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Exploring the Factors Influencing Maternity Care Experiences Among Postpartum Women in Ondo State, Nigeria

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Abstract
Maternity care experiences significantly influence women' s trust in health systems, future care- seeking behaviour, and maternal- neonatal health outcomes. In Nigeria, where the maternal mortality ratio remains high at approximately 993 per 100, 100,000 live births (2023 modelled estimate) and skilled birth attendance is only 43%, poor experiences and expectation disconfirmation are contributing factors to low utilisation of facility- based services. This study investigated socio-demographic, interpersonal, and structural factors influencing maternity care experiences among postpartum women in Ondo State, Nigeria. A concurrent mixed- methods design was employed. Purposive sampling recruited 422 postpartum women (within six weeks of delivery) from primary, secondary, and tertiary health facilities in Ondo State for quantitative data, using a validated structured questionnaire. Expectation disconfirmation was computed as the difference between expectation and experience ratings after 14 in-depth interviews were completed to reach data saturation. Descriptive statistics, chi-square tests, and binary logistic regression (SPSS version 25, $p < 0.05$) were used to analyse quantitative data. Qualitative data were subjected to thematic analysis. Results: Of 422 participants, 53. 8% had high expectations of maternity care, but only 54. 3% had overall positive experiences, indicating notable expectation disconfirmation, particularly in the postpartum period. Binary logistic regression showed that living in an urban area (AOR = 1.63, 95% CI 1.04- 2.10, p = 0.03) and higher education were independent predictors of positive experiences. Major influencing factors included professional support (81.8%), partner involvement (79.6%), psychological support (78.2%), personal expectations (75.8%), and continuity of care (73.9%). Qualitative themes centred on respectful interactions, facility environment and resource adequacy, professional and emotional support, partner involvement, and continuity of care/postpartum follow-up gaps. Quantitative predictors aligned well with qualitative stories, especially regarding rural-urban and educational differences. Intersecting socio-demographic, interpersonal, and structural factors shape maternity care experiences in Ondo State. Women-centred interventions that are context-sensitive and target expectation disconfirmation are urgently needed to improve satisfaction, skilled care use, and maternal health equity.

Keywords: Maternity care experiences, Expectation disconfirmation, Respectful maternity care, Mixed-methods study, Postpartum women

Introduction

Maternal mortality is a key indicator of health inequalities both globally and in Sub-Saharan Africa. Pregnancy and childbirth-related problems claim the lives of an estimated 287,000 women annually, with low- and middle-income nations accounting for 95% of these deaths [19]. Nigeria has a heavy burden, contributing disproportionately to global statistics despite representing only about 2% of the world population. In 2023, the country's maternal death rate was approximately 993 in every 100,000 live births, with only 43% of skilled birth attendance and 39% of facility-based deliveries [14]. Studies using the sisterhood approach in selected local government districts in Ondo State were reported to have maternal death rates of 950 per 100,000 live births in 2020 among adolescents and young adults (15-39 years) at the highest risk[17]. Poor quality of maternity care, including experiences of disrespect and abuse, neglect, long waiting times, inadequate communication, and failure to meet women's expectations, significantly deters utilisation of skilled birth services. These negative experiences maintain high rates of illness and mortality among mothers and

newborns by undermining confidence in the healthcare system and encouraging dependence on inexperienced attendants [6,9,11]. The World Health Organisation (WHO) states that during the prenatal, intrapartum, and postpartum phases, every woman has the right to a positive delivery experience that is respectful, dignified, emotionally supportive, and clinically safe[19]. The dynamic interaction between women affects how they view maternity care, their socio-demographic factors, pre-existing expectations, cultural norms, and the structural context of care provision in often under-resourced health systems.

The Expectation Disconfirmation Theory (Oliver, 1980) provides a strong explanatory framework for understanding satisfaction: positive outcomes are observed when experiences align with or exceed expectations, whereas negative disconfirmation results in dissatisfaction and even avoidance of future care. This study used Likert-scale scores to operationalise expectation disconfirmation as the discrepancy between women's reported expectations and their actual maternity care experiences. This theory is complemented by Social Cognitive Theory (Bandura, 1986), which highlights the interplay of personal (e.g., education, self-efficacy), behavioural (e.g., participation in decision-making) and environmental factors (e.g., facility resources, rural-urban disparities) in shaping health behaviours and perceptions. Recent data from Nigeria and sub-Saharan Africa have consistently documented abuse during childbirth, including verbal abuse, lack of privacy, abandonment, and poor provider attitudes, which negatively impact respectful maternity care (RMC) 9,18. Rigorous mixed-methods research on the moderating effect of socio-demographic variables on the expectation-experience nexus in South-West Nigeria, specifically Ondo State, is scarce. This research addresses the gap by exploring the factors that influence the maternity care experiences of postpartum women across three levels of care in Ondo State and by combining quantitative relationships with in-depth qualitative stories.

Expectation Disconfirmation Theory and Social Cognitive Theory serve as the foundation for this investigation. According to Expectation Disconfirmation Theory (Oliver, 1980) women develop anticipations grounded in previous experiences, media, and family and community discourse. Negative disconfirmation occurs when actual care falls short of expectations, influencing satisfaction and subsequent utilisation. Social Cognitive Theory supplements this by focusing on self-efficacy and environmental barriers/facilitators. Together, these frameworks informed the study of how intersecting determinants affect maternity care experiences in the Ondo context.

Study Objectives
The intended objectives were to: (1) establish the maternity care experiences of postpartum women in the selected facilities in Ondo State; (2) identify the socio-demographic, interpersonal, and structural factors that affect the experiences; and (3) explore the qualitative facets of postpartum women's maternity care experiences in the Ondo State. Study Hypotheses (quantitatively tested):

H01: No significant correlation between socio-demographic factors and maternity care experiences
H02: No significant relationship between the selected factors (e.g., professional support, partner involvement) and maternity care experiences.

Methodology
A descriptive cross-sectional concurrent mixed-methods design was used in this investigation. While the qualitative strand offered in-depth insights into lived experiences and contextual nuances, the quantitative strand allowed statistical evaluation of patterns and relationships. The quantitative strand offered an opportunity to statistically analyze patterns and associations, and the qualitative strand provided in-depth insights into lived experiences and contextual nuances. The data were collected simultaneously with integration at the interpretation stage through merging, joint displays as well as narrative synthesis in order to improve validity by triangulating. The research was carried out in Southwestern Nigeria and Ondo State. It included three purposely chosen facilities that represent the three levels of care: Arakale Primary Health Centre (Akure -primary), General Hospital Ile-Oluji (secondary), and Federal Medical Centre Owo (tertiary). These sites deliver health care to a diverse rural and urban population and are major maternity referral centers which reflect the realities of the health system of the state including resource gradients between the levels.

The study focused on postpartum women aged 15-49 who had delivered within six weeks and received care at the designated facilities. Cochran's formula was used to calculate a sample of 422 women for the quantitative strand (assuming a proportion of 50 to give maximum variability, 95% confidence, 5% margin of error, and adjustment of non-response by 10%). Multi-stage sampling was employed. Senatorial districts were selected, followed by purposive

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selection of one high-volume facility per level and then purposive sampling of eligible postpartum women. In the qualitative strand, 14 in-depth interviews were held with purposively selected women until data saturation (no new themes emerging). Inclusion criteria: recent birth in study facilities and capacity to give consent. Exclusion: extreme medical/psychiatric issues that hamper participation.

Ethical approvals were obtained, and data were collected between January and June 2023. The structured questionnaire was administered privately by trained research assistants. The instrument was adapted from validated tools used in African settings, including socio-demographic items, 4-point Likert scales for expectations and experiences (prenatal, intrapartum, and postpartum), and yes/no questions about influencing factors. It was translated forward and backward into Yoruba. In-depth semi-structured interviews (30-45 minutes) were conducted to explore expectations, experiences, influencing factors, and recommendations. With participants' permission and in their preferred language, the interviews were audio-recorded. Expert review indicated that the questionnaire had good face and content validity (S-CVI = 0.89). Pilot testing involving 30 postpartum women showed a Cronbach's alpha of 0.87 for the expectation/experience scales, indicating high internal consistency. Quantitative: IBM SPSS version 25 was used for data entry and analysis. Frequencies, means, and percentages summarised the characteristics using descriptive statistics. Expectation disconfirmation was calculated as the difference between expectation and experience scores on the Likert scales. Participants whose experience scores were lower than their expectation scores were categorised as having expectation disconfirmation. Chi-square tests were used to examine associations, and binary logistic regression was employed to identify independent predictors ($p < 0.05$).

The researchers conducted a thematic analysis using the Braun and Clarke framework (familiarisation, coding, theme generation, review, definition, and reporting). Member checking, peer debriefing, audit trails, and reflexivity ensured trustworthiness. Quantitative and qualitative data were integrated during interpretation using joint displays (e.g., side-by-side comparisons of themes and statistics) to identify convergence, complementarity, and dissonance. The relevant institutional review board(s) at Achievers University and the facility authorities granted ethical approval. All participants provided written informed consent. Anonymity ensured confidentiality through anonymisation, secure storage, and limited access. Participation was voluntary, with the option to withdraw without repercussions.

Results

Socio-Demographic Characteristics of the Respondents.

The quantitative sample comprised 422 postpartum women with a mean age of 31.09 years. The majority were aged 25 to 34. Most participants were married, self-employed, and lived in urban areas. The level of education was reasonably high. Almost half were primiparous. The sample comprised 51.2% Christians and 64.7% Yoruba women. This profile of urban residence and higher education is important, as higher education and urban residence are known to affect health literacy, the ability to navigate health systems, and expectations of care 11. Their inclusion of women from primary, secondary and tertiary facilities increased their representation of various socio-economic realities in Ondo State.

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Table 1: Socio-Demographic Characteristics of the Respondents

Variables	Frequency	Percentage
Age as at last birthday		
Mean:31.09±6.34	43	10.2
15-24	267	63.3
25-34	99	23.5
35-44	13	3.0
45 and above		
Occupation		
Not employed	108	25.6
Self-employed	206	48.8
Civil servant	108	25.6
Marital status		
Single	96	22.7
Married	310	73.5
Divorce	10	2.4
Separated	6	1.4
Parity		
First	203	48.1
Second	117	27.7
Third	59	14.0
Fourth or more	43	10.2
Religion		
Christianity	216	51.2
Islam	197	46.7
Traditional	9	2.3
Ethnicity		
Yoruba	271	64.7
Igbo	122	28.9
Hausa	29	6.9
Place of residence		
Rural		
Urban	130	30.8
	292	69.2
Highest level of Education		
Primary	79	18.7
Secondary	151	35.8
Tertiary	159	37.7
No formal education	33	7.8

Although 53.8% of the respondents had high expectations of maternity care, only 54.3% reported overall positive experiences. This discrepancy indicates expectation disconfirmation, calculated as the difference between expectation and experience scores, with the highest levels observed in the postpartum period, where women expected continuity of care and sufficient support.

Factors Influencing Maternity Care Experiences

According to Table 2, professional support (81.8%), partner involvement (79.6%), psychological support (78.2%), personal expectations (75.8%), and continuity of care (73.9%), were the most frequently endorsed factors. Slightly more than 55% of respondents approved of respect and good communication by healthcare personnel.

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Table 2: Factors that Influence Women's Maternity Care Experiences

Variables	Yes	No
Professional Support	345(81.8)	77(18.2)
Partner involvement	336(79.6)	86(20.4)
Psychological support	330(78.2)	92(21.8)
Personal expectations	320(75.8)	102(24.2)
Continuity of care	312(73.9)	110(26.1)
Knowledge about maternal health	296(70.1)	126(29.9)
Delivery preparation	253(60.0)	169(40.0)
Good communication	243(57.6)	179(42.4)
Poor referral system	237(56.2)	185(43.8)
Respect by the health-care personnel	233(55.2)	189(44.8)
Adequate information at every stage	228(54.0)	194(46.0)
Delay in receiving care	211(50.0)	211(50.0)
Participation in decision relating to my care	195(46.2)	227(53.8)

Correlations between Socio-Demographic Characteristics and Experiences.
Chi-square tests revealed statistically significant correlations between maternal care experiences and residence (χ^2 = 4.89, p = 0.02) and greatest level of education (χ^2 = 18.85, p = 0.01). There was no discernible correlation with occupation (p=0.70). Rural dwellers and women with lower levels of education were more likely to have negative or subpar experiences.

Table 3:Chi-square test investigating the relationship between postpartum women's Sociodemographic Characteristics and their Maternity Care Experiences

Variables	Maternity care experiences		$\chi 2$	p-value
	Bad	Good		
Age				
15-24	19(9.8)	24(10.5)	0.37	0.94
25-34	124(64.2)	143(62.4)		
35-44	45(23.3)	54(23.6)		
45 and above	5(2.6)	8(3.5)		
Occupation				
Not employed				
Self-employed	52(27.0)	56(24.5)	0.69	0.70
Civil servant				
	90(46.6)	116(50.7)		
	51(26.4)	57(24.9)		
Marital status				
Single			1.55	0.67
Married	46(23.8)	50(21.8)		
Divorce	142(73.6)	168(73.4)		
Separated	3(1.6)	7(3.1)		
	2(1.0)	4(1.7)		

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Variables	Maternity care experiences		χ2	p-value
	Bad	Good		
Parity				
First	95(49.2)	108(47.2)	2.74	0.43
Second	58(30.1)	59(25.7)		
Third	22(11.4)	37(16.2)		
Fourth or more	18(9.3)	25(10.9)		
Religion				
Christianity	89(46.1)	127(55.5)	4.94	0.08
Islam	99(51.3)	100(43.7)		
Traditional	5(2.6)	2(0.9)		
Ethnicity				
Yoruba	136(70.5)	135(59)	7.53	0.02
Igbo	49(25.4)	73(31.9)		
Hausa	8(4.1)	21(9.2)		
Place of residence				
Rural	49(25.4)	81(35.4)	4.89	0.02
Urban	144(74.6)	148(64.6)		
Highest level of Education				
Primary				
Secondary	53(27.5)	26(11.4)	18.85	0.01
Tertiary	61(31.6)	90(39.3)		
No formal	68(35.2)	91(39.7)		
education	11(5.7)	22(9.6)		

Logistic Regression Analysis: Positive maternity care experiences were independently predicted by urban residence (AOR = 1.63, 95% CI: 1.04-2.56, p = 0.03) and secondary/tertiary education (AOR = 1.28, CI=0.11-4.69), according to binary logistic regression. In the final model, professional assistance, effective communication, individual expectations, and participation in decision-making all turned out to be significant **predictors.**

Table 4: Logistic Regression analysis predicting likelihood factors that influencematernity care

Experiences Variables	Statistical significance	Odds Ratio	Confidence interval UB	LB
Ethnicity				
Yoruba	1(ref)			
Igbo	0.08	0.46	1.10	0.19
Hausa	0.25	0.59	1.45	0.23
Place of residence				
Rural	1(ref)			
Urban	0.03	1.63	2.56	1.04
Highest level of Education				
Primary	1(ref)			
Secondary	0.01	1.28	4.69	0.11
Tertiary	0.41	0.71	1.60	0.31
No formal education	0.59	0.80	1.81	0.35

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Qualitative Findings
The thematic analysis of the 14 in-depth interviews showed that five major themes are connected to each other:

Theme 1: Environment and Adequacy of Resources in the Facility.
Respondents in tertiary and urban facilities spoke of cleanliness and the presence of basic facilities, whereas rural respondents frequently complained that the facilities were overcrowded, had poor toilets, and were stocked out of basic supplies. A primiparous rural woman said: **"***The environment was not always clean and there was no water sometimes. We had to manage."*

Theme 2: Respectful Communication and Interpersonal Interactions.
Being addressed by name and having procedures explained were highly valued by many women. Others, however, reported rushed visits and hasty attitudes. One of the multiparous participants said: *"Some nurses were nice and addressed me by name, other nurses shouted and were in a hurry."*

Theme 3: Professional and Psychological Support.
Skilled care during labour, particularly pain management and reassurance of first-time mothers was reported to have a high level of satisfaction. Emotional support helped alleviate anxiety at critical times.

Theme 4: Partner Involvement and Decision-Making Participation
The majority of women highly wanted their husbands to be present during labour to offer emotional support, but the policy of the facility and space limitations often did not allow it. Some of the participants were disappointed: *"I wished that my husband was with me, but they said that it was not possible".*

Th**eme 5: Continuity of Care and Postpartum Follow-up**
This was the most consistently reported gap. Upon discharge, women were left alone with minimal information on what to watch for or how to follow up. One of them complained**:** *"After I gave birth, they simply released me. No one came to see how I was doing at home."*

Quantitative and Qualitative Findings: Integration.
Joint display analysis showed strong convergence: quantitative findings on urban residence and education predicting better experiences aligned closely with qualitative narratives of better-resourced facilities and greater confidence in advocating for care. It was observed that postpartum experiences were divergent with moderate but qualitative endorsement of continuity and overwhelming dissatisfaction and feelings of vulnerability. The given integration enhances the trust in the results and emphasizes the importance of mixed-method design. The empirical results of the study support Expectation Disconfirmation Theory in this low-resource context: 53.8% high expectations were not often met, especially in postpartum follow-up. Absence of continuity and home visits made the women feel abandoned at a delicate time. This has direct implications in future care-seeking and is consistent with meta-syntheses of the postnatal care experiences of care-seekers in sub-Saharan Africa.

Hypotheses Testing
The study used binary logistic regression and chi-square testing to assess hypotheses at a significance level of $p<0.05$.
H1: No significant correlation between socio-demographic factors and maternity care experiences
This hypothesis was rejected. Chi-square tests found significant correlations between maternity care experiences and place of residence, ethnicity, and greatest level of education (Table 3). A binary logistic regression analysis (Table 4) revealed that urban living and higher education were independent determinants of pleasant maternity care experiences.
H2: No significant relationship between the selected factors (e.g., professional support, partner involvement) and maternity care experiences.

This hypothesis was partially rejected. Table 2 shows that professional support, partner involvement, psychological support, personal expectations and continuity of care were the most reported influencing factors. Bivariate analysis revealed significant associations with partner involvement, personal expectations, and knowledge about maternal health, good communication, and participation in decision-making. Binary logistic regression in Table 4 further

confirmed that urban residence (and higher education were independent predictors of positive maternity care experiences.

Discussion

The results show that the maternity care experiences of postpartum women in Ondo State are shaped by a complex interplay of socio-demographic, interpersonal, and structural factors, with clear evidence of expectation disconfirmation contributing to suboptimal satisfaction. Urban residence (AOR=1.63) and higher education (AOR=1.28) were strong predictors of positive experiences. This suggests more resource-rich facilities, shorter waiting times, and greater staff availability in urban centres compared with rural areas. These results align with recent Nigerian research highlighting persistent disparities in the quality of maternal health care across rural and urban areas. Higher education likely improves health literacy, the ability to articulate needs, and the ability to demand respectful treatment for women. In Ondo State, where previous reports have documented MMR in the range of 950 per 100,000 in selected areas (although state-wide endeavours have shown some improvements), addressing disparities in maternal health is crucial.

Professional support and good communication were cornerstone positive factors. Qualitative narratives praised caregivers who provided explanations and emotional reassurance but also highlighted instances of hurried care and disrespect. These results reflect recent evidence on hindrances to respectful maternity care in Southwest Nigeria, including heavy workloads and insufficient training. They complement the WHO focus on respectful maternity care as a key element of quality. The strong support of partner involvement, psychological support, and especially among those who are primiparous, the relational aspect of positive birth experiences is strongly supported. The unavailability of birth companions, as a result of policy by the facility, is a missed opportunity, which is in line with the recent African literature that advocates family-centred care. Involvement in decision-making also empowered women, reducing the power imbalance prevalent in hierarchical Nigerian health systems.

The empirical results support Expectation Disconfirmation Theory in this low-resource context: 53.8% of high expectations were often unmet, especially in postpartum follow-up. The lack of continuity and home visits made women feel abandoned at a delicate time. This has direct implications for future care-seeking and aligns with meta-syntheses of postnatal care experiences among care-seekers in sub-Saharan Africa. Frontline providers such as nurses and midwives are critical in closing the expectation-experience gap. Women-centred care can be improved through routine socio-demographic profiling during antenatal care, as well as through targeted communication and expectation management. Respectful maternity care, emotional support, partner involvement, and cultural competence should be prioritised in pre-service and in-service training.

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Conclusion

The interplay of socio-demographic, interpersonal, and structural factors shapes maternity care experiences among postpartum women in Ondo State, Nigeria. Despite high expectations for respectful, responsive, and continuous care (53.8%), only 54.3% of participants reported overall positive experiences, underscoring an ongoing expectation-experience disconfirmation gap. Urban residence and higher education emerged as significant predictors of more positive experiences, while qualitative narratives highlighted resource constraints, variable interpersonal quality, and weak postpartum continuity, particularly affecting rural and less-educated women.

The results highlight that ensuring respectful maternity care (RMC) and positive childbirth experiences cannot be achieved by infrastructural changes alone; rather, they must be accompanied by attention to the relational and systemic aspects of care. The study offers subtle insight into how personal agency, environmental facilitators, and outcome expectations shape women's perceptions and future health-seeking behaviours. In the context where Nigeria has an unacceptably high national maternal mortality ratio and Ondo State is still struggling with inequities, it is essential to address these gaps to improve skilled birth attendance, reduce preventable mortality, and advance maternal health equity.

Recommendations

Based on the study's findings, the following multi-level recommendations are made:

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1. Incorporate and enact context-specific guidelines on respectful maternity care, including mandatory training on effective communication, pain management, and emotional/psychological support. The facilities must work towards enabling policies on birth companions where the infrastructure permits.
2. Reduce rural-urban disparities by equitably distributing resources, improving staffing in primary facilities, and enhancing supply chains of essential drugs and equipment. Strengthen continuity of care through structured postnatal follow-up protocols, including home visits or community-based tracking within the first six weeks.
3. The Ondo State Ministry of Health and Federal Ministry of Health should institutionalize partner-inclusive care policies, and integrate the RMC indicators into the regular quality-of-care monitoring frameworks. Increase health insurance coverage (e.g., by the Basic Health Care Provision Fund) to eliminate financial barriers, especially among rural and low-income women.
4. Introduce community sensitization to bring the expectations of women in line with the realistic service standards and empower them with health literacy. Engage men and families to promote supportive roles during the maternity continuum.
5. Long-term studies are needed to assess the impact of improved maternity experiences on care-seeking behaviors and maternal outcomes. Future studies need to be able to test targeted interventions (e.g., group antenatal care or mentorship programs on midwives) in a strong experimental design.

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