POSTNATAL WOMEN INVOLVEMENT IN DECISION MAKING AND THEIR SATISFACTION DURING MATERNITY PERIOD IN CALABAR MUNICIPALITY, CROSS RIVER STATE NIGERIA

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ABSTRACT

*In view of the respectful maternity care being promoted globally and the need to respect the rights of women during maternity period to promote maternal satisfaction and reduce morbidity and mortality rate of women and children widely especially in the developing countries and achieve sustainable development goals in 2030. Against this backdrop, the study's focus was to investigate Postnatal women involvement in decision making concerning their care and their satisfaction during maternity period. A descriptive design was employed using questionnaire and in-depth interview study guide, 440 women participated in the study and were selected through multistage sampling technique. Data collected were subjected to statistical analysis using SPSS Version 26 presented in frequencies, tables and percentages. The study was conducted in three health facilities in Calabar Municipality, Cross River State, Nigeria. This study observed that the level of women decision-making during ante- natal period is high (*ɕ *=4), during intra-natal period is high (*ɕ*=4) and during labour is high (*ɕ*=4.3). Finally, this study shows that the level of women decision making concerning their care during pregnancy, birth and post-natal period is high (*ɕ*=4.2). Hypothesis tested showed a significant positive correlation between maternal satisfaction among post-natal mothers and their involvement in decision making regarding their care during labour (P=0.001) and in post-natal period (P<0.001). In conclusion, postnatal women involvement in decision making concerning their care during maternity period is significantly associated with their satisfaction. The study recommends that, women should be more involved in decision making in their maternity care.*

Keywords: Postnatal Women; Decision Making, Maternal Satisfaction; Maternity Period.

INTRODUCTION

Women's roles in decision-making during the maternity period represent an essential element of quality and outcomes of maternal healthcare. In Calabar Municipality in Cross River State, Nigeria, there are huge variations across socio-economic groups and health care systems regarding the involvement of women in decision-making concerning their pregnancy, childbirth and postnatal care. These variations in decision-making have a major impact on the maternal and infant health outcomes. A recent study by Okonofua et al. (2018) shows that maternal autonomy in decision-making about healthcare is strongly associated with the use of antenatal services and facility-based deliveries. Calabar Municipality has, however, always had challenges of including women voices in maternal care strategies, even with Nigeria's Sustainable Development Goals efforts to minimize maternal mortality (Ekanem et al., 2020). The cultural environment in Cross River State, which is mostly patriarchal, mostly mutilates women's agency in health-related decision-making, thus creating complexity in terms of the provision of maternal healthcare (Archibong & Agan, 2022).

The postnatal phase, the time after giving birth, is a crucial period of change for a woman as she assumes a new role as a mother. There are many changes, both physical and emotional, as a woman nears the transition to motherhood. In many societies, including Cross River State in Nigeria, it is critical for women to be involved in healthcare decision-making in this postnatal period to improve women's satisfaction and health outcomes (Bastola et al., 2019). Recently, community innovations emerging in Calabar Municipality highlight various ways of increasing women's involvement. The

"Mother's Voice" Program in three wards of Calabar Municipality has initiated community fora for women to discuss their maternal health priorities in a group and communicate them externally to healthcare providers (Akpan & Udoh, 2023). The digital health innovations of today, including mobile health programmes, which are focused on maternal education and decision support, have been adopted by 38% of pregnant women with smartphones in urban Calabar (Edem et al., 2022). Furthermore, the recent policy developments at the state level in Cross River now require women representatives serving on their health facility management committees, to provide institutional pathways for women's voices in health governance to be accessed (Cross River State Ministry of Health, 2021).

Additionally, literature highlights the importance of shared decision-making in healthcare, particularly in maternal health, where women's preferences and voices are essential to their care experience (McCoy et al., 2020). However, within Cross River State, there is still a notable gap in literature about the impact of socio-cultural dynamics on women's autonomy and participation in these critical decisions. According to Alayi et al (2021), a lot of women face several barriers in Nigeria, including lack of support from their health providers and cultural expectations that restrict their participation in decision-making processes.

The extent of women's participation in maternal decision-making in Calabar Municipality has measurable implications for a range of maternal health outcomes. One study conducted by Ekanem and Udoh (2020) found women who are involved in making decisions for their antenatal care, are 2.3 times more likely to make the recommended four antenatal visits than women who do not have authority to make decisions. The implications of this are direct effects for identifying complications of pregnancy early enough and managing their risks. Equally, Johnson et al. (2021) conducted a study in three primary healthcare centres in Calabar Municipality and established that women's involvement in birth planning led to a 35% increase in facility deliveries and a commensurate decrease in complications of childbirth. Beyond clinical outcomes, women's participation within the maternity continuum is also important in terms of psychological well-being. Archibong and Agan (2022) found that women who had higher levels of involvement in their maternity care reported lower rates of postpartum depression (18.2%) than women who reported lower levels of involvement (42.7%). The psychological benefits of involvement in decision-making extends beyond mental health. An empowered mother is also more likely to practice exclusive breastfeeding and timely immunization (Oyo-Ita et al., 2019) making women's decision-making authority during maternity a precursor to improved health outcomes for mothers and their babies. The economic dimension cannot be ignored. Households are much more likely to commit household resources towards maternal health needs when a woman is involved in the financial decision-making process as demonstrated in a comparative study of households in Calabar South and Calabar Municipality (Peters & Bassey, 2021).

Sadly, women in Calabar Municipality experience considerable hurdles that prevent them from achieving even a minimum degree of meaningfully participating in maternity decision-making. The first is the fundamental obstacle of education. Ukpong and Asuquo (2020) explain that women who had completed secondary education or above were three times more likely to participate in treatment decisions than women who did not attend beyond primary education. Economic dependence creates additional boundaries around women's autonomy, as a study of Nigerian women in which 68% of the women noted financial constraints as the reason for their lack of ability to participate in their health care decisions (Okon et al., 2022). Additionally, the healthcare system itself is often an obstacle to autonomy, since there are structural barriers to autonomy due to the relationship with the medical provider, and since many people are presented with options with little time for negotiation or shared decision-making in public healthcare facilities - (Etim & Bassey, 2019). Further complicating the picture are cultural and religious norms. For instance, traditional ideas about how pregnancies should be managed sometimes interfere with biomedical suggestions, placing the mother's stress in navigating two ideologies (Offiong et al., 2021).

Using a mixed-method, this research will seek to gather complete data from postnatal women in Calabar Municipality. This study aims to combine both qualitative and quantitative data in order to explore the barriers and facilitators for women's participation in decision making during the maternity transition (Chowdhury et al., 2021). It is expected that this research will lead to conclusions that offer insights for healthcare improvement and policy, to create an inclusive agenda with women's interests at the centre of maternal healthcare and maternity services to foster satisfaction with maternity care. The study also seeks to contribute to the conversation on the rights of women, maternal health, and women empowerment in Nigeria as it relates to maternity while hoping to promote changes that enhances women's recognition as respected agents during one of the most significant experiences of their lives. Based on the challenges stated, the researchers conducted the study on postnatal women's involvement in decision-making responsibility and satisfaction during maternity period in Calabar Municipality, Cross River State, Nigeria. The specific objective was to ascertain if mothers were involved in decision making about their care during pregnancy, birth, and post- natal period and the hypothesis was: There is no significant relationship between Maternal care satisfaction among post-natal mothers and involvement of women in decision making towards their care during antenatal, intra-natal and post- natal period.

METHODOLOGY

Study design: The study adopted a descriptive design.

Setting: There are two hospitals located within this region and five major primary health centres. All the available health facilities located within the study area offer maternity services. The two hospitals were University of Calabar Teaching Hospital (UCTH) which is a tertiary health facility and General Hospital, Calabar (GHC), a secondary health facility. The two hospitals and one primary health centre were used for the study sites for the research, making a total of three public health facilities.

Population of the Study: The population of the study was all post-natal women in Calabar Municipality and the accessible population was all mothers who registered and delivered in the selected three public health facilities that were used for the study. The total number was 19884.

Inclusion criteria: postnatal women who were able to give their informed consent; those who obtained their post- natal services from the study sites and those who can expressed themselves in writing.

Exclusion criteria: were the reverse of the above.

Sample Size Determination: The total number used for the study was 400 calculated using Taro Yamane formula including attrition rate of 10% making a total of 440 sample size.

Sampling Technique: The sampling technique used was a multistage sampling technique. The total of four stages were used.

The First Stage: involved purposive selection of the only two referenced in the study area.

The Second Stage: was selection of one primary health centre out of five available health centres through random sampling using balloting with replacement.

Third Stage: Proportionate sampling technique was used, where respondents were selected based on the population of postnatal women in each study area and the number obtained was UCTH - 217, GHC - 162 and Big Qua PHC - 61, giving a total of 440 participants. The results were calculated from finding the percentage of the total population of each health facility, dividing each percentage with the sample size. The selection of women who met the inclusion criteria was the

Fourth Stage: they included those who utilized postnatal services like routine checkup and immunization services. The sample size for qualitative study was 13 selected across the study sites using purposive sampling.

Instrument: The instrument used for this study was structured questionnaire which comprised of 20 items. The questionnaire was structured in two sections: Section A covered socio-demographic data, while Section B covered post-natal women involvement in decision making. The prepared questionnaire was validated by team of experts in maternal and child health care to meet standards of measurements required. The reliability index of the instrument was also tested using split-half technique and results were calculated using

Pearson Product Moment Correlations formula to obtain of 0.87.

Data Collection: The quantitative data were collected from the participants by the team of researchers after due permission was obtained from the heads of units and the postnatal mothers. The questionnaire was distributed on a face-to-face interaction basis to mothers who met the inclusion criteria from each health facilities on their post natal and infant welfare clinic days. The items on the questionnaire were simplified to the mothers in a language they can easily understanding. The research team ensured that each mother was assisted to fill in the questions accordingly. After filling in the questionnaire, all the copies distributed were collected the same day. The exercise continued every week during clinic days in each study area until the required number was obtained. Data collection lasted for twelve weeks from all the study centres from October 2023 to December, 2023.

Data Analysis: The data was subjected to analyses by using SPSS Version 26. Descriptive statistics were presented as frequencies, percentages, Means and Standard Deviation while Inferential statistics - Pearson correlation and Logistic Regression were used to test relationship. The copies of Out of copies of questionnaire distributed were 440 and all retrieved but only 426 copies filled properly giving a percentage of 96.8 response rate.

Ethical Considerations: Ethical protocols as required by Cross River State Ministry of Health Ethical Committee were duly observed until approval was given. Following the approval, the Institutional Heads in charge of UCTH, GHC and Big Qua PHC and other stakeholders were contacted and due permission was obtained. The postnatal women permissions were also obtained through informed verbal and written consents. The data obtained from the questionnaire were kept confidential under lock and key and only made accessible to those authorised pending when they would be destroyed.

RESULTS

This section presents the findings of the mixed research study. The results are discussed under quantitative and qualitative study.

Table 1 shows that the women agreed that during pregnancy, they were involved in decision making concerning their care. These include My decisions were respected by my maternity care provider(s) during antenatal period ($\bar{\chi}$=4.39), My maternity care provider(s) educated me about making the right choices during pregnancy ($\bar{\chi}$=4.45), I was supported by my maternity care provider(s) in doing what I felt was right for me ($\bar{\chi}$=4.22), My maternity care providers paid close attention to my opinion during my care ($\bar{\chi}$=4.26) and My concerns were taken seriously during my maternity care ($\bar{\chi}$=4.29). This study observed that the level of women decision-making during ante natal period is high ($\bar{\chi}$=4.3)

They agreed to have been involved in decision making during labour. They include My decision concerning my choice of birth place was respected (=3.96), I was in control of the decisions made about my birthing positions and movement in labour ($\bar{\chi}$=3.82), My maternity care provider(s) supported my decisions during labour ($\bar{\chi}$=3.90), I felt at ease with my maternal health care provider(s) because they were able to carry me along in all activities involving my child birth ($\bar{\chi}$=4.19), Informed consent was obtained from me in matters concerning my delivery example giving a cut in my vagina (episiotomy) ($\bar{\chi}$=4.09) and My values and beliefs were respected by the health workers during maternity period care ($\bar{\chi}$=4.09). This study inicated that the level of women decision-making during antra-natal period is high ($\bar{\chi}$=4)

The women also agreed to be involved in decision making during postnatal period. They include: I was involved in my post-natal care following the right information given to me ($\bar{\chi}$=4.35), Shared decision was observed in all services given to my baby ($\bar{\chi}$=4.27), My informed choice concerning method of birth control was respected by health care workers ($\bar{\chi}$=4.27) and My informed decision was also respected in the type of feeding and care I rendered to my child ($\bar{\chi}$=4.26). This study revealed that the level of women decision-making during labour is high ($\bar{\chi}$=4.3).

Finally, this study shows that the level of women decision making concerning their care during pregnancy, birth and post-natal period is high ($\bar{\chi}$=4.2)

Table 1: Women's involvement in decision making concerning their care during pregnancy, birth, and post-natal period **n = 426**

S/N	Item	Strongly Disagree n (%)	Disagree n (%)	Uncertain n (%)	Agree n (%)	Strongly Agree n (%)	Mean± SD
	Antenatal period						
1	My decisions were respected b y my maternity care provider(s) during antenatal period	9 (2.1)	10 (4.5)	7 (1.6)	153 (35.9)	238 (55.9)	4.39±0.89
2	My maternity care provider(s) educated me about making the right choices during pregnancy	2 (0.5)	19 (4.5)	1 (0.2)	167 (39.2)	237 (55.6)	4.45±0.76
3	I was supported by my maternity care provider(s) in doing what I felt was right for me	12 (2.8)	28 (6.6)	5 (1.2)	189 (44.4)	192 (45.1)	4.22±0.97
4	My maternity care providers paid close attention to my opinion during my care.	6 (1.4)	31 (7.3)	2 (0.5)	193 (45.3)	194 (45.5)	4.26±0.90
5	My concerns were taken seriously during my maternity care.	5 (1.2)	24 (5.6)	4 (0.9)	199 (46.7)	194 (45.5)	4.29±0.84
	TOTAL	**1.6**	**5.7**	**.88**	**42.3**	**58.5**	**4.3**
	Intra-natal period						
6	My decision concerning my choice of birth place was respected	27 (6.3)	56 (13.1)	3 (0.7)	160 (37.6)	180 (42.3)	3.96±1.24
7	I was in control of the decisions made about my birthing positions and movement in labour	27 (6.3)	74 (17.4)	7 (1.6)	160 (37.5)	158 (37.1)	3.82±1.27
8	My maternity care provider(s) supported my decisions during labour	18 (4.2)	79 (18.5)	2 (0.5)	155 (36.4)	172 (40.4)	3.90±1.23
9	I felt at ease with my maternal health care provider(s) because they were able to carry me along in all activities involving my child birth	6 (1.4)	44 (10.3)	4 (0.9)	177 (41.5)	195 (45.8)	4.19±0.98
10	Informed consent was obtained from me in matters concerning my delivery example giving a cut in my vagina (episiotomy)	14 (3.3)	47 (11.0)	8 (1.9)	172 (40.4)	185 (43.4)	4.09±1.09
11	My values and beliefs were respected by the health workers during maternity period care	13 (3.1)	48 (11.3)	7 (1.6)	179 (42.0)	179 (42.0)	4.09±1.08
	TOTAL	**4.1**	**13.6**	**1.2**	**39.2**	**41.8**	**4**
	Post-natal period						
12	I was involved in my post -natal care following the right information given to me	4 (0.9)	27 (6.3)	2 (0.5)	178 (41.8)	215 (50.5)	4.35±0.85
13	Shared decision was obs erved in all services given to my baby	4 (0.9)	38 (8.9)	2 (0.5)	176 (41.3)	206 (48.4)	4.27±0.93
14	My informed choice concerning method of birth control was respected by health care workers	14 (3.3)	16 (3.8)	6 (1.4)	196 (46)	194 (45.5)	4.27±0.92
15	My informed decision was also respected in the type of feeding and care I rendered to my child	18 (4.2)	23 (5.4)	4 (0.9)	167 (39.2)	214 (50.2)	4.26±1.02
	TOTAL	**2.3**	**6.1**	**0.83**	**42.1**	**48.7**	**4.3**
	Grand mean	**2.7**	**8.5**	**0.97**	**41.2**	**50**	**4.2±0.18**

Table 2 shows that the women were involved in decision making concerning their care during pregnancy (94.8%), Labour (82.2%) and postnatal (92%).

Table 2: Summary of women's involvement in decision making concerning their care during pregnancy, birth, and post-natal period n= 426

Involvement with care	Antenatal No	%	Intra-natal No	%	Postnatal No	%
Involved	404	94.8	350	82.2	392	92.0
Not Involved	22	5.2	76	17.8	34	8.0

Ho1: There will be no significant relationship between Maternal care satisfaction among post-natal mothers and involvement of women in decision making towards their care during antenatal, intra-natal and post-natal period

Table 3 shows a significant positive correlation between maternal care satisfaction among post-natal mothers and their involvement in decision making regarding their care during labour ($p = 0.001$, $r = 0.166$). Similarly, there is a significant positive correlation between maternal care satisfaction among post-natal mothers and their involvement in decision making towards their care during post-natal period ($p < 0.001$, $r = 0.224$).

Table 3: Relationship between Maternal care satisfaction among post-natal mothers and their involvement in decision making t owards their care during antenatal, intra -natal and post-natal period using Pearson Correlation Coefficient formula.

		Involvement		
Satisfaction		Antenatal	Intra-natal	Post-natal
Antenatal	Pearson Correlation Coefficient (r)	0.056		
	P value	0.245		
	N	426		
Intra-natal	Pearson Correlation Coefficient (r)		0.166	
	P value		0.001	
	N		426	
Post-natal	Pearson Correlation Coefficient (r)			0.224
	P value			< 0.001
	N			426

Table 4 shows a significant association between Maternal care satisfaction among post-natal mothers and their involvement in decision making towards their care during intra-natal and post-natal period ($p < 0.05$). Women involved in decision making regarding their care during labour were 4 times more likely to be satisfied than women who were not involved during labour ($p = 0.001$, OR = 3.673, 95% C.I = 1.674 – 8.060). Similarly, women involved in decision making regarding their care during post-natal were 6 times more likely to be satisfied than women who were not involved during postnatal ($p < 0.001$, OR = 6.360, 95% C.I = 2.639 – 15.328).

Table 4: Association between Maternal care satisfaction among post-natal mothers and their involvement in decision making towards their care during antenatal, intra -natal and post-natal period using Logistic Regression

Satisfaction	Involvement		P value	OR	95% C.I for OR
	Involved n (%)	Not involved n (%)			
Antenatal					
Satisfied	388 (96.0)	20 (90.9)	0.259	2.425	0.521 – 11.279
Dissatisfied	16 (4.0)	2 (9.1)			
Intra-natal					
Satisfied	333 (95.1)	64 (84.2)	0.001	3.673	1.674 – 8.060
Dissatisfied	17 (4.9)	12 (15.8)			
Post-natal					
Satisfied	371 (94.6)	25 (73.5)	< 0.001	6.360	2.639 – 15.328
Dissatisfied	21 (5.4)	9 (26.5)			

DISCUSSION

This study assesses postnatal women involvement in decision making concerning their care and their satisfaction during maternity period. The study noted that the level of women decision-making during ante-natal period is high which is supported by Smith et al. (2019), who revealed that when women are involved in their care, they are empowered to take an active role in their prenatal care, leading to better health outcomes. Moreover, Jones and Brown (2020) also are in agreement with the findings of this study as they discovered that increased involvement of mothers in health-related decisions will have significant influence on their overall experiences during pregnancy. The writers explained that this emerging autonomy replicates wider societal changes and highlights the pressing needs of supporting women's agency in healthcare settings.

Similarly, this study observed that the level of women decision-making during intra- natal period is high which aligns with the study carried out by Houghton et al. (2020), where mothers who participated actively in decision-making processes during labour reported higher satisfaction with their childbirth experiences. In addition, this study is also supported by Patel and Roberts (2021) who revealed in their study that women's involvement in labour-related decisions increased their sense of control and empowerment during the birthing process resulting in positive birth outcomes.

Furthermore, it has been shown that the level of women's decision-making concerning their care during the post-natal period is significantly high. The finding of this study is in line with a study conducted by Smith et al. (2021) who revealed that empowering women for decision-making directly associates with improved health outcomes for women and children. Equally, a study done by Thompson and Richards (2020) highlighted that women who actively participate in their post-natal care choices, experience greater gratification and self-confidence in their maternity care roles. These findings accentuate the relevance of nurturing an environment where women feel comfortable in making informed decisions about their care during the post-natal period. This can lead women to enhanced psychosocial and physical health birth outcomes (Johnson & Lee, 2019).

Generally, this study demonstrates that the level of women's decision-making concerning their care during pregnancy, birth, and the post-natal period is high. This study support Agha and

Carton (2021) who discovered that when women are involved in decision-making regarding their maternity care, it significantly improves satisfaction with care and birth outcomes. Their study shows that empowering women to make decisions leads to better maternal and neonatal health indicators. Similarly, Lundgren and Möller (2020) revealed that women's agency in healthcare settings directly impact their experiences of childbirth and postpartum care. Their research findings show that when women have more control over their maternity care, they report better satisfaction and outcomes. Moreover, a systematic review by Raghavan et al. (2020) reveals that women's participation in their healthcare decisions enhances satisfaction and can lead to better health practices during pregnancy, birth and after childbirth. These studies jointly affirm that women's active involvement in decision-making is linked to improved health outcomes during pregnancy, labour and postpartum periods.

In addition, the findings showed a significant positive correlation between maternal care satisfaction among post-natal mothers and their involvement in decision making regarding their care during labour (P=0.001). Similarly, there was a significant positive correlation between maternal care satisfaction among post-natal mothers and their involvement in decision making towards their care during post-natal period (P<0.001). Women involved in decision making regarding their care during labour were 4 times more likely to be satisfied than women who were not involved during labour (P= 0.001). Similarly, women involved in decision making regarding their care during post-natal were 6 times more likely to be satisfied than women who were not involved during postnatal (P<0.001). The results are supported by Mchunu and Dreyer (2020) who revealed that, women's satisfaction is positively associated with their involvement in their care. This implies that when women are involved in decision making during maternity period it will promote their overall satisfaction with childbirth experiences.

From the results above, women involvement in decision making in their labour reveals that they will be 4 times more satisfied than those who were not involved. This shows how crucial it is for mothers to be carried along issues that relate to their delivery. Likewise, in postnatal, women are 6 times more satisfied with care if they are involved in their care than those who are not. Generally, mothers should be able to be given right information for them to participate actively in their care in antenatal, intranatal and postnatal. Though, the results appear not to address antenatal period, it is still very critical.

Hypothesis tested revealed that there is a significant relationship between maternal care satisfaction among post-natal mothers and women in decision making towards their care during antenatal, intra-natal and post-natal period. The result of the study agree with that of Murugesu et al. (2021) on mothers' participation in decision making concerning their maternity care, who reported from their study, they need of mothers to be give opportunities to make their choice as these choices promote mothers' satisfaction.

Furthermore, the result support Slomian et al. (2021) who conducted a study on identifying maternal needs following childbirth. Among the four needs identified, the need of involvement and sharing their experiences was high among pregnant mothers with midwives and physicians than that of mothers during postpartum period (P=0001). Sharing of experiences and involvement by either pregnant or postpartum mothers made them feel people understand them. That of need for practical and maternal support was high during postpartum than pregnancy (P=0.01). If this need is met, it will help to improve the quality of life of mothers.

CONCLUSION AND RECOMMENDATION

Based on the major findings of the study, postnatal women were involved in their maternity care exception of few who complained

of only complying to orders given but not fully involved in their care. In addition, postnatal women involvement in decision making concerning their care during maternity period is significantly associated with their satisfaction. It was therefore recommended that, capacity building for all health care workers should be organized to ensure that evidence-based midwifery best practices are taught so that all women could be more involved in decision making concerning their birthing positions, movement in labour, place of birth and other activities relevant to maternity care.

LIMITATION OF THE STUDY

This study was also limited to the three public health facilities in Calabar Municipality, which may not be a true representation of Cross River State as a whole for generalization of the findings. Moreover, the sample size for the qualitative aspect of the study was few compared to the general population of the study area.

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CONFLICTING INTEREST

We have no conflict of interest to declare

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