

Postnatal Women Involvement in Decision Making and Thier Satisfaction During Maternity Period in Calabar Municipality, Cross River State Nigeria

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Abstract

Introduction and Aims: 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, the necessity to examine how women were involved in decision making concerning their care was 'birthed' as part of the efforts to join other stakeholders in improving quality care 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.

Methodology: A mixed research method was employed using questionnaire and in-depth interview study guide, 440 women participated in the quantitative aspect of the study and 13 postnatal women in qualitative study and were selected through multistage sampling technique. Data collected were subjected to statistical analysis using SPSS Version 26 and that of qualitative data were coded, transcribed and thematic analysis utilized. The study was conducted in three health facilities in Calabar Municipality, Cross River State, Nigeria.

Results: 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 ($p = 0.001$, $r = 0.166$). 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 ($p < 0.001$, $r = 0.224$). However, during antenatal period there was no significant correlation between maternal care satisfaction among post-natal mothers and their involvement in decision making towards their care during post-natal period ($p < 0.001$, $r = 0.224$). In qualitative study post-natal women had varied opinions towards the way they were engaged in decision making and it was more negative than positive compared to that obtained from quantitative findings.

Conclusion and recommendation: These findings highlight the need for women to participate in their care in order to promote their satisfaction and positive birth outcome. The study recommends that, capacity building for all health care workers should be organised to ensure that evidence-based midwifery best practices are taught so that 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.

Keywords: Postnatal women, decision making, maternal satisfaction, pregnancy, birth, post-natal period and Cross River State.

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) explains 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.

Methodology

Study design and setting

The study adopted a cross-sectional design and was carried out in Calabar municipality. 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 and criteria eligibility

The population of the study was all post-natal women in Calabar Municipality and the accessible population all mothers who registered and delivered in the selected three public health facilities that were used for the study. The total number was 19884. The inclusion criteria included 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 while the exclusion criteria were the reverse of the above.

Sample size and Sampling technique

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. The sampling technique used was a multistage sampling technique. The total of four stages were used. The first 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. Proportionate sampling technique was used for the third stage 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 and 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.

Data Collection

The instrument used for the data collection was structured questionnaire for the quantitative aspect of the study which comprised 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. A checklist was used as an instrument for qualitative study to guide an in-depth interview with individuals used for the study.

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.

The qualitative data was collected using a checklist by conducting an in-depth interview with participants who were willing in different locations as consented to by the postnatal women. To ensure the rigour and trustworthiness of the

instrument, the process of confirmability/conformability, credibility, transferability and dependability were diligently observed by keeping audit trail and using multiple sources. This qualitative data was collected after collection of quantitative data. The duration of the interview was about 20 – 30 minutes. The in-depth interview guide consisted of opened ended questions. Opened ended questions encourage free and in-depth discussions that help the participants to express their views and experiences as they reflect on their past activities. Information collected was recorded by the researchers through tape recorder and note taking.

Data Analysis

The quantitative 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. The qualitative data was coded, transcribed verbatim and thematic analysis was utilised following the frequent occurring of themes analysis and best catchy quotations with the aid of NVivo version 14. Thereafter presentation of results were carried out accordingly.

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 and in-depth interview were kept confidential under lock and key and only made accessible to those authorised pending when they would be destroyed.

Results and Discussion

Results

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

Results of the Quantitative study

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 by 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
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
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 observed 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 (46.0)	196 (46.0)	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
Grand mean							4.19±0.18

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 (4.39), My maternity care provider(s) educated me about making the right choices during pregnancy (4.45), I was supported by my maternity care provider(s) in doing what I felt was right for me (4.22), My maternity care providers paid close attention to my opinion during my care (4.26) and My concerns were taken seriously during my maternity care (4.29).

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 (3.82), My maternity care provider(s) supported my decisions

during labour (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 (4.19), Informed consent was obtained from me in matters concerning my delivery example giving a cut in my vagina (episiotomy) (4.09) and My values and beliefs were respected by the health workers during maternity period care (4.09).

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 (4.35), Shared decision was observed in all services given to my baby (4.27), My informed choice concerning method of birth control was respected by health care workers (4.27) and My informed decision was also respected in the type of feeding and care I rendered to my child (4.26).

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

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

Ho1: 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

Table 3: Relationship 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 Pearson Correlation Coefficient formula.

Satisfaction		Involvement		
		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 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 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)			

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).

Results of the qualitative study

The mothers reported that they and their husbands/relatives were not actively engaged in making decisions regarding their maternal care. Instead, they were merely informed about expectations, often without detailed information. They expressed that their involvement was restricted to following orders and executing instructions.

“They were not fully involved in decision making but were only informed on what was expected even though sometimes no detail explanation” (pwg 3)

“my husband participated in that he complied to all that they asked him to do but not directly involved in decision making concerning my care in the hospital” (pwu 1)

Discussion

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 ($p = 0.001$, $r = 0.166$). 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 ($p < 0.001$, $r = 0.224$). 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).

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.

However, since the significant value of the statistics is less than 0.05 level of significance for at least one of the items tested, the null hypothesis is rejected and the alternative accepted. Therefore, maternal care satisfaction among post-natal mothers is statistically significantly related to involvement of women in decision making towards their care during antenatal, intra-natal and post-natal period. Women should be taught how to make choices concerning place of birth, birthing positions, birth plans/birth preparedness and complication readiness, even health professionals that should take care of them. Maternity care should be made flexible where possible to accommodate women choices. This will go along way to improve their self worth and self confidence given them the joy of fulfilment needed for a positive maternity care experiences and their satisfaction.

The results 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. women pointed out the following major shared decisions: pregnancy courses, laboratory test, labour induction, vaccination and options to handle complex and difficult conditions like breech delivery. Other decisions were delivery place, screening test for genetic disorders, pain management during labour, baby feeding, choice for skilled birth attendants and ultrasonography examination at 24 weeks.

Furthermore, the results 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 ($p = 0.001$). 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.

The findings from qualitative analysis revealed the extent of post natal mothers' involvement in decisions affiliated to their care and their foetus during pregnancy, labour and post natal period. Participants generally affirmed lack of involvement in decision making pertaining to their health and that of their husbands and relatives. Moreover, some participants revealed that they merely informed about expectations often without detailed explanation. inability to question or make suggestions. Some health care workers reported of actively involving their clients in decision making concerning their care. They expressed that their involvement was restricted to following orders and executing instructions.

They were not fully involved in decision making but were only informed on what was expected even though sometimes no detail explanation

my husband participated in that he complied to all that they asked him to do but not directly involved in decision making concerning my care in the hospital''

Furthermore, this lack of involvement of women in care could also contribute to making them to seek alternative measures which may land them in the wrong hands and negative birth outcome. This also may result in negative maternity care experiences. For example, the TBAs will do everything possible to ensure that women assume their best position in delivery of their babies and even in respecting their relatives.

The findings of the qualitative study are contrary to that carried out by Jolly et al. (2019) which revealed that, involvement of women in their decision making is one of the important components in respectful maternity care for positive child birth experiences but agrees with Dutta, (2020). However, the quantitative aspect of the study agreed with Murugesu et al. (2021) who pointed out from their study that, mothers with high level of understanding were able to participate intelligently in decision making concerning their care and identify their preferences with their partners and other relevant people while women with low education need training for them to participate in their care and identified their preferences. The findings of quantitative aspect of the study also contradict that of Yuill et al. (2020) who reported that women expressed lack of control over their child birth as they were not involved in their maternity care.

The findings of both quantitative and qualitative study revealed a gap in actual involvement in decision making even though some aspects have been concurred by the majority of the participants. It becomes very clear from the researchers' observations that some health care workers despite awareness to rights of mothers to respectful care, are still holding tight to the former ways of birthing positions and other practices of

'Lording' over mothers during maternity care. Even though it is an established fact, that, the woman who is feeling the pain understands herself better than those who are attending to her, hence the need to respect her opinions and decisions in maternity care. However, if her opinions and wishes are detrimental to her health and that of her baby, the need comes for counselling and persuasion in a very polite way in other for her to do the right thing at the right time. The findings are similar to that of Lathrop and Hodnicki, (2018), Dutta, (2020) and Mylona and Papadopoulou, (2021)

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 organised 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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