REVIEWER'S REPORT

Title: Understanding mistreatment during institutional delivery in Northeast Nigeria: a mixed-method study

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Reviewer: Susan Bradley

Reviewer's report:

REPH-D-18-00043 Understanding respectful maternity care in Northeast Nigeria

This study adds to the evidence from Nigeria on women's perspectives on the quality of maternity care and nicely uses mixed-methods to describe the findings in one state.

The title of the paper suggests the focus is on understanding respectful maternity care (RMC), but the content is almost exclusively focused on mistreatment. For example, the description of the quantitative instrument (p7/8) says, "The respectful care component had 31 items, structured around the seven domains of mistreatment…", and the prevalence and manifestations of RMC practices are reported in terms of mistreatment (see Table 3). This positioning could be seen to imply that the absence of mistreatment constitutes RMC, rather than acknowledging that RMC is a broader concept than this and that the absence of one does not equate to the presence of the other. I appreciate that RMC is tricky to define, but I think you need to unpack this and make clear that your study is looking at mistreatment - and your title should reflect this.

Background

This is rather brief. While it sets up the rationale for the study, it does not provide sufficient detail on the birth context in Nigeria more generally, which would then allow the reader to see how Gombe State compares to the rest of the country. I would have found it interesting to see something about the prevailing model of midwifery care (the 'who with' and 'where' elements) and the socio-cultural factors that may be relevant in this context to the discussion of mistreatment and RMC.

P5 lines 7 - 12 - I would urge you to use more recent references to support the points you are making here as [11] and [12] are rather dated.

Methods

The methods are explained well and only need a few amendments/additions.
Quantitative: It would really help to provide a table of the questionnaire items as it is difficult to assess the validity without seeing how the questions were framed. For example, it is unclear if women were reporting their own direct experience or if the questions could include seeing other women being mistreated.

Qualitative: This is nicely described, but please provide an anonymised identifier for each quote to allow readers to judge the spread of data across participants. A little detail about the type and level of the health facilities from which the sample was drawn would also be informative.

Of the 64 women recruited, 31 took part in IDIs and 32 in FGDs - please account for the missing woman and state if the same 'trained female interviewer' carried out both the IDIs and FGDs.

It would be interesting to know if your analysis found any data that did not fit the a priori coding framework and, if so, how you accounted for it.

On p11 lines 4/5, please clarify what you mean by ensuring "themes were internally homogenous and externally heterogeneous".

Ethics: Please add a bit more detail - type of consent (verbal/written), freedom to withdraw, confidentiality etc.

Findings

These are nicely described for both quantitative and qualitative data.

Data were collected in 10 primary health facilities with the highest volume of births in the state - it would be interesting to hear your thoughts on the implications of this for your findings.

Please clarify the figures for birth attendant - Table 1 reports 20% skilled and 80% non-skilled birth attendant, yet Table 3 shows 'Skilled attendant absent at time of delivery' as 18%.

Were you able to identify any differences in the qualitative data on how women were treated in facilities with lower (Kwami) versus higher (Kaltungo) levels of facility births?

Discussion

Your discussion situates the findings within the existing literature from Nigeria on women's experiences of facility-based birth and draws attention to the inconsistency of prevalence figures across the country. However, it does not engage with the research underway in Nigeria that is trying to find operational and service delivery options to address mistreatment and improve RMC (see references below). It is too light on implications and recommendations e.g. How can your findings be used to inform strategies for improvement? What can be done (structurally as
well as at ward level) to facilitate a more positive birth environment? What facilitators/barriers (policy, socio-economic, cultural etc) specific to the Nigerian context need to be considered and how?


Strengths and limitations

Your comment about data collectors carrying out the translation (p10 line 17-18) should go in here as a strength.

This study was carried out in one region only, so you should acknowledge the lack of transferability of findings, particularly in light of the inconsistencies in other literature from the country that you noted in the discussion.

It would be interesting to hear why women were not included in the pilot testing of the instruments, particularly given the literature on different perceptions between women and health care providers on what constitutes mistreatment.

Proofing

I found some sentences overly long or awkwardly worded and needed to read some twice to understand what you meant to say. It would be helpful if you could check through the manuscript, add some commas, or reword for clarity. In particular, please look at:

* p5, lines 21-25
* p6 lines 13-14
* p10 lines 1-3
Level of interest
Please indicate how interesting you found the manuscript:

An article whose findings are important to those with closely related research interests

Quality of written English
Please indicate the quality of language in the manuscript:

Needs some language corrections before being published

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