

Prevalence of Rhesus D Status, Maternal Awareness and Pregnancy Outcomes Among Antenatal Attendees at Asubiaro State Specialist Hospital, Osun State, Nigeria

^{*1}Daramola Chinonye Lucky, ¹Adeyemi Adeola Oluwadunni,
²Akinwale Oladayo Damilola and ²Adeniyi Victoria Adenike

¹Department of Nursing Science, Redeemer's University, Ede Osun State.

²Faculty of Nursing Science, Osun State University Osogbo.

*Corresponding authors' email: daramolachi@run.edu.ng Phone: +2347038242756

ABSTRACT

RhD-negative status is the absence of the RhD antigen in an individual's blood. It becomes clinically significant in pregnancy when an RhD-negative woman carries an RhD-positive fetus, as exposure to fetal RhD-positive red blood cells may result in maternal anti-D alloimmunization. Maternal-fetal RhD incompatibility is preventable through appropriate screening, awareness, and Anti-D prophylaxis. However, evidence on its prevalence and maternal awareness among antenatal populations in Nigeria remains limited. This study assessed prevalence of Rhesus D status, maternal awareness, and pregnancy outcomes among antenatal attendees at Asubiaro State Specialist Hospital, Osun State, Nigeria. A descriptive cross-sectional study was conducted among 158 pregnant women selected through convenience sampling. Data were collected using a structured questionnaire and laboratory records and analyzed using IBM SPSS Statistics version 27. Descriptive statistics were used to summarize participants' characteristics and study variables. Respondents were predominantly aged 25–29 years (46.8%), married (91.8%), and Yoruba (77.2%). Laboratory-confirmed RhD-negative status was identified in 6 of 158 respondents, giving a prevalence of 3.8%. Maternal awareness of RhD status was generally low, with a grand mean score of 2.17 on a four-point scale. Knowledge was particularly limited regarding partners' RhD status, partners' blood-group testing, and the use of Anti-D prophylaxis. Financial status, attendance at antenatal health talks, early antenatal booking, and previous multiple pregnancies were perceived as factors influencing awareness. RhD-negative status occurred among 3.8% of respondents, while awareness of RhD incompatibility and its prevention was generally low. Repeated, targeted antenatal education on RhD screening, partner testing, and Anti-D prophylaxis is recommended.

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INTRODUCTION

According to the World Health Organization (2021), maternal and child health statistics are an important standard for evaluating healthcare system effectiveness and social development across sub-Saharan Africa. Across developing nations, maternal and perinatal mortality rates remain significant healthcare concerns despite ongoing health policy updates and maternal care programs. While obstetric complications may happen unexpectedly during labor, blood group mismatching, particularly Rhesus (Rh D) negative is a physiological condition that depends on early identification, accurate laboratory screening, and maternal health literacy during routine antenatal care (Yoham & Casadesus., 2023). Research by Otieno et al., (2025) demonstrates that unmanaged Rhesus D negative status is linked to a wide range of adverse outcomes. When rhesus-negative maternal IgG antibodies cross the placental barrier during pregnancy, they bind to fetal Rh-positive red blood cells, causing progressive erythrocyte destruction and fetal anemia (Otieno et al., 2025). In severe unmanaged cases, compensatory tissue swelling and cardiac strain lead to hydrops fetalis and intrauterine fetal death (stillbirth). Furthermore, after birth, the newborn's immature liver becomes overwhelmed by circulating bilirubin breakdown products, resulting in severe neonatal hyperbilirubinemia, deep jaundice, and potential neurological damage known as kernicterus (Musa et al., 2023).

While a large majority of women regularly register for antenatal care and complete routine laboratory screening, many complete their care without understanding what their specific blood group parameters signify for fetal health (Ojo & Osuntusa, 2021). Most mothers can state whether they belong to blood group A, B, AB, or O, but frequently view the positive or negative Rhesus sign as a minor administrative detail on their antenatal cards rather than an essential indicator of pregnancy outcomes (Uzochukwu & Nwachukwu, 2022). Oyeiyemi et al. (2022) revealed that maternal socio-demographic characteristics such as educational level, age, and parity significantly shape how pregnant women process health information during antenatal care. Pregnant women with formal secondary or tertiary education generally demonstrate greater comprehension of biological inheritance and health risks when explained during clinic visits, whereas younger or less formally educated mothers face greater challenges in understanding biological concepts (Oyeiyemi et al., 2022). This variation emphasizes the importance of evaluating how maternal background factors correlate with overall blood group awareness and self-reported pregnancy experiences.

Secondary healthcare facilities play a vital role in delivering essential maternal healthcare services Bello et al 2022. The State Specialist Hospital, Asubiaro, Osogbo, serves as a central secondary referral center connecting primary health

centers with tertiary teaching hospitals across the region. The hospital cares for a diverse population of pregnant women ranging from civil servants and educated professionals to market traders and rural dwellers, making its antenatal clinic a key setting for evaluating baseline blood group prevalence, maternal awareness, and recorded pregnancy outcomes (Bello et al, 2022).

Clinical midwives occupy a pivotal position at the frontline of antenatal care and patient history taking in specialist public hospitals. Midwives lead daily morning health talks, take booking histories, review laboratory cards, and manage patient communication throughout antenatal visits (Irinoye et al., 2023). Understanding what pregnant women actually know about Rhesus factor incompatibility and documenting their self-reported pregnancy experiences allows clinical midwives to tailor health communication, address community misconceptions, and enhance overall maternal monitoring. In line with the recommendations of Ibrahim and Onwudiegwu (2025), generating localized empirical data on Rhesus D status prevalence and maternal awareness is essential for strengthening antenatal nursing care in secondary hospitals. Therefore, the need to assess the prevalence of Rhesus D status, maternal awareness and pregnancy outcomes among antenatal attendees at Asubiaro State Specialist Hospital, Osun State.

MATERIALS AND METHODS

Study Area

The study was conducted at the antenatal clinic of State Specialist Hospital, Asubiaro, Osogbo, Osun State, Nigeria. The hospital is a state-government-owned tertiary health

facility it provides both medical and surgical services to the Osun state populace as well as neighboring states. It also serves as a major referral Centre for maternal and child health services within Osogbo metropolis and its surrounding communities. The antenatal clinic of the hospital runs on scheduled clinic days each week, during which pregnant women receive routine antenatal check-ups, health education and other maternal health services. This setting provides a rich and dynamic environment for research in maternal and child health, with practical access to diverse patient populations, experienced professionals and a history of impactful academic work.

Study Design and Population

A descriptive cross-sectional design was used for the study. The population for the study consisted of all pregnant women in the Antenatal clinic of Asubiaro State Specialist Hospital, Osogbo. Inclusion criteria consisted of pregnant women attending antenatal clinic (ANC) at Asubiaro State Specialist Hospital, Osun State, who provided informed consent to participate in the study, and have antenatal record of RhD status. The exclusion criteria consisted of women who are too ill to participate at the time of data collection, who decline or withdraw consent, and participants whose RhD status cannot be verified.

The total population of pregnant women was estimated based on the hospital's antenatal clinic register, which recorded a total antenatal population within 3 months (April to June), which was 689 pregnant women, giving an average monthly attendance of approximately 230 pregnant women as presented in Table 1 below .

Table 1: Total Population

S/N	Months	Number per month
1	April	245
2	May	205
3	June	239
	Total	689/3= 230

Sample Size Determination

The sample size was determined using the Cochran's formula with finite population at a 5% margin of error.

Formula equation:

$$n = \frac{n_0}{1 + \frac{n_0 - 1}{N}}$$

Where; n= sample size needed N= 230 n_0 = sample size for an infinite population= 384.16 In this study;

$$n = \frac{384.16}{1 + \frac{384.16 - 1}{230}}$$

$$n = \frac{384.16}{1 + \frac{383.16 - 1}{230}}$$

$$n = \frac{384.16}{2.6659}$$

$$n = 144.101$$

$$n \sim 144$$

The total of 144 pregnant women was targeted for data collection. To account for possible non-response, incomplete questionnaires or attrition, the calculated sample size was increased by 10%. This gave an adjusted sample size of approximately 158 respondents ($144 + 14 = 158$). The final sample size was 158 pregnant women.

Sampling Methods

158 Participants were recruited using convenient sampling, whereby eligible antenatal attendees who were available and willing to participate during the data-collection period were enrolled. Although this approach facilitated efficient

recruitment within the antenatal clinic, it may have introduced selection bias because participants were not selected through a probability-based sampling procedure. Consequently, the findings may primarily reflect the characteristics and experiences of the sampled antenatal attendees and should be generalized to the wider pregnant population with caution.

Instrument for Data Collection

Data were collected using a self-developed, structured questionnaire comprising four sections (A–D). The instrument was designed to obtain information on the respondents' socio-demographic characteristics, prevalence of Rhesus D status, maternal awareness of Rhesus D status and pregnancy outcomes, perceived factors influencing maternal awareness of Rhesus incompatibility

Section A: Socio-demographic characteristics and obstetric profile.

Socio-demographic Characteristics: 7 items which measured age. Educational level, marital status, occupational status, estimated monthly household income, ethnicity and religion. Obstetric Profile: 5 items capturing current gestational age, parity, number of living children, history of pregnancy loss and rhesus status

Section B: 6 items which identified the prevalence of Rhesus D status

Section C: 10 item which assessed maternal awareness of Rhesus D status and pregnancy outcomes, on a 4-point likert

scale ranging from mean ≥ 2.50 = Aware; mean < 2.50 = Not Aware.

Section D: 9 items which identified Perceived Factors Influencing Maternal Awareness of Rhesus incompatibility, on a 5-point likert scale based on scale midpoint of 3.00 (mean ≥ 3.00 = Agree; mean < 3.00 = Disagree).

Data Analysis

The analysis was conducted using IBM's Statistical Package for the Social Sciences (SPSS) version 27. Descriptive statistics, including frequencies and percentages, was employed to summarize the data and presented the results in tables and figures.

Ethical Considerations

Approval to conduct the study was obtained from Osun State University Health Research and Ethics Committee with protocol number OSHREC/PRS/2026/842/01/251S. The

study's purpose was explained to the participants, after which consent was obtained. The principle of voluntary participation, and maintenance of anonymity and confidentiality was maintained throughout the time of study.

RESULTS AND DISCUSSION

Socio-demographic Characteristics of the Respondents.

Table 1 presents the socio-demographic characteristics of the respondents. The majority of the respondents were aged between 25-29 years (74, 46.8%), with a mean age of 27.1 ± 4.5 years. Most respondents were married (145, 91.8%). 71 (44.9%) had attained tertiary education while only 6 (3.8%) had no formal education, were self-employed (66, 41.8%), and majority of households earned below ₦150,000 monthly (110, 69.6% combined), were Christian (109, 69.0%) and of Yoruba ethnicity (122, 77.2%).

Table 1: Socio-Demographic Characteristics of Respondents (N = 158)

Variable	Category	Frequency (n)	Percentage (%)
Age Group (years)	Below 20	9	5.7
	20-24	33	20.9
	25-29	74	46.8
	30-34	33	20.9
	35-39	8	5.1
	40 and above	1	0.6
Marital Status	Single	9	5.7
	Married	145	91.8
	Divorced/Separated	3	1.9
	Widowed	1	0.6
Highest Qualification	No formal education	6	3.8
	Primary	19	12.0
	Secondary	62	39.2
	Tertiary	71	44.9
Occupation	Civil servant	38	24.1
	Self employed	66	41.8
	Student	16	10.1
	Unemployed	38	24.1
Estimated Household Income	Monthly Below ₦70,000	54	34.2
	₦70,000 - 150,000	56	35.4
	₦151,000 - 300,000	28	17.7
	₦300,000 - 450,000	15	9.5
	₦500,000 and above	5	3.2
Religion	Christianity	109	69.0
	Islam	43	27.2
	Others	6	3.8
Ethnicity	Yoruba	122	77.2
	Igbo	21	13.3
	Hausa	6	3.8
	Others	9	5.7
Total		158	100.0

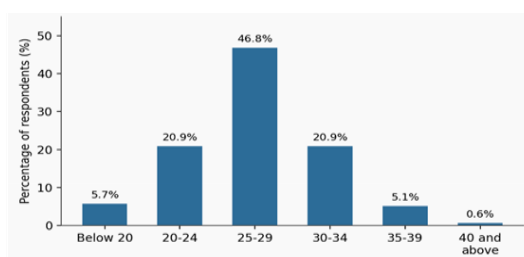


Figure 1: Age Distribution of Respondents (N = 158)

Table 2 shows that about half of the respondents were multigravida (78, 49.4%), and most were in their third trimester (76, 48.1%) at the time of the survey, with an average of 1.5 ± 1.2 living children. About one-fifth of respondents (32, 20.3%) reported a history of miscarriage,

abortion, or pregnancy loss. Most respondents self-reported as Rhesus D positive (147, 93.0%), while 5 (3.2%) self-identified as Rhesus D negative and 6 (3.8%) did not know their Rhesus status.

Table 2: Obstetric Characteristics of Respondents (N = 158)

Variable	Category	Frequency (n)	Percentage (%)
Number of previous birth	Primigravida	46	29.1
	Multigravida (1-3)	78	49.4
	Grand multigravida (>4)	34	21.5
Current Gestational Age (Trimester)	First (1-12 weeks)	16	10.1
	Second (13-27 weeks)	66	41.8
	Third (28 weeks and above)	76	48.1
History of Miscarriage/Abortion /Pregnancy Loss	Yes	32	20.3
	No	126	79.7
Self-reported Rhesus Blood Group Status	Rhesus D positive	147	93.0
	Rhesus D negative	5	3.2
	I don't know	6	3.8
Total		158	100.0

Table 3 shows that RhD-negative status was identified in 6 of the 158 antenatal attendees, giving a prevalence of 3.8% based on hospital laboratory test results independently verified at Asubiaro State Specialist Hospital. Only 52 (32.9%) knew their Rhesus status before booking for antenatal care in this pregnancy, although the majority (129,

81.6%) reported undergoing formal blood group testing early in the current pregnancy. A history of stillbirth or unexplained miscarriage after 20 weeks was reported by 18 (11.4%) of respondents, and 24 (15.2%) reported that a previous newborn had developed severe jaundice within 24-48 hours of birth.

Table 3: Prevalence of Rhesus D Status (N = 158)

Variable	Yes n (%)	No n (%)	I don't know n (%)
Currently identified as Rhesus-negative based on hospital laboratory test results	6 (3.8%)	145 (91.8%)	7 (4.4%)
Knew Rhesus status before registering for antenatal care for this pregnancy	52 (32.9%)	97 (61.4%)	9 (5.7%)
Underwent formal blood group testing early in current pregnancy	129 (81.6%)	27 (17.1%)	2 (1.3%)
Past pregnancy with blood group incompatible with partner's blood group	17 (10.8%)	111 (70.3%)	30 (19.0%)
Experienced stillbirth or unexplained miscarriage after 20 weeks of pregnancy	18 (11.4%)	132 (83.5%)	8 (5.1%)
Previous newborn(s) developed severe jaundice within 24-48 hours after birth	24 (15.2%)	124 (78.5%)	10 (6.3%)

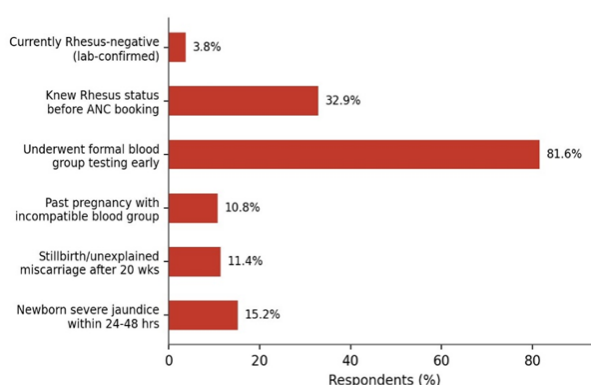


Figure 2: Prevalence of Rhesus D status Among Respondents (N = 158)

Table 4 shows that respondents' awareness of Rhesus D status was generally low, with a grand mean of 2.17 falling below the scale midpoint of 2.50. Awareness was lowest for whether the husband/partner had undertaken a blood test to confirm his Rhesus status (mean = 1.81) and for personal awareness

of the partner's exact Rhesus status (mean = 1.82), with about half of respondents reporting they were not aware on both items (83, 52.5% and 75, 47.5% respectively). Awareness was comparatively higher for the general existence of the Rhesus factor (mean = 2.60) and for recognizing that knowing a

partner's status helps understand incompatibility risk (mean = 3.02), which were the only two items rated as 'Aware'. Therefore, the level of maternal awareness of Rhesus D status and reported pregnancy outcomes among antenatal attendees at Asubiaro State Specialist Hospital can be described as

generally low, particularly regarding knowledge of partner's Rhesus status, awareness of partner's uptake of blood test to confirm Rhesus status, and awareness of AntiD prophylaxis injection usage to prevent a Rhesus-negative mother from developing complications.

Table 4: Level of Maternal Awareness of Rhesus D status and Pregnancy Outcomes

Variable	VA n (%)	MA n (%)	SA n (%)	NA n (%)	Mean	SD	Remark
Every person's blood group contains a Rhesus factor which is either positive or negative.	44 (27.8%)	42 (26.6%)	37 (23.4%)	35 (22.2%)	2.60	1.12	Aware
Rhesus incompatibility occurs when a Rhesus-negative mother carries a Rhesus positive fetus.	16 (10.1%)	25 (15.8%)	49 (31.0%)	68 (43.0%)	1.93	1.00	Not Aware
A child inherits their Rhesus blood factor jointly from both the mother and the father.	27 (17.1%)	38 (24.1%)	37 (23.4%)	56 (35.4%)	2.23	1.11	Not Aware
Untreated Rhesus incompatibility can lead to severe anemia, brain damage, or newborn loss.	28 (17.7%)	45 (28.5%)	41 (25.9%)	44 (27.8%)	2.36	1.07	Not Aware
I am fully aware of my husband's/partner's exact Rhesus blood group status.	11 (7.0%)	24 (15.2%)	48 (30.4%)	75 (47.5%)	1.82	0.94	Not Aware
My husband/partner has undertaken a blood test to confirm his Rhesus status.	18 (11.4%)	17 (10.8%)	40 (25.3%)	83 (52.5%)	1.81	1.03	Not Aware
Knowing my partner's Rhesus status helps me understand our risk of Rhesus incompatibility.	65 (41.1%)	47 (29.7%)	30 (19.0%)	16 (10.1%)	3.02	1.01	Aware
We discussed our blood group compatibility before marriage or before conceiving this child.	16 (10.1%)	28 (17.7%)	49 (31.0%)	65 (41.1%)	1.97	1.00	Not Aware
Anti-D Immunoglobulin injection must be given within 72 hours after delivery, miscarriage, or bleeding.	27 (17.1%)	24 (15.2%)	42 (26.6%)	65 (41.1%)	2.08	1.12	Not Aware
An injection called Anti-D Immunoglobulin can prevent a Rhesus-negative mother from developing complications.	16 (10.1%)	25 (15.8%)	41 (25.9%)	76 (48.1%)	1.88	1.02	Not Aware
Grand Mean					2.17		Not Aware

Keys: VA = Very Aware, MA = Moderately Aware, SA = Slightly Aware, NA = Not Aware. Remark Based on Scale Midpoint of 2.50 (mean $\geq$ 2.50 = Aware; mean $<$ 2.50 = Not Aware).

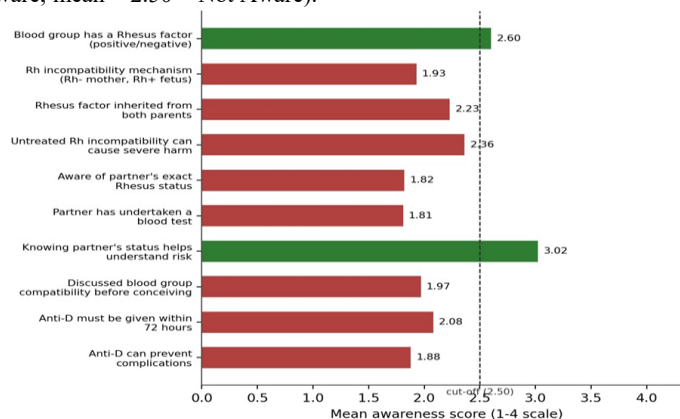


Figure 3: Mean Maternal Awareness Scores by Item (Grand Mean = 2.17; Aware/Not Aware cut-off = 2.50)

Table 5 shows that respondents generally perceived sociodemographic, obstetric, financial, interpersonal, and antenatal-care-related factors as influencing their awareness

of Rhesus incompatibility. Financial status affecting access to early laboratory screening and educational resources recorded the highest mean (3.56), followed by regular attendance at

antenatal health talks as a primary source of awareness (3.51). The only item that respondents disagreed with, on average, was that a past miscarriage prompted them to seek information on Rhesus compatibility (mean = 2.85), suggesting that pregnancy loss alone does not reliably translate into information-seeking behaviour among these

respondents. Therefore, the perceived factors influencing maternal awareness of Rhesus incompatibility among respondents were financial status, health talk attendance, and early antenatal booking, while a past miscarriage was the weakest driver of information seeking behaviour.

Table 5: Perceived Factors Influencing Maternal Awareness of Rhesus incompatibility (N = 158)

Statement	SA n (%)	A n (%)	N n (%)	D n (%)	SD n (%)	M	SD	Remark
My age and maturity have given me better access to information about Rhesus incompatibility.	54 (34.2%)		24 (15.2%)	29 (18.4%)	20 (12.7%)	3.30	1.32	Agree
My level of formal education made it easier to understand health information about blood groups.	39 (24.7%)	48 (30.4%)	26 (16.5%)	24 (15.2%)	21 (13.3%)	3.38	1.36	Agree
My financial status affects my ability to access early laboratory screening and educational resources.	49 (31.0%)	44 (27.8%)	25 (15.8%)	26 (16.5%)	14 (8.9%)	3.56	1.32	Agree
Having had multiple past pregnancies (parity) increased my knowledge about blood group risks.	38 (24.1%)	36 (22.8%)	30 (19.0%)	36 (22.8%)	18 (11.4%)	3.25	1.35	Agree
Communication with my partner makes it easier to discuss and verify our Rhesus status and compatibility.	39 (24.7%)	51 (32.3%)	25 (15.8%)	26 (16.5%)	17 (10.8%)	3.44	1.31	Agree
Registering early (first trimester booking) gave me more time to learn about Rhesus factors from nurses.	46 (29.1%)	39 (24.7%)	30 (19.0%)	30 (19.0%)	13 (8.2%)	3.47	1.31	Agree
Regular attendance at health talks during antenatal clinics is my primary source of Rhesus awareness.	41 (25.9%)	52 (32.9%)	27 (17.1%)	23 (14.6%)	15 (9.5%)	3.51	1.28	Agree
Having had previous pregnancies/deliveries has increased my knowledge about rhesus compatibility.	38 (24.1%)	41 (25.9%)	45 (28.5%)	25 (15.8%)	9 (5.7%)	3.47	1.18	Agree
A past miscarriage made me seek information on rhesus compatibility.	20 (12.7%)	33 (20.9%)	35 (22.2%)	43 (27.2%)	27 (17.1%)	2.85	1.29	Disagree

Keys: SA = Strongly Agree, A = Agree, N = Neutral, D = Disagree, SD = Strongly Disagree. M = Mean. Remark Based on Scale Midpoint of 3.00 (Mean $\geq$ 3.00 = Agree; Mean $<$ 3.00 = Disagree)

Discussion

The findings from the study showed pregnant women aged 25-29 years (46.8%), married (91.8%), and of Yoruba ethnicity (77.2%), with almost half having attained tertiary education (44.9%). This youthful, largely married profile is comparable to Oyeyemi et al. (2022), who studied antenatal attendees in Kwara State and similarly found a predominantly young, married population. This finding is expected, as reproductive-age women who are married are more likely to be actively attending antenatal clinics in Southwestern Nigeria, and Asubiaro State Specialist Hospital, like the facility studied by Oyeyemi et al. (2022), serves a similar tertiary level catchment population.

This study found a laboratory-confirmed Rhesus D-negative prevalence of 3.8% among pregnant women attending Asubiaro State Specialist Hospital. This is similar to the findings of Erhabor et al. (2021) who reported 4.3% prevalence of Rhesus D-negativity among Nigerian women of reproductive age. Kotila et al. (2023), Adeyemi and Bello-Ajao (2016) reported 4.5% and 4.7% respectively among obstetric populations in Southwestern Nigeria. Likewise Imoru et al. (2025) who reported an Rh (D) negativity rate of

4.6% and 8.4% reported by Otomewo et al. (2020) in public health facilities in Lagos State. The difference could be due to the relatively small sample size of a single facility in the present study or to actual variation in Rhesus negativity between sub-populations of Nigeria as suggested by the meta-analysis by Onyango et al. (2025) which showed a range of prevalence of 3.8% to 5.5% across the continent, with the present finding of 3.8% falling within this range. General awareness of Rhesus D status was low, with a grand mean of 2.17 on a 4-point scale. Awareness of partner Rhesus status and Anti-D prophylaxis injection use to prevent a Rhesus-negative mother from developing complications was especially poor. This corroborates with Olu-Abiodun and Sodimu (2025), who found that only 28.4% of pregnant women in Ogun State primary healthcare centres were aware of their Rhesus factor, and with Afolabi and Bello (2023), who found that fewer than 33.3% of pregnant attendees in Osun State public hospitals possessed adequate knowledge of Rhesus inheritance patterns — a finding directly relevant given that the study was also conducted in Osun State. This finding also aligns with Uzochukwu and Nwachukwu (2022), who reported that 68.5% of pregnant women in Anambra

State exhibited poor awareness of Rhesus incompatibility mechanisms and fetal risks. However, the finding contrasts with the antenatal survey at Irrua Specialist Teaching Hospital, Edo State, where 95.9% of women were at least aware of blood grouping in general; this difference may reflect the distinction between broad awareness of blood grouping as a concept, which tends to be high, and specific knowledge of Rhesus factor implications and partner testing, which this study and most of the cited literature consistently found to be poor.

The study agreed that financial status, health talk attendance, early antenatal booking, and multiple past pregnancies are perceived factors that influence maternal awareness of Rhesus incompatibility. This resonates with the findings of Bello et al (2022) who reported that antenatal attendees in higher household income groups had twice the rate of early screening and counselling compared to those in lower household income groups, and Irinoye et al. (2023) reported that pregnant women who attended the midwife-led morning health talks consistently scored 42.0% higher on health literacy assessments. The findings also aligns with Ibrahim and Onwudiegwu (2025), who found that multiparous women had considerably higher Rhesus status awareness (54.2%) than primigravidae (22.8%). However, respondents in this study did not consider a past miscarriage alone (mean = 2.85) to be a strong driver of information-seeking, which is a milder finding than Sulaiman and Abdullahi's (2025) observation that prior counselling during previous antenatal visits was a strong predictor of accurate knowledge of hemolytic risks; a plausible reason for this difference is that a miscarriage on its own, without accompanying midwife counselling at the time, may not translate into active information-seeking by the mother.

CONCLUSION

The findings of this study showed that Rhesus D-negative status was identified in 6 of the 158 antenatal attendees giving a prevalence of 3.8% based on hospital laboratory test results independently verified. The level of maternal awareness of Rhesus D status and reported pregnancy outcomes was generally low with a grand mean of 2.17 falling below the scale midpoint of 2.50. The perceived factors influencing maternal awareness of Rhesus incompatibility includes financial status, health talk attendance, early antenatal booking and multiple past pregnancies. Repeated, targeted antenatal education on RhD screening, partner testing, and Anti-D prophylaxis is recommended.

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