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Study protocol

Assessment of the Implementation of Respectful Maternity Care Charter in North Central Nigeria (Federal Capital Territory and Kwara State): Study Protocol

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ABSTRACT

Respectful Maternity Care (RMC) charter is one of the tools for ensuring quality of care in maternity services. Nigeria is a signatory to RMC charter; therefore, the charter is expected to be the standard of care. However, in Nigeria and other countries, reports of disrespectful maternity care abound; this discourages women from accessing facility-birth. Therefore, to improve the quality of care towards increase in uptake, it is expedient to assess the level of implementation of the RMC charter by key stakeholders for sustainability, impact and scale-up of charter-compliant maternity care in Nigeria. The study aims to assess the implementation of RMC charter in North-central Nigeria. The study is a mixed-method, cross-sectional study; the expected participants are key stakeholders in healthcare (Healthcare workers, Healthcare Administrators, Project Managers, Policy makers) in North-Central Nigeria (Federal Capital Territory and Kwara state). A multistage sampling technique would be used to enroll participants from 18 healthcare facilities (Primary, Private, Secondary and Tertiary) in rural and urban areas and Ministries of Health officials at local and state government levels. Expected outcomes: The study is expected to provide information on the current status of knowledge and implementation of the RMC charter in Nigeria. It would also identify the enablers and barriers to the implementation process and provide evidence for effective scale-up of the process in Nigeria. The outcomes will be widely disseminated to healthcare workers, health administrators and decision-makers in healthcare services through post-study meetings, conference presentations, journal publications and policy briefs for effective RMC charter implementation in Nigeria.

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INTRODUCTION

All over the world, there are reports of neglectful, disrespectful, and abusive care in health facilities; this has stimulated global discourse on the quality of maternity care. In addition, the mistreatment has the potential to discourage childbirth in health facilities and may contribute to adverse maternal and neonatal outcomes [1]. This has led to the advocacy for Quality of Care including Respectful Maternity Care (RMC). The Respectful Maternity Care charter represents a global vision articulating the legal and human rights that women and newborns are entitled to. It describes ten universal rights of women and newborns during facility-births that promote safety, dignity, privacy, consent, non-discrimination, and access to essential information and maternal and newborn interventions during the intrapartum and postnatal periods. The charter was launched in 2011 and revised in 2019 [2]. RMC describes care organized for and provided to all women in a manner that maintains their dignity, privacy, and confidentiality; ensures freedom from harm and mistreatment, enables informed choice and continuous support during labour and childbirth [3]. Therefore, RMC charter follows a human rights-based approach to reducing maternal morbidity and mortality, improve women's experience of labour and delivery as well as address health inequalities.

Nigeria is a signatory to the RMC charter; so, the charter is expected to be the standard of care in maternity services. However, reports showed a dissatisfaction with care by women during labour and delivery in the country. In a report from Abakaliki Nigeria, the prevalence of disrespectful maternity care and abuse was 47.6%. The commonest forms of disrespect and abuse were detention in the health facility (40.2%), physical abuse (34.1%), non-dignified care (37.2%), non-consented care (20.1%), non-confidential care (25%), abandonment of care (18.9%) and discriminatory care (15.2%). The authors identified lack of companionship during delivery, unbooked status and rural residence as associated factors for disrespect and abuse during childbirth [4]. In a report from Lagos, Nigeria; although the participating midwives had a good understanding of the RMC Charter, this did not translate to standard practice [5]. Another study from Lagos, Nigeria reported partial implementation of RMC charter with provision for confidentiality, availability of water and meals as well as labour analgesia. The authors also reported physical abuse, lack of privacy, use of undignified language, threat, non-consented procedures, discrimination, not allowing birth companion, detention and non-availability of commodities [6].

Therefore, for the sustainability, impact and potential scale-up of RMC charter in Nigeria, there is a need to assess the level of implementation by key stakeholders. These will include healthcare workers at private, primary, secondary and tertiary health facilities, heads of facilities, and government officials at the local and state levels.

Despite many published studies on the occurrence, prevalence, and to a lesser extent drivers of mistreatment; there is insufficient evidence to guide the local design, implementation and monitoring of RMC charter interventions as part of comprehensive Maternal and Newborn Health (MNH) programs. Although a local multi-stakeholder process to develop and test interventions based on the local context is ideal; most RMC interventions were implemented as stand-alone rather than part of MNH programs [7].

In addition, the quality of childbirth care in facilities, including women's, newborns and families' experiences of this care, is an important determinant of families' disposition to future use or otherwise of facility childbirth and other services. Therefore, efforts to sustain women's and families' utilization of facility-based services may not succeed if stakeholders do not address the challenges of mistreatment. This can only be possible if we assess the level of implementation of the RMC Charter at our facilities, and identify the enablers and barriers to the implementation. This information will provide a scientific basis for informed decision on the necessary interventions for the sustenance and scale up of the implementation of the RMC charter in Nigeria.

The conceptual framework adopted for the study attempts to give a picture of the process through which the implementation of RMC takes place. The relationship between the providers' demographic, socioeconomic factors, other provider factors, and health facility factors are the independent variables, and the level of implementation of respectful maternity care is the dependent variable. This dependent variable is mediated by the enablers and barriers.

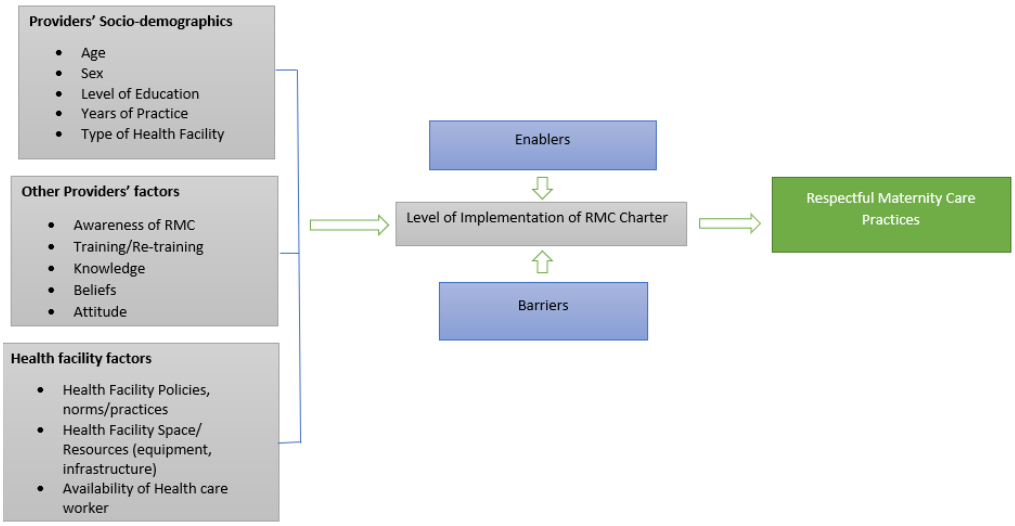

Figure 1. A conceptual framework of the level of Implementation of the RMC Charter: Enablers and Barriers

The study seeks to answer the following research questions: What is the level of knowledge and awareness of stakeholders in implementation of the RMC charter in North-central Nigeria? What is the level of the implementation of the RMC charter in North-central Nigeria? What are the enablers and barriers to the implementation of the RMC charter in North-central Nigeria?

The general objective of the study is to assess the implementation of the Respectful Maternity Care (RMC) Charter in North-central Nigeria. The specific objectives are to determine the level of knowledge, assess the level of implementation, identify enablers as well as barriers to the implementation of the RMC charter in North-central Nigeria.

METHODS

Study design and settings

The study is a descriptive cross-sectional study using a mixed method approach comprising of quantitative and qualitative arms to assess the implementation of RMC charter at state Ministries of Health (SMOH), State Primary Health Care Development Agencies (SPHCDA), Local Government Areas (LGAs) and selected health facilities in FCT and Kwara State, North-central Nigeria.

The study will be conducted in Federal Capital Territory (FCT) and Kwara State in the North-central geopolitical zone of Nigeria.

Federal Capital Territory (FCT) is the capital of Nigeria and is located on latitude 9.0765^0 N and 7.3986° E. It has a total land mass of 7,315km^2 with six area councils. The estimated population of FCT as of 2023 was 6,372,080 projected from the 2006 census at an estimated growth rate of 9.3%. According to the NDHS survey of 2018, 63.2% of women delivered in a health facility in the FCT [8].

Kwara State is located between 8^o 30'N and 5^o 00'E with a land mass of 36,825km^2 and sixteen Local Government Areas (LGAs). The 2023 estimated population of Kwara State was 3,919,049 people projected from the 2006 census at an estimated growth rate of 3%. According to the NDHS 2018, 55.1% of women in Kwara state delivered in a health facility [8].

Study Population

There would be three categories of study participants which constitute the key stakeholders in Health. First are the skilled health care workers at the health facilities providing Reproductive, Maternal, Newborn, Child, Adolescent, Elderly Health and Nutrition (RMNCAEH+N) services i.e doctors, nurses, midwives, community health officers (CHO) and community health extension workers (CHEW). Second, the administrative heads of each of the selected health facilities i.e. heads of facilities, Officers In-Charge or hospital administrators of private facilities. Third, policy makers/ program officers at the Health and Human Services Secretariat (HHSS) and FCT Primary Health Care Development Agency, Kwara State Ministry of Health (SMOH), Kwara State Primary Health Care Development Agency, and Area Councils/Local Government Areas responsible for overseeing functions of the state and LGA facilities.

Inclusion Criteria

For the health facilities, to be eligible for inclusion, the facility must be involved in RMNCAEH+N service delivery and must have had deliveries in the 12 months prior to commencement of the study. The Primary Health Care (PHC) and private health facilities must be offering Basic Emergency Obstetric and Neonatal Care Services while the Secondary health facilities must be receiving referrals from the selected PHCs and private facilities as well as offering Comprehensive Emergency Obstetric and Neonatal Care Services. For the health care workers, eligible individuals must be registered practitioners for the cadre of service employed for, have at least one year of experience as a service provider and must have been working at the facility for at least three months before the commencement of the study.

Exclusion Criteria

Health facilities that are not approved for operation by regulatory bodies and health workers who are not licensed to practice by professional licensing bodies will be excluded from the study.

Sample size determination

The sample size was calculated using the formula for sample size determination for a cross-sectional study [9] and an 80% prevalence for proportion of midwives rendering RMC from a previous similar study [10] and an attrition rate of 10% to yield a minimum sample size of 280 for the quantitative arm of the study.

Sampling Technique

A multistage sampling technique will be used to select the participating health facilities. Stage 1 will involve the selection of area councils/senatorial districts. Two (2) area councils and 2 senatorial districts would be selected randomly from FCT and Kwara State respectively using simple random sampling technique by balloting giving a total of 4 areas/districts. Stage 2 is designed to involve the selection of Tertiary Facility. One tertiary health facility would be selected from each state from all the available tertiary health facilities using simple random sampling technique by balloting. Stage 3 will involve the selection of Secondary Health Facilities. A list of the secondary health facilities that carry out comprehensive emergency obstetrics Care (CEOC) activities would be collated for each of the four selected area councils/senatorial districts. One secondary health facility would be selected from each of the area councils/senatorial districts in each of the two states using simple random sampling technique by use of table of random numbers giving four secondary health facilities. Stage 4 will be the selection of Primary Health Care (PHC) facilities. Two PHC facilities that feed the selected secondary health facilities and offer basic emergency obstetrics care (BEOC) services will be selected using simple random sampling technique by use of table of random numbers, giving a total of eight PHCs. Two (2) Private facilities rendering RMNCAEH+N services would be selected from a list of all private facilities in each study site.

Therefore, one tertiary, two secondary, four PHC and two Private health facilities making a total of nine for each study site and a total of eighteen would be selected for the study. The selection of the facilities would be in ratio 1:1 to capture rural versus urban locations.

Selection of study participants

A Multistage sampling technique will be used to select the participants. Proportional allocation will be done to determine the number of health care workers (HCWs) to be selected from the health facilities depending on their respective population in each health facility. Stage 1 will involve systematic sampling technique. Lists of all eligible HCWs will be obtained from all the participating health facilities to get the sampling frame. For stage 2, the sampling interval (n) will be determined, then the first participant will be selected by simple random sampling technique by balloting. Thereafter, every nth participant will be selected from the list until the required sample size per facility is attained.

Selection of Participants for the Qualitative component of the study

Purposive sampling technique will be used for the selection. The number and cadre of participants for the qualitative interview are as stated in table 2 below. However, any participant who has participated in the quantitative interview is ineligible for participation in the quantitative interview. This is to avoid duplication as well as prevent bias.

Facility assessment

To validate the responses from the quantitative and qualitative interviews, an on-the-spot assessment of all participating facilities will be conducted. This would involve the use of a pretested check list designed for this study. It would include

observation of care of women during labour and delivery, newborn care as well as infrastructural and equipment assessment at the labour and delivery rooms.

Table 1. Selection of Area Councils/Senatorial Districts and Health Facilities

Area council/ Senatorial district		Health Facilities			
		Tertiary (n=2)	Secondary (n=4)	PHC (n=8)	Private (n=4)
Federal Capital Territory (FCT)	Bwari (Rural)	0	Bwari General Hospital	-Kogo PHC -Dutse Alhaji PHC	Daughters of Charity Hospital, Bwari
	AMAC (Urban)	National Hospital, Abuja	Wuse District Hospital	-Jiwa PHC -Kuchingoro PHC	Excel Specialist Hospital and Fertility Centre, Abuja
Kwara State	Kwara South (Rural)	0	General Hospital, Erinle	-PHC Ijagbo -Erinle Model Clinic (PHC)	Folorunsho Clinic, Erinle
	Kwara Central (Urban)	University of Ilorin Teaching Hospital	General Hospital, Ilorin	-Basic PHC Adewole -Basic PHC Alanamu	Surulere Medical Centre, Ilorin.

Table 2. Summary of participants in the Qualitative arm of the study

Interview category	Location	Interview type	Tool to be used	Number per facility/ organization	No of facility/ organization per site	No of participants per site	Total
HCWs providing Maternity Services	Tertiary Facility	IDI	Tool B	4	1	4	8
HCWs providing Maternity Services	Secondary Facility	IDI	Tool B	3	2	6	12
HCWs providing Maternity Services	PHC	IDI	Tool B	2	4	8	16
Health Facility Administrative Heads/Officers In-Charge	Health Facilities	KII	Tool C	1	7	7	14
Policy Makers (Executive Secretary /Directors)	SMOH/SPHCDA	KII	Tool D	1	2	2	4
RH Program Managers	SMOH/ SPHCDA	KII	Tool D	1	2	2	4
Director PHC/Program Managers at LGA level	Area Council/ LGA	KII	Tool D	2	2	4	8

Study Instruments/Tools

The study tools for the study are tool A which is the Health Care Worker Questionnaire and tool B which is the Health Facility Observational Checklist for the quantitative arm of the study. For the qualitative arm, the study tools are tool C which is the Health Care Worker In-depth Interview guide, tool D which is the Health Facility Administrative Heads KII guide and tool E which is the Policy Maker/Program Officers KII guide.

Table 3. Summary of Data Collection Tools

Data Collection Tools	Purpose/Description
Tool A: Health Care Worker Questionnaire	i) To assess the awareness and level of implementation of RMC charter among health care workers providing maternity services ii)To identify enablers and barriers to implementation of RMC charter by the HCWs. (Study Objectives 1, 2, 3 and 4)
Tool B: Health Facility Observational Checklist	i) To validate the level of implementation of RMC charter by health care workers in the health facilities (Study Objective 2)
Tool C: Health Care Worker In-depth Interview guide	i) To explore the knowledge of HCW on RMC charter ii)To explore the level of implementation of RMC charter iii) To identify the enablers and barriers to implementation of RMC charter among health care workers providing maternity services. (Study Objectives 1, 2, 3 and 4)
Tool D: Health Facility Administrative Heads KII guide	i) To explore the level of awareness of health facilities' heads on RMC charter ii) To explore the level of implementation of RMC charter in the health facilities iii) To identify enablers and barriers to implementation of RMC charter in the health facilities. (Study Objectives 1, 2, 3 and 4)
Tool E: Policy Maker/Program Officers KII guide	i)To explore the level of awareness of policy makers and program managers on RMC charter in the state ministries of health, State Primary Health Care Development Agencies and LGA/Area councils ii) To explore the level of implementation of RMC charter by policy makers/program managers. iii)To identify the enablers and barriers to implementation of RMC charter among policy makers and program managers. (Study Objectives 1, 2, 3 and 4)

Data Collection Procedure

Advocacy: Advocacy visits would be paid to the Commissioners of Health, Executive Directors, Directors of Public Health, Program Officers and Heads of facilities in the selected ministries of health, Primary Health Care Development agencies (PHCDA), Local Government Authorities (LGAs) and health facilities respectively. This is to inform them about the study, solicit \their cooperation and support. A letter of introduction from the Federal Ministry of Health (FMOH) through the Department of Research, Planning and Statistics will be obtained to seek for their permission to conduct the study. The purpose and benefits of the study will be explained to them and to the various stakeholders at all levels.

Study Implementation: The study implementation period is expected to span April 2023 to March 2024 and the study will be implemented in four phases. Phase 1 will involve the recruitment of research teams from the two participating states in the country, training of research assistants and advocacy visits to stakeholders intimating them of the research. In phase 2, a pilot study will be conducted in Oyo state in South-west Nigeria which will not be involved in the study. This is to ensure validity of the study instruments and correct for any inconsistencies that may be found. Ten percent of the questionnaire would be pretested at Ogbomosho in Oyo State, south-west Nigeria. Key informants' interviews would also be conducted for each of the identified stakeholder at the ministry of health, state PHCDA, local government area, health facility administrator, while in-depth interviews will be conducted among HCWs. Necessary modifications of the research tools will be made before they are used for data collection for the study. Phase 3 will be for the recruitment of participants at the identified health facilities in the selected area councils and senatorial districts in FCT and Kwara State, respectively. This would include provision of information sheets, collection of informed consent, conduct of the interviews proper and storage of data collected. Also, data analysis would be done at this phase. During phase 4, there will be participatory meetings with all stakeholders from FCT and Kwara state where the study was conducted to discuss the findings of the study, submission of preliminary reports at Technical Working Group Meetings, Submission of policy briefs, submission of manuscripts for publication and final dissemination of study findings.

Each participant on the health facility list (sampling frame) who satisfies the eligibility criteria will be approached to explain the purpose and benefit of the study. The study entails collection of quantitative data through interviews using semi-structured interviewer-administered questionnaire (Tool A) that will be entered on a mobile data collection app, KoboCollect v2021.2.4.

The qualitative component will involve a one-on-one interview with the selected participant using the specific interview guide (Tools C, D, E). The interviews would be audio recorded to ensure complete capture of all information after seeking the consent of the respondent, and notes will also be taken. The participants would be required to give some of their time for the interviews which would be appropriately explained to them before the agreed interview dates. Each prospective participant will be visited at least twice. First, inform them about the study, obtain informed consent and

arrange an appropriate convenient time. The second visit will be for the conduct of the interview. Each participant who consents to participate in the study would be interviewed alone in his or her office or any other space that the respondent considers convenient and safe to ensure quality, fluidity and reliability of their responses. Adequate pre-arrangement for the appropriate time that is convenient would have been made between each prospective participant and the interviewer. For the quantitative study, an estimated 20 minutes will be required for the interview while about 45 to 60 minutes will be required for the in-depth and key informant interviews.

Study Administrative hierarchy

The study hierarchy will consist of the Investigators comprising one principal investigator (a Public Health Physician) and four co-investigators i.e. one obstetrician, one neonatologist and two additional Public Health Physicians. There will be a Project Coordinator who holds a Masters degree in Public Health with experience in research administration and conduct. He/ She will oversee the administrative work and coordination of field activities. There will be two state coordinators (one per study site); these will be holders of Masters degree in Public Health and previous experience in medical research. They will be responsible for coordination of research activities at the study sites and relating with the investigators. A total of 16 research assistants (8 for each study site) will be recruited. These will be medical personnel (Nurses/Midwives, Doctors, or other persons with a background of health-related disciplines or those with previous experience in health research). The statistical analysis will be performed by a certified data analyst with skill and experience in health statistics and health-related research.

All the sixteen research assistants, the project manager and state coordinators will be trained to conduct quantitative and qualitative interviews. The mode of training will include didactic lectures, discussions, role plays, and field practical sessions. There will also be the use of audio-visuals and other teaching aids during the training. Topics that will be discussed will include responsible conduct of research, the study protocol, sampling techniques, the art of conducting a research interview, use of necessary equipment and confidentiality among others.

Timeline for the study

The study is expected to run for twelve months (April 2023 to March 2024). All the study activities including protocol assessment and approval, recruitment and training of staff, advocacy, field work, quality control, data storage, data analysis, report writing, preparation of policy briefs, presentation at the National Technical Working Group on RMNCAEH+N as well as periodic feedback to the sponsors.

Expected outcomes

The outcome of the study would provide useful information to the HCWs, health administrators, policy-makers, project managers, the state and Federal Government as well as international partners on RMC charter and implementation in Nigeria. It will assess the knowledge of RMC charter, its level of implementation as well as identify the enablers and barriers to the implementation process. It is expected to provide evidence on effective potential scale-up of RMC charter implementation in Nigeria. The outcome of the study will be widely disseminated to decision-makers in health services while policy briefs will be generated to assist the government in RMC Charter implementation. In addition, the study results will be presented at learned conferences as well as prepared as articles for publications in peer-reviewed journals.

Data Management and Ethics

Quantitative data obtained from the health care workers providing respectful maternity care services will be entered into a database using SPSS version 25.0. Descriptive analysis will illustrate the socio-demographic characteristics of the respondents, including profession, cadre, years of practice and average monthly income. The main dependent variable will be level of implementation of RMC charter while the independent variables will include demographic and socioeconomic factors of health workers, other providers factors (duration of practice of the health care workers, the level of awareness of the health workers about the RMC charter, training, beliefs, attitude, and health facility factors (availability of RMC policies, adequacy of health facility and equipment, availability of health care workers). Chi-square test and multiple logistics regression will be used to test for the hypothesis. Chi-square test will be used to test for association between socio-demographic characteristics of the health care workers and the level of awareness about RMC charter, as well as the level of implementation of the RMC charter. Regression analysis will be used to identify major predictive factors in implementation of the RMC charter (enablers and barriers of implementation).

Qualitative data obtained from stakeholders interviewed during the in-depth interviews (IDI) and Key Informants interviews (KII) will be audio-recorded and notes will also be taken during the interviews. The audio-recorded data would be transcribed verbatim and labeled with non-identifiable ID numbers in place of names. The transcripts will be processed, coded, and interpreted using the detailed content analysis. Emerging and recurring themes would be carefully

noted and coded while ensuring that the core meanings are not lost or distorted. The codes would then be used to generate categories (depending on the diversity of codes, it may be necessary to develop subcategories then categories) and condensation of related categories into themes that convey the meaning of the data. The coding method and progress will be systematically discussed between the researchers and the principal investigator. The analysis would be done using Atlas-ti. Two researchers will analyses the same data set and be guided by general questions, specific questions, and comparisons, to ensure that the exact responses were appropriately captured and interpreted.

A national ethical approval has been obtained from the National Health Research Ethics Committee with approval number NHREC/01/01/2007 dated 19/04/2023. Local ethical approvals were also obtained from the FCT Department of Research Planning and Statistics, National Hospital ethics committee, University of Ilorin, University of Ilorin Teaching Hospital, General Hospital Ilorin and Kwara State Ethics committees respectively.

Informed Consent: HCWs who meet the inclusion criteria will be approached and informed about the study using the information sheet. A written informed consent would be obtained at recruitment into the study.

Voluntary Participation: Participation in the study will be voluntary and no financial incentive will be provided to the study participants. Participation will be appreciated but refusal to participate will be respected and it will not attract any penalty or disadvantage. Participants will be free to withdraw from the study at any stage without reprimand.

Confidentiality: Participants will be informed that the data collected will be held in strict confidence and all information collected will be de-identified. Each health worker will be interviewed in his or her office and responses will be treated with confidentiality. No personal identification data such as name, file number will be collected from participants.

During the transcription of the interviews all identifying details will be omitted to ensure participants' anonymity. The audio files, transcriptions and electronic data will be encrypted and exported to the designated pass-worded repository which will be stored in a fireproof safe in the principal investigator's office. The audio tapes will have no individual identifiers such as name and address to ensure privacy and confidentiality of the participants. The audio tapes will be destroyed after the data has been transcribed and reviewed by the research team.

Protection from harm: No significant risks or discomfort to participants is envisaged in this study. The risk of participants being interviewed while actively on duty will be mitigated by ensuring that interviews do not affect their service delivery. Interviews will be scheduled with the approval of the participants. The study will not cost the participants any financial loss but their time will be required for interviews

Benefit to Participants: There will be no direct benefits to the participants, however the study will provide an opportunity for the participants to be professionally fulfilled and their opinions will contribute to improvement in service delivery and health systems strengthening.

Dissemination of study results

The planned dissemination of the results of the study include: a): A post-data collection brief with key facility, LGA, state and national stakeholders on the study results and recommendations. B): Presentation of the study report to the National Technical Working Group for RMNAECH+N in Nigeria for consideration in charting the course for a national policy on RMC Charter in Nigeria. C): Presentation of a technical report to the Federal Ministry of Health for consideration in Nigeria's Policy and Strategic Planning for Maternal and Newborn Care. D): Presentation of policy briefs on the study outcomes and recommendations to the governments of FCT, Kwara state and the Nigeria Federal Ministry of Health. E): Presentation of the study outcome at learned conferences and publications in peer-reviewed journals.

Sponsorship

The study is part of the efforts of the Federal Ministry of Health to improve RMNCAEH+N in Nigeria but was sponsored by USAID/MCGL Quality of Care through Jhpiego, a subsidiary of John Hopkins University.

Conflict of interest

There are no additional financial, personal, or professional conflicts of interest to declare.

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تقييم تنفيذ ميثاق رعاية الأمومة المحترم في شمال وسط نيجيريا (إقليم العاصمة الفيدرالية وولاية كوارا): بروتوكول الدراسة

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المستخلص

يعد ميثاق رعاية الأمومة المحترمة إحدى الأدوات لضمان جودة الرعاية في خدمات الأمومة. نيجيريا هي إحدى الدول الموقعة على ميثاق رعاية الأمومة المحترمة .لذلك من المتوقع أن يكون الميثاق هو معيار الرعاية. ومع ذلك، في نيجيريا وبلدان أخرى، تكثر التقارير عن رعاية الأمومة غير المحترمة؛ وهذا لا يشجع النساء على الوصول إلى مرافق الولادة. لذلك، لتحسين جودة الرعاية من أجل زيادة استيعابها، من المناسب تقييم مستوى تنفيذ ميثاق رعاية الأمومة المحترمة من قبل أصحاب المصلحة الرئيسيين من أجل الاستدامة والتأثير وتوسيع نطاق رعاية الأمومة المتوافقة مع الميثاق في نيجيريا. تهدف الدراسة إلى تقييم تنفيذ ميثاق رعاية الأمومة المحترمة في شمال وسط نيجيريا. الدراسة عبارة عن دراسة مقطعية مختلطة المنهج؛ المشاركون المتوقعون هم أصحاب المصلحة الرئيسيون في مجال الرعاية الصحية (العاملون في مجال الرعاية الصحية، ومديرو الرعاية الصحية، ومديرو المشاريع، وواضعو السياسات) في شمال وسط نيجيريا (إقليم العاصمة الفيدرالية وولاية كوارا). سيتم استخدام تقنية أخذ العينات متعددة المراحل لتسجيل المشاركين من 18 منشأة للرعاية الصحية (الابتدائية والخاصة والثانوية والثالثية) في المناطق الريفية والحضرية ومسؤولي وزارات الصحة على المستوى المحلي ومستوى حكومات الولايات. النتائج المتوقعة: من المتوقع أن تقدم الدراسة معلومات عن الوضع الحالي للمعرفة وتنفيذ ميثاق رعاية الأمومة المحترمة في نيجيريا. كما أنه سيحدد عوامل التمكين والحواجز التي تعترض عملية التنفيذ ويقدم الأدلة لتوسيع نطاق العملية بشكل فعال في نيجيريا. سيتم نشر النتائج على نطاق واسع للعاملين في مجال الرعاية الصحية ومديري الصحة وصناع القرار في خدمات الرعاية الصحية من خلال اجتماعات ما بعد الدراسة وعروض المؤتمرات ومنشورات المجلات وموجزات السياسات من أجل التنفيذ الفعال لميثاق رعاية الأمومة المحترمة في نيجيريا.

الكلمات الدالة. صحة الأم والطفل، جودة الرعاية، ميثاق رعاية الأمومة المحترم، أصحاب المصلحة، الحقوق الصحية الشاملة.