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ALIGNING EXPECTATIONS: A COMPARATIVE ANALYSIS OF PROVIDER AND CLIENT PERSPECTIVES ON RESPONSIBLE MATERNAL HEALTH SERVICES IN OKADA, EDO STATE

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ABSTRACT

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Responsible maternal health services (RMHS) depend on alignment between what providers deliver and what clients expect and experience, yet maternal health studies rarely assess both groups together in the same setting. This study compared provider and client perspectives on RMHS in Okada, Edo State, Nigeria. A descriptive cross-sectional study utilizing a mixed-methods (quantitative and qualitative) approach was conducted among 249 females of reproductive age (15–49 years), recruited by two-stage cluster sampling, and 43 health workers, recruited by census. Quantitative data were collected using structured questionnaires assessing knowledge and perception of RMHS; qualitative data were obtained through one focus group discussion, one in-depth interview, and one key informant interview. Good knowledge of RMHS was demonstrated by 217 (87.1%) of clients and 40 (93.0%) of providers, while positive perception was recorded among 223 (89.6%) of clients and 42 (97.7%) of providers. Despite these broadly favourable overall scores, alignment broke down on specific items: only 13 (30.2%) of providers agreed their facility had adequate staff and resources, while 68 (27.3%) of clients cited health worker attitude and 58 (23.3%) cited service quality as barriers to utilization. Providers markedly underestimated client awareness of facility-based delivery (provider mean = 2.44/5.0) relative to clients' self-reported 76.3% awareness of RMHS. Qualitative accounts corroborated these gaps: clients described long waiting times and discomfort with student involvement at the teaching hospital, while the key informant confirmed staffing shortages and drug stock-outs. Providers and clients converge on the value of RMHS and hold broadly positive attitudes toward it, but diverge sharply on facility readiness, respectful care, and client awareness, representing a modifiable expectation gap. Facility-level quality improvement initiatives that explicitly reconcile provider and client perspectives are recommended for Okada and comparable semi-urban Nigerian communities.

Keywords: *Client Perspective, Expectation Gap, Okada, Nigeria, Provider Perspective, Responsible Maternal Health Services.*

Introduction

Maternal mortality remains one of the most persistent global health challenges, with low- and middle-income countries accounting for the overwhelming majority of preventable maternal deaths (WHO, 2024). Responsible maternal health services (RMHS) antenatal, delivery, postnatal, and family planning care delivered in an accessible, respectful, and quality-assured manner sit at the centre of global and national strategies to reduce this burden (WHO, 2016). Nigeria's most recent Demographic and Health Survey confirms that a substantial proportion of births in the country continue to occur outside skilled facility care, underscoring the scale of the utilization gap that RMHS is intended to close (National Population Commission et al., 2024). Achieving the intended impact of RMHS depends not only on the knowledge and health-seeking behaviour of women, but equally on the readiness, attitudes, and self-assessed capacity of the health workers who deliver these services.

Much of the Nigerian maternal health literature has examined either the client side, focusing on women's knowledge, perception, and utilization of maternal health services, or the provider side, focusing on health worker knowledge and facility readiness, but rarely both simultaneously within the same community and study period. A comparative case study of tertiary and primary facilities in Cross River State demonstrated that provider-reported service availability and client-reported utilization patterns can diverge substantially even within the same catchment area, underscoring the value of studying both perspectives together rather than in isolation (Oluwole et al., 2025; Esienmoh et al., 2021).

Existing evidence suggests this expectation gap is not merely theoretical. A study of women's experiences of respectful maternity care in Benin City, Edo State, found that fewer than a third of postpartum women reported truly respectful treatment, even though providers in comparable settings frequently rate their own facilities' interpersonal care favourably (Ogboghodo et al., 2022). Similarly, a qualitative study of policymakers' and providers' perspectives on skilled pregnancy care in rural Nigeria identified staffing shortages, drug stock-outs, and structural constraints as barriers of which providers are acutely aware, but which are experienced by clients simply as poor or indifferent care (Udenigwe et al., 2021). Divergent perceptions between health system actors and the communities they serve have direct implications for facility trust and service utilization, particularly in communities where women retain the option of bypassing local facilities for perceived better care elsewhere.

Okada, a semi-urban community in Ovia North-East Local Government Area of Edo State, offers a distinctive setting in which to examine this alignment.

The community is served by a tertiary teaching hospital, the Igbinedion University Teaching Hospital (IUTH), alongside a primary health care centre, yet a pattern of facility bypassing toward external centres in Usen and Benin City has been observed. Whether this pattern reflects a genuine divergence between provider and client expectations, rather than simple unawareness or inaccessibility, requires directly juxtaposing both perspectives using comparable instruments applied within the same population and timeframe.

This manuscript therefore compares the knowledge, perception, and perceived barriers to RMHS between female clients of reproductive age and health workers providing maternal health services in Okada, Edo State. Specifically, it examines convergence and divergence across matched knowledge and perception domains, including facility adequacy, respectful care, and client awareness, and integrates qualitative accounts from both groups to characterize the nature of the expectation gap identified. The findings are intended to inform providers, facility administrators, and policymakers designing maternal health quality improvement strategies that are responsive to both sides of the care relationship.

Methodology

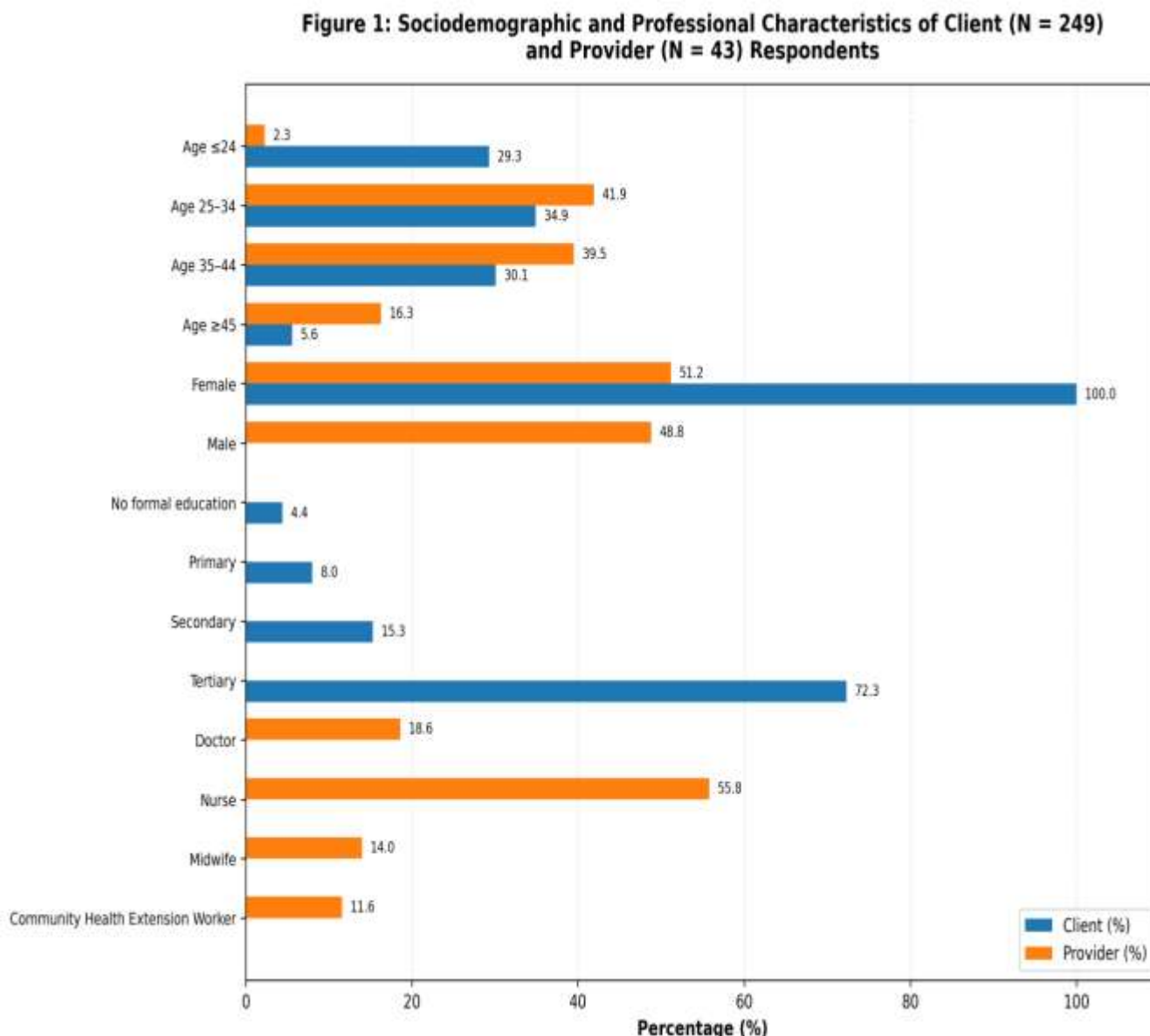
This manuscript draws on data from a descriptive cross-sectional study utilizing a mixed-methods (quantitative and qualitative) design, conducted in Okada, Ovia North-East Local Government Area, Edo State, Nigeria, between May 2025 and May 2026. Two study populations were recruited concurrently to enable direct comparison: females of reproductive age (15 - 49 years) residing in Okada, representing the client perspective, and health workers (doctors, nurses, midwives, and community health extension workers) providing maternal health services within Okada, representing the provider perspective. Clients were recruited using a two-stage cluster sampling technique; the client sample size was determined using the Cochran formula for cross-sectional proportion estimation, and of 277 questionnaires administered, 249 were validly completed and analysed (Cochran, 1977). Health workers were recruited via a census approach given the small, well-defined eligible population in Okada, yielding 43 respondents. Structured, interviewer-administered questionnaires assessed knowledge and perception of RMHS in both groups using parallel item domains. Qualitative data, comprising one focus group discussion and one in-depth interview with clients, and one key informant interview with an obstetric provider, were collected to contextualize and triangulate the quantitative findings. Knowledge was categorized as good using a $\geq 70\%$ correct-response cut-off, and perception was categorized as positive using a mean

Likert score of ≥ 3.0 on a five-point scale, applied consistently to both groups. Client and provider responses on comparable items are presented side by side to characterize points of alignment and divergence; because the two groups represent distinct populations recruited using different sampling frames, no formal

inferential statistical comparison between them was performed, and findings are presented descriptively.

Ethical approval was obtained from the Deputy Chairman Advisory Committee Ethics and Training Committee of Igbinedion University Teaching Hospital (IUTH), Okada (Reference: IUTH/R.24/VOL.I/199), and written informed consent was obtained from all participants.

Figure 1: Sociodemographic and Professional Characteristics of Client (N = 249) and Provider (N = 43) Respondents



Results

Table 1: Socio-demographic and Professional Characteristics of Client (N = 249) and Provider (N = 43) Respondents

Variable	Client n (%)	Provider n (%)
Age Group (years)		
≤24	73 (29.3)	1 (2.3)
25–34	87 (34.9)	18 (41.9)
35–44	75 (30.1)	17 (39.5)
≥45	14 (5.6)	7 (16.3)
Sex		
Female	249 (100.0)	22 (51.2)
Male	0 (0.0)	21 (48.8)
Client Education Level		
No formal education	11 (4.4)	
Primary	20 (8.0)	
Secondary	38 (15.3)	
Tertiary	180 (72.3)	
Provider Professional Qualification		
Doctor		8 (18.6)
Nurse		24 (55.8)
Midwife		6 (14.0)
Community Health Extension Worker		5 (11.6)

Client education and provider professional qualification are distinct, non-comparable categories, presented separately within the same table.

Table 2: Comparative Knowledge of RMHS among Client and Provider Respondents

Knowledge Domain	Client n (%)	Provider n (%)
Overall good knowledge (≥70% cutoff)	217/249 (87.1)	40/43 (93.0)
Recommended ≥8 ANC contacts	178/249 (71.5)	33/43 (76.7)
First-trimester ANC booking	197/249 (79.1)	33/43 (76.7)
IFA supplementation not taken weekly	71/249 (28.5)	29/43 (67.4)
Facility/skilled delivery recommended	194/249 (77.9)	36/43 (83.7)
Family planning integral to maternal care	211/249 (84.7)	36/43 (83.7)

See: Fig 2 & 3 below

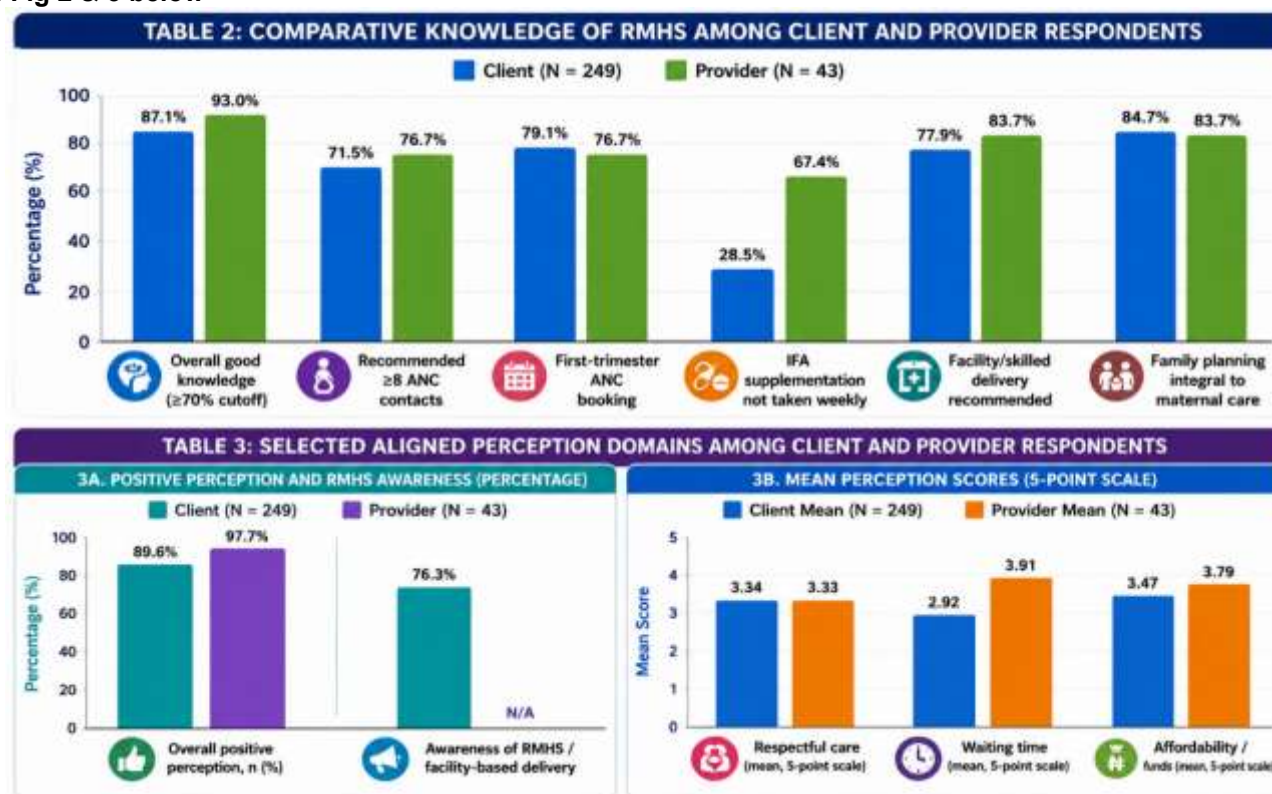


Table 3: Selected Aligned Perception Domains among Client and Provider Respondents

Perception Domain	Client	Provider
Overall positive perception, n (%)	223/249 (89.6)	42/43 (97.7)
Respectful care (mean, 5-point scale)	3.34	3.33
Awareness of RMHS / facility-based delivery	190/249 (76.3) aware	Mean rating = 2.44
Waiting time (mean, 5-point scale)	2.92	3.91
Affordability / funds (mean, 5-point scale)	3.47	3.79

Client items: "Health workers treat women respectfully"; "Waiting time at facilities usually short"; "Cost of MHS is affordable." Provider items: "Facility provides respectful and quality care"; "Most women aware of facility-based delivery"; "Long waiting times discourage women"; "Lack of funds is primary barrier to RMHS."

Fig: 4, showing the client-reported barriers, percentages, and corresponding provider data.

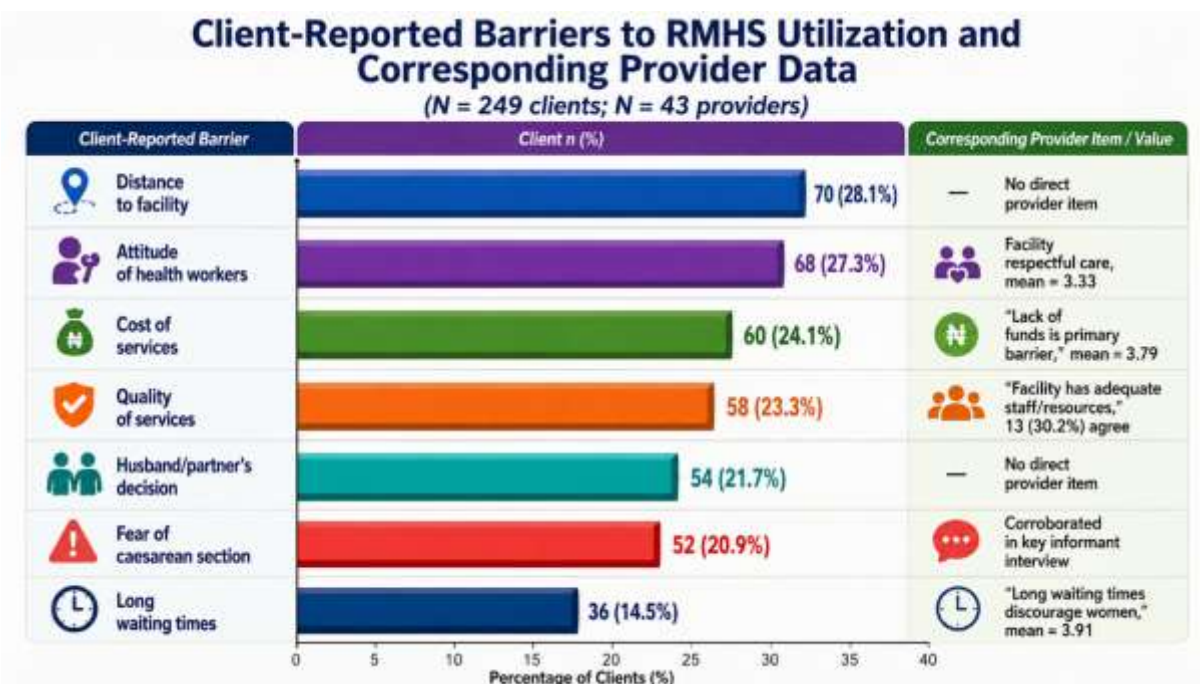


Table 4: Client-Reported Barriers to RMHS Utilization and Corresponding Provider Data (N = 249 clients; N = 43 providers)

Client-Reported Barrier	Client n (%)	Corresponding Provider Item / Value
Distance to facility	70 (28.1)	No direct provider item
Attitude of health workers	68 (27.3)	Facility respectful care, mean = 3.33
Cost of services	60 (24.1)	"Lack of funds is primary barrier," mean = 3.79
Quality of services	58 (23.3)	"Facility has adequate staff/resources," 13 (30.2%) agree
Husband/partner's decision	54 (21.7)	No direct provider item
Fear of caesarean section	52 (20.9)	Corroborated in key informant interview
Long waiting times	36 (14.5)	"Long waiting times discourage women," mean = 3.91

Distance to facility (70; 28.1%), attitude of health workers (68; 27.3%), cost of services (60; 24.1%), and quality of services (58; 23.3%) were the barriers to RMHS utilization most frequently cited by clients. Among providers, 13 (30.2%) agreed that their facility had adequate staff and resources, and 33 (76.7%) indicated a need for further RMHS training.

Qualitative Corroboration

The key informant, identified drug stock-outs of magnesium sulphate and oxytocin, inadequate 24-hour midwifery cover, and the absence of a formalized male

partner engagement programme as facility-level gaps. Three of five focus group discussion participants reported a preference for maternal health facilities outside Okada, citing waiting time and discomfort with student clinical involvement at the teaching hospital. The in-depth interview participant identified long waiting time at IUTH as a deterrent despite an otherwise positive overall care experience.

Discussion

Both clients and providers in Okada demonstrated high overall knowledge and predominantly positive perception of RMHS, a reassuring baseline that is broadly consistent

with national evidence that women's autonomy and awareness are foundational, but not sufficient, drivers of maternal healthcare utilization (Odusina et al., 2023). However, the convergence in aggregate scores masked sharp divergence on specific, actionable items, indicating that knowledge and general attitude alone are inadequate proxies for genuine alignment between what providers deliver and what clients experience. Facility administrators at IUTH and the Okada PHC should move beyond aggregate satisfaction metrics and adopt item-level, dual-sided monitoring, collecting matched provider and client responses on the same specific service dimensions, to detect this kind of divergence before it manifests as reduced utilization.

Respectful care was one of the few domains where client and provider ratings converged closely (client mean 3.34; provider mean 3.33), suggesting both groups share a broadly similar, moderately favourable assessment of interpersonal care quality. This convergence is notable given that respectful care deficits have been widely documented as a driver of facility avoidance in comparable Edo State settings (Ogboghodo et al., 2022). Nonetheless, a moderate score close to the midpoint of the scale, rather than a strongly positive one, still leaves meaningful room for improvement, and 27.3% of clients independently cited health worker attitude as a barrier to utilization, indicating that a subset of women experience interpersonal care far more negatively than the average score suggests. Mandatory respectful maternity care training, monitored through periodic patient exit interviews at IUTH and the Okada PHC, is recommended to close this residual gap and to specifically identify and support the minority of encounters driving negative attitude reports.

The clearest point of divergence was facility readiness: only 30.2% of providers agreed that their facility had adequate staff and resources, and more than three-quarters identified a need for further RMHS training, yet clients did not directly rate facility adequacy and instead expressed this gap indirectly through service-quality (23.3%) and cost-related (24.1%) barrier citations. This pattern, in which providers are more explicit about systemic resource constraints than clients, who instead experience these constraints as generalized dissatisfaction, mirrors a comparative case study of maternal, newborn, and child health service utilization across tertiary and primary facilities in Cross River State (Esienumoh et al., 2021). It suggests that clients in Okada may be attributing structural resource gaps, such as staffing shortages and drug stock-outs, to interpersonal or service-quality failings rather than recognizing them as health-system constraints beyond individual providers' control. The Edo State Ministry of Health and IUTH management should conduct a facility

readiness assessment addressing staffing, essential drug availability (including oxytocin and magnesium sulphate), and equipment, paired with client-facing communication that transparently explains resource constraints so that dissatisfaction is directed toward appropriate advocacy channels rather than eroding trust in individual providers.

Perhaps the starkest divergence identified in this study was providers' substantial underestimation of client awareness: providers rated client awareness of facility-based delivery at a mean of only 2.44 out of 5.0, while 76.3% of clients directly reported having heard of RMHS. This finding indicates that providers in Okada may be operating on an outdated or overly pessimistic assessment of community awareness, a mismatch documented in evaluations of healthcare worker density and its influence on maternal health service utilization patterns across sub-Saharan Africa, where provider perceptions of community engagement have been found to lag behind measured client knowledge (Rosser et al., 2022). If uncorrected, this misperception risks channelling health education resources toward broad general-awareness campaigns that Okada's population has, by and large, already absorbed, rather than toward the protocol-specific knowledge gaps, such as the iron/folic acid supplementation schedule, that both groups genuinely share. Health education efforts at IUTH and the Okada PHC should be redirected from general RMHS awareness messaging toward protocol-specific counselling content, informed by directly measured, rather than assumed, client knowledge levels.

Notably, the IFA supplementation knowledge gap was shared across both groups, with providers answering the item correctly more than twice as often as clients (67.4% versus 28.5%), indicating a systemic educational gap rather than a purely provider-side or client-side deficiency. This is consistent with the global evidence base identifying structured workforce training as among the most impactful health system strengthening interventions for reducing maternal mortality in low- and middle-income countries (Miranda et al., 2024). Because this specific gap is present in both populations, closing it will require synchronized intervention, updating provider training curricula on IFA supplementation guidance while simultaneously incorporating the same specific messaging into every antenatal counselling contact with clients. A structured RMHS competency development programme for health workers at IUTH and the Okada PHC, paired with standardized patient counselling scripts on IFA supplementation, danger sign recognition, and the eight-contact ANC schedule, is recommended as a single coordinated intervention rather than two separate initiatives.

Providers rated long waiting times and lack of funds as stronger barriers (means of 3.91 and 3.79, respectively)

than clients' own ratings of the equivalent facility experience items (waiting time mean 2.92; affordability mean 3.47) suggested. This pattern may reflect providers' first-hand awareness of system-level scheduling and resourcing pressures that are not always consciously attributed by clients to these specific causes, consistent with quality improvement literature identifying patient-centred process metrics, rather than provider assumption, as the more reliable guide to service redesign priorities (Karp et al., 2024). Facility-level quality improvement teams at IUTH and the Okada PHC should institute regular, structured patient experience audits, covering waiting time and perceived affordability specifically, to validate or recalibrate provider assumptions about which barriers most affect client utilization decisions.

The qualitative data reinforced and humanized these quantitative divergences. The key informant's account of drug stock-outs and staffing constraints corroborated the low provider-rated facility adequacy score, while client accounts of long waiting times and discomfort with student clinical involvement corroborated the moderate-to-unfavourable client ratings of the facility experience. This triangulation strengthens confidence that the identified gaps reflect genuine, mutually reinforcing perspectives rather than measurement artefacts, a pattern similarly reported in maternal health stakeholder analyses from Yobe State, where providers and community members converged on the overall value of maternal health services but diverged sharply on specific structural and interpersonal service dimensions (Iwu et al., 2024). These converging qualitative and quantitative findings support co-designed quality improvement interventions at IUTH, developed jointly with providers and community client representatives rather than through provider-only or client-only consultation processes.

The public health relevance of these findings extends beyond Okada. Edo State continues to report a disproportionate burden of maternal mortality within its tertiary health facilities, and satisfaction measurement across Nigerian maternal health studies has historically relied on client-only instruments, leaving the provider side of the alignment equation largely unmeasured (John-Abebe, 2024; Ope et al., 2025). This study demonstrates that a structured, dual-sided comparative approach is both feasible and informative even within a single semi-urban community, and can be replicated by facility quality improvement teams elsewhere in Edo State and similar settings as a low-cost diagnostic tool for distinguishing client dissatisfaction rooted in genuine health-system gaps that providers themselves already recognise from gaps in provider awareness of client experience.

Public Health Implications and Recommendations

The findings of this comparative analysis demand a paradigm shift in how maternal health education and facility management are approached.

1. **Transition to Joint, Protocol-Specific Education:** Facility managers must abandon generic, one-size-fits-all health talks. Providers should be trained to assess individual client knowledge before delivering education, transitioning to targeted, interactive counselling that addresses specific, shared knowledge gaps (e.g., IFA supplementation protocols and pre-eclampsia danger signs).
2. **Address Systemic Stressors to Improve Provider Mindset:** The systemic stress that biases provider perceptions must be alleviated. By addressing critical gaps in essential drug availability, staffing, and 24-hour coverage, health facilities can reduce provider burnout and compassion fatigue, fostering a more collaborative, empathetic and trust-based provider-client dynamic.
3. **Implement Bidirectional Feedback Mechanisms:** Facilities should establish routine, anonymous patient-exit surveys and joint provider-client town hall meetings. This will help dismantle the "deficit model" assumption, allowing providers to see the actual baseline knowledge of their clients and enabling clients to voice their specific needs without fear of reprisal.

Limitation

This study has several limitations. The cross-sectional design prevents the determination of whether the perception gap directly causes poor utilization or is merely correlated with it. The measurement of the perception gap relied on aggregate, self-reported Likert-scale scores rather than direct, observational analysis of actual patient-provider clinical interactions, which may not fully capture real-time communication dynamics. Additionally, both health workers and clients may have been subject to social desirability bias, potentially leading health workers to overestimate their own clinical knowledge and clients to overreport their adherence to health advice.

Conclusion

Clients and providers in Okada converge on high overall knowledge and predominantly positive perception of responsible maternal health services, but diverge sharply on facility readiness, client awareness, and the practical experience of waiting time and cost, reflecting a modifiable expectation gap rather than a rejection of RMHS by either group. Closing this gap requires coordinated, dual-sided intervention: an urgent facility

readiness assessment addressing staffing and essential drug supply, synchronized provider–client education on shared knowledge gaps such as iron/folic acid supplementation, and structured patient experience audits, rather than programmes designed from either perspective alone. Facility administrators at IUTH and the Okada Primary Health Care Centre should institutionalize regular, matched provider–client experience monitoring as a standard quality improvement tool. Only by reconciling what providers believe they deliver with what clients actually experience can Okada convert its favourable knowledge and attitude base into meaningfully improved RMHS utilization.

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