

Research Article

The Women's Satisfaction Levels to Care in Postpartum Period

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Abstract: *Introduction:* Childbirth, which is acknowledged to be a very important experience in a woman's life, and her satisfaction with all that transpires during this period, are utterly important for the mother's health, for her infant's health, and for positive family relations. *Objective:* The purpose of this study was to determine the women's satisfaction levels to care in the postpartum period. *Material and Method:* This was a descriptive study nested within a cohort involving women who gave birth at one public maternity hospital in Turkey. Among 300 women who gave birth during the study recruitment, 36 women did not receive a questionnaire. After giving birth, the women who met the inclusion criteria were invited to take part in the study by one of the researchers. The data were collected using a Survey form and The Scale for Measuring Maternal Satisfaction in Birth in the study. *Results:* It was determined that the total mean scores of the postpartum women who had vaginal delivery were 136.8 ± 14.1 , and the total mean scores of the postpartum women who had caesarean delivery were 138.2 ± 12.1 . *Conclusion:* It was found that the level of satisfaction with the childbirth process were low in both groups.

Keywords: Care; Parturition; Postpartum period; Satisfaction; Type of labor.

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INTRODUCTION

Currently, one of the most important and frequently used criteria to assess the quality of health-care services is the satisfaction of the individuals who receive services [1-4]. As a complex concept comprising numerous factors involving lifestyle, past experiences, future expectations, and personal and social values, patient satisfaction may be defined by different individuals at different times and in different ways [1, 5]. Traditional indicators, such as the rates of maternal/perinatal mortality, delivery traumas, and caesarean delivery, which are accepted as the quality indicators in birth services, have come under review in recent years. While the rapid decrease of mortality/morbidity rates was once a quality indicator, advanced technology has gradually decreased the importance of these traditional indicators and presented the necessity of assessing quality in a multidimensional way that is in alignment with ever-changing conditions. Accordingly, the importance given to assessing the experiences of women during birth and the postnatal period, as well as their satisfaction with the care they receive, has gradually increased [6-8].

Childbirth, which is acknowledged to be a very important experience in a woman's life, and her satisfaction with all that transpires during this period, are utterly important for the mother's health, for her infant's health, and for positive family relations. A woman's negative birth experience may lead to the following conditions: postpartum depression, post-traumatic stress disorder, abortion of unintended pregnancies, a desire for the next birth to be performed via caesarean delivery, sexual dysfunction, insufficiency in mother-infant attachment, breastfeeding problems, and infant neglect [4,9]. Nurses and midwives are the individuals closest to the woman during the postpartum period; they should therefore assess women's opinions regarding the childbirth experience and on possible risks [4].

In the health field, numerous studies on patient satisfaction have been conducted throughout the world and in Turkey [2, 10-12]. The majorities of these studies are related to hospital services, treatment and care services in general, and the care that is provided by nurses and physicians. These studies conducted previously examined the satisfaction levels of women based on only one delivery method [13, 14]. However,

studies that focused on a comparison of both delivery methods limited.

OBJECTIVE

The purpose of this study was to determine the women's satisfaction levels to care in the postpartum period.

MATERIAL AND METHOD

Type and Place of the Study

This was a descriptive study nested within a cohort involving women who gave birth at one public large-scale maternity service in the Erzurum, Turkey. The public maternity service is part of a maternity hospital accredited by the Baby-Friendly Hospital Initiative. This hospital was chosen since it is a region hospital and due to the high number of patients. The hospital provides service to women in all socio-economic statuses. The maternity hospital is reference for usual.

There are two separate clinics [postpartum clinic, caesarean clinic] in the hospital. Each patient room at the related hospital accommodates two individuals. As a routine standard in Turkey, women who deliver normally stay in hospital for 24 h while those who undergo C-section stay 48 h, in the absence of postpartum complications. Midwifery care is provided in both labour and postnatal wards.

On the postnatal ward, the midwives provide care to the postnatal women, and the nurses look after the neonates [included low risk ones], who remain with their mothers or in the nursery. The midwives assess the general physical condition of the woman, how she feels, the post-natal uterine involution, the vaginal blood loss/lochia, the perineum and the breast changes, until discharge. If there are some breastfeeding issues, the midwives will provide advice and support the woman.

Sample Group

The population of the study is composed of all postpartum women between the dates. The study population consisted of 3.000 women who had a normal or C-section birth between January 1 and November 1, 2011. The study focused on determining how satisfied women who gave birth between those dates were with maternal care. Therefore, no sampling was performed. Of the study population, 300 women agreed to participate in this study. Thirty-six incomplete questionnaires were excluded. Of the postpartum women, 9 refused to participate in the study, and 27 women agreed to answer the questionnaire but had no opportunity to do so (for reasons such as caring for the baby or having visitors), and they were therefore not included in the study.

Women were selected about 24 h after delivery. Mothers who did Turkish-speaking and

reading, were not pregnancy complications [such as high blood pressure, gestational diabetes, hypothyroidism, oligohydramnios at term,], were no complications during the postpartum period, did term birth, had healthy neonate in good condition at birth, were rooming in with their newborns, and had initiated breastfeeding, were included. Newborns should be singletons and have been born at term, and should not have any problems that required mother-child separation.

DATA COLLECTION TOOLS

Survey form and The Scale for Measuring Maternal Satisfaction in Birth were used in the study. Survey form: It was prepared by the researchers to determine the demographic characteristics of postpartum women. It consists of 12 questions.

Afterward, the Maternal Satisfaction with Normal Birth Scale (MSNBS) and the Maternal Satisfaction with Cesarean Section (MSCS) developed by Gungör and Beji were used to determine participants' satisfaction with maternal care [6].

The MSNBS consists of 43 items scored on a 5-point Likert type scale, and 10 subscales: patient perception of healthcare providers, nursing care in labor, comfort care measures, information and involvement in decision-making, meeting the baby, maternal care, hospital room, hospital facilities, and respect for privacy and meeting expectations. The total score is the sum of all item responses and ranges from 43 to 215. Higher scores indicate higher satisfaction with maternal care. In both scales measuring satisfaction level of women with natural delivery and cesarean section, an item score which was higher than 3.5 score out of 5.0 point Likert scale was accepted to indicate higher satisfaction while an item score which was lower than 3.5 was accepted to indicate lower satisfaction. Those mothers having scores higher than 3.5 were accepted as satisfied mothers with this item while those having less score than 3.5 were classified as dissatisfied mothers, and the percentages were calculated based on these cut-off point scores. For this reason, total satisfaction score is interpreted as satisfied (scoring ≥ 150.5 , namely 43×3.5) or dissatisfied (scoring < 150.5) [6].

The MSCS consists of 42 items scored on a 5-point Likert type scale, and ten subscales: patient perception of healthcare providers, preparation for cesarean section, comfort care measures, information and involvement in decision making, meeting the baby, maternal care, hospital room, hospital facilities, and respect for privacy and meeting expectations. The total score ranges from 42 to 210. Higher scores indicate higher satisfaction with maternal care. Higher total satisfaction score and dimensions' scores indicate higher satisfaction level with caesarean section. Total

satisfaction score is interpreted as satisfied (scoring ≥ 147 , namely 42×3.5) or dissatisfied (scoring < 147).

Gungor and Beji established the validity and reliability of the scales and reported a Cronbach's alpha of 0.91 for the MSNBS and 0.89 for the MSCS [6]. In this study, the Cronbach's α value was 0.73 for the SMMSNB and 0.75 for the SMMSCB.

DATA COLLECTION

Women were enrolled postnatally from Monday to Friday. Surveys were completed by mothers alone. The participant women with normal delivery completed the questionnaires 24 h after delivery while those with C-section completed the questionnaires 48 h after delivery. After giving birth, the women who met the inclusion criteria were invited to take part in the study by one of the researchers, who explained to them the aim of the study, their involvement and asked them to sign the consent form.

The survey form and SMMSNB were applied to postpartum women who had vaginal deliveries, and the survey form and SMMSCB were applied to those who had caesarean deliveries. All questionnaires were completed by the postpartum women on the day of discharge. The interview lasted for approximately 20 min.

DATA ANALYSIS

Data were analyzed using the Statistical Package for Social Sciences (SPSS for Windows, v. 16.0) at a significance level of 0.05. Chi-square was used to determine the relationship between labour type and sociodemographic characteristics. Independent paired-sample *t* test was used to compare intergroup measures. Multivariate logistic regression was used to estimate odds ratios (ORs) and 95% confidence intervals (CIs) of factors affecting maternal satisfaction.

Ethics

The study protocol was approved by the Ethics Committee of Atatürk University Faculty of Health Sciences. The permission of the Provincial Directorate of Health of T.R. Erzurum Governorship was obtained in order to collect data for the study. Participants were provided with necessary information before the interview, and those who volunteered to participate in the study were accepted after signing the informed consent form.

RESULTS

As seen in Table 1, of the postpartum women in normal delivery (ND), 58.7% were 20–29 years old, 58% were primary-school graduates, 97.3% were housewife, and 86.7% had a middle-income level. Of the postpartum women in cesarean section (CS), 55.3% were 20–29 years old, 60.7% were primary-school graduates, and the majority of them (98%) were housewife. It was determined that the difference between groups was not statistically significant. Moreover, the groups had similar features in terms of variables ($p > 0.05$, Table 1).

Table 2 illustrates the SMMS mean scores of the postpartum women according to the delivery method. As shown, the difference between the mean scores of the SMMS subscales (except for postpartum care) is statistically significant according to the delivery method ($p < 0.05$).

The total scale mean score of the postpartum women in ND was 136.8 ± 14.1 , and the total scale mean score of the postpartum women in CS was 138.2 ± 12.1 . The difference between the scores was not statistically significant. An assessment of the scales according to the cut-off score revealed that both groups had low levels of satisfaction regarding the birth experience.

Table-1: Characteristics of the Postpartum Women

Characteristics	ND (N=150)		CS (N=150)		Overall (N=300)		Significant
	N	%	N	%	N	%	
Age group [year]							NS
15-19	19	12.6	13	8.7	32	10.7	
20-29	88	58.7	83	55.3	171	57.0	
30 +	43	28.7	54	36.0	97	32.3	
Education status							NS
Primary school	87	58.0	91	60.7	178	59.4	
Secondary school	40	26.7	26	17.3	66	22.0	
High school	18	12.0	25	16.7	43	14.3	
College or above	5	3.3	8	5.3	13	4.3	
Working status							NS
Working	4	2.7	3	2.0	7	2.3	
Housewife	146	97.3	147	98.0	293	97.7	
Perceived income level*							NS
Low	20	13.3	19	12.7	39	13.0	
Middle	130	86.7	131	87.3	261	87.0	
Parity							NS
First birth	66	44.0	47	31.3	113	37.7	
Non-first birth 2	34	22.7	38	25.3	72	24.0	
3	35	23.3	46	30.7	81	27.0	
4 and above	15	10.0	19	12.7	34	11.3	

NS: not significant

Note(s): ND, normal delivery; CS, cesarean section

Table-2: Scores and prevalence of satisfaction with each birth service

Subscales	ND				CS				Test and p Value
	No of items	Max score	Cutoff score	mean±SD	No of items	Max score	Cutoff score	mean±SD	
1 Perception of Health Professionals	4	20	14	14.6±2.12	5	20	175	19.4±1.8	t=20.4, p<0.05
2 Nursing Care in Labour/ Preparation for Caesarean Section*	2	10	7	5.1±1.9	2	10	7	7.1±1.5	t=9.7, p<0.05
3 Comforting	4	20	14	9.8±2.1	3	15	105	6.4±1.7	t=15.5, p<0.05
4 Information and Involvement in Decision Making	8	40	28	20.4±2.1	8	40	28	22.2±4.4	t=3.5, p<0.05
5 Meeting Baby	3	15	105	12.4±3.5	3	15	105	8.7±2.4	t=10.3, p<0.05
6 Postpartum Care	6	30	21	14.3±2.8	6	30	21	14.8±3.9	t=1.3, p>0.05
7 Hospital Room	4	20	14	14.2±2.1	3	15	105	11.6±1.1	t=13.1, p<0.05
8 Hospital Facilities	3	15	105	11.2±1.1	3	15	105	10.3±1.6	t=5.5, p<0.05
9 Respect for Privacy	4	20	14	18.2±1.3	4	20	14	17.6±1.3	t=2.5, p<0.05
10 Meeting Expectations	5	25	175	16.2±3.7	5	25	175	18.6±2.9	t=6.1, p<0.05
Overall Scale	43	215	150.5	136.8±14.1	42	210	147	138.2±12.1	t=0.8, p>0.05

*While the second subscale of the Scale for Measuring Maternal Satisfaction-normal birth is “Nursing Care During Action of Birth”, the second subscale of the Scale for Measuring Maternal Satisfaction-caesarean birth is “Preparation to

Caesarean”. All other subscales of both scales are the same.

Note(s): SD: standard deviation

DISCUSSION

According to the results of this study, the mean scores of the postpartum women in CS for the subscale “Perceptions of the Health-Care Team” were higher than the postpartum women in ND. In their study, Özcan and Aslan found that the postpartum women who have caesarean delivery were higher the mean scores of the subscale Perceptions of the Health-Care Team [15]. This difference may be associated with the fact that women who had vaginal delivery perceive this process to be longer and more painful compared to those who had caesarean delivery. The relationship with health-care personnel during the birth process is one of the most important factors that affect the birth experience and the mothers’ satisfaction. Positive communication with health-care personnel is a criterion for expectation and satisfaction that is frequently mentioned by women participants in studies [1, 16, 17]. Studies that were conducted in Turkey reveal that the communication between women and health-care personnel is an important problem [18, 19].

The difference between the mean scores of the postpartum women in ND for the subscale “Nursing Care during the Birth Process” and the mean scores of the postpartum women in CS for the subscale “Preparation for Caesarean” was statistically significant. The mean score was higher in postpartum women who have caesarean delivery in this study. The reason for this difference may be the fact that those who had vaginal delivery were not informed, or were informed insufficiently, about the process; they suffered from pain during the process; and they thought that midwives and nurses who provided their care would not be able to help the process or do anything to shorten its duration. According to Hodnett, support from midwifery and /or nurses during birth could be summarized as emotional support, procurement of physical comfort, informing, advocacy, and assisting the relatives of the patient [20]. Since midwives and nurses are the individuals closest to the women during the delivery, the importance of their support increases. It has been reported that this support creates positive feelings in women regarding the experience of birth and increases their ability to cope, as well as their satisfaction with the process [3, 21, 22].

The mean scores of the postpartum women in ND for the subscale “Comforting” were higher than the postpartum women in CS. As a result of the study, it was found that the mean scores of the subscale comforting of women who had vaginal delivery were higher [15]. The reason for this difference may be the fact that women who had caesarean delivery believed that the midwives and nurses charged to their care had not provided sufficient care to them, since they did not feel the birth process, experience birth pain, and had less anxiety about the outcome of the birth. It has been stated that the support from midwifery and/or nurses provided during a delivery decreases the duration of the

birth, the need for analgesia, and the possibility of interventions, such as delivery by forceps, vacuum, caesarean delivery, and that this type of support increases maternal comfort and satisfaction [23, 24]. For instance, Gençalp, who conducted an experimental study at a maternity hospital in Istanbul, examined “the effect of supportive nursing care given to mothers during action of birth upon birth process” and determined that mothers in the experimental group had fewer negative reactions, such as crying, lip-biting, and screaming. Moreover, their birth duration was shorter, they felt more comforted, and they had greater rates of breastfeeding [25].

According to the results of this study, the mean scores of the postpartum women in CS for the subscale “Agreeing with Decisions and Informing” were higher than the postpartum women in ND. In their study, Özcan and Aslan found that the postpartum women who have caesarean delivery were higher the mean scores of the subscale “Agreeing with Decisions and Informing” [15]. The women who had caesarean delivery were informed about the caesarean operation and were enabled to sign the consent form and thus to agree with the decision could be signified as reason for this difference. Postpartum women expect to be informed about the process of delivery, the examination, and the procedures in a manner that is simple, understandable, ongoing, and accurate. They also expect to be presented information without having to ask. In studies on the expectations and satisfaction of women regarding the birth experience, the benefits of informing and consultancy have been among the issues most emphasized [6, 17, 26, 27]. Additionally, studies frequently stress the idea that women’s agreement with decisions during birth and their sense of control are among the most important factors that affect satisfaction during birth [4, 16, 26, 27].

It was found that the mean scores of the subscale “Meeting the Infant” of postpartum women in ND were higher than another group. This difference may be associated with the fact that women in CS were under the effects of anesthesia and were therefore able to see and cuddle their babies, and consequently start breastfeeding later following the childbirth. The points that are regarded as most significant by women in adopting the role of parenthood following childbirth include the feeling of attachment to their infants and meeting their needs [16]. Thus, postpartum women expect attention, information, and support from health-care personnel regarding this subject, especially in the hospital during the first few days after the birth. It has been reported that the failure to provide this type of support creates a risk factor for women in that they may assess the birth negatively [22].

The difference between mean scores of both groups for the subscale “Postpartum Care” was statistically insignificant. As well as the care, attention,

and support received during the birth process, postpartum experiences and support are a factor affecting the women's satisfaction regarding the birth process. The first postpartum days comprise the period during which the greatest amount of support is required by the mother, who, at that time, is trying to adapt to parenthood while coping with difficulties related to her own care, her relationship with the infant's father, and the increased responsibilities of infant care immediately after a challenging experience such as giving birth. As a matter of course, the mothers' greatest expectation from midwives and nurses during this period is to receive attention in the event of any problems and anxieties and to obtain information and support, especially with respect to maternal and infant care [16, 17]. The literature suggests that nursing care given during the postpartum period increases the quality of the care and patient satisfaction, prevents postpartum complications, and is effective in attaining the aimed outcome criteria [28, 29].

The mean scores of the postpartum women in ND for the subscale "Hospital Room and Hospital Facilities" were higher than the postpartum women in CS. As a result of the study, it was found that the mean scores of the subscale "Hospital Room and Hospital Facilities" of women who had vaginal delivery were higher than another group [15]. The women who had caesarean delivery were not satisfied with the hospital facilities, probably due to the fact that they found the operating room cold, had greater postpartum pain, and proceeded to normal feeding gradually. Both the physical and social comfort provided by hospitals may enable individuals to feel at home and thereby increase their satisfaction [30]. Among the environmental and institutional expectations of women that affect their satisfaction during pregnancy and delivery, those that are researched most often and whose efficiency is proven include the use of single rooms in cases during which the travail-delivery and postpartum care is given in the same environment, establishing a home-like environment, and allowing the participation of husband and other relatives [17, 22, 30].

It was found that the mean scores of the subscale "Respecting Privacy" of women in ND were higher than women in CS. This difference may be associated with the fact that in cases of normal delivery, only women are allowed in delivery rooms. Pregnant women are examined in different locations, and women are able to participate in their own care a short time after the normal birth; on the other hand, in caesarean deliveries, male staff members work in the operating room, and are unable to immediately participate in their own care during the postpartum period. Moreover, numerous medical staff members intervene both physiologically and psychologically in the private lives of women via receiving histories and participation in procedures. Thus, one of the most important responsibilities of the medical staff is to respect the

personal, cultural, and religious limits of women, as well as to ensure their privacy and protect their confidentiality [31].

The difference between the mean scores of the postpartum women in ND and CS for the subscale "Meeting Expectations" was statistically significant. The mean score is higher in postpartum women in CS. This difference might have been caused by the fact that the women who had normal deliveries perceived this process to be longer and more painful, and believed that midwives and nurses had not helped, or done anything to shorten the duration of, the process; on the other hand, women who had caesarean deliveries suffered no pain during the process. Expectations generally involve issues such as good prenatal care, selection of the location and medical professional for the birth, being informed before the birth, the safety of the mother and the infant during the birth, the sense of control during the birth, pain control, participation in decisions about care, communication with the health-care staff, postpartum care, attachment to the infant, and breastfeeding [16]. The literature indicates that the positive or negative expectations women have regarding these subjects before the birth affected their actual delivery experiences and satisfaction [3, 4, 32].

The difference between the total scale mean score of postpartum women in ND and CS was statistically insignificant. Similarly, the study conducted by Kaya revealed that the delivery method does not affect the score obtained from services related to the care provided by midwifery and nursing care and that there is not a statistically significant relation between the mean scores of the two groups [33].

The study was conducted in province centre of Erzurum. It is therefore not clear if these results are generalizable to other regions or countries. Besides, women were excluded if they were less than 38 weeks gestation and had birth complications. These are limitations of the study.

CONCLUSION

This study, which compared the levels of satisfaction with the birth process as experienced by postpartum women who had vaginal delivery versus those who had caesarean delivery, determined that both groups had low satisfaction levels. A woman's satisfaction with her childbirth experience might have abrupt and long-standing effects on her health and her relationship with her infant. In order to increase the satisfaction levels of postpartum women, it is recommended that quality of care services be increased, hospital facilities be improved, and the satisfaction levels of postpartum women regarding the birth experience be regularly assessed. In our country, it is necessary to decrease the rate of caesarean delivery with increasing the fear of birth and the trauma of birth and it has to be increased birth which the least medical

intervention, the support of the woman and pain that the woman can cope with the nonpharmacological methods. It is important the increasing satisfaction of women via encouraging to have a normal birth for individual and community health.

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