Original Article

Supportive Care in Respectful Maternity Care: A Cross-Sectional Quantitative Study of Postnatal Mothers in Osun State, Nigeria

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Article History

Submitted: 20/06/2026; Accepted: 27/06/2026: Published: 30/06/2026

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ABSTRACT

Respectful Maternity Care (RMC) is recognized globally as a fundamental human right and an essential component of quality maternal health services. It encompasses supportive care during childbirth ensuring that women not only survive pregnancy and delivery but also experience care that is compassionate, respectful, and empowering. Despite sustained global advocacy, supportive care remains inadequately prioritized in many low- and middle-income countries. The study assessed supportive care as a domain of RMC among postnatal mothers in selected secondary health facilities in Osun State, Nigeria. A descriptive cross-sectional research design was employed. Three hundred and ninety (390) postnatal mothers were selected using proportional allocation. Data were collected using a semi-structured questionnaire adapted from the Person-Centred Maternity Care (PCMC) scale. Data were analysed using descriptive statistics (frequency and percentage) and inferential statistics (Chi-square tests) at a significant level of 0.05. The findings showed 382 respondents participated in the study. Less than half (173; 45.3%) reported good supportive care. Age, ethnicity, marital status, educational level, and employment status were significantly associated with supportive care ($p<0.05$). None of the medical history were significantly associated with supportive care. The study concluded that supportive care was inconsistently experienced among postnatal mothers in Osun State. This was influenced by socio-demographic characteristics rather than by mothers' medical history. Interventions such as antenatal education should incorporate patient rights training to equip all women to recognise and demand respectful supportive care and patient-centered practices to strengthen supportive care delivery in Nigerian health facilities.

Keywords: Respectful maternity care, Secondary health facilities, Supportive care, Postnatal mothers

INTRODUCTION

Maternal health remains a critical public health priority worldwide, with Respectful Maternity Care (RMC) increasingly recognized as a cornerstone of quality maternal services and a fundamental human right.[1] RMC encompasses dignity, privacy, autonomy, and supportive care during childbirth, ensuring that women not only survive pregnancy and delivery but also experience care that is compassionate, respectful, and empowering.[2] Among these domains, supportive care which is defined as provider attentiveness, emotional reassurance, companionship, and responsiveness to women's needs, has emerged as particularly vital for shaping maternal experiences and outcomes.[3]

Supportive care is more than an adjunct to clinical safety, it is central to women's trust in health systems

Article Access

Website: www.wjmbs.site

10.5281/zenodo.21109003

How to cite this article

Adeyemi AS, Adewoyin SY, Olajide AO, Adeniran GO. Supportive Care in Respectful Maternity Care: A Cross-Sectional Quantitative Study of Postnatal Mothers in Osun State, Nigeria. West J Med & Biomed Sci. 2026;7(2):231-339. DOI:10.5281/zenodo.21109003

and their willingness to seek skilled care in future pregnancies. When supportive care is absent, women frequently report neglect, lack of companionship, and inadequate emotional reassurance, which can lead to trauma, dissatisfaction, and avoidance of facility-based care.[4] Globally, the World Health Organisation's 2025 Compendium on Respectful Maternal and Newborn Care explicitly calls for supportive care to be embedded into health systems as a non-negotiable right, stressing that provider responsiveness and emotional support are essential for quality care and improved maternal outcomes.[5]

Regional studies from Ethiopia, Uganda, and India similarly highlight supportive care gaps, with younger, less educated, or socially marginalized women disproportionately reporting neglect and inadequate emotional support.[6-8] Despite global advocacy, supportive care remains under-prioritized in many low- and middle-income countries (LMICs). A recent commentary described supportive care as the "missing piece" in RMC interventions, noting that psychosocial and emotional support are often overlooked in facility-based maternity care programs.[5] Factor analyses of patient-centered maternity care scales further highlight supportive care as a distinct but weakly upheld domain, requiring targeted interventions to improve provider responsiveness and emotional support.[9]

In Nigeria, systemic challenges such as staff shortages, overcrowded facilities, and poor provider-patient communication continue to undermine supportive care delivery. Evidence from Calabar and Benin City demonstrates that socio-demographic factors including age, marital status, education, and employment significantly influence women's experiences of supportive care, while medical history variables such as parity or mode of delivery often do not.[10,11] These findings suggest that supportive care is shaped more by provider attitudes and systemic conditions than by clinical background. Given these global and regional gaps, this study assessed supportive care as a domain of RMC among postnatal mothers in Osun State, Nigeria.

MATERIALS AND METHODS

Study Area

This study was conducted in four secondary health facilities, in Osun State, and this includes; State Hospital, Asubiaro Osogbo; State hospital Ikirun; State Hospital, Iwo, and State Hospital, Ede. Osun state is located in South-western Nigeria, with 30 local government areas, and a population of approximately 4.7 million people, these facilities serve as referral centres for surrounding communities and provide comprehensive maternal and child health services.

Study Design

A descriptive cross-sectional survey design was employed to assess supportive care experiences among postnatal mothers in selected secondary health facilities in Osun State.

Study Population

The target population for this study were postnatal mothers in the four secondary health facilities, Osun state. This study included postnatal mothers aged 15 years and above, who had recently given birth and were receiving maternity care in the selected secondary health facilities in Osun State, and attended post-natal and infant welfare clinic for immunizations within a 6-week follow-up, and those who were willing to participate. However, women who did not deliver in the selected secondary health facilities, mothers beyond the postpartum period, and those with severe medical or psychiatric conditions that could impair their ability to participate or provide informed responses were excluded from this study.

Sample Size Determination

The sample size was determined using Fisher's formula; $n = \frac{Z^2PQ}{d^2}$

Where, n = Sample size,

Z= a constant which is 1.96 at a 95% confidence interval;

P=estimated prevalence of Respectful Maternity Care = 35.9%.[11]

Q= 1-P

d= absolute precision or sampling error tolerated =5% (0.05).

$$n = \frac{(1.96)^2 \times (0.359) \times (1-0.359)}{(0.05)^2} = 353.6$$

$$n \approx 354$$

Attrition/non-response rate; 10% of sample size

$$\frac{10 \times 354}{100} = 35.4$$

Sample size = 354 + 35.4 = 389.4 (≈ 390).

Sampling Technique

A multistage sampling technique was employed to select study respondents from secondary health facilities in Osun State. First, two of the three senatorial districts in the state were randomly chosen. From each of these districts, two local government areas (LGAs) were selected using simple random sampling through balloting, giving a total of four LGAs. Within each selected LGA, one secondary health facility was purposively chosen to ensure diverse healthcare settings, resulting in four facilities in all. Postnatal mothers in these facilities constituted the sampling frame, and systematic random sampling was then applied to select respondents. The sampling interval (K) was determined proportionally by dividing the estimated number of postnatal mothers in each facility during the study period by the required sample size per facility.

$$K = \frac{N}{n}$$

The first participant was selected randomly, and subsequently, every eligible postnatal mother was included in the study until the required sample size was achieved.

Study Instrument

Data were collected using a pre-tested, structured, and self-administered questionnaire adapted from previous studies and the validated Person-Centered Maternity Care (PCMC) scale.[12] The questionnaire was structured into three sections, as follows;

Section I: Socio-demographic characteristics of the respondents – this comprised 9 items to assess age, ethnicity, religion, marital status, and education level among others.

Section II; Selected medical/obstetric history of respondents – this comprised 7 items to assess previous pregnancy, antenatal attendance, mode of delivery, and other obstetrics characteristics, with 'Yes or No' response.

Section III: Assessment of Supportive Care – this comprised 15 items to assess supportive Respectful Maternity Care experienced by postnatal mothers such as staff responsiveness, trust, and environmental comfort, with a 4-point Likert Scale. The total score range from 0-45 points. Higher scores indicate better supportive care, while lower scores indicate areas where person-centered care might be lacking.

Pilot Study

The reliability of the instrument was assessed using Cronbach's alpha coefficients to determine internal consistency and reliability of the instrument, with an index ≥ 0.70 considered acceptable. Cronbach's alpha reliability index of 0.88 indicated excellent reliability and usefulness of the instrument for this study.

Data Analysis

Data were analyzed using IBM Statistical Package for Social Sciences (SPSS version 27). Descriptive statistics (frequency and percentage) summarized supportive care experiences, and inferential statistics using Chi-square tests examined associations between supportive care, socio-demographic variables and medical history with significance set at $p < 0.05$.

Ethical Consideration

Ethical approval for the study was obtained from the Osun State Health Research and Ethical Committee Ministry of health before the commencement of the study with Ref no; OSHREC/PRS/569T/964. A letter of permission was obtained from the Head of each selected health facility. Informed consent was obtained from all respondents, and they were assured of their right to withdraw from the study at any time or refuse to answer the questionnaire during data collection without penalty. Confidentiality, privacy, and voluntary participation were strictly adhered to throughout the research process.

RESULTS

A total of 390 questionnaires were administered to the respondents, however 382 were returned and valid for analysis, with a response rate of 98%.

Socio-demographic characteristics of the respondents

Table 1 presents the socio-demographic characteristics of the respondents. The majority fell within the 25–34 age group 251 (65.7%), with a mean age of 30 years. Most were married 333 (87.2%), predominantly of Yoruba ethnicity 333

(87.2%), and practiced Islam 199 (50.5%). The largest proportion 145 (38.0%) had one child. Educationally, most respondents had attained tertiary-level education 228 (59.7%), and over half 197(51.6%) were self-employed. Economically, a significant portion earned below ₦50,000 monthly 128 (33.5%), while 29.3% earned between ₦50,000 and ₦100,000. The majority (66.5%, n=254) resided in urban areas.

Assessment of Experience of Supportive Care

Table 2 shows that most of the respondents reported that the facility was clean and comfortable (240; 62.8%), staff explained what to expect during and after delivery (236; 61.8%), and felt the staff took the best care of them (218; 57.1%). Figure 1 present the respondents' experiences of supportive care. Less than average 173 (45.3%) experienced good supportive care. However, 141(36.9%) experienced moderate and 68(17.8%) experienced poor level of RMC.

Relationship between socio-demographic variables and experience of supportive care among postnatal mothers

Table 3 showed that age (χ^2 = 20.322, p=0.000), ethnicity (χ^2 = 27.155, p =0.000), marital status (χ^2 = 29.094, p =0.000), educational level (χ^2 = 14.231, p =0.027), and employment status (χ^2 = 36.894, p=0.000) showed statistically significant relationships with supportive care among postnatal mothers.

Relationship between medical history and postnatal mothers' experience of supportive care.

Table 4 revealed that none of the medical history variables showed a statistically significant relationship with supportive care.

Table 1: Sociodemographic Characteristics of the Respondents (N=382)

Variables	Frequency	Percentage
Age		
17 -24	55	14.4
25 -34	251	65.7
35 -59	76	19.9
Mean = 30.02 ± 6		
Ethnicity		
Yoruba	333	87.2
Igbo	29	7.6
Hausa/Fulani	20	5.2
Religion		
Christianity	179	46.9
Islam	193	50.5
Traditional	10	2.6
Marital Status		
Single	28	7.3
Married	333	87.2
Cohabiting	6	1.6
Separated/divorced	13	3.4
Widowed	2	0.5
Educational Level		
No formal education	14	3.7
Primary	25	6.5
Secondary	115	30.1
Tertiary	228	59.7
Employment Status		
Unemployed	42	11.0
Student	34	8.9
Self -employed	197	51.6
Civil servant	109	28.5
Monthly Income Level		
<N50000	128	33.5
N50000 - N100000	112	29.3
N100000 - N200000	89	23.3
>N200000	53	13.9
Type of Residence		
Urban	254	66.5
Rural	128	33.5
Number of Children		
One	145	38.0
Two	102	26.7
Three	99	25.9
Four or more	36	9.4

Table 2: Experience of Respective Maternal Care-Supportive Care

Variables	No, never	Sometimes	Most of the times	Yes, all the time
Allowed to have someone you wanted (family/friend) to stay with you during labo ur	112 (29.3)	69 (18.1)	30 (7.9)	171 (44.8)
Allowed to have someone you wanted to stay with you during delivery	193 (50.5)	52 (13.6)	26 (6.8)	111 (29.1)
Healthcare providers talked to you about how you were feeling	65 (17.0)	70 (18.3)	57 (14.9)	190 (49.7)
When you needed help, staff paid attention	63 (16.5)	54 (14.1)	52 (13.6)	213 (55.8)
Felt the staff took the best care of you	58 (15.2)	48 (12.6)	58 (15.2)	218 (57.1)
Felt the staff did everything they could to help control your pain	113 (29.6)	43 (11.3)	51 (13.4)	175 (45.8)
Felt you could completely trust the staff with regards to your care	97 (25.4)	40 (10.5)	62 (16.2)	183 (47.9)
Felt safe in the health facility	73 (19.1)	32 (8.4)	62 (16.2)	215 (56.3)
Thought there was enough health staff in the facility to care for you	98 (25.7)	40 (10.5)	47 (12.3)	197 (51.6)
Staff answered your questions clearly	91 (23.8)	49 (12.8)	54 (14.1)	188 (49.2)
Offered food and drink during your stay	154 (40.3)	43 (11.3)	44 (11.5)	141 (36.9)
Facility was clean and comfortable	45 (11.8)	45 (11.8)	52 (13.6)	240 (62.8)
Felt that the staff listened to your concerns	74 (19.4)	37 (9.7)	69 (18.1)	202 (52.9)
Staff explained what to expect during and after delivery	62 (16.2)	39 (10.2)	45 (11.8)	236 (61.8)
	Very L ong	**Long**	**Short**	**Very short**
Amount of time you waited to be seen by staff	135 (35.3)	78 (20.4)	111 (29.1)	58 (15.2)

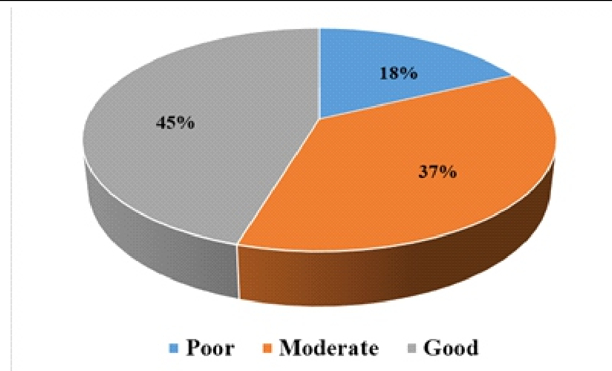

Figure 1 - Overall Level of Experience of Supportive Care

Table 3: Relationship between Socio-demographic Characteristics and experience of Supportive Care

Variable	Category	Poor N (%)	Moderate N (%)	Good N (%)	χ^2	p
Age	17–24	21 (30.9)	11 (7.8)	23 (13.3)	20.322	**0.000**
	25–34	35 (51.5)	101 (71.6)	115 (66.5)		
	35–59	12 (17.6)	29 (20.6)	35 (20.2)		
Ethnicity	Yoruba	47 (69.1)	124 (87.9)	162 (93.6)	27.155	**0.000***
	Igbo	13 (19.1)	11 (7.8)	5 (2.9)		
	Hausa/Fulani	8 (11.8)	6 (4.3)	6 (3.5)		
Religion	Christianity	35 (51.5)	62 (44.0)	82 (47.4)	6.726	0.151
	Islam	31 (45.6)	72 (51.1)	90 (52.0)		
	Traditional	2 (2.9)	7 (5.0)	1 (0.6)		
Marital Status	Single	13 (19.1)	12 (8.5)	3 (1.7)	29.094	**0.000***
	Married	50 (73.5)	124 (87.9)	159 (91.9)		
	Cohabiting	1 (1.5)	0 (0.0)	5 (2.9)		
	Separated/Divorced	3 (4.4)	4 (2.8)	6 (3.5)		
	Widowed	1 (1.5)	1 (0.7)	0 (0.0)		
Education Level	No formal	5 (7.4)	4 (2.8)	5 (2.9)	14.231	**0.027***
	Primary	7 (10.3)	5 (3.5)	13 (7.5)		
	Secondary	27 (39.7)	37 (26.2)	51 (29.5)		
	Tertiary	29 (42.6)	95 (67.4)	104 (60.1)		
Employment Status	Unemployed	17 (25.0)	14 (9.9)	11 (6.4)	36.894	**0.000***
	Student	9 (13.2)	9 (6.4)	16 (9.2)		
	Self-employed	24 (35.3)	63 (44.7)	110 (63.6)		
	Civil servant	18 (26.5)	55 (39.0)	36 (20.8)		
Monthly Income	< ₦50,000	25 (36.8)	39 (27.7)	64 (37.0)	6.876	0.332
	₦50k–₦100k	18 (26.5)	49 (34.8)	45 (26.0)		
	₦100k–₦200k	13 (19.1)	32 (22.7)	44 (25.4)		
	> ₦200k	12 (17.6)	21 (14.9)	20 (11.6)		
Residence	Urban	44 (64.7)	98 (69.5)	112 (64.7)	0.910	0.635
	Rural	24 (35.3)	43 (30.5)	61 (35.3)		
Number of Children	One	23 (33.8)	53 (37.6)	69 (39.9)	5.796	0.446
	Two	18 (26.5)	35 (24.8)	49 (28.3)		
	Three	16 (23.5)	41 (29.1)	42 (24.3)		
	Four+	11 (16.2)	12 (8.5)	13 (7.5)		

*$p<0.05$

Table 4: Relationship between Medical History and Experience of Supportive Care among Postnatal Mothers

Variable	Category	Poor N (%)	Moderate N (%)	Good N (%)	χ^2	p
Previous Pregnancy	Yes	50 (55.0)	68 (56.2)	96 (55.8)	0.021	0.990
	No	41 (45.0)	53 (43.8)	76 (44.2)		
Attended Antenatal Care	Yes	77 (84.6)	103 (85.1)	144 (83.7)	0.095	0.954
	No	14 (15.4)	18 (14.9)	28 (16.3)		
Number of ANC Visits	< 8 visits	60 (65.9)	80 (66.1)	114 (66.3)	0.006	0.997
	≥ 8 visits	31 (34.1)	41 (33.9)	58 (33.7)		
Place of Delivery	Health facility	86 (94.5)	113 (93.4)	160 (93.0)	0.214	0.898
	Non -health facility	5 (5.5)	8 (6.6)	12 (7.0)		
Mode of Delivery	Vaginal	63 (69.2)	84 (69.4)	119 (69.2)	0.004	0.998
	Caesarean/Other	28 (30.8)	37 (30.6)	53 (30.8)		
Complications During Labour	Yes	32 (35.2)	42 (34.7)	61 (35.5)	0.012	0.994
	No	59 (64.8)	79 (65.3)	111 (64.5)		
Outcome of Delivery	Live birth	87 (95.6)	116 (95.9)	162 (94.2)	0.418	0.812
	Stillbirth	4 (4.4)	5 (4.1)	10 (5.8)		

$p > 0.05$

DISCUSSION

This study assessed supportive care as a domain of Respectful Maternity Care (RMC) among postnatal mothers in selected secondary health facilities in Osun State, Nigeria. The study found that the mean age of respondents was 30.02 ± 6 years, with most women within the 25–34 years age group, which represents the peak reproductive age. Similar findings have been reported in studies conducted in Nigeria and Ethiopia.[13-15]

The findings revealed that less than half of the respondents experienced good supportive care, which may reflect issues such as inadequate emotional support, lack of comfort measures, or insufficient attention to patients. This indicates that supportive care practices remain suboptimal in this study, which is in corroboration with a 2025 multi-country review that found "less than half" of women received good supportive care as measured by the person-centred maternity care supportive care subscale.[16] A substantial number reported moderate experiences and a smaller but notable group experienced poor levels of care. This suggests that although some women received adequate emotional, physical, and informational support during childbirth, supportive care is not consistently provided to all women. This finding is consistent with a study that reported that supportive care during childbirth was inadequate, with very few women receiving emotional support, companionship, or pain relief.[4] Similarly, another study found that most women experienced inadequate supportive care, including lack of emotional support, denial of birth companions, and neglect of their concerns.[17] This may be due to systemic challenges such as inadequate staffing, limited resources, and poor provider-patient interaction, which can hinder the consistent provision of supportive care during childbirth.

Furthermore, the presence of moderate and poor experiences among a significant number of respondents indicates that many women still face gaps in supportive care during maternal care. This suggests variability in the extent to which healthcare providers offer emotional reassurance, companionship, and continuous support during labour. This finding aligns with a study that reported that women often coped with inadequate support by remaining silent or complying with instructions despite discomfort, reflecting limited patient engagement.[17] This may be attributed to provider-

centred care practices, high workload, and lack of emphasis on emotional and psychological support as essential components of maternity care.

The current study found a statistically significant relationship between respondents' age and their experience of supportive care. Younger mothers reported poorer supportive care compared to older mothers. This suggests provider bias, where younger women may be perceived as less experienced, leading to reduced attentiveness and emotional support. This finding aligns with a study in Ethiopia that observed that younger women were more likely to experience neglect.[6] Similarly, another study reported that staff often assumed younger mothers lacked maturity, which reduced provider responsiveness.[17] Ethnicity showed a significant relationship with supportive care. This may reflect cultural familiarity and shared language between providers and patients. A study in Benin City found similar results, noting that minority ethnic groups often reported poorer experiences due to communication barriers and subtle discrimination.[11]

A significant relationship was observed between marital status and supportive care. Married women experienced better supportive care than single, separated, or widowed mothers. This suggests that providers may unconsciously favor married women, perceiving them as more socially supported. A study in Calabar reported similar findings, with marital status influencing provider attitudes and care quality.[10]

Respondents' educational level demonstrated a significant relationship with supportive care. Women with tertiary education reported better supportive care. Education empowers mothers to demand respectful treatment and articulate concerns, influencing provider responsiveness. This finding is consistent with studies in Ethiopia and India that reported that higher education was linked to improved RMC experiences.[4,8] Employment status was significantly associated with supportive care. Self-employed and civil servant mothers reported better supportive care compared to unemployed mothers. Employment may enhance confidence and perceived social standing, shaping provider attitudes. A study in Benin City also identified employment status as a predictor of RMC.[11]

Interestingly, this study found that religion, monthly income, type of residence, and parity were not significantly associated with the experience of supportive care. The absence of religious bias indicates that supportive care gaps are systemic rather than faith-related, that supportive care experiences were not shaped by economic status, were widespread across both urban and rural facilities in Osun State, and were inconsistent regardless of whether mothers were primiparous or multiparous. This contrasts with a study in Uganda that reported that religious affiliation influenced perceptions of RMC, with some groups experiencing more neglect.[7] This finding aligns with a study in Calabar that similarly found that financial status was less influential than provider attitudes and systemic challenges.[10] This contrasts with an Ethiopian study that reported that rural women often faced poorer care due to resource constraints.[9] Another Ethiopian study found similar results, reporting that provider attentiveness was inconsistent regardless of parity.[6] In contrast, a Ugandan study noted that parity influenced RMC, with multiparous women sometimes receiving less supportive care.[7]

Finally, this study found no significant association between medical and obstetric history and the experience of supportive care. This indicates that whether a mother was primiparous or multiparous, attending ANC did not guarantee respectful or supportive treatment during delivery; supportive care gaps were present across facilities regardless of delivery location; emotional support and attentiveness were inconsistently applied across delivery modes; and even mothers with complications did not consistently receive better supportive care. A study in Calabar found similar results, noting that ANC attendance did not translate into improved RMC experiences during childbirth, and delivery outcomes did not alter supportive care experiences, underscoring that emotional support and attentiveness should be consistent regardless of outcome.[10] An Ethiopian study similarly reported weak continuity between ANC and delivery experiences, highlighting systemic gaps in provider responsiveness.[6] This contrasts with an Ethiopian

study that found that facility type influenced supportive care, with tertiary hospitals offering better responsiveness compared to lower-level facilities, and complicated pregnancies sometimes led to neglect in supportive care.[19] Another study similarly found supportive care inconsistencies across delivery modes in Addis Ababa, reinforcing that provider attitudes rather than clinical procedures determine supportive care quality.[4]

CONCLUSION

The study revealed less than half of respondents reporting good experiences of supportive care. Many mothers experienced neglect, inadequate emotional support, and delays in care, underscoring systemic gaps in provider attentiveness and responsiveness. Socio-demographic factors such as age, marital status, and employment status significantly influenced supportive care, while medical history variables showed no significant association. These results highlight that supportive care is influenced more by socio-demographic determinants than by individual medical and obstetric history.

Recommendations

Given that supportive care was influenced predominantly by socio-demographic factors rather than medical and obstetric history, interventions should target provider bias and systemic inequities. Providers require training on implicit bias to ensure equitable attentiveness regardless of a mother's age, marital status, education, or ethnicity. Facilities should adopt mandatory supportive care checklists to remove provider discretion and reduce selective neglect of vulnerable groups. Anonymous patient feedback mechanisms should be implemented to empower younger and less-educated mothers to report inadequate care without fear. Cultural mediators or translation services are recommended to address ethnic disparities in communication. Routine satisfaction audits should be disaggregated by socio-demographic characteristics to monitor care equity. Finally, antenatal education should incorporate patient rights training to equip all women to recognise and demand respectful supportive care.

Limitation of the Study

The study was limited to four secondary health facilities in Osun State, which may not fully represent experiences across Nigeria. Data were based on mothers' self-reported experiences, which may be influenced by recall or social desirability bias. Finally, the study focused solely on supportive care as one domain of RMC, without exploring other domains such as dignity, privacy, and autonomy in detail.

Acknowledgement

The authors acknowledge the cooperation of all participants who consented throughout the study period.

Funding: This work had no external funding.

Competing Interests: No conflict of interest declared.

Data Availability: The datasets for this study are available upon reasonable requests from the corresponding author.

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