4	1.0
Tiv	2	0.5
Itsekiri	2	0.5
Idoma	2	0.5
Grebo	1	0.2
Marital status		
Married	328	78.5
Single	44	10.5
Divorced	35	8.4
Separated	5	1.2
Cohabiting	5	1.2
Widowed	1	0.2

A total of 418 respondents participated in the study, with a mean age of 32.42 ± 6.47 years. The majority were aged 26–35 years, 236 (56.5%), followed by 36–45 years, 103 (24.6%), while 65 (15.6%) were aged 18–25 years and 14 (3.3%) were older than 45 years.

The predominant ethnic group was Benin, 181 (43.3%), followed by Igbo, 77 (18.4%), and Esan, 46 (11.0%), while smaller proportions belonged to other ethnic groups. Most respondents were married, 328 (78.5%), while 44 (10.5%) were single and 35 (8.4%) were divorced. Only a few were separated, 5 (1.2%), cohabiting, 5 (1.2%), or widowed, 1 (0.2%).

Table 1B: Sociodemographic characteristics of respondents

Variables	Frequency (n = 418)	Percent
Level of education		
No formal education	11	2.6
Primary	10	2.4
Secondary	118	28.2
Tertiary	279	66.7
Occupation		
Skill level 0	21	5.0
Skill level 1	6	1.4
Skill level 2	282	67.5
Skill level 3	7	1.7
Skill level 4	102	24.4
Monthly income		
<70,000	111	26.6
≥70,000	307	73.4
Mean ± SD	**140,655.50± 142699.36**	
Religion		
Christianity	388	92.8
Islam	26	6.2
African Traditional Religion	4	1.0
Number of children		
1	132	31.6
2	134	32.1
3	99	23.7
4	38	9.1
>4	15	3.6
Mean ± SD	**2.22± 1.14**	

Two hundred and seventy-nine (279) (66.7%) respondents had tertiary education, followed by secondary education, 118 (28.2%), while only a few had no formal education, 11 (2.6%), or primary education, 10 (2.4%). In terms of occupation, the majority belonged to skill level 2, with 282 (67.5%), followed by skill level 4, 102 (24.4%), while smaller proportions were in skill levels 0, 21 (5.0%), 3, 7 (1.7%), and 1, 6 (1.4%).

Three hundred and seven (307) (73.4%) respondents earned ≥₦70,000 monthly, while 111 (26.6%) earned less than ₦70,000, with a mean monthly income of ₦140,655.50 ± ₦142,699.36. Most respondents were Christians, 388 (92.8%), followed by Muslims, 26 (6.2%), and African Traditional Religion worshippers, 4 (1.0%). Regarding family size, 132 (31.6%) of the respondents had one child, while 134 (32.1%) had two children, 99 (23.7%) had three children, 38 (9.1%) had four children, and 15 (3.6%) had more than four children. The mean number of children was 2.22 ± 1.14.

Table 1C: Obstetric-related characteristics of postnatal mothers

Variables	Frequency (n = 418)	Percent
Attendance of Antenatal Care for your last pregnancy		
Yes	393	94.0
No	25	6.0
If yes, number of visits (n = 393)		
Four or more	336	85.5
Three	40	10.2
Two	16	4.1
One	1	0.3
Place of antenatal care attendance (n = 393)		
Public facility	229	58.3
Private facility	159	40.5
Maternity home	11	2.8
Traditional birth attendant	7	1.8
Place of delivery		
Public facility	234	56.0
Private facility	164	39.2
Home	12	2.9
Traditional birth attendant	8	1.9
Length of stay in facility (days)		
≥3	213	51.0
<3	205	49.0
Mode of Delivery		
Vaginal	290	69.4
Caesarean section	128	30.6
Place of delivery of previous child (n = 286)		
Health facility	266	93.0
Traditional birth attendant	10	3.5
Home	9	3.1
Church	1	0.3
Mode of Payment		
Out of pocket	351	84.0
Insurance	67	16.0

Three hundred and ninety-three (393) (94.0%), attended antenatal care during their last pregnancy, while 25 (6.0%) did not. Among those who attended, most had four or more visits, 336 (85.5%), followed by three visits, 40 (10.2%), and two visits, 16 (4.1%). Antenatal care was mainly received at public facilities, 229 (58.3%), followed by private facilities, 159 (40.5%), while few attended maternity homes, 11 (2.8%), or traditional birth attendants, 7 (1.8%).

Most respondents delivered in public facilities, 234 (56.0%), followed by private facilities, 164 (39.2%), while smaller proportions delivered at home, 12 (2.9%), or with traditional birth attendants, 8 (1.9%). Slightly more than half stayed in the facility for three days or more, 213 (51.0%), while 205 (49.0%) stayed for less than three days. The majority had vaginal delivery, 290 (69.4%), while 128 (30.6%) had caesarean section. Among respondents with previous childbirth experience (n = 286), most had delivered their previous child in a health facility, 266 (93.0%), while few delivered with traditional birth attendants, 10 (3.5%), at home, 9 (3.1%), or in church, 1 (0.3%). Most respondents paid out of pocket, 351 (84.0%), while 67 (16.0%) used insurance.

SECTION B: KNOWLEDGE OF RESPECTFUL MATERNITY CARE AMONG POSTNATAL MOTHERS

Table 2: Awareness and source of information about respectful maternity care

Variables	Frequency (n = 418)	Percent
Awareness of Respectful Maternity Care		
Yes	82	19.6
No	336	80.4
Source of information on Respectful Maternity Care (n= 82)*		
Hospital	57	69.5
Internet	14	17.1
Social media	13	15.9
Television	1	1.2
School	1	1.2

*** = Multiple response question**

Only 82 (19.6%) respondents had heard of respectful maternity care, while the majority, 336 (80.4%), had not. Among those who were aware (n = 82), the most common source of information was the hospital, 57 (69.5%), followed by the internet, 14 (17.1%), and social media, 13 (15.9%), while very few reported television, 1 (1.2%), or school, 1 (1.2%) as sources.

Table 3A: Knowledge of Respectful maternity care among postnatal mothers

Variables	Frequency (n = 82)	Percent
Definition of Respectful Maternal Care*		
Care that uphold dignity, privacy, consent and autonomy	38	46.3
Care that ensures women are free from abuse, discrimination, and neglect during childbirth	56	68.3
Component of respectful maternal care*		
Verbal curses during pain	64	78.0
Performing procedures without explanation	33	40.2
Supportive care involves*		
Emotional reassurance during labour	61	74.4
Providing pain relief options when available	36	43.9
Allowing a chosen birth companion for support during labour	33	40.2
Non-discriminatory care means*		
Equal treatment regardless of age or ethnicity	67	81.7
Providing care regardless of HIV status	26	31.7
Fair treatment regardless of religion or educational level	36	43.9
Dignified care includes*		
Calling women by their names	23	28.0
Showing empathy during labour	41	50.0
Protecting privacy during care	55	67.1
Effective communication in RMC includes*		
Explaining procedures clearly	71	86.6
Obtaining consent before interventions	37	45.1
Listening to the woman’s concerns	38	46.3

*** = Multiple response question**

Among respondents aware of respectful maternity care (n = 82), 56 (68.3%) identified it as care that ensures women are free from abuse, discrimination, and neglect during childbirth, while 38 (46.3%) identified care that upholds dignity, privacy, consent, and autonomy. Most respondents identified verbal curses during pain, 64 (78.0%), as not being a component of respectful maternity care, while fewer selected performing procedures without explanation, 33 (40.2%).

Supportive care was identified as emotional reassurance during labour by 61 (74.4%) respondents, provision of pain relief options by 36 (43.9%), and allowing a chosen birth companion by 33 (40.2%). Non-discriminatory care was identified as equal treatment regardless of age or ethnicity by 67 (81.7%), fair treatment regardless of religion or educational level by 36 (43.9%), and providing care regardless of HIV status by 26 (31.7%). Dignified care included protecting privacy during care, 55 (67.1%), showing empathy during labour, 41 (50.0%), and calling women by their names, 23 (28.0%). Effective communication was identified as explaining procedures clearly, 71 (86.6%), listening to women's concerns, 38 (46.3%), and obtaining consent before interventions, 37 (45.1%).

Table 3B: Knowledge of Respectful maternity care among postnatal mothers

Variables	Frequency (n = 82)	Percent
Risk factors for disrespectful care include*		
Health worker burnout and stress	46	56.1
Lack of training on RMC principles	49	59.8
Inadequate facilities and equipment	27	32.9
Facility-level factors contributing to poor RMC include*		
Overcrowding in labour wards	52	63.4
Shortage of staff	37	45.1
Lack of essential supplies	39	47.6
Provider-related risk factors include*		
Negative attitudes toward patients	46	56.1
Poor communication skills	38	46.3
Lack of training on RMC principles	38	46.3
Consequences of disrespectful maternity care include*		
Loss of confidence in health workers	60	73.2
Psychological trauma	43	52.4
Avoidance of health facilities in future pregnancies	33	40.2
Poor RMC may lead to*		
Delay in seeking future care	55	67.1
Preference for home delivery next time	29	35.4
No satisfaction with childbirth experience	40	48.8
Disrespect and abuse during childbirth can result in*		
Postpartum depression	56	68.3
Fear of future pregnancies in facilities	46	56.1
Anxiety during childbirth	28	34.1
Long-term consequences of poor RMC include*		
Increased maternal morbidity due to delayed care-seeking	54	65.9
Erosion of women's rights in healthcare	20	24.4
Lower confidence in seeking care	46	56.1

*** = Multiple response question**

Among respondents aware of respectful maternity care (n = 82), risk factors for disrespectful care identified included lack of training on RMC principles, 49 (59.8%), health worker burnout and stress, 46 (56.1%), and inadequate facilities and equipment, 27 (32.9%). Facility-level factors contributing to poor respectful maternity care included overcrowding in labour wards, 52 (63.4%), lack of essential supplies, 39 (47.6%), and shortage of staff, 37 (45.1%). Provider-related factors identified were negative attitudes toward patients, 46 (56.1%), poor communication skills, 38 (46.3%), and lack of training on RMC principles, 38 (46.3%).

Consequences of disrespectful maternity care identified included loss of confidence in health workers, 60 (73.2%), psychological trauma, 43 (52.4%), and avoidance of health facilities in future pregnancies, 33 (40.2%). Poor respectful maternity care was also linked to delay in seeking future care, 55 (67.1%), no satisfaction with childbirth experience, 40 (48.8%), and preference for home delivery in subsequent pregnancies, 29 (35.4%). In addition, disrespect and abuse during childbirth were associated with postpartum depression, 56 (68.3%), fear of future pregnancies in facilities, 46 (56.1%), and anxiety during childbirth, 28 (34.1%). Long-term consequences identified included increased maternal morbidity due to delayed care-seeking, 54 (65.9%), lower confidence in seeking care, 46 (56.1%), and erosion of women's rights in healthcare, 20 (24.4%).

Table 4: Domains of knowledge of respectful maternity care among postnatal mothers

Good knowledge	Frequency (n=82)	Percent
What does Respectful Maternal Care mean	68	82.9
Which of the following is not a component of respectful maternal care	69	84.1
Supportive care involves	28	34.1
Non-discriminatory care means	27	32.9
Dignified care includes	27	32.9
Effective communication in RMC includes	37	45.1
Risk factors for disrespectful care include	28	34.1
Facility-level factors contributing to poor RMC include	29	35.4
Provider-related risk factors include	26	31.7
Consequences of disrespectful maternity care include	33	40.2
Poor RMC may lead to	31	37.8
Disrespect and abuse during childbirth can result in	30	36.6
Long-term consequences of poor RMC include	29	35.4

The highest proportions of respondents demonstrated good knowledge of what respectful maternal care means, 68 (82.9%), and components that are not part of respectful maternal care, 69 (84.1%). Moderate proportions had good knowledge of effective communication in respectful maternity care, 37 (45.1%), consequences of disrespectful maternity care, 33 (40.2%), poor RMC outcomes, 31 (37.8%), and disrespect and abuse during childbirth, 30 (36.6%).

Lower proportions demonstrated good knowledge of facility-level factors contributing to poor RMC, 29 (35.4%), supportive care, 28 (34.1%), risk factors for disrespectful care, 28 (34.1%), non-discriminatory care, 27 (32.9%), dignified care, 27 (32.9%), and provider-related risk factors, 26 (31.7%). Good knowledge of long-term consequences of poor RMC was reported by 29 (35.4%).

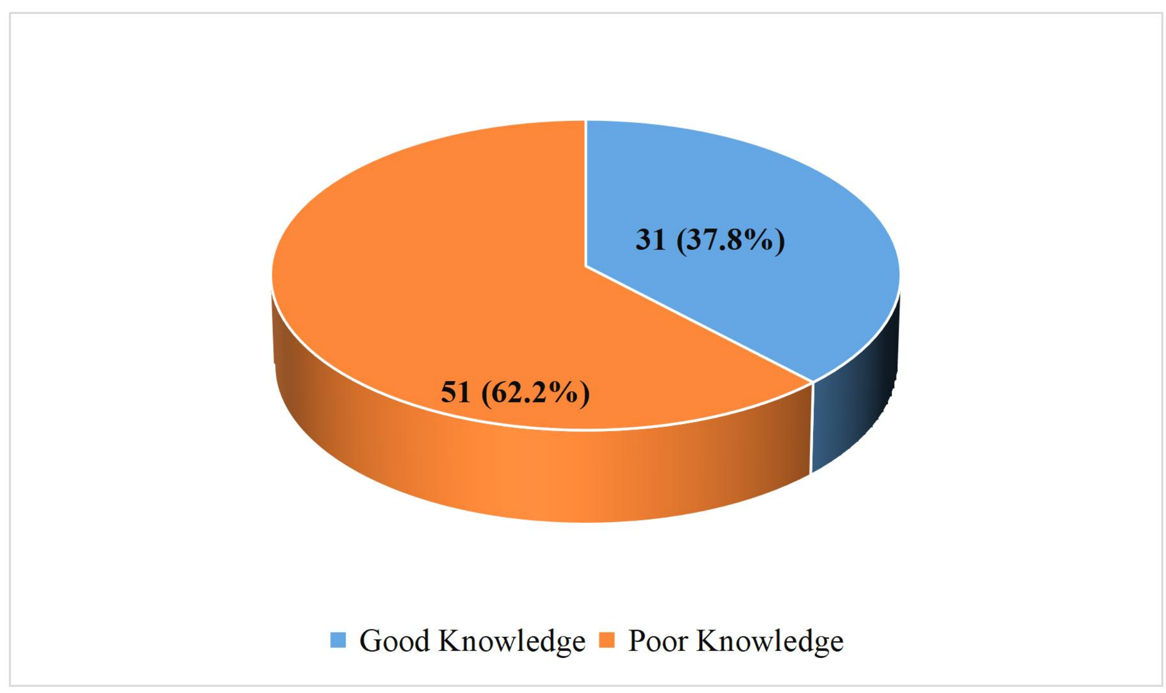

Figure 1: Overall knowledge of postnatal mothers on respectful maternity care

A little over one-third 31 (37.8%) of respondents demonstrated good knowledge, while the majority 51 (62.2%) had poor knowledge.

Table 5: Factors associated with knowledge of respectful maternity care among postnatal mothers

Variables	Knowledge of RMC		Test statistic	p-value
	Good (n=31) Freq(%)	poor (n=51) Freq(%)		
Age (years)				
18–25	3 (27.3)	8 (72.7)	4.898	0.179
26–35	22 (44.9)	27 (55.1)		
36–45	4 (21.1)	15 (78.9)		
>45	2 (66.7)	1 (33.3)		
Ethnicity				
Edo Indigene	15 (30.0)	35 (70.0)	3.319	0.068
Non-Edo Indigene	16 (50.0)	16 (50.0)		
Marital status				
Never married	0 (0.0)	8 (100.0)	5.388*	**0.020**
Ever married	31 (41.9)	43 (58.1)		
Level of education				
No formal education	0 (0.0)	1 (100.0)	0.615	>0.999
Formal education	31 (38.3)	50 (61.7)		
Occupation				
Skill level 0	2 (66.7)	1 (33.3)	4.668	0.198
Skill level 2	16 (32.7)	33 (67.3)		
Skill level 3	0 (0.0)	3 (100.0)		
Skill level 4	13 (48.1)	14 (51.9)		
Monthly income				
<₦70,000	5 (33.3)	10 (66.7)	0.156	0.693
≥₦70,000	26 (38.8)	41 (61.2)		
Religion				
Christianity	29 (38.2)	47 (61.8)	0.622	0.733
Islam	2 (40.0)	3 (60.0)		
African Traditional Religion	0 (0.0)	1 (100.0)		
Number of children				
1 child	6 (30.0)	14 (70.0)	0.317	0.574
>1 child	25 (40.3)	37 (59.7)		
Place of delivery				
Private facility	11 (31.4)	24 (68.6)	2.557	0.465
Public facility	18 (40.9)	26 (59.1)		
Home	1 (50.0)	1 (50.0)		
TBA	1 (100.0)	0 (0.0)		
Mode of delivery				
Vaginal	21 (38.9)	33 (61.1)	0.002	0.967
Caesarean section	10 (35.7)	18 (64.3)		
Mode of payment				
Out of pocket	19 (30.6)	43 (69.4)	4.364	**0.037**
Insurance	12 (60.0)	8 (40.0)		

*Fisher's Exact Test.

The proportion of respondents with good knowledge of respectful maternity care (RMC) was highest among those aged >45 years, 2 (66.7%), followed by respondents aged 26–35 years, 22 (44.9%), while the lowest proportion was observed among those aged 36–45 years, 4 (21.1%). However, age was not significantly associated with knowledge of RMC ($\chi^2 = 4.898$, $p = 0.179$). Ethnicity also showed no statistically significant association, although non-Edo indigenes, 16 (50.0%), demonstrated a higher proportion with good knowledge compared to Edo indigenes, 15 (30.0%) ($\chi^2 = 3.319$, $p = 0.068$). Marital status was significantly associated with knowledge (Fisher's Exact Test, $p = 0.020$), as none of the never married respondents, 0 (0.0%), had good knowledge, whereas ever married respondents, 31 (41.9%), demonstrated good knowledge of RMC.

Level of education was not significantly associated with knowledge (Fisher's Exact Test, $p > 0.999$), although respondents with formal education, 31 (38.3%), had better knowledge compared to those without formal education, 0 (0.0%). Similarly, occupation was not significantly associated with knowledge ($\chi^2 = 4.668$, $p = 0.198$), despite respondents in skill level 0 occupations, 2 (66.7%), having the highest proportion with good knowledge, while none of those in skill level 3 occupations, 0 (0.0%), demonstrated good knowledge. Monthly income ($\chi^2 = 0.156$, $p = 0.693$) and religion ($\chi^2 = 0.622$, $p = 0.733$) were also not significantly associated with knowledge. Respondents with more than one child, 25 (40.3%), had a slightly higher proportion with good knowledge compared to those with one child, 6 (30.0%), although this was not statistically significant ($\chi^2 = 0.317$, $p = 0.574$).

Place of delivery did not show a statistically significant association with knowledge of RMC ($\chi^2 = 2.557$, $p = 0.465$), although respondents who delivered with traditional birth attendants, 1 (100.0%), had the highest proportion with good knowledge, followed by those who delivered at home, 1 (50.0%), public facilities, 18 (40.9%), and private facilities, 11 (31.4%). Mode of delivery was also not significantly associated with knowledge ($\chi^2 = 0.002$, p =

0.967), with respondents who had vaginal delivery, 21 (38.9%), showing similar knowledge levels to those who had caesarean section, 10 (35.7%). However, mode of payment was significantly associated with knowledge ($\chi^2 = 4.364$, $p = 0.037$), as respondents enrolled in insurance schemes, 12 (60.0%), demonstrated a higher proportion with good knowledge compared to those paying out of pocket, 19 (30.6%).

Table 6: Predictors of good knowledge of respectful maternity care among postnatal mothers

Predictors	β	Odds ratio	95% CI for OR Lower	Upper	p-value
Age (years)	0.006	1.006	0.912	1.110	0.902
Ethnicity					
Edo Indigene*		1			
Non-Edo Indigene	0.959	2.608	0.916	7.431	0.073
Marital status					
Never married*		1			
Ever married	18.856	154.921	0.000	—	0.999
Level of education					
No formal*		1			
Formal education	-18.856	0.000	0.000	—	0.999
Occupation					
Low skill*		1			
High skill	-0.058	0.943	0.331	2.691	0.913
Income					
<70,000*		1			
≥70,000	-0.320	0.726	0.187	2.815	0.644
Religion					
Christian*		1			
Non-Christian	-0.075	0.928	0.141	6.109	0.938
Number of children					
1 child*		1			
>1 child	0.019	1.019	0.206	5.041	0.981
Place of delivery					
Private facility*		1			
Public facility	0.671	1.955	0.612	6.247	0.260
Home/TBA	2.862	17.494	0.721	424.107	0.086
Mode of delivery					
Vaginal*	1				
Caesarean section	-0.812	0.444	0.093	2.121	0.310
Mode of payment					
Out of pocket*	1				
Insurance	0.967	2.631	0.781	8.862	0.118

CI = Confidence interval; **OR** = Odds ratio; *reference category

None of the variables were statistically significant predictors of good knowledge of respectful maternity care among postnatal mothers ($p > 0.05$). Although non-Edo indigenes had higher

odds of good knowledge compared to Edo indigenes (OR = 2.608, 95% CI = 0.916–7.431, p = 0.073), this did not reach statistical significance. Mode of payment showed a trend toward significance; respondents who paid through insurance had higher odds of good knowledge compared to those who paid out of pocket (OR = 2.631, 95% CI = 0.781–8.862, p = 0.999), though this was not statistically significant. All other variables including age, marital status, level of education, occupation, income, religion, number of children (OR = 1.019, 95% CI = 0.206–5.041, p = 0.999), place of delivery, and mode of delivery were not statistically significant predictors of good knowledge of RMC ($p > 0.05$). The unstable confidence intervals and p = 0.999 values for some variables reflect complete or near-complete separation in the logistic model due to the small sample size (n = 82).

SECTION C: ATTITUDE TOWARDS RESPECTFUL MATERNITY CARE AMONG POSTNATAL MOTHERS

Table 7A: Attitude of postnatal mothers towards respectful maternity care

Variable (n=418)	SA n (%)	A n (%)	N n (%)	D n (%)	SD n (%)
DIGNITY AND RESPECT					
Women deserve to be treated with dignity and respect by maternity care providers at all times	310 (74.2)	89 (21.3)	11 (2.6)	0 (0.0)	8 (1.9)
Raising one's voice, scolding, or speaking harshly to women in labour is an acceptable way to maintain discipline in the labour ward	28 (6.7)	19 (4.5)	26 (6.2)	87 (20.8)	258 (61.7)
It is the responsibility of providers to ensure that women feel emotionally safe and valued throughout childbirth	273 (65.3)	123 (29.4)	12 (2.9)	1 (0.2)	9 (2.2)
Emotional reassurance, empathy, and compassionate care are critical components of high-quality maternity services	256 (61.2)	129 (30.9)	19 (4.5)	6 (1.4)	8 (1.9)
COMMUNICATION AND AUTONOMY					
Healthcare providers should clearly explain examinations, procedures, and labour progress to women in a manner they can understand	267 (63.9)	128 (30.6)	11 (2.6)	2 (0.5)	10 (2.4)
Women have the right to ask questions and receive honest, respectful responses from maternity staff	279 (66.7)	114 (27.3)	12 (2.9)	3 (0.7)	10 (2.4)
Seeking a woman's consent before performing any procedure is essential for respectful maternity care	260 (62.2)	115 (27.5)	29 (6.9)	5 (1.2)	9 (2.2)
Women should be actively involved in decisions regarding their labour and delivery care	260 (62.2)	124 (29.7)	18 (4.3)	4 (1.0)	12 (2.9)

***SA = Strongly Agree, A = Agree, N = Neutral, D = Disagree, SD = Strongly Disagree**

Under dignity and respect, most respondents strongly agreed or agreed that women deserve to be treated with dignity and respect at all times, 310 (74.2%) and 89 (21.3%) respectively. Similarly, 273 (65.3%) strongly agreed and 123 (29.4%) agreed that providers should ensure women feel emotionally safe and valued throughout childbirth, while 256 (61.2%) strongly agreed and 129 (30.9%) agreed that emotional reassurance, empathy, and compassionate care are critical components of high-quality maternity services. In addition, 87 (20.8%) disagreed and 258 (61.7%) strongly disagreed that raising one's voice, scolding, or speaking harshly to women in labour is acceptable.

Under communication and autonomy, 267 (63.9%) strongly agreed and 128 (30.6%) agreed that healthcare providers should clearly explain examinations, procedures, and labour progress in a manner women can understand. Also, 279 (66.7%) strongly agreed and 114 (27.3%) agreed that women have the right to ask questions and receive honest, respectful responses from maternity staff. Furthermore, 260 (62.2%) strongly agreed and 115 (27.5%) agreed that seeking consent before performing procedures is essential, while 260 (62.2%) strongly agreed and 124 (29.7%) agreed that women should be actively involved in decisions regarding labour and delivery care.

Table 7B: Attitude of postnatal mothers towards respectful maternity care

Variable (n=418)	SA n (%)	A n (%)	N n (%)	D n (%)	SD n (%)
SUPPORTIVE CARE					
Allowing women to have a birth companion of their choice is important for enhancing their childbirth experience	204 (48.8)	137 (32.8)	49 (11.7)	15 (3.6)	13 (3.1)
Providers should respond promptly whenever a woman in labour calls for assistance or expresses concern	262 (62.7)	129 (30.9)	13 (3.1)	6 (1.4)	8 (1.9)
Maintaining a clean, safe, and adequately equipped maternity environment is essential for respectful maternity care	287 (68.7)	107 (25.6)	13 (3.1)	0 (0.0)	11 (2.6)
NON-ABUSE/ETHICAL CARE					
Asking women to pay unofficial fees during childbirth is acceptable	21 (5.0)	19 (4.5)	20 (4.8)	68 (16.3)	290 (69.4)

***SA = Strongly Agree, A = Agree, N = Neutral, D = Disagree, SD = Strongly Disagree**

Within the supportive care domain, 204 (48.8%) strongly agreed and 137 (32.8%) agreed that allowing women to have a birth companion of their choice is important for enhancing childbirth experience. Similarly, 262 (62.7%) strongly agreed and 129 (30.9%) agreed that providers should respond promptly whenever a woman in labour calls for assistance or expresses concern. In addition, 287 (68.7%) strongly agreed and 107 (25.6%) agreed that maintaining a clean, safe, and adequately equipped maternity environment is essential for respectful maternity care.

Under the non-abuse/ethical care domain, 68 (16.3%) disagreed and 290 (69.4%) strongly disagreed that asking women to pay unofficial fees during childbirth is acceptable, while smaller proportions strongly agreed, 21 (5.0%), agreed, 19 (4.5%), or were neutral, 20 (4.8%).

Table 8A: Domains of attitude of postnatal mothers towards respectful maternity care

Attitude domains	Frequency (n=418)	Percent
DIGNITY AND RESPECT		
Women deserve to be treated with dignity and respect by maternity care providers at all times		
Good attitude (agree women deserve dignity and respect at all times)	399	95.5
Raising one's voice, scolding, or speaking harshly to women in labour is an acceptable way to maintain discipline in the labour ward		
Good attitude (disagree that harsh speech is acceptable)	345	82.5
It is the responsibility of providers to ensure that women feel emotionally safe and valued throughout childbirth		
Good attitude (agree providers must ensure emotional safety)	396	94.7
Emotional reassurance, empathy, and compassionate care are critical components of high-quality maternity services		
Good attitude (agree empathy and compassion are critical)	385	92.1
COMMUNICATION AND AUTONOMY		
Healthcare providers should clearly explain examinations, procedures, and labour progress to women in a manner they can understand		
Good attitude (agree providers should clearly explain procedures)	395	94.5
Women have the right to ask questions and receive honest, respectful responses from maternity staff		
Good attitude (agree women have the right to ask questions)	393	94.0
Seeking a woman's consent before performing any procedure is essential for respectful maternity care		
Good attitude (agree consent is essential before procedures)	375	89.7
Women should be actively involved in decisions regarding their labour and delivery care		
Good attitude (agree women should be involved in decisions)	384	91.9

Within the dignity and respect domain, the highest proportion of respondents demonstrated good attitude that women deserve dignity and respect at all times, 399 (95.5%), followed by agreement that providers must ensure emotional safety, 396 (94.7%), and that empathy and compassion are critical components of maternity care, 385 (92.1%). A lower proportion, though still the majority, 345 (82.5%), demonstrated good attitude by disagreeing that harsh speech is acceptable during labour.

Within the communication and autonomy domain, 395 (94.5%) respondents demonstrated good attitude by agreeing that providers should clearly explain procedures, while 393 (94.0%) agreed that women have the right to ask questions and receive respectful responses. Similarly, 384 (91.9%) agreed that women should be involved in decisions regarding labour and delivery care, while 375 (89.7%) agreed that consent is essential before performing procedures.

Table 8B: Domains of attitude of postnatal mothers towards respectful maternity care

Attitude domains	Frequency (n=418)	Percent
SUPPORTIVE CARE		
Allowing women to have a birth companion of their choice is important for enhancing their childbirth experience		
Good attitude (agree birth companion should be allowed)	341	81.6
Providers should respond promptly whenever a woman in labour calls for assistance or expresses concern		
Good attitude (agree providers should respond promptly)	391	93.5
Maintaining a clean, safe, and adequately equipped maternity environment is essential for respectful maternity care		
Good attitude (agree environment must be safe and equipped)	394	94.3
NON-ABUSE/ETHICAL CARE		
Asking women to pay unofficial fees during childbirth is acceptable		
Good attitude (disagree that unofficial fees are acceptable)	358	85.6

In the supportive care domain, 394 (94.3%) respondents demonstrated good attitude by agreeing that the maternity environment must be clean, safe, and adequately equipped. Similarly, 391 (93.5%) agreed that providers should respond promptly whenever a woman in labour calls for assistance or expresses concern, while 341 (81.6%) agreed that women should be allowed to have a birth companion of their choice.

Under the non-abuse/ethical care domain, 358 (85.6%) respondents demonstrated good attitude by disagreeing that asking women to pay unofficial fees during childbirth is acceptable.

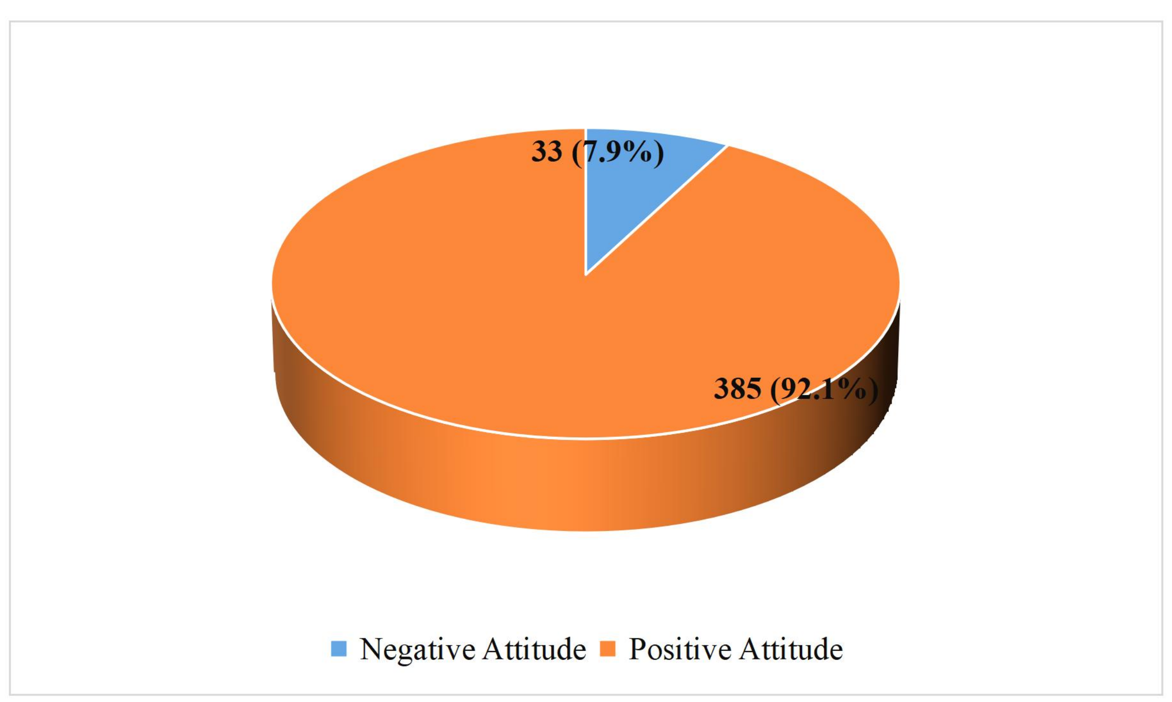

Figure 2: Attitude of postnatal mothers towards respectful maternity care

A large majority, 385 (92.1%) of the respondents had a positive attitude towards respectful maternity care, while a small proportion, 33 (7.9%), had a negative attitude.

Table 9: Factors associated with attitude of RMC among postnatal mothers

Variables	Attitude towards Respectful	Test statistic	p-value

	maternity care			
	Positive (n=385) Freq(%)	**Negative (n=33) Freq(%)**		
Age (years)				
18–25	58 (89.2)	7 (10.8)	1.931	0.587
26–35	220 (93.2)	16 (6.8)		
36–45	95 (92.2)	8 (7.8)		
>45	12 (85.7)	2 (14.3)		
Ethnicity				
Edo Indigene	236 (94.0)	15 (6.0)	3.181	0.075
Non-Edo Indigene	149 (89.2)	18 (10.8)		
Marital status				
Ever married	46 (93.9)	3 (6.1)	0.240	0.624
Never married	339 (91.9)	30 (8.1)		
Level of education				
No formal education	8 (72.7)	3 (27.3)	0.212	**0.048**
Formal education	377 (92.6)	30 (7.4)		
Occupation				
Skill level 0	20 (95.2)	1 (4.8)	1.545	0.819
Skill level 1	6 (100.0)	0 (0.0)		
Skill level 2	258 (91.5)	24 (8.5)		
Skill level 3	7 (100.0)	0 (0.0)		
Skill level 4	94 (92.2)	8 (7.8)		
Monthly income				
<₦70,000	104 (93.7)	7 (6.3)	0.524	0.469
≥₦70,000	359 (92.5)	29 (7.5)		
Religion				
Christianity	359 (92.5)	29 (7.5)	48.990	**<0.001**
Islam	26 (100.0)	0 (0.0)		
African Traditional Religion	0 (0.0)	4 (100.0)		
Number of children				
1 child	120 (90.9)	12 (9.1)	0.177	0.674
>1 child	265 (92.7)	21 (7.3)		
Place of delivery				
Private facility	152 (92.7)	12 (7.3)	8.483	**0.037**
Public facility	218 (93.2)	16 (6.8)		
Home	9 (75.0)	3 (25.0)		
TBA	6 (75.0)	2 (25.0)		
Mode of delivery				
Vaginal	265 (91.4)	25 (8.6)	0.399	0.528
Caesarean section	120 (93.8)	8 (6.2)		
Mode of payment				
Out of pocket	322 (91.7)	29 (8.3)	0.629*	0.629
Insurance	63 (94.0)	4 (6.0)		
Knowledge level				
Good knowledge	29 (93.5)	2 (6.5)	0.071*	0.790
Poor knowledge	356 (92.0)	31 (8.0)		

*Fisher's Exact Test

The proportion of respondents with positive attitude towards respectful maternity care (RMC) was highest among those aged 26–35 years, 220 (93.2%), followed by those aged 36–45 years, 95 (92.2%), 18–25 years, 58 (89.2%), and lowest among those aged >45 years, 12 (85.7%). However, age was not significantly associated with attitude towards RMC (χ^2 = 1.931, p = 0.587). Ethnicity also showed no statistically significant association, although Edo indigenes, 236 (94.0%), had a higher proportion with positive attitude compared to non-Edo indigenes, 149 (89.2%) (χ^2 = 3.181, p = 0.075). Similarly, marital status (χ^2 = 0.240, p = 0.624), occupation (χ^2 = 1.545, p = 0.819), monthly income (χ^2 = 0.524, p = 0.469), number of children (χ^2 = 0.177, p = 0.674), mode of delivery (χ^2 = 0.399, p = 0.528), and mode of payment (Fisher's Exact Test, p = 0.629) were not statistically significantly associated with attitude.

However, level of education was significantly associated with attitude towards RMC (χ^2 = 0.212, p = 0.048), with respondents who had formal education, 377 (92.6%), demonstrating a higher proportion with positive attitude compared to those without formal education, 8 (72.7%). Religion was also significantly associated with attitude (χ^2 = 48.990, $p < 0.001$), as all Muslim respondents, 26 (100.0%), demonstrated positive attitude, followed by Christians, 359 (92.5%), while none of the respondents practicing African Traditional Religion, 0 (0.0%), demonstrated positive attitude. Place of delivery was similarly significant (χ^2 = 8.483, p = 0.037), with respondents who delivered in public facilities, 218 (93.2%), and private facilities, 152 (92.7%), demonstrating higher positive attitude compared to those who delivered at home, 9 (75.0%), or with traditional birth attendants, 6 (75.0%).

Table 10: Predictors of positive attitude of respectful maternity care among postnatal mothers

Predictors	β	Odds ratio	95% CI for OR		p-value
			Lower	Upper	
Age (years)	-0.029	0.972	0.915	1.031	0.343
Ethnicity					
Edo Indigene*		1			
Non-Edo Indigene	-0.720	0.487	0.233	1.014	0.055
Marital status					
Ever married*		1			
Never married	-0.241	0.786	0.220	2.808	0.711
Level of education					
No formal education*		1			
Formal education	1.911	6.757	1.381	33.050	**0.018**
Occupation					
Low skill*		1			
High skill	0.071	1.074	0.434	2.655	0.878
Monthly income					
<70,000*		1			
≥70,000	-0.546	0.579	0.224	1.497	0.260
Religion					
Christian*		1			
Non-Christian	-0.261	0.770	0.222	2.676	0.681
Number of children					
1 child*		1			
>1 child	0.485	1.623	0.705	3.737	0.255
Place of delivery					
Private facility*		1			
Public facility	0.077	1.080	0.489	2.384	0.849
Home/TBA	-1.198	0.302	0.074	1.229	0.094
Mode of delivery					
Vaginal*		1			
Caesarean section	0.292	1.340	0.563	3.190	0.509
Mode of payment					
Out of pocket*		1			
Insurance	0.280	1.323	0.424	4.131	0.629

CI = Confidence interval; **OR** = Odds ratio; *reference category

Level of education was the only statistically significant predictor of positive attitude towards respectful maternity care among postnatal mothers. Respondents with formal education had significantly higher odds of a positive attitude compared to those with no formal education

(OR = 6.757, 95% CI = 1.381–33.050, p = 0.018). Although not statistically significant, non-Edo indigenes had lower odds of a positive attitude compared to Edo indigenes (OR = 0.487, 95% CI = 0.233–1.014, p = 0.055). Similarly, respondents who had more than one child had higher odds of a positive attitude compared to those with one child (OR = 1.623, 95% CI = 0.705–3.737, p = 0.255), while respondents who earned ≥₦70,000 monthly had lower odds compared to those earning <₦70,000 (OR = 0.579, 95% CI = 0.224–1.497, p = 0.260).

Respondents with high-skill occupations had slightly higher odds of a positive attitude compared to those with low-skill occupations (OR = 1.074, 95% CI = 0.434–2.655, p = 0.878). Those who delivered in public facilities had slightly higher odds compared to those who delivered in private facilities (OR = 1.080, 95% CI = 0.489–2.384, p = 0.849), whereas respondents who delivered at home or with a traditional birth attendant had lower odds of a positive attitude (OR = 0.302, 95% CI = 0.074–1.229, p = 0.094), although this was not statistically significant.

Never married respondents had lower odds of a positive attitude compared to ever married respondents (OR = 0.786, 95% CI = 0.220–2.808, p = 0.711). Non-Christians also had lower odds compared to Christians (OR = 0.770, 95% CI = 0.222–2.676, p = 0.681). In addition, respondents who had caesarean section deliveries had slightly higher odds of a positive attitude compared to those who had vaginal delivery (OR = 1.340, 95% CI = 0.563–3.190, p = 0.509), while those enrolled in health insurance had higher odds compared to respondents paying out-of-pocket (OR = 1.323, 95% CI = 0.424–4.131, p = 0.629). Age was also not a statistically significant predictor (OR = 0.972, 95% CI = 0.915–1.031, p = 0.343). Overall, all variables apart from level of education were not statistically significant predictors of positive attitude towards respectful maternity care (p > 0.05).

SECTION D: EXPERIENCE DURING CHILDBIRTH AMONG POSTNATAL MOTHERS

Table 11A: Experience during childbirth among postnatal mothers

Domains	Frequency (n = 418)	Percent
DIGNITY AND RESPECT		
The skilled birth attendant/s cared for you with a kind approach		
Yes	392	93.8
No	26	6.2
The skilled birth attendant/s treated you in a friendly manner		
Yes	385	92.1
No	33	7.9
If No – Who provided your care (n = 33)		
Nurse/Midwife	23	69.7
Doctor	10	30.3
You were treated with respect as an individual by the skilled birth attendant/s		
Yes	387	92.6
No	31	7.4
If No – Who provided your care (n = 31)		
Nurse/Midwife	16	51.6
Doctor	6	19.4
Traditional birth attendant	4	12.9
The skilled birth attendant/s called you by your name		
Yes	279	66.7
No	139	33.3
The skilled birth attendant/s treated you poorly because of your personal attributes		
Yes	26	6.2
No	392	93.8
If Yes – Who provided your care (n = 26)		
Nurse/Midwife	17	65.4
Doctor	4	15.4
Traditional birth attendant	2	7.7

Under the dignity and respect domain, most respondents reported that skilled birth attendants cared for them with a kind approach, 392 (93.8%), treated them in a friendly manner, 385 (92.1%), and treated them with respect as individuals, 387 (92.6%). In addition, 392 (93.8%) reported that they were not treated poorly because of their personal attributes. However, a lower proportion, 279 (66.7%), reported that providers called them by their names.

Among respondents who reported negative experiences, nurse/midwives were most commonly identified as those who were unfriendly, 23 (69.7%), treated respondents without respect, 16 (51.6%), or treated them poorly because of personal attributes, 17 (65.4%), followed by doctors and, to a lesser extent, traditional birth attendants.

Table 11B: Experience during childbirth among postnatal mothers

Domain	Frequency (n = 418)	Percent
COMMUNICATION AND AUTONOMY		
The skilled birth attendant/s talked positively about pain and pain relief		
Yes	343	82.1
No	75	17.9
If No – Who provided your care (n = 75)		
Nurse/Midwife	31	41.3
Doctor	19	25.3
Traditional birth attendant	5	6.7
The skilled birth attendant/s spoke to you in a language you could understand		
Yes	392	93.8
No	26	6.2
If No – Who provided your care (n = 26)		
Nurse/Midwife	9	34.6
Traditional birth attendant	3	11.5
Doctor	2	7.7
SUPPORTIVE CARE		
The skilled birth attendant/s showed concern and empathy toward you		
Yes	389	93.1
No	29	6.9
If No – Who provided your care (n = 29)		
Nurse/Midwife	17	58.6
Doctor	9	31.0
Traditional birth attendant	4	13.8
The skilled birth attendant/s responded to your needs, whether or not you asked		
Yes	368	88.0
No	50	12.0
You were allowed to practice your cultural rituals in the facility (n = 399)		
Yes	128	32.1
No	271	67.9

Under the communication and autonomy domain, most respondents reported that skilled birth attendants talked positively about pain and pain relief, 343 (82.1%), and spoke to them in a language they could understand, 392 (93.8%). Among those who reported negative experiences, nurse/midwives were most commonly identified as not speaking positively about pain and pain relief, 31 (41.3%), or not communicating in an understandable language, 9 (34.6%), followed by doctors and traditional birth attendants.

Under the supportive care domain, 389 (93.1%) respondents reported that skilled birth attendants showed concern and empathy, while 368 (88.0%) stated that their needs were responded to whether or not they asked. In contrast, only 128 (32.1%) reported being allowed to practice their cultural rituals in the facility, while the majority, 271 (67.9%), were not allowed. Among those who did not receive empathy, nurse/midwives were most frequently identified, 17 (58.6%), followed by doctors and traditional birth attendants.

Table 11C: Experience during childbirth among postnatal mothers

Domain	Frequency (n = 418)	Percent
NON-ABUSE (VERBAL AND PHYSICAL ABUSE)		
You were hit or slapped by any skilled birth attendant during labour and delivery		
Yes	54	12.9
No	364	87.1
If Yes – Who provided your care (n = 54)		
Nurse/Midwife	35	64.8
Doctor	9	16.7
Traditional birth attendant	4	7.4
The skilled birth attendant shouted at you because you had not done what you were told		
Yes	95	22.7
No	323	77.3
If Yes – Who provided your care (n = 95)		
Nurse/Midwife	57	60.0
Doctor	9	9.5
Traditional birth attendant	4	4.2
ACCESS AND QUALITY OF CARE		
You were kept waiting for a long time before receiving service		
Yes	94	22.5
No	324	77.5
You were denied or restricted care because of inability to pay for services		
Yes	35	8.4
No	383	91.6
If Yes – Who provided your care (n = 35)		
Nurse/Midwife	20	57.1
Doctor	7	20.0
Traditional birth attendant	1	2.9

Under the non-abuse (verbal and physical abuse) domain, 364 (87.1%) respondents reported that they were not hit or slapped by any skilled birth attendant during labour and delivery, while 54 (12.9%) reported that they were. Similarly, 323 (77.3%) stated that no skilled birth attendant shouted at them because they had not done what they were told, whereas 95 (22.7%)

reported being shouted at. Among those who experienced abuse, nurse/midwives were most commonly identified as those who hit or slapped respondents, 35 (64.8%), and those who shouted at respondents, 57 (60.0%), followed by doctors and traditional birth attendants.

Under the access and quality of care domain, 324 (77.5%) respondents reported that they were not kept waiting for a long time before receiving service, while 94 (22.5%) experienced prolonged waiting time. In addition, 383 (91.6%) reported that they were not denied or restricted care because of inability to pay, whereas 35 (8.4%) reported such experiences. Among those denied or restricted care, nurse/midwives were most frequently identified, 20 (57.1%), followed by doctors and traditional birth attendants**.**

Table 12: Domains of experience of respectful maternity care during childbirth among postnatal mothers

Experience domains of Respectful maternity care	Frequency (n=418)	Percent
DIGNITY AND RESPECT		
The skilled birth attendant/s cared for you with a kind approach		
Respectful maternity care	392	93.8
The skilled birth attendant/s treated you in a friendly manner		
Respectful maternity care	385	92.1
You were treated with respect as an individual by the skilled birth attendant/s		
Respectful maternity care	387	92.6
The skilled birth attendant/s called you by your name		
Respectful maternity care	279	66.7
The skilled birth attendant/s treated you poorly because of your personal attributes		
Respectful maternity care	392	93.8
COMMUNICATION AND AUTONOMY		
The skilled birth attendant/s talked positively about pain and pain relief		
Respectful maternity care	343	82.1
The skilled birth attendant/s spoke to you in a language you could understand		
Respectful maternity care	392	93.8
SUPPORTIVE CARE		
The skilled birth attendant/s showed concern and empathy toward you		
Respectful maternity care	389	93.1
The skilled birth attendant/s responded to your needs, whether or not you asked		
Respectful maternity care	368	88.0
Were you allowed to practice your cultural rituals in the facility (n = 399)		
Respectful maternity care	128	32.1
NON-ABUSE (VERBAL AND PHYSICAL ABUSE)		
Were you hit or slapped by any skilled birth attendant during labour and delivery		
Respectful maternity care	364	87.1
Did any skilled birth attendant shout at you because you had not done what you were told		
Respectful maternity care	323	77.3
ACCESS AND QUALITY OF CARE		
Were you kept waiting for a long time before receiving service		
Respectful maternity care	324	77.5
Were you denied or restricted care because of inability to pay for services		
Respectful maternity care	383	91.6

Within the dignity and respect domain, high proportions of respondents reported respectful maternity care through being cared for with a kind approach, 392 (93.8%), not being treated poorly because of personal attributes, 392 (93.8%), being treated with respect as individuals, 387 (92.6%), and being treated in a friendly manner, 385 (92.1%). A lower proportion, 279 (66.7%), reported being called by their names.

Under the communication and autonomy domain, 392 (93.8%) respondents reported being spoken to in a language they could understand, while 343 (82.1%) reported that providers talked positively about pain and pain relief. Within the supportive care domain, 389 (93.1%) reported that providers showed concern and empathy, while 368 (88.0%) stated that their needs were responded to. However, only 128 (32.1%) reported being allowed to practice cultural rituals in the facility.

Under the non-abuse (verbal and physical abuse) domain, 364 (87.1%) respondents reported not being hit or slapped, while 323 (77.3%) reported not being shouted at during labour. Within the access and quality of care domain, 383 (91.6%) reported not being denied or restricted care because of inability to pay, while 324 (77.5%) reported not being kept waiting for a long time before receiving service.

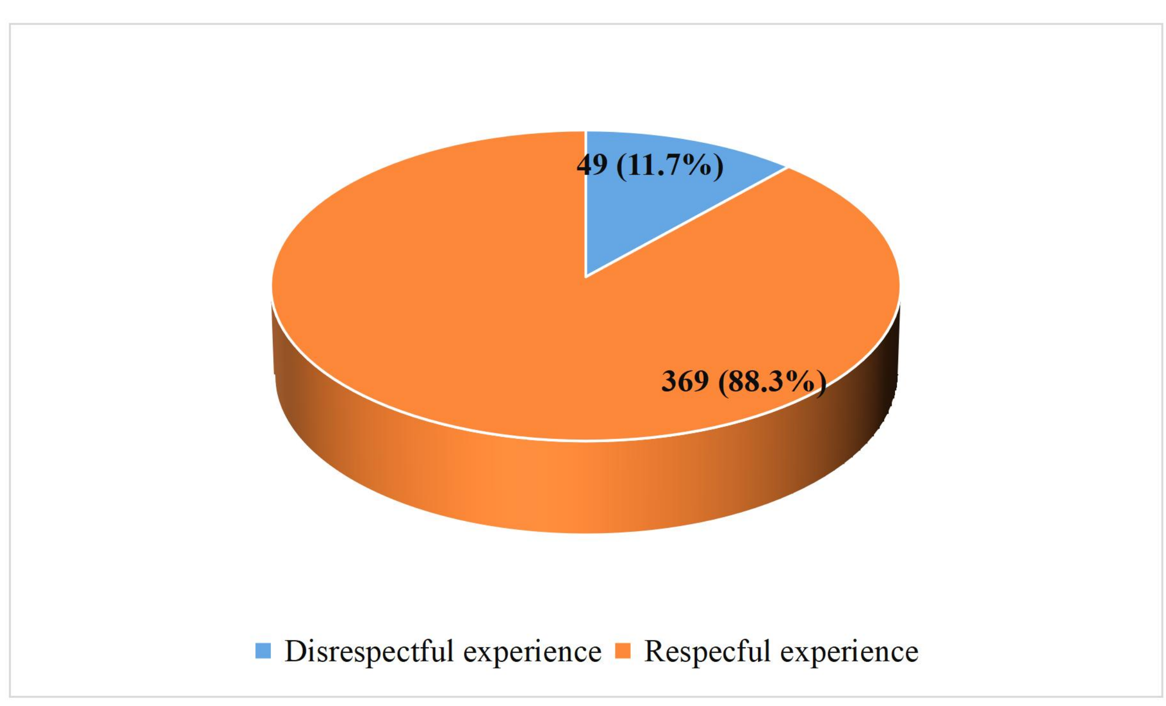

Figure 3: Experience of postnatal mothers during childbirth

A large majority, 369 (88.3%) of the respondents had a respectful experience during childbirth, while a small proportion, 49 (11.7%), had a disrespectful experience.

Table 13: Factors associated with experience of respectful maternity care during childbirth

Variables	Experience of Respectful maternity care		Test statistic	p-value
	Respectful (n=369) Freq(%)	Disrespectful (n=49) Freq(%)		
Age (years)				
18–25	54 (83.1)	11 (16.9)	3.350	0.341
26–35	208 (88.1)	28 (11.9)		
36–45	95 (92.2)	8 (7.8)		
>45	12 (85.7)	2 (14.3)		
Ethnicity				
Edo Indigene	224 (89.2)	27 (10.8)	0.566	0.452
Non-Edo Indigene	145 (86.8)	22 (13.2)		
Marital status				
Ever married	43 (87.8)	6 (12.2)	0.015	0.904
Never married	326 (88.3)	43 (11.7)		
Level of education				
No formal education	7 (63.6)	4 (36.4)	0.218	**0.030**
Formal education	362 (88.9)	45 (11.1)		
Occupation				
Skill level 0	17 (81.0)	4 (19.0)	2.957	0.565
Skill level 1	6 (100.0)	0 (0.0)		
Skill level 2	250 (88.7)	32 (11.3)		
Skill level 3	7 (100.0)	0 (0.0)		
Skill level 4	89 (87.3)	13 (12.7)		
Monthly income				
<₦70,000	96 (86.5)	15 (13.5)	0.468	0.494
≥₦70,000	273 (88.9)	34 (11.1)		
Religion				
Christianity	346 (89.2)	42 (10.8)	4.223	0.121
Islam	20 (76.9)	6 (23.1)		
African Traditional Religion	3 (75.0)	1 (25.0)		
Number of children				
1 child	118 (89.4)	14 (10.6)	0.101	0.750
>1 child	251 (87.8)	35 (12.2)		
Attitude level				
Negative attitude	24 (72.7)	9 (27.3)	8.372*	**0.004**
Positive attitude	345 (89.6)	40 (10.4)		
Place of delivery				
Private facility	153 (93.3)	11 (6.7)	16.459	**0.001**
Public facility	202 (86.3)	32 (13.7)		
Home	10 (83.3)	2 (16.7)		
TBA	4 (50.0)	4 (50.0)		
Mode of delivery				
Vaginal	250 (86.2)	40 (13.8)	3.297	0.069
Caesarean section	119 (93.0)	9 (7.0)		
Mode of payment				
Out of pocket	310 (88.3)	41 (11.7)	0.001	>0.999
Insurance	59 (88.1)	8 (11.9)		
Knowledge level				
Good knowledge	29 (93.5)	2 (6.5)	0.637*	0.425
Poor knowledge	340 (87.9)	47 (12.1)		

*Fisher's Exact Test.

The proportion of respondents who experienced respectful maternity care during childbirth was highest among those aged 36–45 years, 95 (92.2%), followed by respondents aged 26–35 years, 208 (88.1%), >45 years, 12 (85.7%), while the lowest proportion was observed among those aged 18–25 years, 54 (83.1%). However, age was not significantly associated with experience of respectful maternity care ($\chi^2 = 3.350$, $p = 0.341$). Ethnicity also showed no statistically significant association, although Edo indigenes, 224 (89.2%), had a slightly higher proportion reporting respectful care compared to non-Edo indigenes, 145 (86.8%) ($\chi^2 = 0.566$, $p = 0.452$). Similarly, marital status was not significantly associated with experience, with comparable proportions observed among never married respondents, 326 (88.3%), and ever married respondents, 43 (87.8%) ($\chi^2 = 0.015$, $p = 0.904$).

Level of education was significantly associated with experience of respectful maternity care ($\chi^2 = 0.218$, $p = 0.030$). Respondents with formal education, 362 (88.9%), reported a markedly higher proportion of respectful care compared to those without formal education, 7 (63.6%). Occupation was not significantly associated with experience ($\chi^2 = 2.957$, $p = 0.565$), although respondents in skill level 1 and skill level 3 occupations, 6 (100.0%) and 7 (100.0%) respectively, reported entirely respectful care experiences, while respondents in skill level 0 occupations had the lowest proportion, 17 (81.0%). Monthly income also showed no statistically significant association ($\chi^2 = 0.468$, $p = 0.494$), though respondents earning ≥₦70,000, 273 (88.9%), reported slightly higher respectful care compared to those earning <₦70,000, 96 (86.5%).

Religion was not significantly associated with experience of respectful maternity care ($\chi^2 = 4.223$, $p = 0.121$), although Christians, 346 (89.2%), had the highest proportion reporting respectful care compared to Muslims, 20 (76.9%), and those practicing African Traditional Religion, 3 (75.0%). Number of children was also not significantly associated with

experience (χ^2 = 0.101, p = 0.750), with similar proportions observed among respondents with one child, 118 (89.4%), and those with more than one child, 251 (87.8%).

Attitude level, however, was significantly associated with experience of respectful maternity care (Fisher's Exact Test, p = 0.004). Respondents with positive attitude, 345 (89.6%), were more likely to report respectful care compared to those with negative attitude, 24 (72.7%). Place of delivery also demonstrated a statistically significant association (χ^2 = 16.459, p = 0.001), with respondents who delivered in private facilities, 153 (93.3%), reporting the highest proportion of respectful care, followed by public facilities, 202 (86.3%), home deliveries, 10 (83.3%), while those delivered by traditional birth attendants had the lowest proportion, 4 (50.0%). Mode of delivery was not significantly associated with experience (χ^2 = 3.297, p = 0.069), although respondents who had caesarean section, 119 (93.0%), reported higher respectful care compared to those who had vaginal delivery, 250 (86.2%). Likewise, mode of payment was not significantly associated with experience (Fisher's Exact Test, p > 0.999), with similar proportions observed among respondents paying out of pocket, 310 (88.3%), and those enrolled in insurance schemes, 59 (88.1%).

Table 14: Predictors of respectful maternity care experience among postnatal mothers

Predictors	β	Odds ratio	95% CI for OR		p-value
			Lower	Upper	
Age (years)	0.034	1.035	0.980	1.092	0.217
Ethnicity					
Edo Indigene*		1			
Non-Edo Indigene	-0.178	0.837	0.449	1.560	0.575
Marital status					
Ever married*		1			
Never married	-0.004	0.996	0.380	2.610	0.993
Level of education					
No formal education*		1			
Formal education	1.030	2.801	0.680	11.533	0.154
Occupation					
Low skill*		1			
High skill	0.030	1.030	0.497	2.137	0.936
Monthly income					
<70,000*		1			
≥70,000	0.324	1.382	0.677	2.823	0.374
Religion					
Christian*		1			
Non-Christian	-0.656	0.519	0.194	1.388	0.191
Number of children					
1 child*		1			
>1 child	-0.281	0.755	0.356	1.603	0.465
Attitude level					
Negative attitude*		1			
Positive attitude	1.100	3.005	1.234	7.319	0.015
Place of delivery					
Private facility*		1			
Public facility	-0.917	0.400	0.191	0.835	**0.015**
Home/TBA	-1.247	0.287	0.072	1.148	0.078
Mode of delivery					
Vaginal*		1			
Caesarean section	0.785	2.192	0.974	4.930	0.058
Mode of payment					
Out of pocket*		1			
Insurance	-0.336	0.715	0.299	1.707	0.450

CI = Confidence interval; **OR** = Odds ratio; *reference category

Attitude level and place of delivery were statistically significant predictors of respectful maternity care experience among postnatal mothers. Respondents with a positive attitude had significantly higher odds of experiencing respectful maternity care compared to those with a negative attitude (OR = 3.005, 95% CI = 1.234–7.319, p = 0.015). In contrast, respondents

who delivered in public facilities had significantly lower odds of experiencing respectful maternity care compared to those who delivered in private facilities (OR = 0.400, 95% CI = 0.191–0.835, p = 0.015). Although not statistically significant, respondents who delivered through caesarean section had higher odds of experiencing respectful maternity care compared to those who had vaginal delivery (OR = 2.192, 95% CI = 0.974–4.930, p = 0.058). Similarly, respondents with formal education had higher odds of respectful maternity care experience compared to those with no formal education (OR = 2.801, 95% CI = 0.680–11.533, p = 0.154), while respondents who earned ≥₦70,000 monthly also had higher odds compared to those earning <₦70,000 (OR = 1.382, 95% CI = 0.677–2.823, p = 0.374).

Non-Edo indigenes had lower odds of respectful maternity care experience compared to Edo indigenes (OR = 0.837, 95% CI = 0.449–1.560, p = 0.575). Likewise, non-Christians had lower odds compared to Christians (OR = 0.519, 95% CI = 0.194–1.388, p = 0.191), and respondents with more than one child had lower odds compared to those with one child (OR = 0.755, 95% CI = 0.356–1.603, p = 0.465). Respondents who delivered at home or with traditional birth attendants also had lower odds of respectful maternity care experience compared to those who delivered in private facilities (OR = 0.287, 95% CI = 0.072–1.148, p = 0.078), although this was not statistically significant.

Never married respondents had similar odds of respectful maternity care experience compared to ever married respondents (OR = 0.996, 95% CI = 0.380–2.610, p = 0.993). High-skill workers had similar odds compared to low-skill workers (OR = 1.030, 95% CI = 0.497–2.137, p = 0.936), while respondents enrolled in insurance had lower odds compared to those paying out-of-pocket (OR = 0.715, 95% CI = 0.299–1.707, p = 0.450). Age was also not a statistically significant predictor (OR = 1.035, 95% CI = 0.980–1.092, p = 0.217). Overall, all variables apart from attitude level and place of delivery were not statistically significant predictors ($p > 0.05$).

SECTION E: PROVIDER AND FACILITY-LEVEL FACTORS INFLUENCING RESPECTFUL MATERNITY CARE

Table 15: Provider and facility-level factors influencing Respectful maternity care among postnatal mothers

Variables	Frequency (n = 418)	Percent
Skilled birth attendant was available during labour		
Yes	400	95.7
No	18	4.3
Skilled birth attendant appeared overworked or stressed		
Yes	146	34.9
No	272	65.1
Lack of space or crowding affected care		
Yes	84	20.1
No	334	79.9
Felt intimidated or afraid of the skilled birth attendant		
Yes	46	11.0
No	372	89.0
Asked for unofficial payments or bribes		
Yes	22	5.3
No	396	94.7

Skilled birth attendants were available during labour for the majority of respondents, 400 (95.7%), while 18 (4.3%) reported otherwise. About one-third of respondents stated that the skilled birth attendant appeared overworked or stressed, 146 (34.9%), whereas 272 (65.1%) did not report this.

Regarding facility conditions, 84 (20.1%) respondents reported that lack of space or crowding affected their care, while 334 (79.9%) did not. A smaller proportion, 46 (11.0%), reported feeling intimidated or afraid of the skilled birth attendant, whereas 372 (89.0%) did not feel so. In addition, 22 (5.3%) respondents reported being asked for unofficial payments or bribes, while the majority, 396 (94.7%), did not report such experiences.

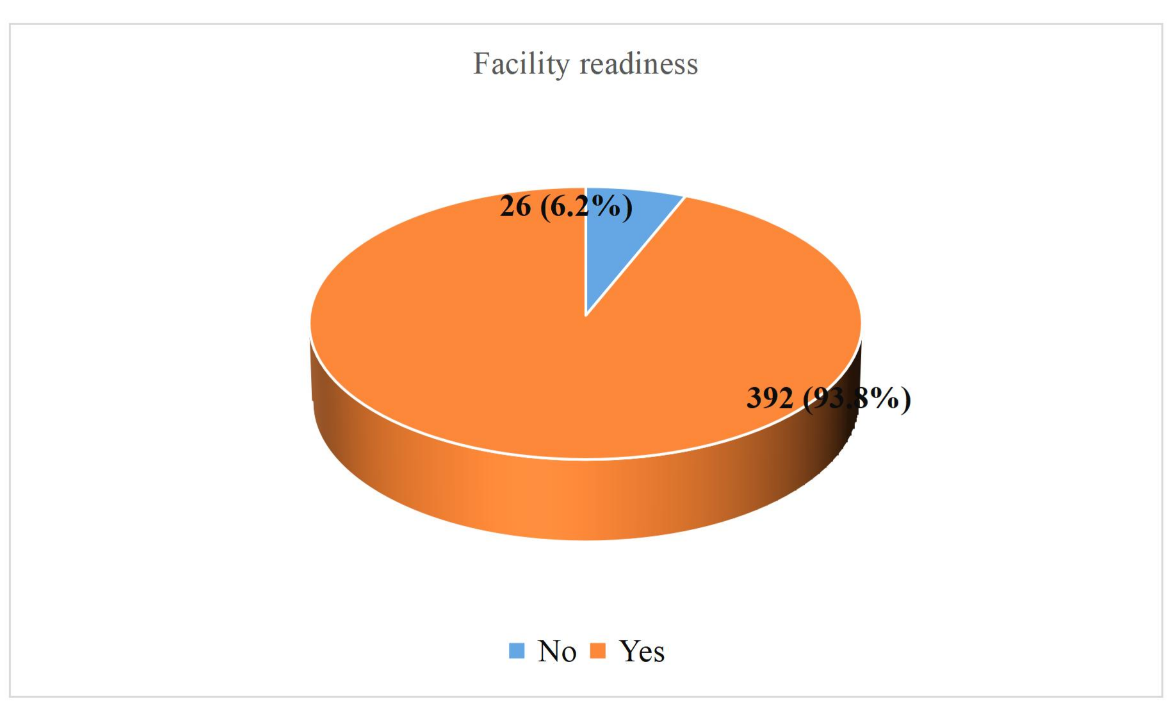

Figure 4: Respondents' Perceived Facility Readiness

Over nine-tenths, 392 (93.8%) of the respondents reported facility readiness for respectful maternity care, while less than one-tenth, 33 (7.9%), reported No ready facilities.

Table 16: Factors associated with respondents perceived facility readiness

Variables	Perceived readiness of facility		Test statistic	p-value
	Yes (n=392) Freq(%)	No (n=26) Freq(%)		
Age (years)				
18–25	55 (84.6)	10 (15.4)	11.832	**0.008**
26–35	224 (94.9)	12 (5.1)		
36–45	100 (97.1)	3 (2.9)		
>45	13 (92.9)	1 (7.1)		
Ethnicity				
Edo Indigene	234 (93.2)	17 (6.8)	0.329	0.566
Non-Edo Indigene	158 (94.6)	9 (5.4)		
Marital status				
Ever married	44 (89.8)	5 (10.2)	1.510*	0.219
Never married	348 (94.3)	21 (5.7)		
Level of education				
No formal education	9 (81.8)	2 (18.2)	2.771*	0.096
Formal education	383 (94.1)	24 (5.9)		
Occupation				
Skill level 0	19 (90.5)	2 (9.5)	1.688	0.793
Skill level 1	6 (100.0)	0 (0.0)		
Skill level 2	263 (93.3)	19 (6.7)		
Skill level 3	7 (100.0)	0 (0.0)		
Skill level 4	97 (95.1)	5 (4.9)		
Monthly income				
<₦70,000	104 (93.7)	7 (6.3)	0.002	0.965
≥₦70,000	288 (93.8)	19 (6.2)		
Religion				
Christianity	365 (94.1)	23 (5.9)	2.572	0.276
Islam	24 (92.3)	2 (7.7)		
African Traditional Religion	3 (75.0)	1 (25.0)		
Number of children				
1 child	125 (94.7)	7 (5.3)	0.096	0.757
>1 child	267 (93.4)	19 (6.6)		
Place of delivery				
Private facility	156 (95.1)	8 (4.9)	2.281	0.516
Public facility	217 (92.7)	17 (7.3)		
Home	12 (100.0)	0 (0.0)		
Traditional birth attendant	7 (87.5)	1 (12.5)		
Mode of delivery				
Vaginal	268 (92.4)	22 (7.6)	0.122*	0.122
Caesarean section	124 (96.9)	4 (3.1)		
Mode of payment				
Out of pocket	327 (93.2)	24 (6.8)	0.404*	0.404
Insurance	65 (97.0)	2 (3.0)		

*Fisher's Exact Test.

The proportion of respondents who perceived the facility as ready was highest among those aged 36–45 years, 100 (97.1%), followed by >45 years, 13 (92.9%), 26–35 years, 224 (94.9%), and lowest among those aged 18–25 years, 55 (84.6%). This association was statistically significant ($\chi^2 = 11.832$, $p = 0.008$). Ethnicity was not significantly associated with perceived facility readiness, although non-Edo indigenes, 158 (94.6%), had a slightly higher proportion perceiving the facility as ready compared to Edo indigenes, 234 (93.2%) ($\chi^2 = 0.329$, $p = 0.566$). Marital status was also not statistically significant (Fisher's Exact Test, $p = 0.219$), despite respondents who were never married, 348 (94.3%), reporting slightly higher perceived readiness compared to ever married respondents, 44 (89.8%).

Level of education did not show a statistically significant association with perceived readiness (Fisher's Exact Test, $p = 0.096$), although respondents with formal education, 383 (94.1%), reported higher perceived readiness than those without formal education, 9 (81.8%). Occupation was similarly not significant ($\chi^2 = 1.688$, $p = 0.793$), although respondents in skill level 1 and skill level 3 occupations, 6 (100.0%) and 7 (100.0%) respectively, all perceived the facility as ready. Monthly income ($\chi^2 = 0.002$, $p = 0.965$), religion ($\chi^2 = 2.572$, $p = 0.276$), and number of children ($\chi^2 = 0.096$, $p = 0.757$) were also not statistically significantly associated with perceived readiness.

Place of delivery did not demonstrate a statistically significant association with perceived readiness ($\chi^2 = 2.281$, $p = 0.516$), although all respondents who delivered at home, 12 (100.0%), perceived the facility as ready, compared to 156 (95.1%) of those who delivered in private facilities, 217 (92.7%) in public facilities, and 7 (87.5%) among those delivered by traditional birth attendants. Mode of delivery was also not significantly associated (Fisher's Exact Test, $p = 0.122$), though respondents who had caesarean section, 124 (96.9%), had higher perceived readiness compared to those who had vaginal delivery, 268 (92.4%). Similarly, mode of payment was not statistically significant (Fisher's Exact Test, $p = 0.404$), although respondents enrolled in insurance schemes, 65 (97.0%), had slightly higher perceived readiness compared to those paying out of pocket, 327 (93.2%).

SECTION F: OVERALL SATISFACTION TOWARDS CARE

Table 17: Satisfaction of care by postnatal mothers

Variables	Frequency (n = 418)	Percent
Overall satisfied with care received during childbirth		
Yes	372	89.0
No	46	11.0
Are you willing to return to same facility		
Yes	356	85.2
No	62	14.8
Are you willing to refer someone to same facility		
Yes	378	90.4
No	40	9.6

Most respondents were satisfied with the care received during childbirth, 372 (89.0%), while 46 (11.0%) were not satisfied. The majority also reported willingness to return to the same facility for future childbirth services, 356 (85.2%), whereas 62 (14.8%) were unwilling. Similarly, most respondents indicated willingness to refer someone to the same facility, 378 (90.4%), while 40 (9.6%) were unwilling to make such referrals.

CHAPTER FIVE

DISCUSSION

This study assessed the knowledge, attitude, experiences, and determinants of respectful maternity care among mothers in Benin City, Edo State, Nigeria, as well as the provider and facility-level factors shaping those experiences. The findings are discussed below in relation to the specific objectives of the study, and are situated within the WHO framework for quality maternal and newborn care, which provided the conceptual basis for the research. This framework positions the experience of respectful maternity care as an outcome shaped by three interacting domains: individual or client-level factors, which include a woman's knowledge, attitudes, and personal characteristics; provider-level factors, encompassing the conduct and working conditions of healthcare workers; and facility-level factors, which refer to the structural and institutional conditions under which care is delivered.

The majority of respondents in this study were women in their late twenties to mid-thirties, placing them firmly within their most active reproductive years. Most were married, held tertiary-level education, identified as Christian, had attended antenatal care during their most recent pregnancy, and delivered in either a public or private health facility, with most settling their bills through out-of-pocket payments.

This pattern is not unexpected given the urban character of Benin City, where proximity to health facilities, higher levels of female literacy, and greater exposure to health information tend to favour both antenatal attendance and institutional delivery. The predominance of married women likely shows the sociocultural context of southern Nigeria, where childbirth is closely tied to formal unions and where spousal support plays a meaningful role in determining whether women seek facility-based care. The high proportion of respondents with tertiary education and skilled employment may have further reinforced healthcare-

seeking behaviour, as educated women tend to place greater value on skilled attendance and are more likely to persist with facility use even when earlier experiences were unsatisfactory.

This sociodemographic pattern is consistent with a cross-sectional study conducted in 2023 among postpartum women in Ogun State, Nigeria, which reported a similar profile of married, educated, urban women and observed that this group represents those most likely to engage with formal maternal health services.[51] A multi-state cohort study carried out in 2022 across three Nigerian states similarly found that urban residence, marital status, and formal education were consistently associated with higher rates of institutional delivery attendance.[83] The public health implication is that the findings of this study are most representative of women already engaged with the health system, and that those most vulnerable to disrespectful care, women with little or no formal education, those in underserved communities, and those who deliver outside facilities, are less likely to have been captured. Expand maternal health awareness programmes beyond facility settings into communities, using trained community health extension workers to reach women who fall outside the reach of routine antenatal care.

The study found that the large majority of respondents had never heard of respectful maternity care as a concept, and even among the minority who were aware of it, fewer than half demonstrated good overall knowledge of its principles. Knowledge was highest for obvious violations such as verbal abuse and discrimination but fell considerably lower in domains relating to supportive care, non-discriminatory treatment, informed consent, and autonomy during labour. Hospitals were almost the exclusive source of information for women who had any awareness at all, with schools, community settings, and mass media contributing very little.

Several interacting factors within the Nigerian maternal healthcare setting help to explain this finding. Respectful maternity care remains a relatively recent concept in the country, and even where it has entered facility-level policy, it has rarely been translated into structured patient education. Routine antenatal counselling continues to focus on clinical matters such as danger signs, birth preparedness, and immunisation, with little deliberate attention given to women's rights during childbirth. Even among largely educated urban women, general schooling alone does not automatically generate awareness of maternity rights if those rights are not explicitly communicated as part of maternal health education. Beyond this, the normalisation of disrespectful practices in many facilities may further widen conceptual gaps, since women who have grown accustomed to being shouted at or subjected to procedures without explanation may come to regard these experiences as ordinary features of childbirth rather than violations of their dignity. The finding that hospitals were the dominant source of awareness further suggests that knowledge of RMC has not yet entered public discourse and remains largely facility-dependent. An important observation from the field reinforces this point: many women who could not define or recognise respectful maternity care as a concept were able, when asked directly, to describe experiences of having been shouted at, slapped, or ignored in previous deliveries. The gap is not in lived experience but in the conceptual language that would allow women to name those experiences as rights violations rather than as something they simply had to endure.

This finding is consistent with a community-based study carried out in 2022 among postpartum women in Kano State, Nigeria, which similarly found that formal awareness of respectful maternity care was very low even though most women could identify mistreatment when presented with specific scenarios, and the authors argued that this gap between experiential recognition and rights-based understanding is one of the most significant barriers to demand-side accountability in Nigerian maternity care.[84] A cross-sectional study

conducted in 2023 in Ethiopia found that women who received structured rights-based education during antenatal care were significantly more likely to recognise violations and raise concerns with providers, pointing to the power of deliberate education.[85] In contrast, a study carried out in 2021 in Sweden reported considerably higher maternity rights awareness among postpartum women, attributed to the routine integration of patient rights education into antenatal programmes and the broader cultural entrenchment of informed consent in healthcare.[86] The difference between these settings shows a deliberate institutional investment in women's health literacy that is largely absent in the Nigerian setting. Poor knowledge of respectful maternity care has direct consequences: it reduces the likelihood that violations will be identified or challenged, allows disrespectful practices to persist without generating institutional pressure for change, and leaves women unable to make informed demands of their care providers. Incorporate rights-based maternal health education materials into routine antenatal care visits, rather than offered as optional additions.

Despite the low awareness of respectful maternity care as a formal concept, the overwhelming majority of respondents held positive attitudes toward its underlying principles. Almost all agreed that women deserve dignified and compassionate treatment throughout childbirth, that providers should communicate clearly and obtain consent before procedures, and that the maternity environment should be safe and adequately equipped. Verbal abuse, unofficial payment demands, and discriminatory treatment were broadly rejected. The desire for respectful care, in other words, appears to exist independently of formal knowledge of rights.

These positive attitudes may be connected to the relatively high educational level of respondents and the growing awareness of patient-centred care among urban women in southern Nigeria. Women with higher education may be more likely to understand concepts

such as autonomy and informed consent through their broader engagement with formal institutions and access to health information. Urban settings like Benin City also expose women to social media, advocacy messaging, and community conversations about women's rights in ways that may reinforce expectations of dignified treatment. Women who have personally experienced disrespectful care in earlier deliveries may also, through that experience, become more acutely aware of what respectful care should look like, and the strong rejection of verbal abuse and unofficial payments observed in this study may in part reflect a growing frustration with practices that were previously endured without complaint. Formal education emerged as the only statistically significant predictor of positive attitude in the multivariate analysis, reinforcing the view that exposure to formal institutions plays a meaningful role in shaping expectations of dignified care. That said, not all attitudes were straightforwardly positive. During data collection, a subset of women described experiences of having been shouted at or physically restrained during labour and genuinely believed that the provider was acting in their best interest, framing coercion as dedication rather than abuse. This form of deeply internalised normalisation is qualitatively different from simply having a negative attitude; it reflects a belief that disrespect is not only acceptable but possibly necessary for a safe delivery, and it presents a different kind of challenge to RMC advocacy.

This finding is in agreement with a cross-sectional study conducted in 2023 among postpartum women in Rivers State, Nigeria, which found that while the majority held positive attitudes toward respectful care, women without formal education were significantly more likely to describe verbal reprimands and non-consented procedures as acceptable, pointing to education as a key vehicle through which patient rights expectations are formed.[87] A qualitative study carried out in 2022 in Ghana documented the same rationalisation of abuse as care observed in this study, with participants attributing provider aggression to genuine concern for the safety of the delivery, particularly among women who had experienced

multiple disrespectful births over successive pregnancies.[88] In contrast, a study from Sweden conducted in 2021 found that women who experienced mistreatment during childbirth consistently evaluated their care negatively and sought redress, a pattern linked to stronger institutional accountability and a more embedded patient rights culture.[86] The public health implication is that positive attitudes, while encouraging, must be translated into active self-advocacy and cannot coexist with cultural narratives that frame abuse as care. Community health campaigns should explicitly challenge the belief that shouting or physical coercion by a provider is a sign of clinical dedication, and antenatal education sessions should help women distinguish between authoritative care and abusive conduct.

The majority of respondents reported a broadly positive childbirth experience, describing their providers as kind, empathetic, and respectful in manner. Experiences of being communicated with in a language they understood, having their needs responded to, and being treated without discrimination were widely reported. However, beneath this generally positive depiction, specific and serious violations persisted. More than one in five women reported being shouted at during labour, more than one in ten reported being physically struck, and a meaningful proportion experienced prolonged waiting, denial of care due to inability to pay, or failure to be addressed by their names. The suppression of cultural practices during labour was almost universal, representing a near-complete failure in cultural autonomy.

The generally favourable overall experience may be connected to the urban character of Benin City and the relatively better-resourced facilities available there, compared to more rural or peripheral settings where staffing and infrastructure tend to be considerably weaker. High antenatal attendance among respondents may also have fostered some degree of familiarity between women and their providers, which can soften interactions even in busy

clinical environments. However, the persistence of verbal and physical abuse, financial gatekeeping, and the suppression of cultural practices points to an incomplete institutionalisation of respectful care that cannot be explained away by structural factors alone. Ingrained hierarchical practices, poor accountability, and the absence of clear facility-level standards for provider conduct during labour are likely contributors. An important point also arises here from what was observed during data collection. A number of women who reported positive experiences for their most recent delivery had in fact experienced serious mistreatment in earlier pregnancies and had responded by deliberately changing facilities. Their reported positive experience therefore reflects not a generally improved system, but a personal and adaptive decision made in the aftermath of prior harm. Equally, women who had normalised disrespectful treatment would not recognise or report it as such, even if it had occurred during the delivery in question. Both dynamics work in the same direction: they cause a survey focused on the most recent delivery to present a more favourable picture of respectful care than the system as a whole deserves.

Nurse/midwives were identified as responsible for the majority of reported mistreatment across all domains, including physical and verbal abuse, unfriendly treatment, and denial of care. This is not simply a reflection of their larger numbers in the labour ward; it points to specific cadre-level gaps in training, supervision, and accountability that must be addressed directly. A cross-sectional study carried out in 2023 among postnatal women in Delta State, Nigeria, similarly documented a high overall rate of positive experience but identified facility-switching as a common and underreported client-level response to prior mistreatment, leading the authors to argue that last-delivery survey designs overestimate RMC quality at the system level.[89] A prospective cohort study conducted in 2022 in Ghana, which followed the same women across two deliveries, found that women who experienced disrespect in their first delivery were far more likely to change facilities for their second and to report better

experiences as a result, directly corroborating the pattern observed in this study.[90] The near-universal denial of cultural practices documented here has also been described in a qualitative study conducted in 2023 in Southwest Nigeria, where postpartum women reported systematic institutional suppression of traditional birth practices by providers who regarded them as incompatible with clinical management, regardless of whether they posed any risk.[92] The persistence of physical and verbal abuse alongside a broadly positive overall experience reinforces the need for healthcare facility managers to introduce structured postnatal feedback mechanisms that go beyond general satisfaction ratings, and for professional bodies overseeing nurses and midwives to strengthen conduct standards and enforcement during intrapartum care.

The study found that while skilled birth attendants were available to the majority of respondents during labour, about one-third perceived their provider as overworked or stressed at the time of their delivery. Overcrowding and lack of space were reported as affecting care by a notable proportion, some women described feeling intimidated by their birth attendant, and a small number reported being asked for unofficial payments. Despite these concerns, most respondents perceived the facility overall as ready for respectful maternity care, though younger women expressed less confidence in facility readiness than older ones.

These findings reveal the familiar structural pressures of the Nigerian public health system. Maternity units in public facilities operate under chronic strain from high patient volumes, inadequate staffing, poor remuneration, and limited institutional support for healthcare workers. When providers work under such conditions for sustained periods, burnout, diminished empathy, and reduced tolerance are predictable consequences, and the co-occurrence of high perceived provider stress alongside documented rates of verbal and physical abuse in this study is not coincidental. These are connected phenomena, and any

honest engagement with disrespectful care must engage with the working conditions that produce it, rather than treating individual incidents of abuse as isolated failures of character. At the same time, structural pressure does not fully account for all misconduct. Providers who shout at or strike labouring women are making behavioural choices that are often sustained by an institutional culture where such conduct goes unchallenged, and sometimes quietly endorsed as a means of managing uncooperative patients. The high perceived facility readiness despite documented violations further suggests that women's assessments of readiness may reflect structural factors such as staff availability and cleanliness, rather than the more intangible dimensions of interactional quality and accountability. The finding that a small number of women were asked for unofficial payments during labour is also notable; where most women pay out of pocket, financial coercion during the vulnerability of active labour is a serious governance failure that reflects poorly on both individual providers and the institutions that tolerate it.

These findings resonate with those of a mixed-methods study carried out in 2020 in Ebonyi State, Nigeria, which identified poor ward design, inadequate training, weak accountability, and the normalisation of mistreatment as the key drivers of disrespectful maternity care in public facilities.[93] A cross-sectional study conducted in 2023 in Kaduna State found a significant association between provider burnout and rates of verbal abuse and non-consented care during labour, with the heaviest workloads consistently linked to the most dismissive patient interactions.[91] A systematic review and meta-analysis published in 2024 examining provider-level determinants of mistreatment across Sub-Saharan Africa identified inadequate in-service training, high patient-to-midwife ratios, and absent accountability mechanisms as the three strongest predictors of physical and verbal abuse in public maternity facilities.[2] A study from Anambra State conducted in 2022 found that women who were asked for unofficial payments during labour were significantly more likely to report overall

disrespectful care experiences, and that this was more prevalent in public than private settings, pointing to an institutional governance gap rather than isolated individual misconduct.[94] The public health implication is that reducing disrespectful care in public maternity facilities requires not only improvements in staffing and infrastructure but the active cultivation of an institutional culture in which provider accountability is real and the dignity of labouring women is treated as a clinical standard rather than a courtesy. Hospital management committees and state health authorities should introduce regular facility-level assessments of provider conduct, with clear procedures for responding to substantiated reports of abuse.

In the multivariate analysis, positive attitude toward respectful maternity care and place of delivery emerged as the only statistically significant independent predictors of a respectful childbirth experience. Women with positive attitudes were approximately three times more likely to report a respectful experience, while women who delivered in public facilities had substantially lower odds of a respectful experience compared to those who delivered in private facilities.

The association between positive attitude and positive experience is best understood as a client-level relationship in which women's expectations shape how they engage with their providers and, to some extent, how they perceive and describe the care they receive. Women who enter the labour ward with a strong expectation of respectful treatment are more likely to communicate actively, seek clarification, and signal their preferences, behaviours that may in turn influence how providers interact with them. It is also possible that the relationship runs in the opposite direction, as prior positive experiences in healthcare can consolidate favourable attitudes over time. However, women who have normalised disrespectful care, and who therefore hold lower expectations of what dignified treatment looks like, are also more likely to report a positive experience even where violations occurred. The association in this

study may therefore partly show a real relationship between women's assertiveness and the quality of their care, and partly a measurement effect in which attitude shapes how experiences are perceived and described. Cross-sectional data cannot fully separate these two pathways, and this should be acknowledged when interpreting the finding. The significant association between public facility delivery and lower odds of respectful care is among the most policy-relevant findings of the study. Public maternity facilities in Nigeria generally operate at higher patient volumes relative to staffing, with fewer financial incentives to maintain patient satisfaction and weaker institutional accountability than private facilities. The result is a systematic inequality in the quality of interpersonal care that falls most heavily on women who have no financial alternative to public services.

A cross-sectional study conducted in 2024 in Oyo State, Nigeria, found a nearly identical public-private disparity, with women in public facilities more likely to report disrespectful care across all domains, and identified staffing ratios, provider training quality, and accountability culture as the principal mediating factors.[96] A multi-country mixed-methods study published in 2023 similarly found that the quality gap between public and private maternity care was widest in settings with weak regulatory oversight of public facilities and dysfunctional or absent patient feedback systems, both of which are recognisable features of the Nigerian context.[18] A cross-sectional study carried out in 2023 in Zambia also noted that women with lower baseline expectations of care quality tended to report higher satisfaction despite evidence of more violations during their deliveries, reinforcing the interpretive caution raised above.[95] Positive attitudes strengthen a woman's capacity to advocate for herself during labour and can create informal pressure on providers to maintain higher standards of interpersonal care. Equally, closing the quality gap between public and private facilities requires deliberate policy attention to accountability structures, supervisory frameworks, and institutional culture in the public sector. Respectful maternity care should be

made a measurable component of public facility performance assessments, with findings reporting transparently and linked to corrective action plans at the facility level.

CONCLUSION

This study set out to assess the extent, determinants, and implications of respectful maternity care experiences among mothers in Benin City, Edo State, guided by five specific objectives.

This study assessed the knowledge and attitude of respectful maternity care among postnatal mothers, the study found that formal awareness of RMC as a concept was poor among the majority of respondents, with the hospital being almost the sole source of information for those who had any awareness at all. Knowledge was weakest in domains relating to supportive care, non-discriminatory treatment, informed consent, and autonomy during labour, reflecting the absence of deliberate rights-based education in routine maternal health communication. Despite this, the overwhelming majority held positive attitudes toward the principles underlying respectful care, and formal education emerged as the only significant predictor of positive attitude, underscoring the important but insufficient role of general literacy in building maternity rights awareness.

This examined postnatal mothers' experiences of respectful or disrespectful maternity care during childbirth, the majority reported broadly positive experiences, particularly in relation to dignity, kindness, empathetic communication, and non-discriminatory treatment. However, verbal abuse, physical abuse, prolonged waiting, denial of care due to inability to pay, failure to be addressed by name, and the near-universal suppression of cultural practices during labour represented persistent and serious violations that sat uneasily alongside the generally favourable overall picture. Two dynamics observed during data collection add important context to these findings: a number of women with positive recent experiences had changed facilities following mistreatment in earlier deliveries, and some women had so normalised abusive conduct from providers that they did not experience it as mistreatment at all. Both patterns point to a system whose true quality is worse than a last-delivery survey can capture.

This sought to identify provider and facility-level determinants of RMC violations, the study found that perceived provider overwork and stress co-occurred with the documented rates of physical and verbal abuse, implicating workforce strain as a structural driver of disrespectful conduct. Overcrowding, infrastructure constraints, intimidation by birth attendants, and unofficial payment demands were also identified as facility-level factors compromising care quality. Nurse/midwives were disproportionately identified as responsible for mistreatment across all abuse domains, pointing to cadre-specific gaps in training and accountability that must be addressed directly rather than subsumed within general system-level concerns.

This assessed the determinants of respectful maternity care experience, positive attitude toward RMC and place of delivery were the only statistically significant independent predictors in the multivariate analysis. Women with positive attitudes had substantially higher odds of reporting a respectful experience, reflecting the role of client-level expectations and assertiveness in shaping care interactions. Women who delivered in public facilities had significantly lower odds of a respectful experience compared to those in private facilities, confirming a structural quality gap that is rooted in differences in accountability, staffing, and institutional culture between the two sectors.

This aimed to advocate for institutional policy changes promoting RMC, the cumulative findings of this study make a compelling case for reform at multiple levels. The persistence of abuse, the absence of structured rights-based antenatal education, the lack of functional patient feedback mechanisms, the public-private quality gap, and the normalisation of disrespectful conduct among both providers and women all point to a system that has not yet made respectful maternity care a consistent institutional standard. Addressing these gaps is essential not only as a matter of women's rights and dignity but as a practical strategy for sustaining facility delivery uptake, rebuilding trust in the health system, and ultimately

contributing to the reduction of preventable maternal and neonatal morbidity and mortality in Benin City and beyond.

RECOMMENDATIONS

To Edo State Ministry of Health

1. Develop and integrate a standardised RMC educational module, covering women's rights during childbirth, informed consent, birth companionship, and reporting pathways, into all antenatal care curricula in Edo State public facilities, with mandatory documentation of attendance in antenatal cards.
2. Commission a state-level RMC media campaign across television, radio, and social media platforms targeting women aged 18–35 years, particularly never-married and less-educated women, to extend RMC awareness beyond the facility setting, which should be tracked quarterly.

To Healthcare Facility Administrators

1. Healthcare facility administrators should organise regular training and retraining programmes for maternity staff on respectful maternity care, communication skills, empathy, informed consent, and patient-centred care delivery.
2. Hospital management boards should work to improve labour ward infrastructure by addressing overcrowding, ensuring adequate privacy, and creating conditions that support emotional care and birth companionship during labour and delivery.
3. Healthcare institutions should put in place functional complaint and feedback mechanisms that allow women to report disrespectful treatment safely and without fear of victimisation.
4. The government and hospital authorities should improve staffing levels, welfare packages, and psychological support for maternity healthcare providers in order to reduce burnout and the effects of work-related stress on care quality.

To Healthcare Providers and Professional Bodies

1. Professional bodies and training institutions should give greater emphasis to respectful maternity care principles within undergraduate and postgraduate curricula for medicine, nursing, and midwifery.
2. Medical and nursing training institutions should revise undergraduate curricula to include at least one dedicated credit unit on patient-centred communication, informed consent in obstetric care, and women's rights during childbirth, with clinical assessment of these competencies prior to graduation.

For Researchers and Policymakers

1. Further research should be carried out in rural communities and private healthcare facilities within Edo State to build a broader understanding of respectful maternity care experiences across different healthcare settings.
2. The National Primary Health Care Development Agency (NPHCDA) and Federal Ministry of Health should develop and enforce a national RMC standard with facility-level indicators that can be integrated into the national health facility assessment tool, Service Availability and Readiness Assessment (SARA), enabling cross-state benchmarking and accountability.

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APPENDICES

APPENDIX A: QUESTIONNAIRE

ASSESSMENT OF RESPECTFUL MATERNITY CARE EXPERIENCES AMONG POSTNATAL MOTHERS IN BENIN CITY, EDO STATE

Dear Respondent,

We are 600-level medical students at the University of Benin conducting a study which aims at "Assessing Respectful Maternity Care Experiences among Postnatal Mothers in Benin City, Edo state. **All information given will be treated confidential**. Please mark and fill all sections as appropriate.

Thank you for your time and participation.

SECTION A: SOCIODEMOGRAPHICS

1. Age (in years): _______

2. Ethnicity: __________

3. Marital Status: [ ] Single [ ] Married [ ] Divorced [ ] Widowed [ ] Separated [ ] Cohabiting

4. Highest level of Education: [ ] No formal education [ ] Primary [ ] Secondary [ ] Tertiary

5. Occupation: ___________________________

6. Montly income __________

7. Religion: [ ] Christianity, [ ] Islam [ ] African traditional religion

8. Number of children: ________

9. Did you attend Antenatal Care for your last pregnancy: [ ] Yes [ ] No.

I0 If yes, number of visits: [ ] one [ ] Two [ ] three [ ] > Four

11.Where did you attend antenatal care [ ]private facility [ ]public facility [ ] Traditional birth attendant [ ]Maternity home (TICK ALL THAT APPLY)

12.Where did you deliver [ ] private facility [ ] public facility [ ] Home [ ] Traditional birth attendant [ ] Church

13.Length of stay in the facility after delivery: __________

14. Mode of Delivery: [ ] Vaginal [ ] Caesarean Section

15. Place of delivery of previous child (If any) [ ] Health facility [ ] Home [ ] Traditional birth attendant [ ] Church

16. Mode of Payment: [ ] Out of pocket [ ] Insurance (specify) __________

SECTION B: KNOWLEDGE OF RESPECTFUL MATERNITY CARE (RMC) (MULTIPLE RESPONSE QUESTIONS)

17.Have you heard of the term Respectful Maternal Care (RMC) [ ] yes [ ] No if no skip to section C

18.If Yes, Where did you hear of the term RMC [ ] Hospital [ ] Internet [ ] social media [ ] Television [ ] others(specify) ______

19.What does Respectful Maternal Care mean [ ] care centered on hospital/facility rules [ ] care focused on preventing complication [ ] care that uphold dignity, privacy, consent and autonomy [ ]care based on provider judgement [ ] care that ensures women are free from abuse, discrimination, and neglect during childbirth

20.Which of the following is not a component of respectful maternal care [ ]Equality, Freedom from discrimination [ ] Taking informed consent [ ] verbal curses during pain [ ] performing procedures without explanation [ ] maintaining privacy and confidentiality during care

21.Supportive care involves **[ ]** Emotional reassurance during labour [ ]Ignoring complaints of pain [ ] Providing pain relief options when available [ ] Performing procedures secretly [ ] allowing a chosen birth companion for support during labour

22.Non-discriminatory care means **[ ]**Equal treatment regardless of age or ethnicity [ ]Prioritizing wealthy women over others [ ] Providing care regardless of HIV status [ ] Refusing care based on marital status [ ] Fair treatment regardless of religion or educational level

23.Dignified care includes [ ]Calling women by their names [ ]Using insulting language [ ]Showing empathy during labour [ ] Slapping women during delivery [ ] Protecting privacy during care

24.Effective communication in RMC includes:[ ]Explaining procedures clearly [ ]Using medical jargon without explanation [ ]Obtaining consent before interventions [ ] Making decisions without consulting the woman [ ] Listening to the woman's concerns

25. Risk factors for disrespectful care include [ ]Health worker burnout and stress [ ]Adequate staffing and supervision [ ]Lack of training on RMC principles [ ] Strong accountability systems [ ] Inadequate facilities and equipment

26. Facility-level factors contributing to poor RMC include [ ]Overcrowding in labour wards [ ]Availability of clear patient rights policies [ ]Shortage of staff [ ]Supportive supervision [ ] Lack of essential supplies

27.Provider-related risk factors include**[ ]**Negative attitudes toward patients [ ] Empathy training [ ] Poor communication skills [ ] Patient-centered care models [ ] Lack of training on RMC principles

28. Consequences of disrespectful maternity care include [ ]Loss of confidence in health workers [ ] Increased institutional delivery rates [ ]Psychological trauma [ ]Improved maternal satisfaction [ ] Avoidance of health facilities in future pregnancies

29. Poor RMC may lead to [ ]Delay in seeking future care [ ]Increased community confidence in facilities [ ] Preference for home delivery next time [ ] Better provider-patient relationships [ ] No satisfaction with childbirth experience

30. Disrespect and abuse during childbirth can result in [ ]Postpartum depression [ ]Improved maternal bonding [ ] Fear of future pregnancies in facilities [ ]Higher satisfaction with services [ ] Anxiety during childbirth

31. Long-term consequences of poor RMC include [ ]Increased maternal morbidity due to delayed care-seeking [ ]Greater adherence to antenatal visits [ ]Erosion of women's rights in healthcare [ ]Stronger patient-provider relationships [ ] Lower confidence in seeking care

SECTION C: ATTITUDE TOWARDS RESPECTFUL MATERNITY CARE

Please tick the most appropriate response for each statement. (SD=Strongly Disagree, D=Disagree, N=Neutral, A=Agree, SA=Strongly Agree)

S/N	STATEMENT	SD	D	N	A	SA
32	Women deserve to be treated with dignity and respect by maternity care providers at all times.					
33	Raising one's voice, scolding, or speaking harshly to women in labour is an acceptable way to maintain discipline in the labour ward.					
34	It is the responsibility of providers to ensure that women feel emotionally safe and valued throughout childbirth.					
35	Healthcare providers should clearly explain examinations, procedures, and labour progress to women in a manner they can understand.					
36	Women have the right to ask questions and receive honest, respectful responses from maternity staff.					
37	Seeking a woman's consent before performing any procedure is essential for respectful maternity care.					
38	Women should be actively involved in decisions regarding their labour and delivery care.					
39	Emotional reassurance, empathy, and compassionate care are critical components of high-quality maternity services.					
40	Allowing women to have a birth companion of their choice is important for enhancing their childbirth experience.					
41	Providers should respond promptly whenever a woman in labour calls for assistance or expresses concern					
42	Maintaining a clean, safe, and adequately equipped maternity environment is essential for respectful maternity care.					
43	Asking women to pay unofficial fees during childbirth is acceptable.					

SECTION D: EXPERIENCE DURING CHILDBIRTH

Please answer Yes or No

44. Who attended to your Birth during the delivery of your last child? [ ] Doctor [ ] Nurse [ ] Traditional birth attendant [ ] Others________ (TICK ALL THAT APPLY)

45. Did the skilled birth attendant/s care for you with a kind approach? [ ]Yes [ ] No

46. Did the skilled birth attendant/s treat you in a friendly manner? [ ]Yes [ ] No . If No, who provided your care?[ ] Nurse/Midwife [ ] Doctor[ ] Traditional birth attendant [ ] Others (specify) ________

47. Did the skilled birth attendant/s talk positively about pain and pain relief? [ ]Yes [ ] No. If No, who provided your care?[ ] Nurse/Midwife [ ] Doctor[ ] Traditional birth attendant [ ] Others (specify) ________

48. Did the skilled birth attendant/s show concern and empathy toward you? [ ]Yes [ ] No. If No, who provided your care?[ ] Nurse/Midwife [ ] Doctor[ ] Traditional birth attendant [ ] Others (specify) ________

49. Were you treated with respect as an individual by the skilled birth attendant/s? [ ]Yes [ ] No. If No, who provided your care?[ ] Nurse/Midwife [ ] Doctor[ ] Traditional birth attendant [ ] Others (specify) ________

50. Did the skilled birth attendant/s speak to you in a language you could understand?[ ]Yes [ ] No. If No, who provided your care?[ ] Nurse/Midwife [ ] Doctor[ ] Traditional birth attendant [ ] Others (specify) ________

51. Did the skilled birth attendant/s call you by your name? [ ]Yes [ ] No

52. Did the skilled birth attendant/s respond to your needs, whether or not you asked?[ ]Yes [ ] No

53. Were you hit or slapped by any skilled birth attendant during labour and delivery?[ ]Yes [ ] No. If Yes, who provided your care?[ ] Nurse/Midwife [ ] Doctor[ ] Traditional birth attendant [ ] Others (specify) ________

54. Did any skilled birth attendant shout at you because you had not done what you were told?[ ]Yes [ ] No. If Yes, who provided your care?[ ] Nurse/Midwife [ ] Doctor[ ] Traditional birth attendant [ ] Others (specify) ________

55. Were you kept waiting for a long time before receiving service? [ ]Yes [ ] No

56. Were you allowed to practice your cultural rituals in the facility? [ ]Yes [ ] No

57. Were you denied or restricted care because of inability to pay for services?[ ] Yes [ ]No. If Yes, who provided your care?[ ] Nurse/Midwife [ ] Doctor[ ] Traditional birth attendant [ ] Others (specify) ________

58. Did any skilled birth attendant/s treat you poorly because of your personal attributes (e.g., age, ethnicity, religion, social status)? [ ] Yes [ ] No. If Yes, who provided your care?[ ] Nurse/Midwife [ ] Doctor[ ] Traditional birth attendant [ ] Others (specify) ________

SECTION E: PROVIDER AND FACILITY-LEVEL FACTORS

Please tick the most appropriate response for each statement.

59 .Was there a skilled birth attendant/s available during your labour?[ ] Yes [ ]No

60. Did a skilled birth attendant/s appear overworked or stressed?[ ] Yes [ ] No

61.Did lack of space/facility crowding affect your care?[ ] Yes [ ] No

62.Did you feel intimidated or afraid of the skilled birth attendant/s?[ ] Yes [ ] No

63.Were you asked for unofficial payments or bribes?[ ] Yes [ ] No

SECTION F: OVERALL PERCEPTION AND POLICY SUGGESTIONS

64.Are you satisfied with care you received during childbirth. [ ]Yes [ ]No

65.Are you willing to go back to the facility used?[ ] Yes [ ] No

66.Are you willing to refer some one to the facility used?[ ] Yes [ ] No

THANK YOU FOR YOUR RESPONSES

APPENDIX B: INFORMED CONSENT FORM

TITLE OF RESEARCH: ASSESSMENT OF RESPECTFUL MATERNITY CARE EXPERIENCES AMONG POSTNATAL MOTHERS IN BENIN CITY, EDO STATE, NIGERIA.

NAME AND AFFILIATION OF INVESTIGATOR:

Ayibatonbra Ebisintei Awudu and Oluwatosin Oghenefejiro Ladokun

Department of Public Health and Community Medicine,

University of Benin Teaching Hospital,

PMB 111 Ugbowo, Benin-Lagos Express Road,

Benin City, Edo State.

Email: ayibatonbra.awudu@med.uniben.edu , oluwatosin.ladokun@med.uniben.edu

PURPOSE OF RESEARCH: To assess the extent, determinants and implications of respectful maternity care experiences among postnatal mothers in Benin City, Edo State.

PROCEDURES INVOLVED IN THE STUDY: In this study, questions will be asked regarding the knowledge, attitude, provider and facility determinants of Respectful maternity care experiences among postnatal mothers in Benin City, Edo State

CONFIDENTIALITY: All data collected will be treated with utmost confidentiality. Patients who volunteer to participate in this study will be given a unique study number, and data will be collected. Participants' information will be stored safely secured by codes in computers. All those handling data will not at any time reveal participants' identity.

FINANCIAL COMPENSATION: There shall be no monetary compensation for participation in this study.

VOLUNTARY PARTICIPATION: Your participation in this study is entirely voluntary. If you desire to withdraw from this study at any time, no punitive measures will be meted

against you for your withdrawal. Your refusal to participate or withdraw from the study will not involve any negative consequences or loss of benefits to which you are otherwise entitled.

RISK: It is not expected that any harm will come to you because of your participation in this study. The study does not entail any activity that would harm you.

BENEFIT: The study will help advocate for institutional policy changes promoting Respectful maternity care in the maternity services for postnatal mothers in Benin City.

FINANCIAL SPONSORSHIP: This study will be sponsored by the principal investigators.

The under-listed may be contacted in case you have any clarifications to make:

Ayibatonbra Ebisintei Awudu and Oluwatosin Oghenefejiro Ladokun

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Ethics and Research Committee,

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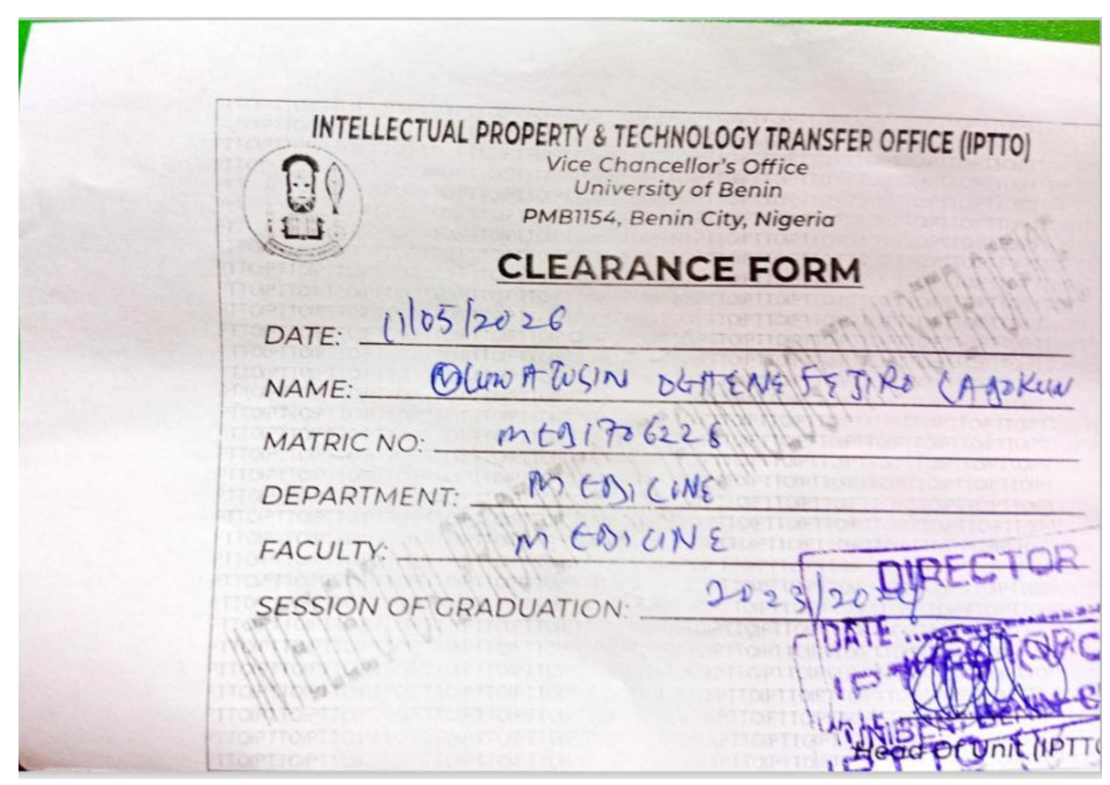
APPENDIX C: PLAGIARISM SLIP

INTELLECTUAL PROPERTY & TECHNOLOGY TRANSFER OFFICE (IPTTO)
Vice Chancellor's Office
University of Benin
PMB1154, Benin City, Nigeria

CLEARANCE FORM

DATE: 11/05/2026
NAME: AWUBU AYIBATONBRA EBISINTEI
MATRIC NO: MED1706186
DEPARTMENT: MEDICINE
FACULTY: MEDICINE
SESSION OF GRADUATION: 2023/2024

DIRECTOR
DATE ...
IPTTO
UNIBEN. BENIN CITY
Head Of Unit (IPTTO)



INTELLECTUAL PROPERTY & TECHNOLOGY TRANSFER OFFICE (IPTTO)
Vice Chancellor's Office
University of Benin
PMB1154, Benin City, Nigeria

CLEARANCE FORM

DATE: 11/05/2026
NAME: OLUWATOSIN OGHENEFEJIRO CAGOKUN
MATRIC NO: MED1706226
DEPARTMENT: MEDICINE
FACULTY: MEDICINE
SESSION OF GRADUATION: 2023/2024

DIRECTOR
DATE ...
IPTTO
UNIBEN. BENIN CITY
Head Of Unit (IPTTO)

APPENDIX D: ETHICAL CLEARANCE

HEALTH RESEARCH
ETHICS COMMITTEE (HREC)

UNIVERSITY OF BENIN TEACHING HOSPITAL

P.M.B. 1111 BENIN CITY NIGERIA Telephone: 052-600418 Website: ubth.org

CHIEF MEDICAL DIRECTOR
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Prof. (Mrs.) Antoinette N. Ofili

HREC OFFICE:
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Registration Number:
NHREC-UBTH-HREC/24/12/2022B

PROTOCOL NUMBER: ADM/E 22/A/VOL. VII/1486549127281

PROPOSAL TITLE: "ASSESSMENT OF RESPECTFUL MATERNITY CARE EXPERIENCES AMONG POSTNATAL MOTHERS IN BENIN CITY, EDO STATE, NIGERIA"

PRINCIPAL INVESTIGATOR(S): AWUDU AYIBATONBRA EBISINTEI, OLUWATOSIN OGHENEFEJIRO LADOKUN

DEPARTMENT/INSTITUTION: DEPARTMENT OF PUBLIC HEALTH AND COMMUNITY MEDICINE, SCHOOL OF MEDICINE, UNIVERSITY OF BENIN, BENIN CITY, EDO STATE, NIGERIA

DATE CONSIDERED: FEBRUARY 23RD, 2026

DECISION OF THE COMMITTEE: APPROVED

THIS APPROVAL DATES 23/02/2026 TO 22/01/2027. IF THERE IS DELAY IN STARTING THE RESEARCH, PLEASE INFORM THE HREC SO THAT THE DATES OF APPROVAL CAN BE ADJUSTED ACCORDINGLY

REMARK:

CHAIRMAN: PROF. (MRS) A.N. OFILI SIGNATURE & DATE 23/2/2026

UNIVERSITY OF BENIN TEACHING HOSPITAL, RESEARCH COMMITTEE, Sign..., Date..., BENIN CITY P.M.B. 1111

SUPERVISOR (S): PROF. E. O OGBOGHODO

DECLARATION BY INVESTIGATOR(S):

PROTOCOL NUMBER (please quote in all enquiries)

Note that no participant accrual or activity related to this research may be conducted outside of these dates and you **are to furnish the committee with the research activities at the completion of the study**. All informed consent forms used in this study must carry the HREC assigned number and duration of HREC approval of the study. In multiyear research, endeavor to submit your annual report to the HREC early in order to obtain renewal of your approval and avoid disruption of your research. No changes are permitted in the research without prior approval by the HREC except in circumstances outlined in the Code. The HREC reserves the right to conduct compliance visit your research site without previous notification.

Signature & Date........ 24/02/26

ubthresearchethics@gmail.com **Registration Number: NHREC/24/01/2020**