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Prevalence and associated factors of respectful maternity care at a public regional referral hospital in Uganda: A cross-sectional study.

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Abstract

Background:

Respectful maternity care (RMC) as opposed to disrespect and abuse (D&A) is very crucial in promoting skilled birth attendance. This study assessed the prevalence and associated factors of RMC during labor and childbirth.

Methods:

A total of 356 postnatal women consented to take part in the study. A pre-tested structured questionnaire was administered by trained research assistants. The outcome variable (RMC) was measured by twelve behavioral descriptors, while disrespect and abuse (D&A) were measured by eleven items related to the mistreatment of women. Data was analyzed using STATA (version 18.5) with frequencies and proportions used at the univariate level.

Results:

The average prevalence of RMC was 62.3%. Treating patients with respect (77.5%), speaking to patients in a language they could understand (73.3%), and showing concern and empathy (72.5%). were the top 3 most reported RMC elements. The occurrence of D&A care among the study participants was 43.6%. Women aged 25 to 29 years (95% CI: 0.74, 0.92, p-value = 0.001), having a planned pregnancy (95% CI: 1.05, 1.30, p-value = 0.005), and having come to the hospital with a husband (95% CI: 1.00, 1.21, p-value = 0.064) were statistically significantly related to respective maternal care.

Conclusions:

The prevalence of D&A was 43.6%, which is high compared to the literature. The prevalence of RMC was 62.3%, which is moderate compared to others in the literature. The occurrence of disrespectful and abusive care among the study participants was 43.6%, which is comparatively high.

Recommendations

Specific strategies and interventions, including male involvement and providing youth-friendly maternal health services, should be designed to increase the magnitude of respectful maternity care during childbirth within Uganda's health facilities.

Keywords: *Respectful maternity care, Abusive care, Disrespect, Maternal health, Uganda, Antenatal care, Labor and delivery, postnatal care.*
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Background

Global efforts aimed at improving maternal health have, over the decades, emphasized access to skilled birth attendants. [1]. However, Africa as a region has continued to be the largest contributor to global maternal mortality rates, with the World Health Organization report of 2020 putting estimates at a record of 69% [2]. In Uganda, maternal mortality rates stood at 44% (189/100,000 live births) as per the 2022 Uganda Demographic Health Survey report. [3].

Increased attendance by mothers to skilled birth attendants is one of the key strategies for reducing maternal and neonatal deaths [4, 5]. However, women globally still face disrespectful and abusive care that violates their rights [6–8]. Such negative experiences result in negative maternal health outcomes, poor perinatal health, and adverse effects on future health-seeking behaviors among women [9]. The poor quality of care faced by women during skilled birth

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attendance, largely due to disrespectful and abusive care, is one of the major challenges faced in the improvement of skilled birth attendance [10, 11].

The World Health Organization (WHO) developed a framework and guidelines on Respectful Maternity Care (RMC) in an attempt to promote dignified and respectful care as a fundamental right for every woman. [12]. Respectful Maternal Care is an approach to healthcare that emphasizes the positive interpersonal interactions of mothers with healthcare providers during labor and the postpartum period. [13, 14]. This ensures empowered decision-making and makes labor and childbirth a satisfying experience.

Respectful care for mothers and newborns is not only a right but also an important aspect of ensuring high-quality and acceptable care. RMC not only involves the absence of mistreatment but also the integration of person-centered care [15].

There are up to 10 components used in the assessment of RMC, and these include: physical abuse, privacy, use of dignified tone/language/threat/neglect, obtaining consent for procedures during labor and delivery, discrimination, allowing birth companion, detention, mobility, positioning, and availability of commodities. [16,17]. The few studies carried out in the Sub-Saharan Africa (SSA) setting show varying prevalence rates of disrespect and abuse (D&A) of women during maternal care. A mixed-methods study in Ethiopia showed that 29.7% of healthcare providers had disrespected a woman. (15), and a prevalence rate of 20% was reported in Kenya [18]. Some aspects of disrespect and abuse can occur amidst RMC, causing suboptimal skilled birth attendance. As a result, women attend to unskilled maternity care providers and other sources, such as Traditional Birth Attendants (TBAs).

There is no comprehensive understanding of the extent to which women receive RMC, its facilitators, and the impact that D&A of women during childbirth has had on maternal health-seeking behavior. Developing measures that will increase skilled birth attendance, while dealing with abuse and disrespect, is still a challenge. Therefore, this study aimed to understand the magnitude of RMC, its associated factors, and the impact of D&A on maternal health-seeking behavior at a public regional referral hospital in Uganda.

Methods

Study design

The study used a cross-sectional design.

Study setting

The study was conducted between April and August, 2025 at the postnatal ward of Kayunga regional referral hospital (RRH) located in Kayunga district in the central region of Uganda, approximately 51 kilometers (32 mi) north-east of Mukono, and about 67.5 kilometers (42 mi) north-east of Mulago National Referral Hospital. The hospital has a total bed capacity of 300, with specialized Obstetrics and Gynecology services, and a theatre that carries out an average of 40 caesarean sections, among others. The hospital also offers neonatal intensive care unit (NICU) services, which provide life support and treatment for neonates with complications. The hospital serves as a regional referral for six districts of Kayunga, Mukono, Buikwe, Nakasongola, Luwero, and Kamuli. [19].

Participant recruitment

The study participants were selected using simple random sampling and were recruited from the postnatal ward at Kayunga RRH. Adult (³18 years) postnatal women who were eligible to take part in the study were approached by a trained research assistant and consented to enroll.

Sample size

The Kish Leslie formula [20] of sample size estimation was used, taking a 95% confidence interval and a 5% margin of error, with the estimated prevalence rate of RMC taken to be 63% [21]. The study had a sample size of 356 women participating.

Out of the 546 women sampled in the postnatal ward, 417 were potentially eligible to participate in the study, and 378 were confirmed eligible. However, 13 participants declined to consent to the study, leaving a total of 365 participants. None of the participants withdrew from the study. As such, the calculated sample size of 356 participants was achieved.

Data collection

The data were collected using a pre-tested, structured, interviewer-administered paper-based questionnaire in English. This collected sociodemographic characteristics of pregnancy-related events (antenatal care attendance, duration in labor, time of delivery, mode of delivery) and also included 11 structured questions developed based on Hill's (2010) domains of disrespectful and abusive care and 12 domains of respectful maternity care. (16,17). The outcome variable (Respectful Maternal Care Yes/No) was obtained by scoring 12 standard questions that assess Respectful Maternal Care. Participants who scored 6/12 and above were coded "Yes", and the others were coded "No".

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Following participants' consent, questionnaires were anonymized with codes and completed by a trained research assistant page by page.

Data management and analysis

Data entry, cleaning, and statistical analysis were conducted using STATA version 18.5. Descriptive statistics for sociodemographic, pregnancy, labor, and delivery characteristics were presented as frequencies and proportions for categorical variables and medians with interquartile ranges for continuous variables. Associations between the dependent variables and the outcome variable (respectful maternal care: yes/no) were evaluated using chi-square or Fisher's exact tests for categorical variables, and the Mann-Whitney U test for continuous variables. Statistical significance was set at a p-value of <0.05. Bivariate analysis was conducted using a modified Poisson regression model, with variables showing p-values <0.2 included in the adjusted multivariable model. Backward elimination was employed during the multivariable analysis.

Ethics

The study was approved by the Mildmay Uganda Research Ethics Committee (MUREC), registration number: **MUREC-2024-469** (approval date: 29/10/2024), and Uganda National Council of Science and Technology, registration number**: HS5710ES** (approval date: 11/04/2025)**.** Clearance of the study was done by the hospital administration and the Department of Obstetrics and Gynecology. Informed consent was obtained from all study participants.

Results

Demographic characteristics of postpartum women

Table 1 shows the socio-demographic, pregnancy, labor, and delivery characteristics of the women who took part in the study. More than half (56.2%) of the women in the study were within the age range of 25 to 29 years. In regard to marital status, the majority were either single (39.3%) or married (39.3%) and mainly residing in rural settings (55.3%). Considering their education levels, a majority (53.9%) had a secondary level. In terms of occupation status, 179 (49.4%) were housewives, while 113 (31.7%) were working mothers. The average monthly income of most (59.3%) women ranged between Ugsh 100,000 to 500,000 Ugsh (about USD 27 to USD 136).

Table 1. Frequency and percentage distribution of demographic characteristics of the study participants.

Characteristic	Overall, N (Col% %)	***Respectful Maternal Care		p-value
		No, N (Row% %)	Yes, N (Row% %)	
Overall	***356***	***68(19.1%)***	***288(80.9%)***	
Age in years (Median (IQR))	26.0 (24.0, 28.0)	26.0 (25.0, 28.0)	26.0 (24.0, 28.0)	*0.056*^{M}
Age Category				*<0.001*^{F}
18-24	102 (28.7)	7 (6.9)	95 (93.1)	
25-29	200 (56.2)	52 (26.0)	148 (74.0)	
30-34	38 (10.7)	5 (13.2)	33 (86.8)	
35 and above	16 (4.5)	4 (25.0)	12 (75.0)	
Marital Status				*0.004*^{C}
Divorced	46 (12.9)	13 (28.3)	33 (71.7)	
Married	140 (39.3)	15 (10.7)	125 (89.3)	
Single	140 (39.3)	30 (21.4)	110 (78.6)	
Widowed	30 (8.4)	10 (33.3)	20 (66.7)	
Residence				*0.920*^{C}
Rural	197 (55.3)	38 (19.3)	159 (80.7)	
Urban	159 (44.7)	30 (18.9)	129 (81.1)	
Employment				*0.034*^{C}

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Employed	113 (31.7)	30 (26.5)	83 (73.5)	
Housewife	176 (49.4)	30 (17.0)	146 (83.0)	
Unemployed	67 (18.8)	8 (11.9)	59 (88.1)	
Education Level				*0.811*^{F}
College and above	28 (7.9)	7 (25.0)	21 (75.0)	
None	12 (3.4)	2 (16.7)	10 (83.3)	
Primary	124 (34.8)	22 (17.7)	102 (82.3)	
Secondary	192 (53.9)	37 (19.3)	155 (80.7)	
Religion				*0.206*^{F}
Born-again Pentecostal	48 (13.5)	11 (22.9)	37 (77.1)	
Catholic	62 (17.4)	16 (25.8)	46 (74.2)	
Muslim	54 (15.2)	11 (20.4)	43 (79.6)	
Protestant	186 (52.2)	28 (15.1)	158 (84.9)	
SDA	6 (1.7)	2 (33.3)	4 (66.7)	
Average monthly income**				*0.081*^{C}
100,000-500,000	211 (59.3)	43 (20.4)	168 (79.6)	
Less than 100,000	125 (35.1)	18 (14.4)	107 (85.6)	
More than 500,000	20 (5.6)	7 (35.0)	13 (65.0)	

Col% % stands for column percentage, Row% % stands for row percentages, and IQR stands for inter-quantile range.
^{M} stands for Mann-Whitney U test, χ^2 ^{S}tands for Pearson Chi-square, and ^{S}tands for Fisher's exact test.
****The outcome variable (Respectful Maternal Care Yes/No) was obtained by scoring 12 standard questions that assess Respectful Maternal Care. Participants who scored 6/12 and above were coded "Yes", and the others were coded "No".*
***1 USD =37,000 Ugsh.*

Pregnancy-related attributes

Table 2 shows the responses related to pregnancy, labor, and child delivery by the study participants. The majority (309; 86.8%) of the women were multigravida (had been pregnant at least a second time), and had attended at least one antenatal visit (289; 81.2%), but did not complete all the required eight visits. The majority (74.3%) reported not having experienced any complications during their pregnancy, and over half (53.4%) reported having planned for their pregnancy. The majority (204; 57.3%) were delivered by spontaneous vaginal delivery and delivered during daytime (184; 51.7%). Over half (182; 51.1%) reported having been escorted to the hospital by the husband, and were attended to by a female health worker (188; 52.8%).

Table 2. Frequency and percentage distribution of identified pregnancy, labor, and delivery-related attributes of the postpartum women.

Characteristic		***Respectful Maternal Care		p-value
	Overall, N (Col% %)	No, N (Row% %)	Yes, N (Row% %)	
Gravidity				
Multigravida	309 (86.8)	62 (20.1)	247 (79.9)	*0.236*^{C}
Prim gravida	47 (13.2)	6 (12.8)	41 (87.2)	
ANC Visits				
Completed	44 (12.4)	13 (29.5)	31 (70.5)	*0.042*^{C}
Did not do at all	23 (6.5)	7 (30.4)	16 (69.6)	
Not completed	289 (81.2)	48 (16.6)	241 (83.4)	
Complications during Pregnancy (N=354)				

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No	263 (74.3)	51 (19.4)	212 (80.6)	*0.413*[C]
Yes	91 (25.7)	16 (17.6)	75 (82.4)	
Planned Pregnancy				
No	166 (46.6)	45 (27.1)	121 (72.9)	*<0.001*[C]
Yes	190 (53.4)	23 (12.1)	167 (87.9)	
Mode of Delivery				
Caesarean section	146 (41.0)	23 (15.8)	123 (84.2)	*0.013*[F]
Instrument assisted	6 (1.7)	4 (66.7)	2 (33.3)	
Spontaneous vaginal delivery	204 (57.3)	41 (20.1)	163 (79.9)	
Complications During Delivery				
No	172 (48.3)	40 (23.3)	132 (76.7)	*0.054*[C]
Yes	184 (51.7)	28 (15.2)	156 (84.8)	
Time of Delivery				
Day time	184 (51.7)	28 (15.2)	156 (84.8)	*0.054*[C]
Night time	172 (48.3)	40 (23.3)	132 (76.7)	
Came to the hospital with husband				
No	182 (51.1)	41 (22.5)	141 (77.5)	*0.093*[C]
Yes	174 (48.9)	27 (15.5)	147 (84.5)	
Sex of Healthcare Worker				
Female	188 (52.8)	41 (21.8)	147 (78.2)	*0.169*[C]
Male	168 (47.2)	27 (16.1)	141 (83.9)	

Col% % stands for column percentage, Row% % stands for row percentages, and IQR stands for inter-quantile range.
[M] stands for Mann-Whitney U test, χ^2 [S]tands for Pearson Chi-square, and [F stands] for Fisher's Exact test.
****The outcome variable (Respectful Maternal Care Yes/No) was obtained by scoring 12 standard questions that assess Respectful Maternal Care. Participants who scored 6/12 and above were coded "Yes", and the others were coded.*

Characteristics of women who reported not having received respectful maternity care

The study showed that women who reported disrespect and abuse (not having received respectful maternity care) were likely not to have had a planned pregnancy (p-value= 0.001), having delivered by C-section (p-value= 0.013), delivered during daytime (p-value= 0.054), and did not come to the hospital with the husband (p-value= 0.093).

Prevalence of respectful maternity care (RMC)

The average prevalence of respectful maternal care was 62.3%. The top 3 frequently practiced RMC elements were treating patients with respect (77.5%), speaking to patients in a language they could understand (73.3%), and showing concern and empathy (72.5%). The prevalence of mistreatment and abuse of women was 43.6%, with the most commonly reported form of mistreatment of women being not attending to the patient's pain during childbirth (52.8%). The reported prevalence of respectful maternal care (RMC) and disrespect is shown in Table 3.

Table 3. Prevalence of Respectful Maternal Care (RMC) as reported by study participants.

Characteristic (N=356)	Frequency (%)
Respectful Maternal Care	
Were you allowed to eat food or take a drink during labor?	
No	163 (45.8)
Yes	193 (54.2)
Did you receive any confidential care during labor and childbirth?	

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No	148 (41.6)
Yes	208 (58.4)
Were you denied freedom to move during labor and childbirth?	
No	193 (54.2)
Yes	163 (45.8)
Were you asked for consent in any procedure they performed on you?	
No	110 (30.9)
Yes	246 (69.1)
I felt that the healthcare workers cared for me with a kind approach.	
No	220 (61.8)
Yes	136 (38.2)
Healthcare workers treated me in a friendly manner.	
No	119 (33.4)
Yes	237 (66.6)
The healthcare workers were talking positively about pain and relief.	
No	104 (29.2)
Yes	252 (70.8)
The healthcare provider showed concern and empathy towards me.	
No	98 (27.5)
Yes	258 (72.5)
All healthcare workers treated me with respect as an individual.	
No	80 (22.5)
Yes	276 (77.5)
The healthcare providers spoke to me in a language I could understand.	
No	95 (26.7)
Yes	261 (73.3)
The healthcare providers called me by my name.	
No	107 (30.1)
Yes	249 (69.9)
The healthcare providers responded to my needs whether or not I asked.	
No	172 (48.3)
Yes	184 (51.7)

Table 4: Prevalence of disrespect as reported by study participants.

Disrespectful Maternal Care	
Some healthcare providers slapped me during delivery for different reasons.	
No	237 (66.6)
Yes	119 (33.4)
Some healthcare providers shouted at me because I hadn't done what I was told to do.	
No	213 (59.8)
Yes	143 (40.2)
I was kept waiting for a long time before receiving services.	

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No	183 (51.4)
Yes	173 (48.6)
Service provision was delayed due to the health facility's internal problems.	
No	246 (69.1)
Yes	110 (30.9)
Some healthcare providers did not treat me well due to my personal attributes.	
No	181 (50.8)
Yes	175 (49.2)
Some healthcare providers insulted my companions and me due to personal attributes.	
No	248 (69.7)
Yes	108 (30.3)
I was not allowed to practice cultural rituals in the facility.	
No	205 (57.6)
Yes	151 (42.4)
I was made to pay money for the services I received.	
No	173 (48.6)
Yes	183 (51.4)
No one cared to know or attend to the pain I was experiencing after birth.	
No	168 (47.2)
Yes	188 (52.8)
My emotional health has not been assessed or attended to since I gave birth.	
No	204 (57.3)
Yes	152 (42.7)
The healthcare provider has been communicating with me frequently and with empathy.	
No	150 (42.1)
Yes	206 (57.9)

Factors associated with respectful maternal care (RMC).

Factors selected into the adjusted model if they had a p-value<0.2 at un-adjusted. Statistical significance in the adjusted model was considered for variables that obtained a p-value < 0.05. The study found that women aged 25 to 29 years (95% CI: 0.74, 0.92, p-value = 0.001), having a planned pregnancy (95% CI: 1.05, 1.30, p-value = 0.005) and having come to the hospital with a husband (95% CI: 1.00, 1.21, p-value = 0.064) were statistically significantly related to respective maternal care.

Table 5: Factors associated with respectful maternal care (RMC) in labor and delivery in Bivariate regression Models (n = 356).

Characteristic	Un-adjusted PR (95% CI)	p-value	Adjusted PR (95% CI)	p-value
Age Category				
18-24	Reference		Reference	
25-29	0.79(0.72-0.88)	*<0.001*	0.84(0.74-0.92)	*<0.001**
30-34	0.93(0.81-1.07)	*0.309*	0.94(0.82-1.07)	*0.344*
35 and above	0.81(0.6-1.07)	*0.141*	0.87(0.66-1.14)	*0.319*
Education Level				

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College and above	Reference		N/A	N/A
None	1.11(0.80-1.55)	*0.534*	N/A	N/A
Primary	1.10(0.87-1.38)	*0.43*	N/A	N/A
Secondary	1.08(0.86-1.35)	*0.521*	N/A	N/A
Average monthly income**				
100,000-500,000	1.22(0.88-1.7)	*0.227*	1.24(0.91-1.69)	*0.166*
Less than 100,000	1.32(0.95-1.83)	*0.102*	1.29(0.94-1.75)	*0.112*
More than 500,000	Reference		Reference	
Gravidity				
Multigravida	Reference		Reference	
Prim gravida	1.09(0.97-1.23)	*0.164*	1.01(0.89-1.14)	*0.895*
ANC Visits				
Completed	1.01(0.73-1.41)	*0.94*	N/A	N/A
Did not do at all	Reference		N/A	N/A
Not completed	1.2(0.91-1.58)	*0.197*	N/A	N/A
Planned Pregnancy				
No	Reference		Reference	
Yes	1.21(1.08-1.34)	*0.001*	1.16(1.05-1.30)	*0.005**
Mode of Delivery				
Caesarean section	2.53(0.81-7.87)	*0.109*	2.52(0.83-7.61)	*0.175*
Instrument assisted	Reference		Reference	
Spontaneous vaginal delivery	2.4(0.77-7.46)	*0.131*	2.45(0.82-7.45)	*0.11*
Complications During Delivery				
No	Reference		Reference	
Yes	1.1(1-1.22)	*0.057*	1.08(0.97-1.20)	*0.175*
Time of Delivery				
Day time	1.1(1-1.22)	*0.057*	1.07(0.97-1.19)	*0.183*
Night time	Reference		Reference	
Came to the hospital with husband				
No	Reference		Reference	
Yes	1.09(0.99-1.21)	*0.093*	1.10(1.00-1.21)	*0.064**
Sex of Healthcare Worker				
Female	Reference		Reference	
Male	1.07(0.97-1.19)	*0.167*	1.04(0.94-1.15)	*0.417*

PR denotes Prevalence Ratios and 95% CI obtained by fitting a modified Poisson regression model on complete cases (N=356). *P-value significant at 0.05 level. Prevalence Ratio (PR), CI-Confidence Interval, Ref- Reference group. **I USD = 3,700 Ugsh

Discussion

This study presents an analysis of the prevalence and associated factors of RMC at a public regional referral hospital in Uganda. The study contributed to the growing interest in the promotion of RMC globally and revealed that the average prevalence of RMC was 62.3% which is high compared to results in other settings. For example, a systematic review and meta-analysis done in Ethiopia found the pooled prevalence of respectful maternity care at 48.44% which is lower compared to the present study. [22]. However, a cross-sectional study done in Rwanda, an East African country, reported that 70.2% of women received respectful maternity care, which is much higher than the findings of this present study. [23]. This difference in the RMC prevalence rates may be explained by the different study designs, study participant socio-demographic characteristics, and sample size in these studies.

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The top 3 frequently practiced RMC elements identified from this study were treating patients with respect (77.5%), speaking to patients in a language they could understand (73.3%), and showing concern and empathy (72.5%). These findings vary in different settings, such as Nigeria, where a qualitative explanatory inquiry showed that the provision of confidentiality, availability of showers and water, availability of meals and drinks to women, and pain relief during labor and delivery were some of the most practiced elements of RMC. [24]. The study from Rwanda showed that the commonly provided RMC elements were allowance of light food and fluid intake (98.5%), non-discrimination care (96.2%), receipt of necessary services (96.1%), and ensuring privacy (91.3%) [23]. Several reasons for these observed differences in RMC provision in different settings exist and may include factors like provider attitudes and perceptions, existing capacity and training among health workers, and resource availability, especially for the health care workers. [15, 25, 26].

The prevalence of disrespect and abuse (D&A) from this study stood at 43.6%, a rate relatively high compared to other settings in SSA. A study from Kenya showed the prevalence rate of D&A among women to be 20% [27]. However, a systematic review and meta-analysis study showed the pooled prevalence of disrespect and abuse of women during childbirth in East Africa to be 46.85% [28], a rate almost close to that of the present study. This study revealed that the top 3 commonly reported forms of mistreatment of women were not attending to the patient's pain during childbirth (52.8%), being made to make unethical payment for services received (51.4%), and not being treated well due to personal attributes (49.2%). The study findings have similar attributes to the findings from the study done in Kenya on D&A that reported neglect (14.3%), non-dignified care (18%), and physical abuse (4.2%) as the commonly reported forms of mistreatment [27]. An interventional mixed methods study in Ethiopia reported the lack of privacy during physical examination (39.1%) and the use of physical force (21.9%) as the most prevalent forms of mistreatment [15]. It is important to note how the rates of D&A from both the studies done in Kenya and Ethiopia are lower than those from this study from Uganda.

The study showed that women aged 25 to 29 years (95% CI: 0.74, 0.92, p-value = 0.001), having a planned pregnancy (95% CI: 1.05, 1.30, p-value = 0.005) and having come to the hospital with a husband (95% CI: 1.00, 1.21, p-value = 0.064) were statistically significantly related to RMC. These findings relate to those reported from an Ethiopian study that showed having a planned pregnancy [AOR = 2.95%; CI: 1.3, 4.3] was statistically significantly related to RMC during labor and delivery [29]. Also, these study findings are similar to a systematic review and meta-analysis study done in Ethiopia that showed a strong statistical significance between having a planned pregnancy [AOR = 4.43, 95% CI: 2.74, 6.12] and giving birth during the daytime [AOR: 2.61, 95% CI: 1.92, 3.31] with RMC.

A systematic review of studies on RMC among low and middle-income countries found a direct correlation between income and the quality of maternal care. [6]. The financially stable women were able to procure quality maternal care. However, this study did not find any statistical significance (p-value=0.91) between monthly income and RMC. A study on RMC in Ethiopia reported that a higher likelihood of offering a high level of RMC was associated with a male healthcare provider (^ β ¼ 0:65, p = 0.012). However, this study did not find any statistical significance between receiving RMC and the gender of the attending healthcare provider. The same study [7] noted that laboring women accompanied by a companion (^ β ¼ 0:99, p = 0.003) experienced high RMC rates, which was the case in the study, which also found statistical significance between RMC and being escorted to the hospital by the husband (95% CI: 1.00, 1.21, p-value = 0.064). This finding underscores the role of male involvement in maternal care in the Ugandan setting.

Conclusion

The results of this study show that the prevalence of respectful maternity care during labor and delivery in a public tertiary hospital was 62.3%, which is moderate compared to others in the literature. The occurrence of disrespectful and abusive care among the study participants was 43.6%, which is comparatively high. Factors such as having a planned pregnancy, being aged between 25 and 29 years, and being escorted to the hospital by the husband were positively associated with respectful maternity care during childbirth. Based on factors associated with RMC.

Limitations of the study

The study faced a challenge of social desirability due to the presumed effects of poor maternal care from the skilled birth attendants. This affected the quality of the data collected. However, this challenge was minimized by reassuring the participants about confidentiality and the importance of providing actual information in improving maternal care.

Recall bias due to the cross-sectional study design may have underestimated the prevalence rates of RMC. Giving ample time during data collection and allowing the participants to

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confirm whatever responses they gave was observed to minimize recall bias.

Recommendations

Specific strategies and interventions, including male involvement and providing youth-friendly maternal health services, should be designed to increase the magnitude of respectful maternity care during childbirth within Uganda's health facilities.

List of abbreviations

ANC Antenatal Care
C-Section Cesarean section
D&A Disrespect and Abuse
LMIC: Low and middle-income countries
NICU Neonatal Intensive Care Unit
RMC Respectful Maternal Care
SSA Sub-Saharan Africa
SVD Spontaneous Vaginal Delivery
TBA Traditional Birth Attendant
WHO World Health Organization

Consent for publication

Not applicable.

Availability of data and materials

The data and materials can be accessed from the corresponding author upon reasonable request.

Competing interests

The authors declare that they have no competing interests

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Authors' contributions

Omulepu Isaac: Contributed to the conception of the research idea, training research assistants, data collection, and writing the manuscript.
Nalwoga Joannah: Contributed to refining the research concept, seeking ethical clearance, data analysis, and writing the manuscript.
Nakitto Sophia: Contributed to guiding the writing process and data collection.

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