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TABLE OF CONTENTS

QUALITATIVE INQUIRY INTO MOTHER'S EXPERIENCE OF RESPECTFUL MATERNITY CARE IN SECONDARY HEALTH CARE FACILITIES IN ONDO STATE, NIGERIA

SOWUNMI CHRISTIANAH OLANREWAJU &OLUWASEYI OMOBOLA TEMILOLA

ABSTRACT

Respectful Maternity Care (RMC), a key component of quality care involves respect for women's basic human rights during maternity care. Studies have reported high levels of disrespectful care and subsequent low patronage in healthcare facilities contributing to maternal mortality. The experience of mothers on RMC in secondary health care facilities in Ondo State was explored. It is a cross-sectional exploratory qualitative study involving six focused group discussions with 40 pregnant and postnatal mothers accessing care at three secondary health facilities in each of the three senatorial districts of Ondo State, Nigeria. Two focused group each with the mothers were held per facility in November 2023. An unstructured focus group guide was used to collect qualitative data. Qualitative data were thematically analyzed. MKP-RMC adapted 3 domains from Shakibazadeh et al's 12 domains of RMC which served as the thematic framework for data analysis. Four themes emerged; knowledge of RMC, giving emotional support, providing safe care and preventing maltreatment. The sub-themes that emerged at pre-intervention were verbal abuse and hitting of patients, no pain management, no respect for birthing position, birth companion and culture. There should be sensitization for patients to know and demand for their rights in a good way whenever they access health care in these facilities and there should be regular up-to-date workshops and seminars for nurses and midwives to get them abreast with current trends in RMC. Government should ensure provision of adequate equipment and materials needed for effective delivery of the midwives' job.

Keywords: RMC, Secondary health facilities; MKP-RMC; Focused Group Discussion; experience of mothers.

INTRODUCTION

Pregnancy and childbirth are critical events in the reproductive life of women and denote a period of high susceptibility. Every woman has a right to humane, dignified, considerate, and respectful healthcare throughout pregnancy as well as skillful delivery care (World Health Organization 2014). Facility-based deliveries and skilled attendance at birth are key drivers of reductions in maternal morbidity and mortality globally (Silveiraa et al, 2015). The rate of maternal and infant mortality in Nigeria is so high and it is at an unprecedented rate[3]. Poor treatment during childbirth contributes both directly and indirectly to maternal mortality. Respectful Maternity Care (RMC) therefore, as a crucial component of quality care is a human right and is key to reducing maternal mortality through quality midwifery care. Currently, RMC is a top priority in the World Health Organization (WHO) recommendations on intra-partum care or a positive childbirth experience

According to WHO (WHO 2014), RMC is defined as care organized for 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. A recent systematic review by Shakibazadeh et al, (2018) confirms 12 domains of RMC which includes 'protecting women from harm and mistreatment, upholding confidentiality and privacy, preserving their dignity, providing information and requesting informed consent, ensuring ongoing access to family and community support, improving the quality of the physical

environment and resources, providing equitable maternity care, engaging in effective communication, respecting women's choices that increase their capacity to give birth, and having access to qualified and motivated healthcare providers'. The domains used in this study are from the 12 domains and adapted from MKP-RMC, to suit mothers. It includes: knowledge of RMC, giving emotional support, providing safe care and preventing mistreatment.

In a Nigerian survey of 446 mixed rural and urban women, 98 percent of the participants reported experiencing some form of abuse or disrespect during their most recent delivery. In another study carried out by Thapaliya et al.,[7] on Disrespect and abuse during facility-based childbirth in Pokhara Metropolitan City. Finding revealed that the overall disrespect and abuse during facility-based childbirth was 70.1% and only 29.9% of the postnatal mothers received respectful non-abusive care.

Therefore, there is the need to scale up maternity care in contemporary health care facilities to reflect fundamental human rights. Meanwhile, studies have shown that a lot of the patients are not aware of their rights and tend to take in abuse so far the outcome is favourable (Bulto et al., 2020). Statements have been credited to mothers signifying perceptions that normalize disrespect for some women and deviate from global definitions which stipulate that all women deserve RMC. Statistics have shown that patients are dissatisfied with care received in the health care facilities hence they don't come to deliver or access obstetric care. Disrespect and Abuse contribute to delays 1 and 2 concept of maternal mortality. Non utilization of the health care facilities as a result of Disrespect and Abuse amongst others leads to untold complications which include, Pre-eclampsia toxaemia, eclampsia, ante-partum and post-partum haemorrhage, and sepsis, fetal and maternal mortality amongst others.

Respectful maternity Care is evolving and needs to be strengthened in Ondo State. There are also limited studies done in this area in the study setting making information on RMC during facility based childbirth to be limited. There's the need for inquiry into mother's experience of RMC in health care facilities in Ondo State

Methods

Study design: It is a cross-sectional exploratory qualitative study

Research Setting: The study was conducted in Ondo state, south western region of Nigeria. There are three (3) senatorial districts in Ondo State; the Northern, Southern and Central senatorial districts. The study was carried out in the selected secondary health care facilities in each Senatorial districts in the state which are: State Specialist Hospital, Akure (Ondo Central), State Specialist Hospital, Ikare (Ondo North) and General Hospital, Ore (Ondo South). The character of each LGA is reflected in the socio-demographic characteristics of mothers accessing the health facilities. The health facilities were selected based on their relatively large volume of clients.

Method of Data Collection

The study participants were pregnant women in their second and third trimesters attending ANC that are registered at these health facilities, and mothers in post-natal wards. They were selected by the research assistants with support from the nursing staff who introduced the research assistants and explained the purpose of the research to them. The health providers introduced the research team to the women. The FGDs were conducted in a separate and secluded room away from the nurses and other staff within the facility, during one of their regular antenatal clinic days and after all health education activities had been concluded. The FGDs lasted about 45 min on average. Two focus group discussions (FGDs) were conducted per facility until saturation was achieved. This was done in the three selected facilities for two weeks using the Focus Group Discussion guidelines among the pregnant women to assess their experience on RMC.

The: researchers involved in the FGDs were all females, which helped to prevent gender and social desirability bias.

Five to ten (5-10) obstetric women per group were drawn. Simple random sampling (balloting) was used to select the population of pregnant mothers. This was achieved by giving mothers who met the inclusion criteria ballots of Yes and No. Any mother with a Yes was recruited until saturation and interviewed

A combination of data collection instruments was used which comprised of Focused Group Discussions (FGDs) with the help of FGDs guide, digital recorder and field notes. A focused group discussion guide had 12 items in all that explored the experience of pregnant women on RMC in selected secondary health care facilities.

FGD guide was developed from the 3 domains of MKP-RMC, coined from the 12 domains of RMC proposed by Shakibazadeh et al as their thematic framework. These includes; giving emotional support, promoting safe care, preventing maltreatment. A total of 12 questions in all were asked from the women. The discussion began by a general RMC question and their knowledge of what RMC means, and then the participants were asked to express their opinion about the 3 domains. Interesting responses were probed. All the FGDs were audio-recorded using a digital voice recorder.

Method of Data Analysis

In this study, the audio-recorded focused group discussions of the women were transcribed verbatim in English language. The transcribed FGDs were imported, initially coded using deductive coding guided by the 3 domains coined from the 12 domains of RMC proposed by Shakibazadeh et al as their thematic framework. Afterwards, inductive coding was done for the remaining information not yet coded. The transcript was coded using NVIVO software, version II. The code was arranged into themes which informed the analysis that was done to explain pregnant women opinion and experience on RMC; this was analyzed through thematic analysis.

Ethical Consideration: Ethical clearance and approval for the study was obtained from Babcock University Research Ethical Committee (BUHREC) with the approval number BUHREC 999/23. The Researcher submitted letter of introduction to Ondo State Research Ethical Review Committee along with an application to conduct the study. Ethical approval was obtained from Ondo State Research Ethical Review Committee (OSHREC) with the assigned number OSHREC/05/12/2023/604. Participants were made to understand the purpose of the study. Participation was made voluntary and participants were informed of their right to withdraw at any stage of the study without losing anything. Informed consent (Written) was obtained from all the participants

Results

Table 1: Socio-demographic Characteristics of Participants in FGD

Participants	Age	Marital status	Religion	Parity	Occupation	Education	Number of ANC visits
Akure - Group 1(Hosp 1)							
P1	32	Married	Christian	2	Civil servant	Tertiary	3
P2	32	Married	Christian	2	Business	Tertiary	2
P3	32	Married	Muslim	2	Fashion designer	Tertiary	3
P4	25	Married	Christian	1	Civil servant	Tertiary	3
P5	31	Married	Christian	2	Business	Tertiary	1
P6	24	Married	Christian	1	Business	Secondary	2
P7	33	Married	Muslim	1	Civil servant	Tertiary	3
Group 2							
P1	27	Married	Christian	1	Business	Tertiary	1
P2	32	Married	Muslim	2	Business	Tertiary	3
P3	24	Married	Muslim	1	Business	Tertiary	1
P4	28	Married	Muslim	3	Civil servant	Tertiary	3
P5	26	Married	Christian	2	Fashion designer	Tertiary	4
Ore - Group 1 (Hosp 2)							
P1	32	Married	Christian	2	Business	Tertiary	3
P2	26	Married	Christian	3	Business	Secondary	3
P3	29	Married	Christian	1	Business	Secondary	3
P4	24	Married	Muslim	1	Civil servant	Secondary	3
P5	27	Married	Muslim	2	Civil servant	Tertiary	2
P6	29	Married	Christian	1	Business	Tertiary	3
P7	33	Married	Christian	2	Business	Secondary	2
Group 2							

Group 2							
P1	27	Married	Muslim	2	Business	Secondary	3
P2	34	Married	Muslim	4	Business	Secondary	4
P3	28	Married	Muslim	2	Business	Secondary	3
P4	31	Married	Christian	2	Banker	Tertiary	4
P5	25	Married	Christian	2	Business	Tertiary	4
P6	29	Married	Christian	4	Business	Secondary	3
P7	31	Married	Christian	4	Business	Primary	2
Ikare - Group 1 (Hosp 3)							
P1	34	Married	Muslim	4	Teacher	Tertiary	4
P2	25	Married	Christian	1	Banker	Tertiary	3
P3	23	Married	Christian	1	Fashion designer	Secondary	3
P4	32	Married	Muslim	4	Business	Secondary	3
P5	25	Married	Muslim	1	Fashion designer	Secondary	3
P6	41	Married	Muslim	4	Civil servant	Tertiary	4
P7	24	Married	Muslim	1	Business	Secondary	3
Group 2							
P1	25	Married	Christian	2	Business	Secondary	3
P2	23	Married	Christian	1	Business	Secondary	4
P3	34	Married	Muslim	4	Business	Tertiary	3
P4	31	Married	Muslim	3	Business	Secondary	3
P5	34	Married	Muslim	4	Teacher	Tertiary	3
P6	35	Married	Muslim	3	Teacher	Tertiary	3
P7	27	Married	Christian	2	Banker	Tertiary	4

Socio- Demographic Characteristics of Respondents for FGDs

Participants' socio-demographic variables for focused group discussion were discussed in Table 1 above. A total of 40 pregnant women were recruited for the study, with 14 participants each from the three selected towns. For the 3 settings, majority of the women (50.0%) were between the ages of 20 and 30 years. Akure (50.0%), Ore (64.3%) and Ikare (50.0%). The overall mean age of the participants was 28.39±6.92

Table 2: Themes and subthemes generated on mother's experience of RMC

S/N	Construct	Themes	Sub-Themes
1	Knowledge of respectful maternal care among obstetric women in health care facilities	Knowledge of the RMC	Prompt attention Response to needs Reactions of health workers to patients Consent and confidentiality
2	Experience of women regarding respectful maternal care	Emotional Support Domain of Respect	Pleasant experience with a warm welcome Insufficient labour ward orientation Adequate respect in terms of labour room support Calling names with respect No choice or respect for the birthing position No respect for the birth companion No respect for our culture
			Confidentiality Informed consent Preferential Treatment
		Providing Safe Care Domain of Respect	Respect for privacy in the labour room Pain relief during labour -Fix drip -Rubbing Back Experience of verbal abuse as a weapon of cooperation Hitting of women during labour (physical abuse)
		Preventing Maltreatment Domain of Respect	

The women displayed their knowledge regarding RMC under the following sub-themes: Prompt Attention. The discussant explained that, to say a health worker respects her client; such a client must have received her services promptly and without any delay.

Prompt attention

As we come to the hospital we are supposed to be promptly attended to (Hosp 3, FGD1P1)

When I am attended to without delay that is what respect is to me (Hosp 2, FGD 2, P 4).

Response to Needs

What I can say is that the nurses are trying, in terms of putting us through things we need to take into consideration and avoid during pregnancy (Hosp 1, FGD 2, P 4).

When I came to the hospital, they checked my BP, and they took care of someone the way they were supposed to take care of someone (Hosp 3 FGD 2, P 2).

Reactions of health workers to Patients

Well, to me, respect for pregnant women means understanding what they are going through and

seeing how you can be part of it to encourage them in that moment. (Hosp 1, FGD 1 P 4)

I feel that, ermm, the way to respect pregnant women is that, okay, assuming this person is coming, the tendencies are that the person will have some mood swings; they should not still compound it by using words like, "Did I give you work?" or "Am I the one who did it?" I just feel like (Hosp 1, FGD 1, P 3)

Consent and Confidentiality .

The way I understand respectful maternity care is that it entails care for the patients, confidentiality, consent-taking, and informing the patients and their family members about whatever pertains to their health (Hosp 1. FGD 2, P 4).

EXPERIENCE OF MOTHERS WHILE BEING GIVEN EMOTIONAL SUPPORT BY HEALTH WORKERS

The experience of women regarding emotional support received in the health facility during their antenatal period was explored. However, one of the points mentioned is that the senior nurses, who have spent more years in the service and have more experience, give more support to the patients compared to the younger nurses.

Young nurses, they don't have experience, and they don't know how to react to pressure. So, when they have little pressure, they tend to talk anyhow (Hosp 2 FGD1, P 1).

They talk anyhow; only the matrons and those who are their superiors are those who calm them down and tell them that they shouldn't be addressing their patients that way (Hosp 1, FGD 1, P 5).

Pleasant Experience with a Warm Welcome

Some expressed their opinion that they had a negative opinion of how the nurses welcomed the women in the facilities, and they were discouraged from even attending or registering in the facility. Contrary to their expectations, their experiences were different from what they heard about the facility.

Insufficient Labor Ward Orientation

Regarding this, a higher proportion of women reported that they were never shown around the labor ward during delivery.

During my first visit, I could remember that the nurses took us, the pregnant woman, around, showed us the labor room, and gave us a well-defined description of how to make our movements at any time (Hosp 1, FGD 1,P1).

They didn't also take me around the ward, and I also didn't request it (Hosp 2 FGD 1, P 4).

Adequate respect in terms of labor room support

The women reported that they received adequate respect and encouragement in terms of support when they were in the labor room.

Like I said, they will rub my back and waist, and they will be greeting me sorry too. (Hosp 2, FGD 1 P 5)

Where they told me to lie, I just lied there, and at a point when I just wanted to stand up, one of the nurses came to gently explain to me that I needed to hold the pain for my own good. She then helped me to rub my back. (Hosp 1, FGD 1, P 5)

Calling Names with Respect

They reported that some add no respect to the way they address them; they call them by their first name, and that alone infuriates them. Others say, they usually give them various appellations, such as mama lawyer, mummy doctor, and fine girl. This, in a way, encourages them and makes them feel happy.

They call us by name; they insult (Hosp 1, FGD 1 P 2).

About calling, they call us by name; the nurses—I don't know why they do that—they'll just call you by your name as if they are above everyone. (Hosp 1, FGD 1, P 1)

No Choice or Respect for the Birthing Position

All the things they have been saying are true; in antenatal care, they didn't explain methods to us; there is only one method we use (Hosp 3, FGD 1 P 6)

It is not possible for them to allow that for us; we have to sleep in a certain position. (Hosp 1 FGD 1P 1)

No Respect for a Birth Companion

The report varied across locations; while some women mentioned that they allowed them to bring in companions, a higher percentage reported that they don't allow them to bring in companions.

And in regards to allowing people in, they don't. My husband will only stay at the entrance, and when the baby has been delivered, they will show him the sex of the baby and hand over the planceta to him (Hosp 3, FGD 1 P 6).

Even if there are no other women in the labor ward with us, they don't allow our relatives in; even if they do, they will send them out after a short stay. (Hosp 1 FGD1 P 4)

No Respect for Our Culture

According to our respondents, culture is one thing that one must not bring to the hospital because they don't respect it. You are only permitted to follow the rules and regulations of the health facility for a positive health outcome.

Even as Muslims, we are not allowed to cover our heads in labor wards; just that, we tie a rapper, put on a hair net, and go inside to give birth. That's all (Hosp 3 FGD1 P2).

They don't. They don't consider it. (Hosp 1 FGD1 P1)

Providing Safe Care as a Form of Respectful Maternal Care

It was reported that the kind of care they received in the facility was highly encouraging compared to the impression given before visiting the facility.

Confidentiality

A positive report was recorded from almost all the discussants.

They keep it simple; when they talk, they don't shout; they talk calmly so that others will not hear. (Hosp 3 FGD1 P 7)

The secret between doctors and patients is very strong, and they don't say it out; in fact, when you meet them, they don't give you a judgmental look (Hosp 2 FGD 2 P 7).

Informed consent is always sought and respected

According to our discussant, they opined that they usually seek their consent before taking any decision.

They do seek consent, and they will tell us to cooperate, like when I gave birth to my firstborn, I had tears, and they told me that they would stitch it and that it would be painful, but I should not shout, they told me. (Hosp 2 FGD2 P2)

Preferential Treatment

They reported that there was no significant preferential treatment and no form of partiality was ever recorded.

What I know is that they attend to us based on our arrival; some people will still come late, and they will attend to them also, but they were attending to those of us that came early first. (Hosp 3 FGD 1 P 5)

Experience of Respectful Maternal Care While Preventing Maltreatment

We examined privacy in the labor room and treatment given to women in labor pain.

Respect for privacy in the labor room

We explored access to privacy in labor among women who attend antenatal and postnatal clinics.

They don't allow anybody to enter anyhow, even if it's your family. (Hosp 2 FGD 2 P 4)

They don't allow, and even when we take clothes away, they still cover us back (Hosp 3 FGD 2 P 1).

Pain Relief During Labour

The women said that during labor, the health workers attended to them well, and below are some of the things they did for them while in pain.

Fix Drip to Reduce Pain

They gave me, and they will ask me if they should fix the drip for me. I will agree, and they will fix it, and immediately I will be relieved (Hosp 3 FGD 2 P6).

Rubbing Our Back

like I have said they will rub my back and waist, they will be greeting me sorry too. (Hosp 2 FGD 2P5)

EXPERIENCE OF VERBAL ABUSE AS A WEAPON OF COOPERATION

Some mentioned that the health worker always shouts at them to cooperate in a situation.

Like this morning, when I came to drop my card, the woman there was just shouting. Some nurses don't know how to attend to someone (Hosp 3 FGD 2 P1).

When we scream in pain of labor, they do shout at us, saying, "Shut up!" "Am I there when you are having sex?" Normally they do shout at us; I don't know why they do that at that stage. (Hosp 1 FGD1 P 1)

HITTING OF WOMEN DURING LABOUR (PHYSICALABUSE)

They see the beating as normal and part of what they must experience to realize their goal, which is to give birth successfully. Some even said that they had to do it for their own benefit. This form of disrespect and abuse is accepted and normal at almost all the facilities visited.

When you are not complying at all, they will hit you. Like me now, they do beat me very well, consistently, and I know it's for me so that I will not press the baby's head together with my thighs (Hosp 3 FGD 2 P 4).

They can beat you when you don't cooperate when the baby is coming, to protect the baby. (Hosp 1 FGD1 P 4)

Discussion

Socio-Demographic Characteristics of the Women at the Pre and Post Intervention Stage

The socio-demographic characteristics of women were analyzed. An observed key factor, consistent with prior research findings, was the age distribution of the participants. This demographic composition is advantageous for the study, as younger participants are more likely to undergo pregnancy stages in the future, thereby providing insights. Unlike older women, younger participants are better positioned to recall detailed experiences, facilitating a comprehensive understanding of RMC implementation in healthcare facilities and enabling effective post-intervention comparisons. Similar age distributions were observed in other studies (Bulto et al., 2020; Orpin et al., 2018) underscoring the prevalence of younger participants in studies evaluating women's experiences of RMC.

Interestingly, this study reveals that all respondents had previous childbirth experiences, a finding consistent with prior research (Mwasha et al., 2023), where most participants also had at least one childbirth experience. Furthermore, an analysis of the socio-demographic characteristics of the women, particularly regarding religion, with a majority identifying as Christians in two of the locations, while the majority in Ikare were Muslims. This contrasts with findings from study (Mwasha et al., 2023), where a majority of participants were Christians.

Exploring Women Experience of RMC

The experiences of obstetric mothers with midwives, particularly concerning respectful maternal care, are influenced by their knowledge of such services. This study's findings indicate that women's knowledge of RMC primarily revolves around four sub themes: prompt attention, response to their needs, health workers' reactions to patients, and respect for consent and confidentiality. These constructs significantly shape women's experiences of RMC playing a vital role in their emotional well-being throughout these processes. This is averse to a study carried out on Disrespect and abuse in maternity care in a low-resource setting in Tanzania: Provider's perspectives of Practice where four main themes were identified from the data: Physical and verbal abuse; Lack of professional ethics and integrity; Vulnerable working environment; Abuse and disrespect to care providers (Moridi et al., 2020)

Authors expressed similar perspective of the multidimensional side of women emphasizing the importance of being treated as human beings with emotions and expectations rather than merely as patients by midwives, highlighting the significance of respecting their rights in accessing maternal care services to enhance facility utilization and achieve positive pregnancy outcomes (Lukpata et al., 2020)

Generally, in terms of emotional support, women across all three locations (Ore, Akure and Ikare) universally agree that older midwives with extensive experience tend to display more empathy than their younger counterparts. Emotional support during and after delivery is deemed essential for RMC (Dzomeku et al., 2021) with friendly interaction identified as an initial step in providing respectful maternity care(Lukpata et al., 2020). Although the intensity of emotions may vary among women due to factors such as parity or state of mind, the importance of emotional support in RMC remains paramount, as inadequate management may heighten the risk of postpartum depression. These authors (Moridi et al., 2020) also supports the assertion that junior midwives also disrespect and abuse women

Additionally, the absence of supportive birthing environments that accommodate alternative positions was noted in the studies of these authors(Mgawadere et al., 2021; Wassihun et al., 2018). Moreover, obstetric women highlighted the importance of having a birth companion, especially their spouses, present during labor to alleviate tension and provide emotional support, particularly during first births. However, these authors (Lukpata et al., 2020; O'Brien et al., 2021) in their studies have identified a lack of woman-centered care delivered with compassion and respect, reflecting deficiencies in the care experiences of obstetric women.

In the context of Respectful Maternal Care (RMC), women's experiences regarding emotional support often intersect with the respect for their cultural and religious practices within health facilities. The disregard for these practices by health facilities can deter women from utilizing delivery services, as observed in Iran where midwives' adherence to cultural and religious norms positively influenced women's attendance at health facilities (Lukpata et al., 2020). Conversely, a significant proportion of women across various locations expressed satisfaction with the safe care provided, particularly in maintaining confidentiality and obtaining informed consent, which not only fosters a sense of respect but also alleviates fears associated with undisclosed health conditions that may affect maternal and child health outcomes.

Ensuring a well-informed consent policy further enhances trust in healthcare services, as evidenced by studies suggesting that women who experience disrespect or abuse are less likely to seek care at the same facility (Orpin et al., 2018). Moreover, women's relationships with midwives are shaped by their ability to exercise choice, contingent upon the level of trust established (Ajayi 2020). In Nigeria, a robust study revealed discrepancies in the application of non-preferential treatment, with reports of women receiving better care if they had personal connections with healthcare providers or offered monetary incentives (Chang et al., 2018).

Moreover, elements such as privacy in the labor room and the treatment received by women during labor pain were pivotal in assessing the domain of preventing maltreatment before the intervention. Positive responses, including pain relief measures and ensuring privacy, were noted, potentially attributed to the implementation of initiatives like the maternity initiative "Abiye," aimed at enhancing women's healthcare facility utilization. Such initiatives contribute to healthcare system improvements, aligning with previous studies highlighting enhanced maternal healthcare utilization in regions like Ondo state (Raval et al., 2021; Mgawadere & Shuaibu 2021)

Despite predominantly positive responses from women, significant objections emerged during discussions, particularly regarding

verbal and physical abuse by healthcare practitioners, often associated with the challenges of public health facilities and potential deficiencies in governmental oversight mechanisms. Authors (Raval et al., 2021; Umar et al., 2020; Ratcliffe et al., 2016) in their recommendations underscore the importance of adequate preparation, monitoring, and sustainability of interventions to ensure effective communication and align outcomes with women's priorities, local culture, and the context of labor and birth care, emphasizing the need for governmental policies to address these aspects comprehensively.

Summarily, based on the findings of this study, it could be identified that in exploring the experiences of women on RMC before the intervention, certain lags are still prevalent and which to some extents are more emotionally inclined to the women experiencing respect in terms of receiving maternal health care services. Although positive responses were acknowledged by the respondents in terms of the services rendered by the health practitioner, but the mode at which these services are rendered and limitations in the public health facility to establishing changes deterred achieving RMC.

Persistent exposure to mistreatment not only undermines the emotional well-being of affected mothers but also undermines their confidence in the effectiveness of respectful maternal care practices within healthcare facilities, thus increasing their likelihood of seeking alternative care options. This corroborates with the findings of these authors (O'Brien, Butler, & Casey 2021). in which disrespect and abuse were identified as significant barriers to skilled birth utilization, surpassing more commonly recognized obstacles such as financial and geographical constraints. Studies in Enugu further support these findings, with a majority of women reporting instances of abuse during childbirth (Mwasha, Kisaka & Pallangyo 2023).

Recommendations

There should be sensitization for patients to know and demand for their rights in a good way whenever they access health care in these facilities.

Limitations

Despite the significant outcome of this study, there are few limitations. There is the need to explore other players in the team of RMC such as midwives

Conclusion

The patients had fairly good experience with respect to obstetric care. They reported that younger midwives tend to address patient anyhow and the elderly ones are better in terms of respect and they cope better under pressure. It was also noted that patients do not have understanding of their rights hence they tend to take in whatever the midwives do to them as normal and that the outcome of the whole experience is the most important.

Conflict of interest

None

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