Women's Satisfaction with Hospital-Based Intrapartum Care and Determinants: Insights from a Private Health Facility in Abuja, Nigeria

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ABSTRACT

Background: Positive childbirth experiences extend beyond favourable maternal and neonatal outcomes to include respectful care, effective communication, psychosocial support, autonomy and adequate pain management. However, evidence on factors associated with women's satisfaction with intrapartum care in Nigeria remains limited. This study assessed women's satisfaction with hospital-based intrapartum care and explored factors influencing their childbirth experiences in a private health facility in Abuja, Nigeria.

Methods: A mixed-methods descriptive cross-sectional study was conducted at Nisa Premier Hospital, Abuja, between February and June 2021. A total of 216 women who had vaginal or emergency Caesarean deliveries were assessed using a structured questionnaire, while 16 participants underwent in-depth interviews. Quantitative data were analysed using descriptive statistics, chi-square tests and logistic regression. Satisfaction was assessed across five dimensions: psychosocial support, effective communication, pain management, hospital facilities and workforce, and newborn care. Qualitative data were analysed thematically using ATLAS.ti.

Results: Of the 216 women assessed for overall satisfaction, 203 (94.4%) reported a satisfactory childbirth experience. However, assessment across the five predefined dimensions classified 117 (54.1%) of the 216 participants as satisfied. Satisfaction was highest for newborn care (51.4%) and effective communication (38.4%), while psychosocial support and pain management recorded the lowest satisfaction levels (21.8% each). In multivariable analysis, lack of coordinated pain management (AOR 6.29, 95% CI: 1.16–33.93), perceived inadequate pain control (AOR 18.24, 95% CI: 1.62–205.82), and public/private sector employment (AOR 5.48, 95% CI: 1.30–23.05) were associated with higher odds of dissatisfaction. Qualitative findings highlighted the importance of autonomy, psychosocial support, communication, respectful care, pain management, facility readiness and newborn outcomes in shaping women's childbirth experiences.

Conclusion: Although most women reported satisfactory overall childbirth experiences, substantial dissatisfaction was identified across specific dimensions of intrapartum care, particularly psychosocial support and pain management. Promoting freedom of movement and appropriate oral intake during labour, strengthening coordinated pain management, and ensuring respectful, participatory communication may

improve women's experiences of childbirth. Assessing satisfaction across specific dimensions may provide a more informative measure of intrapartum care quality than relying solely on a single global satisfaction question.

Keywords: Patient satisfaction, Intrapartum care, Childbirth experience, Respectful maternity care, Maternal health services, Nigeria.

INTRODUCTION

The birth process is perhaps the most remarkable event in the reproductive life of a woman. It is preceded with anxiety and expectations culminating in birth fantasies or life-long bitter experiences. Contemporary obstetric care aim to provide a childbirth experience that is positive and satisfactory, safe and ideal for the mother and baby.[1,2]

Undesirable pregnancy outcome results in negative birth experience or dissatisfaction. This could affect the emotional wellbeing of a woman and her desire to go through the childbirth process again. It is associated with disorders of breastfeeding, low self-esteem, a prolong memory of pains and posttraumatic stress disorders and lower quality of life.[3] Studies have reported such experiences to result in increased request for Caesarean delivery in subsequent pregnancies and is likely to result in the overall compromise in the wellbeing and mental health of the women and their infants.[4]

However, the United Nations global strategy for women's, children' and adolescents on transformational healthcare is focused not only on successful child birth and proper management of complications but also that the women may thrive and reach their full potential for quality health and life.[5] It is a vision driven by the WHO for high quality healthcare for pregnant women and their newborn through the course of pregnancy, child birth and postnatal period. This is the WHO emphasis of the concept of positive birth experience.[6,7]It is therefore a paradigm shift in the outcome of birth processes which is focused on respectful and dignified maternal care, enhanced women participation in the birth process, access to information and freedom of choice beyond a healthy mother and child at delivery irrespective of interventions.[8] The WHO described a positive birth experience as one with an outcome of a healthy baby in a clinically and psychologically safe setting with continuous emotional support from care givers with demonstrable technical competence.[6,7]

Despite the increasing global shift on the instruments of measurement of outcome of labor, most studies in the sub-Sahara African countries like Nigeria are largely focused on the availability of skilled birth attendance and the level of medicalization of the labor process. Several other published studies in Nigeria were largely focused on the events of antenatal period.[9, 10, 11]There is consequently a paucity of published studies on the contemporary social and psychological determinants of women's satisfaction in intrapartum care. With the increase in incidence of litigations arising from obstetric practices in Nigeria, a good understanding of what matters to women in labor will aid in stemming the trend of such cases.

It is believed that outcome of this study will bring about increased awareness in women's satisfaction in the events of labor resulting in positive birth experience in the African sub region. This will enhance the empowerment of our women in the reproductive age, further improvement in antenatal care attendance and facility-based delivery with their attendant reproductive health benefits

METHODOLOGY

Study Area

This study was conducted at Nisa Premier Hospital, Jabi, Abuja, Nigeria. Nisa Premier Hospital is a privately owned multispecialty hospital providing a range of medical and surgical services, including obstetric and gynaecological care. The hospital provides antenatal, intrapartum and postnatal services and has dedicated labour and theatre facilities for obstetric care. The hospital records approximately 45–70 labour cases monthly, with about 45–63 vaginal deliveries per month during the study period.

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Study Design

A descriptive cross-sectional study design with a qualitative component. (Mixed methods study). It was a questionnaire-based exit interview on 216 consecutive women and in-depth interview on 16 randomly selected women among the respondents who have met the inclusion criteria for this study.

Study Duration

The questionnaire-based study and in-depth interview was carried out over a 5-month period between February 2021 and June 2021.

Study Population

Women who presented in spontaneous active phase of labor or induction of labor, having met the inclusion criteria and eventually had successful vagina or emergency Caesarean delivery.

Inclusion Criteria

Participants were consenting women aged 15–45 years who had uncomplicated deliveries and were clinically stable during the postpartum period before discharge.

Exclusion Criteria

Women who were seriously ill, had babies requiring neonatal unit admission, experienced fetal anomalies or neonatal death, or presented in advanced second stage and delivered immediately after arrival at the facility were excluded.

Data Collection

Data were collected using a structured questionnaire and in-depth interviews. The questionnaire was developed following a review of relevant literature, expert opinion and adaptation of the WHO recommendations on intrapartum care. It was pretested among 10 women to assess clarity, comprehensibility and face validity, following which minor modifications were made. Questionnaire administration was undertaken during the stable postpartum period before discharge. Participants completed the questionnaires privately, with assistance from trained research assistants where required, particularly for respondents with limited formal education or those requiring language interpretation. The study procedures were designed to provide participants with an opportunity to express their experiences of care without the direct involvement of the healthcare workers responsible for their clinical management.

The questionnaire comprised three sections. Section A collected sociodemographic and obstetric characteristics, including age, parity, ethnicity, marital status, religion, social class, labour process and mode of delivery. Section B assessed determinants of childbirth experience, while Section C assessed overall experience and delivery outcomes. Women's satisfaction was assessed across five dimensions: psychosocial support, effective communication, pain management, hospital facilities and workforce, and condition and care of the newborn. The instrument comprised 18 items rated on a five-point Likert scale. Internal consistency was assessed using Cronbach's alpha, yielding a reliability coefficient of 0.702. A composite satisfaction score was calculated from the 18 items, with a predefined cut-off score of 75 used to classify respondents as satisfied or dissatisfied. Satisfaction was also assessed separately across the five dimensions to identify specific areas of positive and negative childbirth experiences. Social classification was determined using the method described by Olusanya et al.[11]

Qualitative data were obtained through in-depth interviews with a purposively selected sample of 16 eligible women, comprising equal proportions of primiparous and multiparous participants. Interviews were conducted privately using a semi-structured interview guide exploring participants' experiences of labour, including pain management, psychosocial support, communication, respectful care, hospital facilities, healthcare workforce and newborn care. With participants' consent, interviews were audio-recorded and supplemented with field

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notes. Language interpretation was provided by trained research assistants where necessary. Each interview lasted approximately one hour.

The interviews were transcribed and reviewed, and the data were coded and analysed thematically using ATLAS.ti.

Data Analysis

Data were entered into a predesigned database, verified against the original questionnaires, and analysed using IBM SPSS Statistics version 23.0. The internal consistency of the questionnaire was assessed using Cronbach's alpha, which yielded a reliability coefficient of 0.702.

Descriptive statistics were used to summarize participants' sociodemographic, obstetric and satisfaction-related characteristics. Satisfaction with intrapartum care was assessed using five-point Likert-scale items across the identified determinants, and an overall satisfaction score was derived. Participants were categorized as satisfied

or not satisfied based on the predefined cut-off score of 75.

Associations between satisfaction and relevant sociodemographic and intrapartum care variables were assessed using the chi-square test. Variables significantly associated with satisfaction were further examined using bivariate and multivariable logistic regression to determine crude and adjusted odds ratios (COR and AOR), respectively. Statistical significance was set at $p<0.05$.

Qualitative interview data were transcribed, reviewed and coded, and related codes were grouped into themes using thematic analysis.

Ethical Consideration

Ethical approval for the study was obtained from the hospital board through the Institute of Medical Sciences Africa, the academic affiliate of the Nisa Hospital Group. Nisa REC Protocol Number IMSA/NISA/20/014. During recruitment, the researcher or the assistants carefully explained the study to the participants and informed consent obtained from each participant before recruitment into the study.

RESULTS

Table 1: Demographic and Obstetric Characteristics of the Study Participants

Variables	Frequency (n=216)	Percentage
Age (years)		
15-24	43	19.9
25-34	118	54.6
35-44	54	25
≥45	1	0.5
Number of Child birth		
Primipara	91	42.1
Multipara	113	52.3
Grand multipara	12	5.6
Ethnicity		
Hausa/Fulani	75	34.7
Yoruba	21	9.7
Ibo	38	17.6
North central tribes	52	24.1

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Other tribes	30	13.9
Religion		
Muslim	99	45.8
Christian	117	54.2
Marital Status		
Single	3	1.4
Married	211	97.7
Separated	2	0.9
Educational status		
Tertiary	169	78.2
Secondary	44	20.4
Primary	3	1.4
Occupation		
Professionals	22	10.2
Public Servants/Private Sector	76	35.2
Business/Self Employed	69	31.9
House wife	49	22.7
Social class[81]		
Class 1	44	20.4
Class 2	88	40.7
Class 3	70	32.4
Class 4	14	6.5
Labour Process		
Spontaneous labour	151	69.9
Induction of labour	65	30.1
Route of delivery		
Spontaneous vaginal delivery	162	75
Assisted vaginal delivery	18	8.3
Caesarean section	**36**	**16.7**

From table I above, majority (54.6%) of the study participants were between the ages of 25 -34 years. This was followed by 25% of women aged 35-44 years. More of the study participants (52.3%) were multipara.

More Hausa/Fulani women (34.75) and women from the north central region (24.1%) inclusive of the Tiv, Idoma, Gbagi, Igbira and Igalas were represented in this study. The Yoruba and Ibos were a relative majority tribe in the study population. In addition, almost every participant in the index study was married.

From the table, 70% of the study participants presented in spontaneous a labor. Notably, 83.3 % of the study population had successful natural birth when compared to 16.7% who had Caesarean birth.

Table 2. Mean Scores and Standard Deviation of Intrapartum Variables of the Participants.

Variables (n=216)	**Mean**	**SD**	**p-value***
Total satisfaction (18 items) Scores ≥ 75 considered to be satisfied	***69.63***	***5.41***	
Subscale 1: Psychosocial support in labour (4 items) scores ≥ 19 considered to be satisfied	**16.86**	**2.02**	
(1) Did you have any or were you allowed to have a relative or companion	4.28	1	0.091

of choice in labor?			
(2) Were you allowed taking a walk or change in position when necessary in labor?	4.17	0.92	0.001
(3) Were you allowed to have a drinks, snack or light meal in labor?	3.68	1.12	<0.0001
(4) Did you enjoy desired support from the labor ward staff?	4.73	0.61	0.031
Subscale 2: Effective communication in labour (4 items) scores ≥ 20 considered to be satisfied	**18.45**	**1.71**	
(1) Were there discussions with you or seeking your opinion on events in your labor?	4.4	0.87	<0.0001
(2) Was there a regular monitoring for you and your baby in labor?	4.73	0.57	0.006
(3) Were you updated regularly on your labor progress?	4.58	0.63	<0.0001
(4) Did you enjoy a respectful care or empathy in labor?	4.75	0.62	0.048
Subscale 3: Pain management in labour (5 items) scores ≥ 14 considered to be satisfied	**11.67**	**2.27**	
(1) If you did not have any pain control, were you satisfied with your pain level?	3.36	1.16	0.012
(2) If you had injection of pain drugs, were you satisfied with the pain control?	3.3	0.99	0.168
(3) If you had epidural in labor, were you satisfied with the pain control?	4.26	0.91	0.023
(4) Did you enjoy a coordinated care on pain response?	4.01	1.12	<0.0001
(5) Do you think your pain control in labor was fair enough or reasonable?	3.99	0.94	<0.0001
Subscale 4: Hospital facilities and workforce (3 items) scores ≥ 15 considered to be satisfied	**13.43**	**1.33**	
(1) How conducive was the labor and delivery environment?	4.43	0.64	<0.0001
(2) Were you satisfied with the available basic medical facilities/equipment in the labor ward in case they are needed for your care?	4.45	0.58	<0.0001
(3) Were you satisfied with the skill of the staffs in labor ward?	4.55	0.6	<0.0001
Subscale 5: Condition and Care of the newborn (2 items) scores ≥ 10 considered to be satisfied	**9.24**	**0.95**	
(1) Were you satisfied with the handling and care of your baby at delivery?	4.58	0.57	0.007
(2) Were you satisfied with the condition of your baby at birth?	4.66	0.55	0.116

*p-values for the association between determinants and total satisfaction. P value is significant at <0.05

Table 2 shows the Likert scale summation of scores from the 18 intrapartum variables within the 5 subscales in this study. The mean score and standard deviation of the variables were derived. On x^2 analysis, the variables with p values of < 0.05 reflect a statistically significant level of agreement of the participants with their satisfaction or dissatisfaction with intrapartum care thereby an expression of their observations.

Overall satisfaction with intrapartum care among respondents

Satisfaction with intrapartum care	**Frequency (n)**	**Percentage (%)**
Satisfactory	203	94.4
Not satisfactory	12	5.6
Total	**215**	**100**

A total of 215 women were assessed for their overall satisfaction with hospital-based intrapartum care. Of these, 203 (94.4%) respondents reported satisfactory experiences, while 12 (5.6%) reported unsatisfactory experiences. Overall, the findings indicate a high level of satisfaction with hospital-based intrapartum care

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among the women studied, with approximately 19 out of every 20 respondents reporting a satisfactory experience

Table 3: Level of Quantitative Satisfaction in Labour

Variables	Satisfied n(%)	Dissatisfied n (%)
Psychosocial Support	47(21.8)	169(78.2)
Effective Communication	83(38.4)	133(61.6)
Pain Management	47(21.8)	169(78.2)
Hospital Facilities and Workforce	55(25.5)	161(74.5)
Condition and Care of the Newborn	111(51.4)	105(48.6)
Total	**117(54.1)**	**99(45.9)**

Table 3 represented a quantitative analysis of levels of satisfaction with the five dimensions of intrapartum care in the current study by summation of the mean scores and standard deviation of the 5 point Likert scales of each intrapartum variable. 117 women of the entire study population representing 54.1% were satisfied compared with 99 women (45.9%) who felt dissatisfied with their intrapartumcare. The highest level of satisfaction was attributed to the subscale of care of the newborn representing 51.5% when compared to 48.6% of women who felt dissatisfied. This was followed by 38.4% level of satisfaction in relation to 61.8% of women who felt dissatisfied with the level of effective communication they had in labor. Psychosocialsupport and pain management both had the lowest comparative satisfaction scores of 21.8% as shown.

Table 4a: Binary and Logistic Regression of Demographic Determinants and Level of Satisfaction with Intrapartum Care

Variables	Crude OR (95%CI)	Adjusted OR (95%CI)
Age (Years)		
15-24	4.714 (0 .26- 84.77)	0.238 (0.006-10.187)
25-34	2.688 (0.16- 44.26)	0.139 (0.004-5.349)
35-44	27.000 (1.20- 605.63)*	7.591(0.193-298.444)
>45	1(Referent)	
Number of child birth		**NA**
Primipara	0.215 (0.215-1.753)	
Multipara	0.643 (0.643-5.368)	
Grand multipara	1 (Referent)	
Ethnicity		**NA**
Hausa/Fulani	1.734 (0.634-4.743)	
Yoruba	2.182 (0.504-9.450)	
Ibo	0.699 (0.245-2.000)	
North central tribes	3.418 (1.00-11.66)*	
Other tribes	1 (Referent)	
Educational status		**NA**
Tertiary	10.519 (0.921-120.134	
Secondary	4.769 (0.397-57.310)	
Primary	1 (Referent)	
No formal education		

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Participant occupation		
Professionals	1.800 (0.517-6.271)	0.210 (0.022-2.019)
Public servants/Private Sector	5.680 (1.894-17.037)*	5.482 (1.304-23.047)
Business/Self Employed	1.053 (0.466-2.377)	0.746 (0.207-2.689)
House wife	1 (Referent)	
Labour process		**NA**
Spontaneous labour	2.606 (1.302-5.217)	
Induction of labour	1 (Referent)	

* p<0.05, ** p<0.01

From table 4a, the age and occupation of the study participants were found to be statistically significant in determining the level of dissatisfaction with the events of labor.

The women aged 15-44years were more likely to be dissatisfied with the events of labor when compared to the age group of 45 years or more. In comparison, women within the age of 35 – 44 years were over 7 times more likely to be dissatisfied {AOR 7.59, 95% CI (0.193 – 29.844)} when compare to other women of younger age.

House wives were more satisfied when compared to the other categories of occupation in this table above. More so, participants in the public service or private sector were more likely to be dissatisfied {AOR 5.482, 95% CI (1.304 – 23.047)} when compared with the other categories of the study participants who were non-house wives in this study.

Table 4b: Binary and Logistic Regression of Intrapartum Determinants and Level of Satisfaction with Intrapartum Care.

Determinants	**Crude OR (95%CI)**	**Adjusted OR (95%CI)**
Psychosocial support in labour		
Were you allowed taking a walk or change in position when necessary in labor?	4.267 (1.255-14.509)*	2.800 (0.560-14.003)
Were you allowed to have a drinks, snack or light meal in labor?	17.02 (3.988-72.642)**	6.862 (7.97-59.068)**
Did you enjoy desired support from the labor ward staff?	1.464 (0.17-12.5)	**NA**
Effective communication in labor		
Were there discussions with you or seeking your opinion on events in your labor?	4.000 (0.92-17.49)	**NA**
Was there a regular monitoring for you and your baby in labor?	1.213 (0.14-10.67)	**NA**
Were you updated regularly on your labor progress?	1.481 (0.32-6.89)	**NA**
Did you enjoy a respectful care or empathy in labor?	1.220 (0.14-10.73)	**NA**
Pain management in labour		
If you did not have any pain control, were you satisfied with your pain level?	1.427 (0.37-5.44)	**NA**
If you had epidural in labor, were you satisfied with the pain control?	3.067 (0.63-14.87)	**NA**
Did you enjoy a coordinated care on pain response?	9.244 (2.156-39.630)*	6.285 (1.164-33.927)**
Do you think your pain control in labor was fair enough or reasonable?	28.26 (3.8-210.22)*	18.242 (1.617-205.82)*
Hospital facilities and workforce		

How conducive was the labor and delivery environment?	1.560 (0.47-5.17)	**NA**
Were you satisfied with the available basic medical facilities/equipment in the labor ward in case they are needed for your care?	1.091 (0.23-5.25)	**NA**
Were you satisfied with the skill of the staffs in labor ward?	1.220 (0.26-5.79)	**NA**
Condition and care of the new born		
Were you satisfied with the handling and care of your baby at delivery?	1.719 (0.21-14.36)	**NA**

* $p<0.05$, ** $p<0.01$

In table 4b, women were more likely to be dissatisfied with their psychosocial support and pain management in labor when compared with other subscales of intrapartum care in this study.

In respect of psychosocial support in labor, women who were not allowed to have drinks or light meals were over 6 times more likely to be dissatisfied{AOR 6.862, 95% CI of (7.79 – 59.068)}with their labor and birth experience when compared to those who had drinks or light meals in labor. Similarly women who were not allowed taking a walk or change in position in labor were also 2 times more likely to be dissatisfied {AOR of 2.800, 95% CI (0.560 – 14.003)} with their events of labor and childbirth when compared to those who had change in position or took a walk in labor.

In the management of pain in labor, women who did not enjoy a coordinated care on pain response were 6 times more likely to be dissatisfied with their labor experience{AOR 6.29 with 95% CI of (1.164 – 33.927) } when compared to those who had a coordinated pain care in labor. Similarly, women who felt their pain control in labor was not effective were 18 times more likely to be dissatisfied {AOR 18.24, 95% CI (1.617 – 205.82)} in comparison with their counterpart who had coordinated pain care in labor.

4.2 Results of in-Depth Interview

Table 5: Profile of the Interviewed Respondents

Variable	**Frequency (n=16)**	**Percentage**
Age (Years)		
15-24	6	37.25
25-34	4	25
35-44	5	31.25
≥45	1	6.25
Number of Child Birth		
Primipara	8	50
Multipara	8	50
Ethnicity		
Hausa/Fulani	7	43..75
Yoruba	3	18.75
Ibo	2	12.5
North central tribes	3	18.75
Other tribes	1	6.25
Religion		
Muslim	9	56.2
Christian	7	43.8

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Marital Status		
Single	1	6.25
Married	14	87.5
Separated	1	6.25
Educational Status		
Tertiary	11	68,75
Secondary	3	18.75
Primary	2	12.5
Occupation		
Professionals	3	18.75
Public servants/Private Sector	6	37.5
Business/Self Employed	4	25
House wife	3	18.75
Social class[81]		
Class 1	4	25
Class 2	5	31.25
Class 3	3	18.75
Class 4	4	25
Labour Process		
Spontaneous labour	10	62.5
Induction of labour	6	37.5
Route of Delivery		
Spontaneous vaginal delivery	9	56.25
Assisted vaginal delivery	1	6.25
Caesarean section	6	37.5

Table 5 above is the distribution is the characteristics and distribution of the respondents involved in the in-depth interview in the current study. The selected respondents were matched for parity as shown in the above table.

Thematic Presentation Of The In-Depth Interview Findings

Thematic analysis of the 16 in-depth interviews generated six themes: **pain management, psychosocial support, effective communication, hospital facilities and workforce, condition and care of the newborn, and overall labour experience**. The qualitative findings largely contextualised the quantitative results and highlighted how women's perceptions of care were shaped by interpersonal support, autonomy, communication, pain experiences and maternal–newborn outcomes.

Pain management

Pain experiences varied considerably among participants. Six women described suboptimal pain control, although only a few regarded pain management as the main determinant of their overall satisfaction. Participants differed in their expectations and interpretations of labour pain, with some viewing it as an expected or natural aspect of childbirth and others preferring pharmacological relief.

Women who received epidural analgesia generally described effective pain control, but some expressed concerns about perceived complications, including back pain, spinal injury and possible effects on the baby. Conversely, some women preferred to experience labour without analgesia. One participant described epidural

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analgesia as highly beneficial, while another who had previously experienced effective epidural analgesia deliberately chose to labour without medication in a subsequent pregnancy.

Psychosocial support and autonomy

Participants generally described positive interactions with nurses and doctors, particularly encouragement, assistance with mobility and emotional support during labour. However, previous experiences in other facilities highlighted restrictions on movement, food and companionship. These experiences were described as distressing and were associated with feelings of reduced autonomy and loss of control.

Privacy and companionship also emerged as important aspects of psychosocial support. Women who used partitioned labour rooms reported concerns about limited privacy and restricted access for spouses or relatives. At the same time, participants valued the emotional support provided by staff and companions, particularly when labour became physically or emotionally challenging.

Effective communication and respectful care

Most participants described communication with healthcare workers positively. Women reported that staff introduced themselves, explained procedures and medications, provided updates on labour progress, and regularly monitored both mother and baby. Respectful and non-discriminatory treatment was repeatedly emphasised.

Regular reassurance was particularly important to participants. Women described feeling safer when staff explained what was happening and communicated information about the condition of the mother and baby. These accounts supported the relatively high quantitative scores observed for communication and respectful care.

Hospital facilities and workforce

Most interviewed women expressed confidence in the hospital's capacity to manage labour and potential complications. Participants described the labour environment as clean and adequately maintained and reported satisfaction with the availability of equipment and the competence of staff. Some participants had specifically assessed the facility during antenatal care or through health-insurance processes before choosing the hospital.

Participants also valued continuity and coordination among members of the clinical team. They described doctors, nurses and senior staff as knowledgeable and confident in their roles. Nevertheless, one participant perceived staffing pressure when several women were simultaneously in labour, suggesting that workload may influence the level of individual attention available.

Condition and care of the newborn

The birth of a healthy baby was a major source of satisfaction for all interviewed women. Participants particularly valued hearing the baby's first cry, immediate contact with the newborn and reassurance regarding the baby's condition. Newborn assessment, cleaning, dressing, weighing, cord care and assistance with early feeding were also positively described.

Some participants expressed preferences concerning newborn hygiene, infection prevention, cord care and room temperature. Despite these reservations, satisfaction with newborn care was consistently high, reflecting the importance of a healthy maternal and neonatal outcome to women's overall assessment of childbirth.

Overall labour experience

Despite reservations about specific aspects of care, most participants described their overall labour experience positively. Women used expressions such as “good care,” “amazing labour experience,” “unforgettable experience” and “pleasant care” to describe their experiences. Positive interactions with healthcare workers and the birth of a healthy baby appeared to shape their overall perception of care.

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However, satisfaction was not universal. One participant reported dissatisfaction despite the birth of a healthy baby, indicating that a favourable maternal or neonatal outcome did not necessarily eliminate concerns about the quality of care received.

Integration of quantitative and qualitative findings

The qualitative findings provided context for the quantitative pattern of satisfaction. The relatively low quantitative satisfaction with psychosocial support and pain management was reflected in interview accounts describing restrictions on mobility, food and companionship, as well as variable expectations and experiences of pain relief. In contrast, the higher scores for effective communication, hospital facilities and newborn care were consistent with participants' reports of respectful communication, regular monitoring, staff competence, adequate facilities and satisfaction with newborn care. Overall, the findings suggest that women's satisfaction with intrapartum care was influenced not only by clinical outcomes but also by their experiences of autonomy, interpersonal support, communication and the quality of pain management.

DISCUSSION

When asked to comment on their overall labor and delivery process, 94% of the women described their childbirth experience as satisfactory at Nisa Premier Hospital in Abuja. Similar studies carried out in the African sub-region reported satisfaction rates of 61.9% in Ethiopia and 56% in Nairobi, Kenya.[12,13] In contrast, a multicentre questionnaire-based study in Eritrea reported a much lower satisfaction rate of 20.8%.[14] Differences in study settings and levels of service delivery may partly explain these variations. The current study was conducted in a private health facility, which may also have contributed to the higher level of satisfaction observed.

However, quantitative analysis of the five subscales of intrapartum care showed that only 54.1% of participants were satisfied with their labour and childbirth experience. This difference from the 94% overall verbal assessment highlights the value of assessing satisfaction across specific dimensions of intrapartum care rather than relying solely on a global assessment.

On further analysis of the intrapartum subscales, women were most satisfied with the handling and care of their newborns (51.4%) and interpersonal communication with the labour ward team (38.4%), whereas satisfaction was lowest with psychosocial support and pain management, both rated at 21.8%.

Although several studies have reported the state of the baby at birth as an important determinant of satisfaction with intrapartum care,[15,16,17,18] few have focused specifically on women's perceptions of newborn handling and care immediately after birth.[19,20] Findings from the current study showed that women valued aspects of newborn care including cleaning, dressing, gentle handling and early mother–child bonding. The qualitative findings further demonstrated the importance women placed on the care and wellbeing of their newborns. These findings are consistent with WHO recommendations regarding early mother–baby contact and bonding.[21] However, the condition of the newborn was not statistically significant in determining women's satisfaction in this study.

Effective communication was the next highest determinant of satisfaction after newborn care. The factors assessed included seeking women's opinions before obstetric interventions, explaining the events and progress of labour, and providing respectful care. Women who were not involved in discussions about their labour or were not given the opportunity to participate in decisions were more likely to be dissatisfied. This finding is consistent with findings from the US National Survey on Experiences from Childbearing Women and the UK Birthright Survey.[22,23] Previous studies have also described poor communication and failure to involve women in decisions as potentially traumatic experiences and components of disrespectful maternity care.[24,25,26] The qualitative findings further supported the importance of healthcare workers explaining procedures and seeking consent before examinations and interventions.

Women also scored caregivers highly in respectful care and expressed resentment towards disrespect during labour. Respectful care included privacy, appropriate covering during examinations, empathy and dignity. This

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finding is consistent with the WHO 2018 intrapartum guideline and previous studies identifying respectful, women-centred care as an essential component of quality intrapartum care.[6,27,14,28] Regular monitoring and updating women on their progress in labour were also important. Participants described reassurance from regular monitoring of their vital signs, the baby's heartbeat and communication about their progress and wellbeing.

Although poor pain control is considered one of the most difficult aspects of childbirth, previous studies have reported that pain management may not always be a major determinant of satisfaction when maternal and fetal outcomes are favourable, with cultural and religious beliefs also influencing perceptions of labour pain.[29-30] The current study, however, showed that 78.2% of women were dissatisfied with pain management compared with only 21.8% who were satisfied. Despite this high level of dissatisfaction, overall satisfaction with the childbirth experience remained relatively high.

There was no significant difference in satisfaction among women who received injectable analgesia, whereas other aspects of pain management showed significant associations with satisfaction. Women who did not receive coordinated pain care, including non-pharmacological measures such as back massage, breathing exercises, music or other forms of distraction, were more likely to be dissatisfied. These findings support the increasing focus on non-pharmacological approaches to pain management in labour.[27,30,31,71] Overall, perceived inadequacy of pain management was an important determinant of dissatisfaction. The use of an exit interview may also have contributed to the prominence of pain in participants' responses because the experience was still recent at the time of assessment.

Women who were not allowed to walk around or have drinks or light meals during labour demonstrated higher levels of dissatisfaction than those who did not receive the desired support from labour ward staff. This suggests that women may have had fewer reservations about the interpersonal support they received than about restrictions on mobility and oral intake. The findings underscore the importance of allowing women appropriate freedom of movement and access to light meals and drinks during labour, as supported by previous studies.[31-32,33-34]

The study also assessed women's perceptions of the availability of workforce and basic medical facilities required for the safe management of labour and newborn care. There was a significant association between the availability of skilled personnel and necessary equipment and satisfaction with intrapartum care. Some women specifically identified the availability of facilities and skilled staff as important in the event of complications. These findings highlight the relevance of facility readiness and workforce competence to women's perceptions of the quality and safety of intrapartum care.

Across previous studies, findings on the relationship between women's satisfaction and sociodemographic characteristics have been inconsistent. In the current study, age and occupation were the most notable sociodemographic determinants of satisfaction. Women aged 35 years and above were more likely to be dissatisfied with labour and childbirth when compared with younger women, consistent with observations from previous studies.[16,12] This may be related to differences in obstetric risk, previous childbirth experiences and expectations of care among women of more advanced maternal age.

Women employed in the public or private sector were also more likely to be dissatisfied compared with housewives and women in other occupational groups. This may reflect differences in expectations of care and awareness of available services. Women with tertiary education were also more likely to report dissatisfaction than those with lower levels of education, consistent with findings from previous studies.[35]Greater awareness of women's rights and expectations regarding the quality of care may partly explain this finding. There was no significant association between parity, ethnicity or labour process and satisfaction in this study.

CONCLUSION

Overall, a higher level of satisfaction with the events of childbirth (94%) was observed in this study. However, with a 5dimensional quantitative analysis of satisfaction on the subscales of intrapartum events of labour and delivery, only 54.1% were noted to be satisfied. Findings from this study was in keeping with lowest level of

satisfaction with pain management and psychosocial support which were both (21.8%) while highest level of satisfaction was attributed to the handling and care of the newborn (54.1%) and (38.4%) in effective communication in labor.

There was significant dissatisfaction among women who were not allowed changes in position and taking a walk 2.800 (0.560-14.003) or not allowed oral intake 6.862 (7.97-59.068). Similarly on pain control, women who did not enjoy coordinated care on response to pain 6.285 (1.164-33.927) or who felt their overall pain control was not fair enough or reasonable 18.242 (1.617-205.82) were also significantly dissatisfied. Although the respondents were satisfied with the handling of their newborn and the level of effective communication they enjoyed in labor, they were more likely to be dissatisfied with lack of discussion or not seeking their opinion on their events of labor and childbirth.

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