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ORIGINAL PAPER

The process of childbirth as a factor influencing women's satisfaction

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Abstract

Aim: The aim of the research was to find significant factors that influence women's satisfaction with childbirth. *Design:* A cross-sectional study design was chosen. *Methods:* The Czech version of the Birth Satisfaction Scale – Revised, supplemented with demographic questions and questions related to the process of childbirth, was used for data collection. The online questionnaire was completed by 870 women who met the inclusion criteria for the study. *Results:* Several statistically significant results were found: women's satisfaction with childbirth increases with increasing age ($p < 0.05$), secondary / multipara women are more satisfied with the experience of childbirth than primipara women ($p < 0.05$), and the experience of spontaneous vaginal birth leads to higher satisfaction than operative birth ($p < 0.05$). The term of delivery, place, and perception of pain during delivery also influence women's satisfaction with birth ($p < 0.05$). *Conclusion:* The midwife's duty in caring for the woman is not only to ensure safety but also to promote the emergence of a positive and satisfying experience. Situations such as acute operative delivery or preterm birth are unavoidable in obstetrics. However, respectful care and emotional support provided during labor can develop women's ability to perceive control over the situation, cope with labor pain and prevent negative experiences.

Keywords: women's satisfaction, childbirth, age, pain, parity, place of delivery, Birth Satisfaction Scale – Revised.

Introduction

Women's satisfaction with childbirth is one of the important components of measuring the quality of perinatal care provided. Larkin et al. (2009) define birth experience as an individual life event, involving interrelated subjective psychological and physiological processes, influenced by social, environmental, organizational, and political contexts. Birth experience is therefore a complex, multidimensional, and subjective construct that involves and is influenced by a range of prenatal and peripartum factors.

The experience of childbirth has an immediate as well as a long-term positive or negative impact on a woman's life, well-being, and health. A positive experience can be remembered as an empowering life event associated with the personal growth and confidence that come with motherhood (Nilvér et al., 2017). A negative birth experience increases the risk of negative health outcomes, such as postpartum depression or secondary tokophobia, which may affect future reproduction or may lead to a request for a cesarean section in a subsequent pregnancy (Nilvér et al., 2017).

Women's satisfaction with childbirth can be defined as a retrospective assessment of the birth experience by the mother (Hollins Martin et al., 2012) which is influenced by many situational, cognitive and emotional factors (Preis et al., 2019). Satisfaction and dissatisfaction may not necessarily form a continuum; people may be satisfied with some aspects of the experience and dissatisfied with others (Hodnett, 2002; Lemmens et al., 2021). Perceptions of the birth experience are unique and highly subjective. Women's views on what is a positive / satisfying experience and what is not can vary widely.

Aim

The aim of the pilot study was to find significant factors that influence women's satisfaction with childbirth. The type of relationship between women's satisfaction with childbirth and these variables was statistically described:

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- age, education;
- parity, mode of delivery, term of delivery;
- place of delivery;
- perceived pain during delivery.

Methods

Design

A cross-sectional study design was chosen.

Sample

The inclusion criteria for respondents in the quantitative pilot study were Czech-speaking women over 18 years of age who had given birth in the last two years. Participants were recruited online using convenience sampling. We used Survio, a company that meets recognized standards for information security management systems, to develop and distribute the questionnaire. Informed consent to participate in the study was included in the questionnaire. Respondents' participation was anonymous and voluntary. The invitation to participate and the online questionnaire were posted on six different Facebook forums for women on maternity and parental leave in the Czech Republic, and 891 responses were obtained. We excluded 21 questionnaires from women who gave birth more than two years ago.

Data collection

In addition to demographic and birth-related questions, the questionnaire used the Czech version of the Birth Satisfaction Scale – Revised (CZ-BSS-R), validated in 2022 (Ratislavová et al., 2024), as the main measurement tool. The Birth Satisfaction Scale (BSS) was developed by Hollins Martin and Fleming (2011) in the UK as a 30-item psychometric scale to assess women's perceptions of childbirth. The BSS was revised to ten items (BSS-R) in 2014 (Hollins Martin & Martin, 2014). It has good psychometric properties, is a robust, valid, and reliable multidimensional psychometric instrument for measuring women's satisfaction with childbirth and has three subscales that measure different domains: (1) Quality of care provision, (2) Women's personal attributes, and (3) Stress experienced during labor. Each item is rated on a Likert scale of 0–4, with statements ranging from strongly agree to strongly disagree with a neutral central point. The total BSS-R score ranges between 0 and 40, with higher scores representing higher birth satisfaction. It is recommended by the International Consortium for Health Outcomes Measurement as the main tool for measuring women's experiences of childbirth (Nijagal et al., 2018).

Data analysis

Data collection was conducted in October and November 2021. The online questionnaire was duly completed by the 870 women who met the inclusion criteria for the study. Based on the stated hypotheses, the data were statistically processed using Kruskal-Wallis test (non-parametric ANOVA) and two-sample Wilcoxon test. Statistical tests were evaluated at the 5% significance level ($\alpha = 0.05$). We rejected the null hypothesis if p-value $\leq \alpha$. Data were analyzed using the NCSS11 software.

Results

Sample characteristic

Women aged 18–46 years (M = 30.0 years; SD = 5.0) participated in the study: 465 women up to 12 months postpartum and 405 women between 13 and 20 months postpartum. The majority of the respondents were married (52.99%), mostly with complete secondary (38.62%) or tertiary (34.94%) education and employed (60.57%). There were 622 (71.49%) primiparas, 183 (21.03%) secondiparas, 54 (6.21%) terciparas, and 11 (1.26%) women had given birth to more than three children. The scores of CZ-BSS-R and its subscales are given in Table 1.

Women's satisfaction with childbirth and demographic factors

A statistically significant effect of women's age on satisfaction with childbirth ($p < 0.05$) was found for the total CZ-BSS-R scale and its subscales. The correlations were relatively small but positive. Women's satisfaction with childbirth increases with increasing age. In addition, for the overall CZ-BSS-R scale and its subscales, there was a statistically significant effect in terms of parity ($p < 0.05$). Multiple comparisons show that there is a significant difference between mothers with one child and two children, and one child and three / more children. There is a significant association between CZ-BSS-R and parity, with primipara women being statistically significantly less satisfied with childbirth than secondipara / multipara women.

There was no statistically significant effect regarding education ($p > 0.05$) or time (within 12 months vs. 13–20 months) since delivery ($p > 0.05$) for the total CZ-BSS-R scale or its subscales.

Women's satisfaction with childbirth and mode of delivery

For the overall CZ-BSS-R scale and its subscales, there was a statistically significant effect regarding mode of delivery (see Table 2) on women's satisfaction with delivery ($p < 0.05$). Multiple

comparisons show that the values of the total Cz-BSS-R scale and the values of the subscales Stress Experienced during labor (SE) and Personal Attributes (WA) of women who gave birth spontaneously vaginally are statistically significantly higher than those of women from other groups; while the values of the subscale Quality of Care Provision (QC) for women who gave birth by acute cesarean section are statistically significantly lower than for women who gave birth by other methods.

We also looked at the association between women's satisfaction with childbirth and the timing of delivery. The sample included 723 women (83.10%) who gave birth on the expected delivery date, 84 women (9.66%) who reported preterm delivery, and 63 women (7.24%) who reported delivery more than two weeks after the due date. For the total scale of CZ-BSS-R and the subscales of SE and WA, there was a statistically significant effect of the date of delivery on women's satisfaction with childbirth ($p < 0.05$). The scores of CZ-BSS-R and the subscale of SE were statistically significantly lower for women who delivered after the due date compared to women who delivered at the expected date of delivery. On the WA subscale, scores were statistically significantly higher for women who gave birth at term compared with other women (preterm and postterm). There was no statistically significant difference in scores for the QC subscale.

Table 1 Results of the CZ-BSS-R and its subscales

	N	Mean	SD	Median	Min	Max
CZ-BSS-R	870	25.4	8.3	27.0	1.0	40.0
Stress experienced during labor (SE)	870	9.1	4.0	10.0	0.0	16.0
Women's personal attributes (WA)	870	4.6	2.2	5.0	0.0	8.0
Quality of care provision (QC)	870	11.6	3.5	12.0	1.0	16.0

Table 2 Effect of the mode of delivery on women's satisfaction with the delivery (CZ-BSS-R and its subscales)

Mode of delivery	**CZ-BSS-R**		**SE**		**WA**		**QC**	
	N	Mean	SD	Mean	SD	Mean	SD	Mean	SD
Spontaneous vaginal	390	28.2	6.9	10.7	3.4	5.3	1.9	12.2	3.2
Vaginal medical	233	24.9	7.9	8.7	3.8	4.5	2.2	11.8	3.5
Acute cesarean section	123	19.0	8.3	6.3	3.9	3.0	2.1	9.7	3.8
Elective cesarean section	69	26.4	7.5	9.6	3.5	4.7	2.2	12.1	2.8
Surgical intervention*	55	20.2	9.0	6.1	4.2	3.3	2.2	10.8	4.0
p-value		< 0.001		< 0.001		< 0.001		< 0.001	

**Surgical intervention: forceps, vacuum extraction, revision or lysis manualis placentae.*

Women's satisfaction with childbirth and place of delivery

The respondents included 454 women (52.18%) who delivered in a large maternity hospital, 403 women (46.32%) who delivered in a small district hospital and nine women (1.03%) who delivered at home. For the subscales of SE and WA, there was a statistically significant effect regarding place of delivery on women's satisfaction with childbirth ($p < 0.05$). The values of the subscales of SE and WA were statistically significantly higher for women who delivered at home compared to women who delivered in large and small district hospitals. There was no statistically significant difference in values for the total CZ-BSS-R scale and the QC subscale (see Table 3).

We were interested in whether women chose the place of delivery themselves. While 493 women (56.67%) chose the place of delivery themselves, 374 women (42.99%) reported that they had no other choice, or it was unplanned. There was a statistically significant effect of choice of place of delivery ($p < 0.05$) for the total CZ-BSS-R scale and its subscales. The results of the CZ-BSS-R scale were significantly dependent on choice of place of delivery. It is evident that women who chose the place of delivery themselves had significantly higher mean scores on the CZ-BSS-R and its subscales than those who reported that they had no choice or that the place of delivery was not chosen in advance.

Women's satisfaction with childbirth and perceived pain during labor

We compared two groups of women: a group of respondents (N = 491; 56.44%) who did not feel pain or perceived pain as tolerable (without medication) and a group of respondents (N = 230; 26.44%) who perceived pain as very severe

and managed it only with the use of medication (drugs, gas, epidural analgesia). A statistically significant effect regarding perceived pain ($p < 0.05$) was found for the total scale of the CZ-BSS-R and its subscales SE and WA. The results of the CZ-BSS-R and these two subscales indicate that women who did not perceive pain or perceived it as tolerable were significantly more satisfied with their labor than women who reported that pain during labor was very severe and managed it only with the use of medication. For the QC subscale, the effect of pain perception was not statistically significant.

We also compared a group of women (N = 491; 56.44%) who did not feel pain or perceived pain as tolerable (without medication) and a group of women (N = 140; 17.13%) who perceived pain as very severe but without medication (medication was not offered or refused) or perceived pain as very severe even with medication. In this case, for the total CZ-BSS-R scale and all its subscales, there was a statistically significant effect regarding perceived pain ($p < 0.05$). When women perceived pain as very severe, their satisfaction with the delivery was statistically significantly lower than the satisfaction of women who perceived pain as not severe or who perceived no pain.

Table 3 Effect of the place of delivery on women's satisfaction with the delivery (CZ-BSS-R and its subscales)

Place of delivery	N*	CZ-BSS-R		SE		WA		QC	
		Mean	SD	Mean	SD	Mean	SD	Mean	SD
Large maternity hospital	454	25.3	8.3	9.0	3.9	4.6	2.2	11.7	3.6
Small district hospital	403	25.3	8.4	9.1	4.0	4.5	2.2	11.6	3.5
Home delivery	9	30.8	6.2	13.4	3.7	7.1	2.3	10.2	3.7
p-value		0.0795		0.0052		0.0012		0.3541	

**Four women described the place of delivery as 'other' (not listed in the table).*

Discussion

The influence of age, education, or parity on women's satisfaction with childbirth is not clear in research. Most authors do not attribute significant influence to these demographic factors. Our finding that women's satisfaction with childbirth increased with increasing age correlates with the results of Lemmens et al. (2021). In a Slovak study (Mazúchová et al., 2020), statistically significant differences were found between age groups in women's satisfaction with the factor of women's control and participation in decision-making during childbirth. The highest mean score in the evaluation of the factor under study was in the group of women aged 41–50 years and lowest in the group of women aged 20 years and younger. In general, however, most research has not confirmed the influence of age on women's satisfaction with childbirth. On the contrary, primiparity is more often associated with dissatisfaction with childbirth (Nystedt & Hildingsson, 2018; Poikkeus et al., 2014) and multiparity more often with positive experiences of childbirth (Mattison et al., 2018). These results may be related to the fact that primipara have higher expectations of childbirth than multipara who have already experienced childbirth (Chabbert et al., 2021).

Education had no significant effect on women's satisfaction with childbirth in our study. In contrast to our results, Khalife-Ghaderi et al. (2021) found that women with higher education were less satisfied with childbirth than women with only primary education, as did Oweis (2009). However, Jafari et al. (2017) found the opposite.

According to our research, one of the main factors that influence satisfaction with childbirth is the way the birth was conducted. These findings are consistent with other research findings. Women who gave birth spontaneously vaginally report higher levels of satisfaction with their birth than women who had a cesarean section (Falk et al., 2019; Ratislavová et al., 2024; Weeks et al., 2017). Operative vaginal birth (forceps, vacuum extraction) is perceived more negatively by women than spontaneous vaginal birth, and acute cesarean section tends to be identified by women as one of the most negative experiences (Coates et al., 2020; Emmens et al., 2021; Kempe & Vikström-Bolin, 2020). Coates et al. (2020) reported that women who had an acute cesarean section reported negative experiences such as: feeling ignored and powerless, loss of control, feeling uninformed, and contravention of their preference for vaginal birth. Other studies have presented similar findings. Dissatisfaction with operative delivery is likely to be influenced by a number of intrapartum and psychological variables such as high levels of negative feelings, feelings of lack of control, negative experiences of care and / or incongruence with the preferred mode of delivery.

In our study, women who gave birth prematurely or after their due date were less satisfied with their delivery. Women who gave birth before 38 or after 41 weeks of pregnancy and women who experienced complications of childbirth such as sphincter injury, and postpartum haemorrhage were less satisfied with their birth (Falk et al., 2019), induction of labor, epidural analgesia, oxytocin administration (Kempe & Vikström-Bolin, 2020), prolonged labor, pharmacological pain control, continuous fetal monitoring or episiotomy (Weeks et al., 2017). These factors also played a role in our research in assessing the association between satisfaction with childbirth and perception of pain and its control. Women who did not perceive pain or perceived it to be tolerable were significantly more satisfied with their birth than women who reported that the pain in labor was very severe and managed it only with the use of medication. Not surprisingly, the women's personal attributes and stress during labor played a major role. Green et al. (1990) reported that the most satisfied women in their research were those who did not use analgesics during labor.

Some studies report that retrospectively, pain management during childbirth can lead to self-satisfaction and fulfillment (Johnson et al., 2007; Karlsdottir et al., 2014; Leap et al., 2010; Whitburn et al., 2019). However, in our research, women who perceived the pain as very severe but without medication (medication was not offered or refused) or too severe even with medication were statistically significantly less satisfied with the birth than women who perceived the pain as tolerable. Relieving very painful contractions during labor can have a positive effect on women's satisfaction with childbirth.

According to some research, the place of delivery is also important for parturient satisfaction. Our investigation confirmed this. Women prefer the care of familiar health professionals at birth, preferring to give birth in a comfortable, home-like environment (Hodnett, 2002). Women cope differently with labor pain at home, in a birthing centre or in a maternity hospital (where entonox, epidural analgesia etc. are exclusively available). The environment itself can affect women's ability to cope with the pain of childbirth. The level of safety in hospital delivery rooms is high, but the level of autonomy and the woman's sense of control over the situation is lower. Research shows that women's satisfaction with childbirth tends to be higher in women who planned their birth and gave birth at home or in a birthing centre than in women who gave birth in a hospital (Fleming et al., 2016; Preis et al., 2022). A woman's autonomy in choosing where to give birth is significant. Women who chose the place of birth themselves were significantly more satisfied with their birth experience than those who reported that they had no other choice, or it was unplanned.

Our results suggest that it is important to discuss women's expectations regarding childbirth during pregnancy. Midwives should prepare women for the likelihood that changes may occur during pregnancy and birth and encourage flexibility in their approach to birth and pain management options rather than creating strict birth plans. Thus, they should alert women to the possibility that changes may occur, both in the course of labor and in their own preferences, and support women to express their needs assertively. It is important to support women's autonomy and informed choice about their midwifery care. Midwives should place particular emphasis on preparing first-time mothers for childbirth. If a woman is not satisfied with the birth, the midwife has the opportunity to talk to her about her feelings and experiences in the postnatal period to alleviate her feelings of guilt or failure and to support her emotionally. Acute cesarean birth appears to be the most problematic. Above all, a holistic approach, professional communication skills, and a psychological approach to women should be applied.

The results of our study are limited to obstetric factors only, but psychological and social factors, which are not included in our results, also play a very important role in assessing satisfaction. Of course, online quantitative research has its limitations. In our case, a specific group of women completed the questionnaire. For this reason, we did not focus on the level of women's satisfaction, but only on the context and the factors presented.

Conclusion

The basic determinants of quality maternity care include respectful care, communication with the partner, meeting the woman's personal expectations, a high level of professionalism, support from health professionals, the woman's involvement in decision-making, and respect for her choices (Wilhelmová et al., 2022).

The midwife's duty in caring for a woman during labor is not only to ensure safety, but also to promote a positive and satisfying experience. Respectful care and emotional support provided during labor can develop women's sense of control over the situation and their ability to cope with labor pain and prevent negative experiences. Situations such as acute operative delivery or preterm birth cannot be avoided

in obstetrics. However, it is possible to provide a woman with the maximum level of support not only in the difficult situation during childbirth, but also afterwards in the six-week period when she is processing the whole, often traumatic experience.

In midwifery education, we recommend, based on our results, that soft skills such as communication, empathy, establishing a relationship with the client, behaviour in emotionally stressful situations and other interpersonal skills be developed.

Satisfaction with childbirth has an impact on the future health of the woman and the newborn baby, so more attention needs to be paid to women's birth experiences. Further research should focus on factors that midwives can use in their practice to increase women's satisfaction with childbirth.

Ethical aspects and conflict of interest

Ethical approval for the investigation was obtained from the Research Ethics Committee of the University of West Bohemia in Pilsen, reference number ZCU 000213/2021. The authors declare no potential conflicts of interest concerning the research, authorship, and / or publication of this article.

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Author contributions

Conception and design (KR, CM), data collection (KR, EHL), data analysis and interpretation (KR), manuscript draft (KR, KJ), critical revision of the manuscript (EHL, CM), final approval of the manuscript (KR, KJ, CM).

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