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Mistreatment during facility-based childbirth and its implications for maternal satisfaction and future facility use in Ebonyi State, Nigeria

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Abstract
Background: Mistreatment during childbirth undermines women's dignity, autonomy, satisfaction with maternity services and confidence in facility-based care. This study examined mistreatment during facility-based childbirth and its implications for maternal satisfaction and future facility use among women in selected communities of Ebonyi State, Nigeria.
Methods: A community-based cross-sectional mixed-methods design was adopted. The quantitative component involved 300 women who had delivered in a health facility within the preceding 12 months in selected communities of Abakaliki, Afikpo and Izzi Local Government Areas. Childbirth experiences in primary healthcare centres, general hospitals and private facilities were assessed. The study was conceptually informed by Bohren *et al.*'s typology of mistreatment and respectful maternity-care principles. Quantitative variables included physical abuse, non-consented care, non-dignified care, abandonment or neglect, detention, discrimination, facility type, birth companionship, out-of-pocket payment, knowledge of respectful maternity-care rights, maternal satisfaction and future facility-birth intention.
Results: Overall, 205 of 300 women (68.3%) experienced at least one measured form of mistreatment. Non-dignified care was most prevalent (68.3%), followed by abandonment or neglect (36.3%), non-consented care (28.0%), discrimination (16.3%), physical abuse (14.0%) and detention (14.0%). Mistreatment was significantly associated with facility type, birth companionship, out-of-pocket payment, educational status and knowledge of respectful maternity-care rights. Women who experienced mistreatment reported substantially lower satisfaction (mean 2.25 ± 0.78) than women without mistreatment (4.82 ± 0.39, $p < .001$). Only 49.8% of mistreated women intended to use a health facility for future childbirth, compared with 100% of women who reported no mistreatment.
Conclusion: Mistreatment during facility-based childbirth was common and was strongly associated with poorer maternal satisfaction and reduced intention for future facility delivery. Strengthening respectful maternity-care standards, birth companionship, informed consent, financial protection, provider communication, accountability and women's knowledge of maternity-care rights is essential. Several complete or near-complete associations in the dataset require verification against original field records before final multivariable modelling.

Keywords: Respectful maternity care, mistreatment during childbirth, obstetric abuse, maternal healthcare, birth companionship, informed consent, facility-based delivery, maternal satisfaction, Ebonyi State, Nigeria

Introduction

Maternal healthcare has increasingly moved beyond the traditional objective of preventing maternal and neonatal mortality to encompass the quality, dignity, safety, autonomy and experience of women throughout pregnancy and childbirth. Although increasing the proportion of births attended by skilled health personnel remains fundamental to reducing preventable maternal and neonatal morbidity and mortality, facility delivery cannot be considered high-quality care merely because a woman survives childbirth. The interpersonal and institutional conditions under which childbirth occurs constitute an essential dimension of quality maternity care. Respectful maternity care (RMC) has consequently become an important component of global strategies for improving maternal and newborn health. The World Health Organization (WHO, 2018) [13] describes respectful maternity care as care that maintains women's dignity, privacy and confidentiality, protects them from harm and mistreatment, and enables informed choice and continuous support during labour and childbirth.

Mistreatment during childbirth represents a violation of these principles and may take several forms, ranging from overt physical or verbal abuse to less visible violations such as performing procedures without informed consent, neglecting women during labour, denying privacy, discriminatory treatment, restricting companionship or detaining women because they cannot pay medical bills. These practices raise clinical, ethical, public-health and human-rights concerns. Contemporary maternal healthcare therefore recognizes that women have a right not only to technically competent obstetric care but also to compassionate, person-centred and culturally appropriate treatment.

One of the most influential conceptualizations of mistreatment during childbirth was developed by Bohren *et al.* (2015) [1] through a mixed-methods systematic review of 65 studies conducted across 34 countries. Seven major domains were identified: physical abuse; sexual abuse; verbal abuse; stigma and discrimination; failure to meet professional standards of care; poor rapport between women

and providers; and health-system conditions and constraints. This framework shifted the literature from relatively narrow concepts of disrespect and abuse towards a multidimensional understanding of mistreatment during childbirth.

Mistreatment should not be interpreted solely as deliberate misconduct by individual healthcare providers. Institutional constraints can create environments in which disrespectful practices become normalized. Understaffing, excessive workloads, inadequate infrastructure, insufficient privacy, shortages of supplies, weak supervision, inadequate provider training, poor accountability mechanisms and dysfunctional payment systems may all influence women's experiences of care. This perspective is particularly relevant to health systems in resource-constrained settings where maternity workers may operate under significant structural and occupational pressures.

Respectful maternity care is particularly important because childbirth represents a period of exceptional physical and psychological vulnerability. Women in labour often depend extensively on healthcare professionals for information, reassurance, clinical decision-making and emergency intervention. The inherent power imbalance between provider and patient can become especially pronounced when a woman is experiencing pain, fear, obstetric complications or limited knowledge of her rights.

Non-consented care is an important dimension of mistreatment. Women's autonomy requires that they receive understandable information about proposed interventions and, where practicable, participate meaningfully in decisions affecting their bodies. Consent should therefore be regarded as an ongoing communication process rather than simply the signing of a document. Physical abuse, including slapping, hitting, pinching, unnecessary restraint and deliberately forceful procedures, represents a particularly serious manifestation of mistreatment and violates bodily integrity and professional standards.

Non-dignified and verbally abusive care may be more subtle but can be equally consequential. Shouting at women, insulting them, mocking expressions of pain, threatening them, blaming them for pregnancy or labour difficulties and using humiliating language undermine dignity and can create traumatic childbirth experiences. Abandonment or neglect during labour is also clinically important because maternal and fetal conditions may deteriorate rapidly when monitoring and support are inadequate.

Financial practices can similarly affect women's experiences. Detention following childbirth because of inability to settle medical bills illustrates the intersection between healthcare financing and respectful maternity care. Discrimination on the basis of socioeconomic status, age, ethnicity, parity, marital status, health condition or other characteristics further undermines equitable maternity services.

The presence of a birth companion represents another potentially important determinant of women's childbirth experience. A companion may provide emotional reassurance, practical assistance and communication support and may strengthen a woman's sense of security and agency. Women's knowledge of respectful maternity-care rights may also influence their capacity to identify mistreatment, participate in decisions and seek redress.

The consequences of mistreatment extend beyond the immediate childbirth episode. Maternal satisfaction is an important patient-reported outcome reflecting the extent to which healthcare experiences correspond with women's needs, expectations and perceptions of quality. Negative childbirth experiences may also affect subsequent healthcare-seeking behaviour. Women who perceive facilities as abusive, neglectful or humiliating may become reluctant to return for subsequent deliveries, potentially undermining efforts to increase skilled birth attendance.

This issue is particularly important in Nigeria, where maternal healthcare operates within a heterogeneous health system encompassing primary healthcare centres, general and tertiary hospitals and private facilities. Evidence from South-East Nigeria and Ebonyi State confirms that disrespectful maternity care is an empirically documented problem. Nevertheless, important knowledge gaps remain regarding community-recruited women, differences across facility types and the relationship between mistreatment, satisfaction and subsequent facility-use intentions.

Accordingly, the present study examines mistreatment during facility-based childbirth and its implications for maternal satisfaction and future facility use among women in selected communities of Ebonyi State, Nigeria. The study focuses on women who delivered within the preceding 12 months across selected communities in Abakaliki, Afikpo and Izzi and encompasses childbirth experiences in primary healthcare centres, general hospitals and private facilities.

Study Objectives

The broad objective of the study is to assess mistreatment during facility-based childbirth and determine its implications for maternal satisfaction and future facility use among women in selected communities of Ebonyi State, Nigeria.

1. Determine the prevalence and patterns of mistreatment experienced by women during facility-based childbirth.
2. Assess the occurrence of physical abuse, non-consented care, non-dignified care, abandonment or neglect, detention and discrimination during childbirth.
3. Determine the relationship between facility type and women's experiences of mistreatment.
4. Examine whether birth companionship and out-of-pocket payment are associated with the likelihood of experiencing mistreatment.
5. Assess the relationship between women's knowledge of respectful maternity-care rights and reported mistreatment.
6. Determine the association between mistreatment during childbirth and maternal satisfaction with maternity services.
7. Examine the relationship between mistreatment and women's intention to use a health facility for future childbirth.
8. Explore women's perceptions and experiences of respectful and disrespectful maternity care in the selected communities.

Study Significance

The study provides evidence at the intersection of quality of care, human rights and maternal-health service utilization. By linking specific forms of mistreatment with maternal satisfaction and future facility-use intentions, it moves beyond documenting disrespectful maternity care to assessing its potential consequences for women's subsequent healthcare decisions. The findings may inform maternity-

provider training, birth-companion policies, informed-consent procedures, community education on RMC rights, facility accountability systems and financing reforms designed to reduce abusive or discriminatory practices.

Review of Related Literature

Concept of Respectful Maternity Care

Respectful maternity care has become a central component of contemporary maternal-health quality frameworks because safe childbirth involves more than prevention of maternal and neonatal morbidity and mortality. The WHO (2014) [12] recognized respectful childbirth care as a human-rights issue, while WHO (2018) [10] emphasized woman-centred care and a positive childbirth experience as essential dimensions of high-quality maternity services. Respectful maternity care incorporates dignity, privacy, confidentiality, effective communication, informed consent, emotional support, non-discrimination and freedom from physical and verbal abuse. The WHO (2025) Compendium on Respectful Maternal and Newborn Care further emphasizes person-centred care organized for and delivered with women, newborns and families.

Concept of Mistreatment during Childbirth

Mistreatment during childbirth refers broadly to acts, omissions, institutional practices and health-system conditions that undermine women's dignity, autonomy, safety or rights during maternity care. Bohren *et al*. (2015) [1] proposed a seven-domain typology comprising physical abuse, sexual abuse, verbal abuse, stigma and discrimination, failure to meet professional standards of care, poor rapport between women and providers, and health-system conditions and constraints. In the present study, mistreatment is operationalized through six measured experiences: physical abuse, non-consented care, non-dignified care, abandonment or neglect, detention and discrimination.

Physical Abuse during Childbirth

Physical abuse includes slapping, hitting, pinching, pushing, forceful restraint and other unnecessary or punitive physical actions against women during labour and childbirth. Such conduct violates bodily integrity and professional standards. Nigerian evidence confirms that physical abuse remains present in maternity settings, although prevalence varies according to setting and measurement approach.

Non-Consented Care and Women's Autonomy

Non-consented care occurs when examinations, procedures or treatments are performed without adequate explanation, permission or meaningful participation by the woman. Informed consent is a fundamental expression of patient autonomy and should be understood as an ongoing communication process. WHO guidance identifies coercive or unconsented procedures as violations of respectful maternity care.

Non-Dignified Care and Verbal Abuse

Non-dignified care includes shouting, insults, humiliation, threats, ridicule, mocking and communication that diminishes a woman's sense of worth. Nigerian literature has repeatedly identified negative and unfriendly provider attitudes as prominent forms of disrespect and abuse. Provider-based evidence from Ebonyi State has also documented witnessed and perpetrated verbal abuse.

Abandonment and Neglect during Labour

Abandonment or neglect occurs when women are left without necessary attention, monitoring, emotional support or timely clinical intervention. It may arise from individual behaviour or from staff shortages, high workloads and inadequate organization of care. Because maternal and fetal conditions can deteriorate quickly, abandonment is both an experiential and clinical quality concern.

Detention for Inability to Pay

Detention occurs when women or newborns are prevented from leaving health facilities because medical bills have not been paid. It illustrates the intersection between disrespectful maternity care and financial barriers. The practice can expose women to humiliation, psychological distress and additional financial burden.

Discrimination during Childbirth

Discrimination refers to inferior or differential treatment based on characteristics unrelated to legitimate clinical need, including age, ethnicity, socioeconomic position, HIV status, marital status, educational level or parity. Evidence suggests that existing social inequalities can shape women's vulnerability to disrespectful maternity care.

Facility Type and Mistreatment

Facility characteristics can influence women's experience of maternity care. Primary healthcare centres, general hospitals and private facilities differ in staffing, workload, infrastructure, financing, supervision and organizational culture. Evidence from African settings suggests that institutional conditions and facility type can influence exposure to mistreatment.

Birth Companionship and Respectful Maternity Care

Birth companionship involves the presence of a person chosen by a woman to provide support during labour or childbirth. Companions may provide reassurance, practical assistance, advocacy and communication support. WHO recommends supportive companionship during labour, and multicountry evidence indicates that women without companions may be more likely to report several forms of mistreatment.

Out-of-Pocket Payment and Mistreatment

Out-of-pocket payment can create financial stress and may affect provider-user relationships. High maternity-care costs may exacerbate socioeconomic inequalities, contribute to disputed charges or detention and discourage subsequent healthcare utilization. Nigerian evidence has identified high service costs among policy-level drivers of disrespectful maternity care.

Knowledge of Respectful Maternity-Care Rights

Women's awareness of maternity-care rights may influence their capacity to identify mistreatment, participate in decisions and demand accountability. Low awareness can contribute to normalization of disrespectful behaviour. Nigerian research has identified low awareness of rights and inadequate empowerment among factors associated with disrespectful maternity care.

Mistreatment and Maternal Satisfaction
Maternal satisfaction reflects women's evaluation of the care received during labour and childbirth. Clinical outcomes matter, but dignity, communication, responsiveness, privacy, emotional support and participation in decision-making are also important. Multicountry evidence demonstrates a close relationship between mistreatment and lower satisfaction.

Mistreatment and Future Facility-Based Childbirth
Negative childbirth experiences may affect subsequent healthcare-seeking behaviour. Women who perceive facilities as humiliating, neglectful or abusive may be reluctant to return for subsequent deliveries. Nigerian evidence suggests that disrespectful care can undermine trust and facility-based childbirth utilization.

Conceptual Framework
The conceptual framework is principally informed by the mistreatment typology developed by Bohren *et al*. (2015) [1] and WHO respectful maternity-care principles. Women's experience of mistreatment constitutes the principal dependent construct and is measured through physical abuse, non-consented care, non-dignified care, abandonment or neglect, detention and discrimination. Potential explanatory factors include socio-demographic characteristics, parity, facility type, birth companionship, out-of-pocket payment and knowledge of respectful maternity-care rights. The model further proposes that mistreatment may affect maternal satisfaction and intention to use a health facility for future childbirth.

Conceptual pathway: Socio-demographic and maternity-care factors → Experience of mistreatment → Maternal satisfaction → Future facility-use intention.

Empirical Review

Global Evidence
Global evidence demonstrates that mistreatment occurs across geographic regions and income levels. Bohren *et al*. (2015) [1] documented a wide spectrum of abusive and disrespectful practices. Subsequent WHO work has reinforced that respectful maternity care remains insufficiently implemented. Intervention reviews indicate that provider training, facility awareness activities, feedback mechanisms and multi-component health-system approaches can improve women's experiences.

Evidence From Africa and West Africa
Studies across sub-Saharan Africa have documented physical and verbal abuse, non-consented care, neglect and discriminatory treatment. Dzomeku *et al*. (2026) [4] reviewed West African evidence and found persistent physical and verbal abuse, non-consented care and violations of dignity, with age, marital status, facility type and structural barriers influencing women's experiences.

Empirical Evidence From Nigeria
Nigerian research shows that mistreatment is widespread but heterogeneous. Ishola *et al*. (2017) [6] identified non-dignified treatment and negative provider attitudes as particularly prominent, alongside socioeconomic disadvantage, weak supervision, training deficiencies and health-system weaknesses. Mixed-methods research in northern Nigeria has similarly documented multiple forms of mistreatment and important structural constraints.

Evidence From South-East Nigeria and Ebonyi State
Studies from South-East Nigeria have identified maternal, provider, institutional, community and policy drivers of disrespectful maternity care. Reported factors include low awareness of women's rights, provider stress and workload, inadequate privacy, weak female autonomy, normalization of abuse and high costs of maternal healthcare. Evidence from Ebonyi State has documented both provider-reported and patient-reported mistreatment, supporting the need for further community-based investigation.

Research Gap
Despite the expanding literature, important gaps remain. Much Nigerian research has been facility based, particularly within tertiary hospitals. There is limited comparative evidence across primary healthcare centres, general hospitals and private facilities in Ebonyi State. Several studies focus primarily on prevalence without simultaneously examining maternal satisfaction and future facility-use intentions. Financing-related experiences, birth companionship and knowledge of RMC rights also require further analytical attention. The present study addresses these gaps through a community-based investigation among 300 women in Abakaliki, Afikpo and Izzi.

Methodology

Study Design
The study adopted a community-based cross-sectional mixed-methods design, combining quantitative and qualitative approaches. The quantitative component estimated prevalence and patterns of mistreatment and examined associations with socio-demographic, facility-related and maternity-care characteristics, maternal satisfaction and future facility-use intention. The qualitative component was intended to provide contextual understanding of women's experiences and perceptions.

Study Area
The study was conducted in selected communities in Ebonyi State, South-East Nigeria, with participants recruited from Abakaliki, Afikpo and Izzi Local Government Areas. The state has a mixture of urban, semi-urban and rural populations and a maternal-healthcare system comprising primary healthcare centres, general hospitals, tertiary institutions and private facilities.

Study Population
The target population consisted of women of reproductive age who had given birth in a health facility within the 12 months preceding the survey and were resident in the selected communities.

Sample Size
The quantitative component comprised 300 eligible women. For the qualitative component, participants were to be purposively selected to provide variation in facility type, companionship, mistreatment and satisfaction, with interviewing continued until adequate thematic depth was reached.

Sampling Procedure

A multistage sampling procedure was used. Abakaliki, Afikpo and Izzi LGAs were included to provide geographic and service diversity. Communities were selected within participating LGAs, eligible women were identified at community level, and participants were recruited until the required quantitative sample was achieved. Purposive sampling was proposed for the qualitative component.

Data Collection Instrument

Quantitative data were collected using a structured interviewer-administered questionnaire informed by Bohren *et al*. (2015) [1] and respectful maternity-care principles. It covered socio-demographic characteristics, obstetric characteristics, facility type, birth companion, out-of-pocket payment, RMC-rights knowledge, six forms of mistreatment, satisfaction and future facility-birth intention.

Validity and Data Collection

The questionnaire was aligned with established respectful maternity-care literature and reviewed for relevance to the Nigerian context. Interviews were conducted face to face with attention to privacy, informed consent and sensitivity to potentially distressing experiences. Quantitative responses were checked for completeness and consistency.

Data Management

Data were coded and cleaned before analysis. Procedures included duplicate checks, verification of coding, missing-value assessment, range checks, consistency checks between specific mistreatment indicators and ANY_MISTREATMENT, and verification of parity coding.

Statistical Analysis

Descriptive statistics summarized respondent characteristics and prevalence. Pearson chi-square or Fisher's exact tests examined categorical associations, while appropriate parametric or non-parametric tests compared continuous or ordinal measures. Binary logistic regression was planned for ANY_MISTREATMENT and future facility-birth intention, and ordinal logistic regression was considered for satisfaction. Adjusted odds ratios, 95% confidence intervals and p-values were to be reported where model assumptions permitted. Statistical significance was set at $p < .05$.

Qualitative Data Analysis

Qualitative interviews were intended to be transcribed and analyzed thematically using deductive and inductive coding. Deductive categories included the six mistreatment domains, companionship, rights knowledge, satisfaction and future facility use. Actual qualitative themes and quotations were not generated in the absence of interview transcripts.

Ethical Considerations

Ethical principles governing research involving human participants were observed. Ethical approval and administrative permissions were to be obtained from appropriate authorities. Participation was voluntary, informed consent was required, confidentiality was maintained and respondents could withdraw without penalty.

Study Variables and Operational Definitions

- ANY_MISTREATMENT: 0 = No; 1 = Yes. A respondent was classified as mistreated if she reported at least one measured form.
- PHYSICAL_ABUSE: 0 = No; 1 = Yes.
- NON_CONSENT: 0 = No; 1 = Yes.
- NON_DIGNITY: 0 = No; 1 = Yes.
- ABANDONMENT: 0 = No; 1 = Yes.
- DETENTION: 0 = No; 1 = Yes.
- DISCRIMINATION: 0 = No; 1 = Yes.
- FACILITY_TYPE: 1 = PHC; 2 = General Hospital; 3 = Private.
- BIRTH_COMPANION: 0 = No; 1 = Yes.
- PAID_OUT_POCKET: 0 = No; 1 = Yes.
- KNOW_RMC_RIGHTS: 0 = No; 1 = Yes.
- SATISFACTION: five-point Likert scale, with higher scores indicating greater satisfaction.
- FUTURE_FACILITY_BIRTH: 0 = No; 1 = Yes.

Parity was analyzed according to the values in the operational dataset. Because values 4 and 5 occurred although the original codebook defined only categories 1–3, the coding requires verification against the original field records before final inferential interpretation.

Results

A total of 300 women were included in the quantitative analysis. Participants were equally distributed across Abakaliki, Afikpo and Izzi (100 each; 33.3%). The mean age was 31.31 ± 6.18 years, with a median of 31 years and a range of 21–44 years.

Characteristic	Frequency (n)	Percentage (%)
Abakaliki	100	33.3
Afikpo	100	33.3
Izzi	100	33.3
No formal education	36	12.0
Primary education	75	25.0
Secondary education	127	42.3
Tertiary education	62	20.7
PHC	117	39.0
General hospital	121	40.3
Private facility	62	20.7
No birth companion	111	37.0
Birth companion present	189	63.0
No out-of-pocket payment	84	28.0
Paid out of pocket	216	72.0
No knowledge of RMC rights	205	68.3
Knowledge of RMC rights	95	31.7

Prevalence and Forms of Mistreatment

Overall, 205 of 300 women experienced at least one measured form of mistreatment, giving a prevalence of 68.3% (95% CI: 62.9%–73.3%). Non-dignified care was the most frequently reported form. In the supplied dataset, every respondent classified as having any mistreatment also reported non-dignified care; therefore ANY_MISTREATMENT and NON_DIGNITY were identical. This exact correspondence should be verified against the original questionnaires.

Form of mistreatment	n	%	95% CI
Any mistreatment	205	68.3	62.9–73.3
Physical abuse	42	14.0	10.5–18.4
Non-consented care	84	28.0	23.2–33.3
Non-dignified care	205	68.3	62.9–73.3
Abandonment/neglect	109	36.3	31.1–41.9
Detention	42	14.0	10.5–18.4
Discrimination	49	16.3	12.6–20.9

Mistreatment by Selected Characteristics

Mistreatment occurred among 62.0% of women from Abakaliki, 67.0% from Afikpo and 76.0% from Izzi. The overall relationship between LGA and mistreatment was not statistically significant, $\chi^2(2) = 4.65$, $p = .098$.

LGA	No mistreatment n (%)	Mistreatment n (%)
Abakaliki	38 (38.0)	62 (62.0)
Afikpo	33 (33.0)	67 (67.0)
Izzi	24 (24.0)	76 (76.0)

Women reporting mistreatment were older (33.86 ± 5.76 years) than those reporting no mistreatment (25.81 ± 2.15 years), Welch's t = 17.55, p < .001; Cohen's d ≈ 1.64.

Education	No mistreatment n (%)	Mistreatment n (%)
None	0 (0.0)	36 (100.0)
Primary	0 (0.0)	75 (100.0)
Secondary	33 (26.0)	94 (74.0)
Tertiary	62 (100.0)	0 (0.0)

Education was strongly associated with mistreatment, $\chi^2(3) = 187.12$, p < .001; Cramer's V = .790.

Facility type	No mistreatment n (%)	Mistreatment n (%)
PHC	2 (1.7)	115 (98.3)
General hospital	31 (25.6)	90 (74.4)
Private facility	62 (100.0)	0 (0.0)

Facility type was strongly associated with mistreatment, $\chi^2(2) = 184.36$, p < .001; Cramer's V = .784.

Birth companion	No mistreatment n (%)	Mistreatment n (%)
No	0 (0.0)	111 (100.0)
Yes	95 (50.3)	94 (49.7)

Birth companionship was significantly associated with mistreatment, $\chi^2(1) = 79.34$, p < .001; Cramer's V = .514.

Out-of-pocket payment	No mistreatment n (%)	Mistreatment n (%)
No	52 (61.9)	32 (38.1)
Yes	43 (19.9)	173 (80.1)

Out-of-pocket payment was significantly associated with mistreatment, $\chi^2(1) = 47.38$, p < .001; Cramer's V = .397. The crude odds of mistreatment among women who paid out of pocket were approximately 6.54 times the odds among those who did not.

Knowledge of RMC rights	No mistreatment n (%)	Mistreatment n (%)
No	0 (0.0)	205 (100.0)
Yes	95 (100.0)	0 (0.0)

Knowledge of RMC rights demonstrated near-perfect association with mistreatment, $\chi^2(1) = 295.40$, p < .001; Cramer's V = .992. The complete 100%/0% separation requires verification against original field records.

Parity and Mistreatment

Recorded parity code	n	Mistreatment n (%)
1	132	39 (29.5)
2	67	65 (97.0)
3	55	55 (100.0)
4	37	37 (100.0)
5	9	9 (100.0)

The association between the recorded parity codes and mistreatment was statistically significant, $\chi^2(4) = 164.05$, p < .001. Substantive interpretation should await reconciliation of the parity codebook.

Mistreatment and Maternal Satisfaction

Women without mistreatment had a mean satisfaction score of 4.82 ± 0.39, compared with 2.25 ± 0.78 among women who experienced mistreatment. The difference was statistically significant, Welch's t = 38.27, p < .001.

Satisfaction score	No mistreatment n	Mistreatment n
1	0	42
2	0	69
3	0	94
4	17	0
5	78	0

Mistreatment and Future Facility Birth Intention

Overall, 197 women (65.7%) intended to use a health facility for future childbirth. All 95 women without mistreatment intended future facility delivery, compared with 102 of 205 mistreated women (49.8%). The association was statistically significant, $\chi^2(1) = 70.48$, p < .001.

Mistreatment	No future facility birth n (%)	Future facility birth n (%)
No mistreatment	0 (0.0)	95 (100.0)
Mistreatment	103 (50.2)	102 (49.8)

Multivariable Modelling and Data-Separation Issue

Conventional maximum-likelihood logistic regression cannot be validly interpreted from the dataset in its present form because several predictors exhibit complete or quasi-complete separation. These include RMC-rights knowledge, private-facility use, absence of a birth companion, selected educational categories and some parity categories. Standard coefficients would therefore be unstable or divergent. Original records should be verified; if zero cells are confirmed, Firth penalized logistic regression or exact logistic regression should be considered.

Discussion

High Prevalence of Mistreatment

The study found that 68.3% of respondents experienced at least one measured form of mistreatment during facility-based childbirth. This indicates a substantial quality-of-care problem. The prevalence is broadly consistent with Nigerian evidence showing that mistreatment remains common, although estimates vary according to setting, population and measurement approach (Ishola *et al.*, 2017; Okedo-Alex *et al.*, 2020; Dzomeku *et al.*, 2026) [4, 6, 8].

Predominance of Non-Dignified Care
Non-dignified care was the most prevalent measured form. This supports Nigerian literature identifying negative, unfriendly and disrespectful provider attitudes as prominent dimensions of childbirth mistreatment. However, the perfect overlap between ANY_MISTREATMENT and NON_DIGNITY in the dataset should be verified.

Abandonment and Neglect
More than one-third of respondents reported abandonment or neglect. This may reflect interpersonal neglect but can also arise from staffing shortages, workload, weak supervision and inadequate organization. Addressing neglect therefore requires both provider-level and health-system interventions.

Non-Consented Care
More than one-quarter of respondents experienced non-consented care, highlighting continuing challenges in communication and autonomy. Informed consent should be institutionalized as an ongoing process of explanation and participation rather than an administrative formality.

Physical Abuse, Detention and Discrimination
Physical abuse and detention were each reported by 14.0%, while discrimination affected 16.3%. Although less prevalent than non-dignified care, these experiences remain serious violations of respectful maternity-care standards and illustrate the interaction between interpersonal behaviour, social inequalities and financing practices.

Facility Type as a Major Correlate
Mistreatment was reported by 98.3% of PHC users and 74.4% of general-hospital users, while none of the sampled private-facility users was classified as mistreated. Facility context is therefore potentially important, but the complete absence of mistreatment among private-facility users should be verified and not generalized uncritically.

Protective Role of Birth Companionship
All women without companions were classified as mistreated, compared with 49.7% of women with companions. The direction of the relationship is consistent with evidence that companionship can provide emotional support, advocacy and increased transparency during labour. The perfect separation among unaccompanied women nevertheless warrants data verification.

Out-of-Pocket Payment and Mistreatment
Mistreatment affected 80.1% of women who paid out of pocket compared with 38.1% of those who did not. The association highlights the potential relevance of financing arrangements to women's experiences, although cross-sectional data cannot establish causality.

Knowledge of RMC Rights
Knowledge of respectful maternity-care rights was associated with dramatically lower mistreatment. Awareness may strengthen women's capacity to request explanations and challenge inappropriate conduct. However, the exact 100% versus 0% pattern is unusually deterministic and should be checked against original field questionnaires.

Mistreatment and Maternal Satisfaction
Mean satisfaction was substantially lower among mistreated women (2.25) than among women without mistreatment (4.82). This finding is consistent with international evidence showing that dignity, communication, autonomy and interpersonal treatment are central to women's evaluations of maternity care.

Mistreatment and Future Facility Use
All women without mistreatment intended to use a facility for future childbirth, compared with 49.8% of mistreated women. This suggests that negative experiences may weaken trust and willingness to return, with potential implications for skilled birth attendance and continuity of maternal healthcare.

Implications of the Findings
Collectively, the results suggest that mistreatment is multidimensional and encompasses provider communication, consent, neglect, financial practices, discrimination and institutional conditions. A multi-level response involving provider training, supportive supervision, birth companionship, financing reform, accountability and community education is therefore required.

Quantitative-Qualitative Integration
No qualitative interview or focus-group transcripts were supplied with the quantitative dataset. Qualitative themes and quotations were therefore not fabricated. Actual qualitative data should be analyzed and integrated before the study is finally presented as a completed mixed-methods investigation.

Conclusion and Recommendations
Conclusion
This study demonstrates that mistreatment during facility-based childbirth remains a substantial maternal-health and quality-of-care concern among women in the selected communities of Ebonyi State. More than two-thirds of respondents experienced at least one measured form of mistreatment, with non-dignified care being the most frequently reported experience.
Marked differences were observed according to facility type, birth companionship, out-of-pocket payment, education and knowledge of respectful maternity-care rights. Mistreatment was also strongly associated with substantially lower maternal satisfaction and reduced intention to use a health facility for future childbirth.
The findings reinforce the principle that improving maternal health cannot be achieved through clinical competence alone. Safe childbirth must also be respectful, dignified, woman-centred and responsive to women's rights and preferences. Effective interventions should operate at provider, facility, community and health-system levels.
Several variables showed complete or near-complete separation, and the parity variable contained codes not fully defined in the original codebook. These data characteristics should be verified against original field records before final publication and before conventional multivariable logistic-regression estimates are interpreted.
Although the study was conceived as mixed methods, the present analysis is based on the quantitative dataset.

Qualitative findings should be incorporated only after authentic interview or focus-group data have been analyzed.

Recommendations

Strengthen Respectful Maternity Care Training: Provide regular competency-based training on dignified communication, informed consent, prevention of abuse, privacy, non-discrimination and compassionate care.

Prioritize Quality Improvement in PHCs and General Hospitals: Assess staffing, workload, privacy, supervision, equipment and compliance with respectful maternity-care standards, with targeted corrective action where indicators are poor.

Institutionalize Birth Companionship: Adopt policies that permit a woman's companion of choice during labour and childbirth where clinically appropriate and desired by the woman.

Strengthen Informed-Consent Practices: Require understandable explanations before examinations and procedures and treat consent as a continuing communication process.

Address Non-Dignified Communication: Adopt zero tolerance for insults, threats, ridicule and humiliating language while also addressing provider stress, burnout and excessive workload.

Reduce Abandonment and Neglect: Improve staff deployment, labour monitoring, escalation protocols, handover procedures and audit of unattended or delayed-care incidents.

Improve Financial Protection for Maternity Care: Expand insurance and subsidized maternity services, improve transparency of charges and prevent degrading treatment or inappropriate detention for inability to pay.

Establish Effective Complaint and Accountability Mechanisms: Provide confidential complaint channels, patient-relations systems and routine patient-experience surveys, with timely investigation and protection from retaliation.

Increase Women's Awareness of RMC Rights: Integrate education on dignity, consent, privacy, freedom from abuse, non-discrimination and complaint mechanisms into antenatal and community programmes.

Integrate Respectful Maternity Care Into Antenatal Education: Prepare women for childbirth procedures, consent, companionship, expected charges, warning signs and maternity-care rights.

Monitor Maternal Satisfaction Routinely: Use patient-reported experience measures alongside clinical indicators as part of maternity quality assurance.

Protect Future Facility Utilization: Recognize respectful experience as a determinant of service use and ensure facilities are perceived as safe, trustworthy and dignified.

Strengthen Professional and Facility Accountability: Define unacceptable practices clearly and combine accountability with supportive interventions addressing staffing, remuneration, equipment and workload.

Undertake Further Research: Replicate the study with larger samples, prospective designs and authentic qualitative data; evaluate RMC interventions and investigate financing, provider and institutional determinants.

Policy Implication

The findings support integration of respectful maternity care into maternal-health policy and quality-assurance systems in Ebonyi State. Respectful care should be monitored alongside traditional clinical indicators and incorporated into facility accreditation, supervision, workforce training and maternal-health programme evaluation. Improving childbirth outcomes requires a dual commitment: women must survive childbirth, and they must also experience childbirth with dignity, autonomy, safety and respect.

References

1. Bohren MA, Vogel JP, Hunter EC, Lutsiv O, Makh SK, Souza JP, *et al*. The mistreatment of women during childbirth in health facilities globally: A mixed-methods systematic review. PLOS Medicine,2015:12(6):e1001847. https://doi.org/10.1371/journal.pmed.1001847
2. Cantor AG, Jungbauer RM, Skelly AC, Hart EL, Jorda K, Davis-O'Reilly C, *et al*. Respectful maternity care: A systematic review. Annals of Internal Medicine,2024:177(1):50–64. https://doi.org/10.7326/M23-2676
3. Dhakal P, Creedy DK, Gamble J, Newnham E, McInnes R. Educational interventions to promote respectful maternity care: A mixed-methods systematic review. Nurse Education in Practice,2022:60:103317. https://doi.org/10.1016/j.nepr.2022.103317
4. Dzomeku VM, Agyekum TP, Issah I, Emikpe AO, Owusu LB, Dwumfour CK, *et al*. Respectful and dignified maternity care in West Africa: A systematic review of evidence, gaps, and implications for practice. Midwifery,2026:160:104888. https://doi.org/10.1016/j.midw.2026.104888
5. Gebeyehu NA, Adella GA, Tegegne KD. Disrespect and abuse of women during childbirth at health facilities in Eastern Africa: Systematic review and meta-analysis. Frontiers in Medicine,2023:10:1117116. https://doi.org/10.3389/fmed.2023.1117116
6. Ishola F, Owolabi O, Filippi V. Disrespect and abuse of women during childbirth in Nigeria: A systematic review. PLOS ONE,2017:12(3):e0174084. https://doi.org/10.1371/journal.pone.0174084
7. Maung TM, Mon NO, Mehrtash H, Bonsaffoh KA, Vogel JP, Aderoba AK, *et al*. Women's experiences of mistreatment during childbirth and their satisfaction with care: Findings from a multicountry community-based study in four countries. BMJ Global Health,2021:5(Suppl. 2):e003688. https://doi.org/10.1136/bmjgh-2020-003688

8. Okedo-Alex IN, Akamike IC, Nwafor JI, Abateneh DD, Uneke CJ. Multi-stakeholder perspectives on the maternal, provider, institutional, community, and policy drivers of disrespectful maternity care in South-East Nigeria. International Journal of Women's Health,2020:12:1145–1159. https://doi.org/10.2147/IJWH.S277827
9. Okedo-Alex IN, Akamike IC, Okafor LC. Does it happen and why? Lived and shared experiences of mistreatment and respectful care during childbirth among maternal health providers in a tertiary hospital in Nigeria. Women and Birth,2021:34(5):477–486. https://doi.org/10.1016/j.wombi.2020.09.015
10. Orpin J, Puthussery S, Davidson R, Burden B. Women's experiences of disrespect and abuse in maternity care facilities in Benue State, Nigeria. BMC Pregnancy and Childbirth,2018:18:213. https://doi.org/10.1186/s12884-018-1847-5
11. Umar N, Quaife M, Exley J, Shuaibu A, Hill Z, Marchant T. Toward improving respectful maternity care: A discrete choice experiment with rural women in northeast Nigeria. BMJ Global Health,2020:5(3):e002135. https://doi.org/10.1136/bmjgh-2019-002135
12. World Health Organization. The prevention and elimination of disrespect and abuse during facility-based childbirth: WHO statement. World Health Organization, 2014.
13. World Health Organization. WHO recommendations: Intrapartum care for a positive childbirth experience. World Health Organization, 2018.
14. World Health Organization. Compendium on respectful maternal and newborn care. World Health Organization, 2025.