# Women's Satisfaction regarding Care in the Delivery Room

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## Abstract

Background: Women's satisfaction has been examined in relation to a number of care-related dimensions. First satisfaction items have been linked to interpersonal factors like opportunities for active participation in labor and delivery, including the ability to choose between options, decide when certain actions will be taken, and receive information about the reasons behind those decisions. Aim of the study: To assess women's satisfaction regarding care in the delivery room. Methods: Descriptive research design carried out to evaluate the women's satisfaction regarding care in the delivery room begin from (14. January to 18. May. 2018). Current study sample involve (100) women in the post delivery room. Questionnaire used for data collection by interview forms was obtain from the extensive review of relevant literature and related studies. Results: The current study showed that women satisfaction overall responses were good at the interpersonal care domain, fair at the information and decision making domain, and poor at the physical birth environment domain. Conclusion: based on the finding of present study the overall assessment for the women satisfaction regarding care in the delivery room was poor. Recommendations: Midwives' practices are being updated through ongoing in-service training programs and the provision of courses teaching them about the medical care that should be provided before, during, and after childbirth. The ministry of health conducts routine inspections and follow-ups to ensure good midwifery care practices and that women are satisfied with the care provided in the delivery room and birth environment.

Keywords: Women's Satisfaction, care, delivery room.

## 1. Introduction

The caliber of intrapartum care is frequently linked to women's happiness with maternity services since the nature of the support provided throughout labor and childbirth is indicative of a happy birth experience. (Abdel and Berggren, 2011).
The satisfaction and experience of the women are a crucial component of the quality of maternity care. [Pittrof, et al,. 2009]. A broad and multifaceted notion, satisfaction encompasses the structure, process, and result of treatment. (Redshaw, et al, 2008) (Green and Baston, 2013)
Researchers' interest in reproductive health increased after the 1994 International Conference on Population and Development to include satisfaction with maternal and reproductive health care. (Alden, and Bhawuk, 2004). The World Health Organization (WHO) encourages competent presence at every delivery to lower maternal mortality and suggests gauging women's satisfaction to raise the standard and efficacy of medical care. (WHO, 2014). WHO stresses patient satisfaction as a supplementary method of preventing maternal mortality since contented women may be more inclined to follow medical professionals' advice. (WHO, 2014).
Women's satisfaction has been examined in relation to a number of care-related dimensions. First satisfaction items have been linked to interpersonal factors like opportunities for active participation in labor and delivery, including the ability to choose between options, decide when certain actions will be taken, and receive information about the reasons behind those decisions. (Rudman et al., 2007).
The results of childbirth and the pleasure of women are said to be improved by perceptions of support from caregivers during labor. (Hodnett et al., 2009).
Second, the provision of information and involvement in decision-making have been connected to women's satisfaction with intrapartum care. (Dencker et al., 2010). Procedures may influence how satisfied women feel. Satisfaction with intrapartum treatment might be negatively impacted by situations including surgical birth, a protracted and hard labor, inadequate pain relief, more obstetric procedures, and transferring the baby to a neonatal unit. (Hatamleh et al., 2013)
The third factor is the physical environment, which affects staff morale, effectiveness of care, and health and safety. (Fouveur et al., 2010).
In most developing nations, efforts have been made to provide a more comfortable, less clinical environment for labor and delivery. (Sheehy et al., 2014).
Physical environment plays a key role in predicting how satisfied and happy women are with their overall labor and delivery experiences. (Fouveur et al., 2010).
It is crucial to acknowledge that in recent years, there has been a lot of press about women's displeasure with maternity services. The reasons for this discontent include the feeling that caregivers are

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unhelpful, the lack of continuity of care, the lack of power and participation in decision-making, and the lack of knowledge. The kind and caliber of information are just two factors in the complex evaluation of care given to women during childbirth. the presence of a trusting relationship with midwives, a sense of control over care and the birthing process (Amdemichael, et al,. 2014).

the importance of women's happiness with midwifery treatment to healthcare professionals, administrators, and decision-makers in the field of health (Rudman et al., 2007).

It is critical to examine maternal satisfaction and its causes at a time when international efforts to reduce maternal mortality have intensified. Evidence on women's perceptions of and satisfaction with the quality of midwifery care assists in identifying other areas of care in developing country contexts that need strengthening to support long-term demand, produce significant changes in maternal care-seeking behavior, and identify barriers that can and should be removed. (Redshaw, et al,. 2008).

It has been demonstrated that a woman's pleasure with the birthing process affects her relationship with her child, her self-esteem and self-image, and her expectations for future pregnancies. (Reisz, et al., 2015).

At the end improvement of midwifery care and arriving to high level of women satisfaction (Abdel and Berggren, 2011).

## 2. Methodology

1. Study design: To achieve the study's goal, a descriptive study is used.
2. Setting: The current study is being conducted in the AL-Zahra Teaching Hospital in Al-Najaf Al-Ashraf, Iraq.
3. Sampling: Non – probability purposive sample that include (100) women in the post delivery room at Al-Zahra teaching hospital.
4. Questionnaire of study: The data collected by using questionnaire was obtaining from the extensive review of relevant literature and related studies).

Maternity Services Satisfaction Survey (M.H.2014) the questionnaire divided in to three parts:

### Part I: Demographic characteristic

"Age, marital status, educational level, Place of residence, Occupation".

**Part II:** That concerned Pregnancy and Delivery Characteristics which are; "Parity, Type of delivery, Gestational age, Labor/Delivery Support, Health care Provider at Delivery, Duration of Labor (Hours), Episiotomy, Obstetric Interventions and Pain management".

**Part III:** This part comprises (24) items; that concerned Interview questions regarding Women's satisfaction, which are sub- divided as the following:

**Section one:** This section includes (11) items which contains Interpersonal care.

**Section two:** This section includes (7) items which contains Information and decision-making.

**Section three:** This section includes (6) items which contains physical birth environment.

### Data collection

Utilizing a specially designed questionnaire, data were gathered through direct interviews with women who were admitted to the post-delivery room following labor and delivery. However, each interview took an average of fifteen to forty-five minutes for each woman. However, data collection began on April 2 and continued through April 30, 2018.

### Validity

questionnaire given to (9) experts in the field who had at least ten years of experience was used to determine the validity. To achieve the study's goals, the logical corrections and suggestions were taken into account.

## 3. Results of Study

Table 1: Demographic Characteristics of the Study Sample. N=100

| Demographic Characteristics | Groups | Frequency | Percent |
|---|---|---|---|
| Age of women | Less than 20 years | 23 | 23.0 |
| | From 20 – 29 years | 49 | 49.0 |
| | More than 30 | 28 | 28.0 |
| | Total | 100 | 100.0 |
| | Mean ± SD 24.86 ± 5.16 | | |
| Educational level | Illiterate | 18 | 18.0 |
| | able to read and write | 11 | 11.0 |
| | Primary education | 25 | 25.0 |
| | Secondary education | 32 | 32.0 |
| | Professional studies diploma or Bachelor's Degree | 13 | 13.0 |
| | Master or Doctorate degree | 1 | 1.0 |
| | Total | 100 | 100.0 |
| Martial status | Married/Living with Partner | 98 | 98.0 |
| | Other | 2 | 2.0 |
| | Total | 100 | 100.0 |
| Place of residence | Urban | 75 | 75.0 |
| | Rural | 25 | 25.0 |
| | Total | 100 | 100.0 |
| Occupation | Housewife | 88 | 88.0 |
| | Employee | 12 | 12.0 |
| | Total | 100 | 100.0 |

Table (1) this table showed the majority of the study sample was women within 20 – 29 years (49.0%), with mean and standard deviation equal to 24.86 ± 5.16. Concerning educational level, the results showed that most of the study samples were Secondary education (32.0%). the majority of the study sample marital status at married/living with Partner was (98.0%). Moreover, the place of residence (75.0%) of them were living urban areas. Regarding the occupation, the results showed that most of the study sample was housewife (88.0%).

Table2: Distribution of Study Sample by their Pregnancy and Delivery Characteristics:

| Pregnancy and Delivery Characteristics | Groups | Frequency | Percent |
|---|---|---|---|
| Parity | Primigravida | 43 | 43.0 |
| | Multigravida | 57 | 57.0 |
| | Total | 100 | 100.0 |
| Type of delivery | Spontaneous vaginal delivery | 54 | 54.0 |
| | Artificial delivery | 46 | 46.0 |
| | Total | 100 | 100.0 |
| Gestational age | Pre-term (<37 weeks) | 10 | 10.0 |
| | Full-term (37-40 weeks) | 68 | 68.0 |
| | Post-term (>40 weeks) | 22 | 22.0 |
| | Total | 100 | 100.0 |
| Labor Delivery Support | Partner | 42 | 42.0 |
| | Parent / family of mother or partner | 52 | 52.0 |
| | Health care Staff only | 6 | 6.0 |
| | Total | 100 | 100.0 |
| Health care Provider atDelivery | Midwife | 95 | 95.0 |
| | Nurse | 5 | 5.0 |
| | Total | 100 | 100.0 |
| Duration of Labor | Less than 6 hours | 56 | 56.0 |
| | From 7-10 hours | 33 | 33.0 |
| | From 11 - 15 hours | 6 | 6.0 |
| | More than 16 hours | 5 | 5.0 |
| | Total | 100 | 100.0 |
| Episiotomy | Yes | 48 | 48.0 |
| | None | 52 | 52.0 |
| | Total | 100 | 100.0 |
| Obstetric Interventions | Labor Induced with Pitocin | 83 | 83.0 |
| | Artificial Rupture of Membranes | 17 | 17.0 |
| | Total | 100 | 100.0 |
| Pain management | Intravenous (IV) Medication Only | 39 | 39.0 |
| | Intravenous Medication + epidural | 2 | 2.0 |
| | None | 59 | 59.0 |
| | Total | 100 | 100.0 |

Table (2) this table showed of the study samples number of Parity at multigravida were (57.0%), in regard to the number of Type of delivery, the higher percentage (54.0%) of the spontaneous vaginal delivery. Relative to the number Gestational age, most of the study subjects (68.0%) were Full-term (37-40 weeks). Concerning labor delivery support, the results showed that the majority of the study parent / family of mother or partner (52.0%). However, most of the study sample with regard to their Health Care Provider at delivery at midwife, the results indicate that the highest percentage is (95%). Regarding the Duration of Labor, the results showed that most of the study sample was Less than 6 hours (56.0%). The episiotomy was none (52.0%), obstetric interventions at labor induced with Pitocin were (83.0%), and pain management (59.0%) of them was none.

Table 4: Overall Assessment of the Women Satisfaction Regarding Care in theDelivery Room: -

| Women Satisfaction Regarding Care in the Delivery Room Domains | Rating | F. | P. % | M.S | S.D | Chi-Square | | | | Asse. |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | $\chi^2$ | d.f | P- value | Sig. | |
| InterpersonalCare | Good | 36 | 36.0 | 2.17 | 0.72 | 10.46 0 | 2 | 0.005 | H. S | Good |
| | Fair | 45 | 45.0 | | | | | | | |
| | Poor | 19 | 19.0 | | | | | | | |
| Information andDecision Making | Good | 43 | 43.0 | 2.15 | 0.83 | 4.220 | 2 | 0.02 | S | Fair |
| | Fair | 29 | 29.0 | | | | | | | |
| | Poor | 28 | 28.0 | | | | | | | |
| Physical BirthEnvironment | Good | 34 | 34.0 | 2.01 | 0.82 | 0.020 | 2 | 0.990 | N. S | Poor |
| | Fair | 33 | 33.0 | | | | | | | |
| | Poor | 33 | 33.0 | | | | | | | |
| Overall Assessment | Good | 33 | 34.0 | 1.98 | 0.79 | 0.011 | 2 | 0.890 | N. S | Poor |
| | Fair | 33 | 33.0 | | | | | | | |
| | Poor | 34 | 33.0 | | | | | | | |

Table (4) According to this table, overall satisfaction among women was high in the area of interpersonal care, fair in the area of information and decision-making, and low in the area of the physical birth environment. Additionally, there was a poor overall

evaluation of the women's happiness with the treatment they received in the delivery room.

| Table 4.5: Relationship between the sample demographics and their assessment of the women's satisfaction with the care received in the delivery room: - | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Demographic Characteristics | Groups | Overall Assessment | | | Chi-Square | | | |
| | | Poor | Fair | Good | χ2 | d.f | P-value | Sig. |
| Age of women | Less than 20 years | 10 | 7 | 6 | 2.263 | 4 | 0.220 | N.S |
| | From 20 – 29 years | 15 | 15 | 19 | | | | |
| | More than 30 | 8 | 11 | 9 | | | | |
| Educationallevel | Illiterate | 7 | 6 | 5 | 32.745 | 10 | 0.000 | H.S |
| | able to read and write | 3 | 3 | 5 | | | | |
| | Primary education | 7 | 10 | 8 | | | | |
| | Secondary education | 11 | 8 | 13 | | | | |
| | Professional studies diploma or bachelor's degree | 5 | 6 | 2 | | | | |
| | Master or Doctoratedegree | 0 | 0 | 1 | | | | |
| Martial status | Married/Living withPartner | 32 | 33 | 33 | 1.006 | 2 | 0.657 | N.S |
| | Other | 1 | 0 | 1 | | | | |
| Place of residence | Urban | 26 | 23 | 26 | 0.787 | 2 | 0.001 | H.S |
| | Rural | 7 | 10 | 8 | | | | |
| Occupationstatus | Housewife | 29 | 29 | 30 | 0.003 | 2 | 0.005 | S |
| | Employee | 4 | 4 | 4 | | | | |

Table (5) This table demonstrated a significant relationship between the overall satisfaction of women with the care they received in the delivery room and their education level, place of residence, occupation status, and age. However, there was no significant relationship with their marital status or marital status at a p-value of more than 0.05.

| Table 6: Association between the Pregnancy and Delivery Characteristics with their Overall Assessment of the Women Satisfaction Regarding Care in the Delivery Room:- | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Pregnancy and Delivery Characteristics | Groups | Overall Assessment | | | Chi-Square | | | |
| | | Poor | Fair | Good | χ2 | d.f | P-value | Sig. |
| Parity | Primigravida | 14 | 13 | 16 | 0.408 | 2 | 0.03 | S |
| | Multigravida | 19 | 20 | 18 | | | | |
| Type of delivery | Spontaneous vaginaldelivery | 14 | 20 | 20 | 2.678 | 2 | 0.117 | N. S |
| | Artificial delivery | 19 | 13 | 14 | | | | |
| Gestational age | Pre-term (<37 weeks) | 4 | 4 | 2 | 21.163 | 4 | 0.000 | H. S |
| | Full-term (37-40 weeks) | 24 | 21 | 23 | | | | |
| | Post-term (>40 weeks) | 5 | 8 | 9 | | | | |
| Labor Delivery Support | Partner | 15 | 13 | 14 | 11.639 | 4 | 0.02 | S |
| | Parent / family ofmother or partner | 15 | 19 | 18 | | | | |
| | Health care Staff only | 3 | 1 | 2 | | | | |
| Health care Provider at Delivery | Midwife | 28 | 33 | 34 | 10.686 | 2 | 0.004 | H. S |
| | Nurse | 5 | 0 | 0 | | | | |
| Duration of Labor | Less than 6 hours | 18 | 19 | 19 | 4.004 | 6 | 0.281 | N. S |
| | From 7-10 hours | 12 | 11 | 10 | | | | |
| | From 11 - 15 hours | 3 | 1 | 2 | | | | |
| | More than 16 hours | 0 | 2 | 3 | | | | |
| Episiotomy | Yes | 17 | 14 | 17 | .629 | 2 | 0.496 | N. S |
| | None | 16 | 19 | 17 | | | | |
| Obstetric Interventions | Labor Induced withPitocin | 27 | 26 | 30 | 21.108 | 2 | 0.01 | H. S |
| | Artificial Rupture ofMembranes | 6 | 7 | 4 | | | | |
| Pain management | Intravenous (IV)Medication Only | 17 | 5 | 17 | 14.529 | 4 | 0.02 | S |
| | Intravenous Medication + epidural | 0 | 2 | 0 | | | | |
| | None | 16 | 26 | 17 | | | | |

Table (6) This table demonstrated a significant association between the overall level of women's satisfaction with care in the delivery room and their (gestational age, healthcare provider at delivery, obstetric interventions), a significant association between these variables and parity, labor delivery support, and pain management, and a non-significant association between these variables and their (method of delivery, length of labor, and episiotomy) at a p-value greater than 0.05

## 4. Discussion

### Part 1: Discussion of Demographic Characteristics

In the present study, women between the ages of 20 and 29 made up the majority of the study sample (49.0%). This finding is consistent with research done at the University of Nairobi by Zachariah (2012), who found that the majority of his study group was between the ages of (20-29) years old.

The results of the current study showed that the majority of the study sample was married (98.0%), and the majority was a housewife (88.0%). Natalie R. Stevens (2011) also supported that the majority of participants were married (94.5%).The present study had also revealed that most of the study samples were Secondary education (32.0%) This result agrees with studies conducted in University of Nairobi by Zachariah (2012) reported that most of their study sample were Secondary education (30,0%).

### Part 2: Distribution of the Study Sample by their Pregnancyand Delivery Characteristics

The study indicates that the study samples number

of Parity at multigravida were (57.0%), Concerning the number of type of delivery, the higher percentage (54.0%) of the spontaneous vaginal delivery. Relative to the number gestational age, most of the study subjects (68.0%) were full-term (37-40 weeks). Concerning labor delivery support, the results showed that the majority of the study parent / family of mother or partner (52.0%). The study by Marie et al., which was conducted in Canada in 2014, supports these findings.However, most of the study sample with regard to their Health Care Provider at delivery at midwife, the results indicate that the highest percentage is (95%). Regarding the duration of labor, the results showed that most of the study sample was Less than 6 hours (56.0%). Episiotomy was none (52.0%), obstetricinterventions at labor induced with Pitocin were (83.0%), and pain management (59.0%) of them was none. These results supported by the study of Natalie that conducted in Ireland at 2015.

### Part 3: Overall Assessment of the Women Satisfaction RegardingCare in the Delivery Room:

The study indicate that women satisfaction overall responses were good at the interpersonal care domain, poor at the physical birth environment domain fair at the information and decision-making domain. This results agree with study conducted by Yuba R. in Nepal (2015) stated that the skill of service providers received the highest mean satisfaction score, while facility cleanliness and decision-making received the lowest. Furthermore, the overall assessment for the women satisfaction regarding midwifery care in the delivery room was poor. This result agrees with Hundley study that conducted in Aberdeen Maternity Hospital, Grampian at 2010.

### Part 4-A: Association between the Samples Demographical Characteristics with their Overall Assessment of the Women Satisfaction Regarding Care in the Delivery Room

The study found a significant relationship between women's overall satisfaction with midwifery care in the delivery room and their education level and place of residence (at p-values less than 0.01), occupation status (at p-values less than 0.05), and occupation (at p-values less than 0.05). However, there was no significant relationship with women's age and marital status (at p-values more than 0.05). These findings supported with study conducted in Ethiopia by Tadele M, et al., in 2014.

### Part 4-B: Association between the Pregnancy and Delivery Characteristics with their Overall Assessment of the Women Satisfaction Regarding Care in the Delivery Room:

The results of the study revealed a highly significant correlation (p-value less than 0.01) between the overall satisfaction of women with midwifery treatment in the delivery room and their (gestational age, healthcare provider at birth, and obstetric interventions). In addition, there was no significant correlation with their (kind of delivery, length of labor, episiotomy) at p-values greater than 0.05. There was a significant (parity, labor delivery support, pain management) at p-values less than 0.05. These findings supported with study conducted in Northwest Ethiopia by Kurabachew B, et al., in 2015.

## 5. Conclusion

### According to the study's findings, it can be said that:

1. 1-Women's satisfaction toward care in the delivery room is poor. 2-Women's satisfaction are good regarding interpersonal care.
2. Fair Women's satisfaction at the information and decision- making, and poor satisfaction regarding the physical birth environment.
3. There is association between women's satisfaction and their educational level, place of residence, gestational age, health care provider at delivery and obstetric interventions

There is a significant association between women's satisfaction with their occupation status, parity, and labor delivery support and pain management.

There is no-significant association between women's satisfaction with their age of women, marital status, type of delivery, duration of labor, episiotomy.

## 6. Recommendations

- According to the current study, the Iraqi Ministry of Health must enhance midwifery services in the delivery room by:Additional concern must give to the labor rooms to improve the work environment.

1. Updating practice of midwives through continuing in-service educational programs and providing training programs for midwifes about health care that should be given during labor and childbirth and at regular intervals.
2. Consistent monitoring and inspection of the physical birth environment by the ministry of health.
3. Emphasizing on the importance of providing information about labor and childbirth to the pregnant women at all health facilities and provide training program for health care provider about respect, dealing with decision- making of pregnant women.
4. 7-Further studies must have done about women's satisfaction in the delivery room in middle Euphrates hospitals in al- Iraq.

## References

Abdel. R and Berggren V, “Parturient needs during labor: Egyptian women's perspective toward childbirth experience, a step toward excellence in clinical practice,” Journal of Basic and Applied Scientific Research, vol. 1, no. 12, pp. 2935–2943,

2011.
Alden DL, Do MH, Bhawuk D. Client satisfaction with reproductive health-care quality: integrating business approaches to modeling and measurement, Soc Sci Med , 2014, vol. 591(pg. 2219-32).
Amdemichael R, Tafa M, and Fekadu H, "Maternal satisfaction with the delivery services in Assela Hospital, Arsi Zone, Oromia Region, Ethiopia, 2013," Obstetrics & Gynecology (Sunnyvale), vol. 4, article 257, 2014.
Green J and Baston A, "Feeling in control during labor: concepts, correlates, and consequences,"Birth, vol. 30, no. 4, pp. 235–247, 2013.
Green M and Baston H, "Feeling in control during labor: concepts, correlates, and consequences,"Birth, vol. 30, no. 4, pp. 235–247, 2003.
Hodnett ED, Gates S, Hofmeyr GJ, Sakala C. Continuous support for women during childbirth. Cochrane Database Syst Rev. 2007;(3)CD003766
Kurabachew B, Mekonnen A, and Kedir Y; Maternal Satisfaction on Delivery Service and Its Associated Factors among Mothers Who Gave Birth in Public Health Facilities of Debre Markos Town, Northwest Ethiopia, Published online 2015 Aug 10. doi: 10.1155/2015/460767
Marie. N, Bélanger. L, Marilou. P, Naomé. R, Simon. B, and Jean.C; Maternal and paternal satisfaction in the delivery room: a cross-sectional comparative study, Published online 2014 Feb 22. doi: 10.1136/bmjopen-2013-004013.
Natalie. R, Perceived Control and Maternal Satisfaction with the Childbirth Experience, University of Kansas, April 7, 2011.
Pittrof. R,Campbell. O, and Filippi. A, "What is quality in maternity care? An international perspective," Acta Obstetricia et Gynecologica Scandinavica, vol. 81, no. 4, pp. 277–283, 2009.
Redshaw M, "Women as consumers of maternity care: measuring 'satisfaction' or 'dissatisfaction'?"Birth, vol. 35, no. 1, pp. 73–76, 2008.
Reisz S, Jacobvitz D, George C. Birth and motherhood: childbirth experience and mothers' perceptions of themselves and their babies. Infant Ment Health J. 2015;36(2):167–178
Tadele M, Yirgu G, Daniel Band Dereje H; Assessment of client satisfaction in labor and delivery services at a maternity referral hospital in Ethiopia, Published online 2014 Jan 31. doi: 10.11604/pamj.2014.17.76.3189.
WHO. Media Center, Maternal mortality Fact sheet N°348, 2014
Yuba R, Suresh M, Deepak P, Maureen D, Krishna K, Pradeep P, Stuart K, and Sarah B; Women's Satisfaction of Maternity Care in Nepal and Its Correlation with Intended Future Utilization, Nepal Health Research Council, Ministry of Health.
Zachariah. K; influence of intrapartum care on women's satisfaction with child birth in public hospitals in kenya: a case of kisii level five hospital, kisii county, University of Nairobi, 2012.