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Original research article

Psychosocial factors affecting women's satisfaction with birth

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Abstract
Introduction: Women's satisfaction with childbirth can be defined as a retrospective assessment that reflects the overall level of satisfaction, well-being, and emotional response to the birth process.
Aim: To search for significant psychosocial factors that influence women's satisfaction with childbirth.
Methods: A retrospective cross-sectional study was conducted using an online questionnaire. We obtained 870 properly completed questionnaires from postpartum women. The main measurement tool was the Czech version of the Birth Satisfaction Scale-Revised (CZ-BSS-R).
Results: There was a statistically significant effect of women's previous experience of childbirth, the effect of psychological state before childbirth, and the effect of undisturbed contact with the newborn after childbirth ($p < 0.05$) on women's satisfaction with childbirth (CZ-BSS-R total score and its subscales). Women who had a close person present at the birth ($p < 0.05$) were significantly more satisfied with the experience, as were women who had a private midwife or doula attend the birth ($p < 0.05$). Women with a birth plan were significantly less satisfied with the quality of care during labour than women without a birth plan ($p > 0.05$).
Conclusion: Health professionals, especially midwives, can influence a woman's birth experience in a positive way. The key elements of women-centred care are respect for individuality, knowing what women expect from birth, paying attention to women's psychological state before birth, allowing women uninterrupted contact with their newborn immediately after birth, the right to choose, and continuous care from midwives.

Keywords: Birth Satisfaction Scale-Revised; Midwifery; Psychosocial factors; Satisfaction with childbirth; Women-centred care

Introduction

A woman's satisfaction with childbirth can be defined as the mother's retrospective assessment of the birth (Hollins Martin et al., 2012) that reflects her overall level of satisfaction, well-being, and emotional response to the birth process. Satisfaction with birth is influenced by a variety of factors, including the physical and emotional support a woman receives during labour, the quality of communication and involvement of health professionals, the level of control and autonomy a woman feels during labour, and the outcome of the birth itself (Carquillat et al., 2016; Chabbert et al., 2021; Goodman et al., 2004). Women's experiences of childbirth can vary widely, from positive and empowering to negative and traumatic. Satisfaction with childbirth is also influenced by the fact that each woman's expectations, wishes, and experiences are unique.

The World Health Organization (WHO, 2018) has emphasized the positive birth experience of women and their families in its latest document "Intrapartum care for a positive childbirth experience".

The importance of woman-centred care, through which the quality of perinatal care is optimised by a holistic, human rights-based approach, is highlighted. A positive birth experience is defined as an experience that fulfils or exceeds the personal and socio-cultural beliefs and expectations of childbearing women. This includes giving birth to a healthy baby in a clinically and psychologically safe environment with continuous practical and emotional support from those present at the birth; including kind, professional, and technically skilled health personnel. Most women desire a physiological birth and want a sense of personal achievement and control through involvement in decision-making, even when medical intervention is needed or desired (WHO, 2018).

Satisfaction with childbirth is an important measure because it can affect women's psychological well-being, recovery after childbirth, and future reproductive decisions. High levels of birth satisfaction are associated with better mother-in-

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fant bonding, higher breastfeeding rates, lower rates of postpartum depression, and overall better maternal health and well-being (Nilvér et al., 2017). Understanding the full range of women's experiences of childbirth is necessary to support women's rights to achieve positive birth experiences. Women's satisfaction with childbirth is an important aspect of maternity care and is increasingly recognised as a valuable outcome measure in assessing the quality of midwifery care and in supporting women's emotional wellbeing as they transition into motherhood.

Aim

The aim of our research is to identify significant psychosocial factors that influence women's satisfaction with childbirth. In the research results, the relationship between women's satisfaction with childbirth and the following variables is statistically described:

- The woman's previous experience with childbirth.
- Preparation for childbirth.
- Subjective perception of the woman's psychological state before childbirth.
- Uninterrupted contact between mother and newborn after delivery.
- Social support of the woman during labour.

Materials and methods

A retrospective cross-sectional study was conducted between October and November 2021. A call for participation in the study and an online questionnaire were posted on six different forums for women on maternity and parental leave in the Czech Republic. The inclusion criteria for respondents in the quantitative study included Czech-speaking women over 18 years of age who had given birth in the last 24 months. Participants were selected online using convenience sampling. Informed consent to participate in the study was included in the questionnaire. In the women's satisfaction with childbirth survey, 891 responses were obtained, and 870 questionnaires were properly completed (N = 465 women within 12 months of delivery, and N = 405 women between 13 and 20 months of delivery).

In addition to socio-demographic data, the questionnaire included information about the birth (parity, quality of previous birth experience, time elapsed since birth, method of preparation for birth, psychological state before birth, mode of delivery, persons present at birth, condition of the baby, bonding).

The main measurement instrument was the Czech version of the Birth Satisfaction Scale- Revised (CZ-BSS-R). The BSS-R was developed in 2014 (Hollins Martin and Martin, 2014). The CZ-BSS-R has good psychometric properties, it is a robust, valid, and reliable multidimensional psychometric instrument for measuring women's satisfaction with childbirth, Cronbach's alpha is 0.87 (Ratislavová et al., 2022). It has three subscales that measure different domains: Quality of care provision (QC), Women's personal attributes (WA), and Stress experienced during labour (SE). Each item is rated on a five-point Likert scale, which is limited by statements of 'strongly agree' and 'strongly disagree' with a neutral central point. The total score of the CZ-BSS-R 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).

Ethical approval for the research investigation was obtained from the Research Ethics Committee of the University of West Bohemia in Pilsen, reference number ZCU 000213/2021. The Research Ethics Committee confirmed that the study participants were volunteers, their human dignity was not violated, and they were not exposed to physical, psychological, or social risks. Only anonymous data were collected from the study participants; their privacy and data protection were guaranteed according to the relevant law.

Based on the hypotheses, the data were statistically analysed using the Kruskal–Wallis test (non-parametric ANOVA) and two-sample Wilcoxon test. Statistical tests were evaluated at 5% significance level ($\alpha = 0.05$). The null hypothesis was rejected if p-value $\leq \alpha$. Data were analyzed using the NCSS11 software.

Results

Sample characteristics

The participants were women aged 18–46 years (M = 30.0 years; SD = 5.0). The basic demographic characteristics of the sample are presented in Table 1 and the scores of CZ-BSS-R and its subscales are presented in Table 2.

Women's satisfaction with childbirth and quality of previous experience

We included 176 women (20.23%) who reported that their previous birth experience was excellent/good (N = 138; 15.86%) or poor/very poor (N = 38; 4.37%). We did not include

Table 1. Demographic characteristics of the respondents

Demographic characteristics of the respondents	*N*	%
Marital status		
Single	382	43.91
Married	461	52.99
Divorced	27	3.10
Education		
Primary	41	4.71
Secondary school	136	15.63
High school	336	38.62
Higher vocational	53	6.09
University	304	34.94
Occupation		
Employed	527	60.57
Unemployed	50	5.75
Housewife	248	28.51
Self-employed	45	5.17
Childbirth		
First	622	71.49
Second	183	21.03
Third	54	6.21
More than third	11	1.26
Type of birth		
Vaginal	623	71.61
Acute caesarean section	123	14.14
Elective caesarean section	84	7.93
Operative	63	2.99
Timing of delivery		
In term	723	83.10
Pre-term	84	9.66
Post-term	63	7.24

Table 2. Results of the CZ-BSS-R scale 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 labour	870	9.1	4.0	10.0	0.0	16.0
Women's personal attributes	870	4.6	2.2	5.0	0.0	8.0
Quality of care provision	870	11.6	3.5	12.0	1.0	16.0

women who were first-time birth attendants (N = 622) and women who reported that their experience was both good and poor (N = 72). There was a statistically significant effect of a woman's previous experience of childbirth on the total CZ-BSS-R scale and its subscales ($p < 0.05$). Parturients with excellent/good previous birth experience had significantly higher mean scores on the CZ-BSS-R and its subscales than women with previous poor/very poor experience.

Women's satisfaction with childbirth and preparation for childbirth

We compared women's satisfaction with childbirth among 160 respondents (18.39%) who had received antenatal preparation by a midwife or other professional, and 332 respondents (38.16%) who had not received any preparation for childbirth. There was no statistically significant effect of expert-led antenatal preparation ($p > 0.05$) for the total CZ-BSS-R scale or its subscales.

Next, we focused on preparation for childbirth in the form of a birth plan/wish. We included 138 women (15.86%) who had prepared a birth plan before delivery and 332 women (38.16%) who had not prepared for delivery. In the case of the QC subscale, the effect of the prepared birth plan was statistically significant ($p < 0.05$). The mean score of the QC subscale for women with no preparation was significantly higher than that of women with a prepared birth plan. There was no statistically significant effect of a prepared birth plan on women's satisfaction with childbirth for the total scale of CZ-BSS-R and subscales of SE, WA ($p > 0.05$).

Women's satisfaction with childbirth and their subjective perceived psychological state before childbirth

The women were divided into four groups according to their responses: Group 1 – women felt calm and balanced before delivery (N = 553; 63.56%), Group 2 – women felt fear/anxiety before delivery (N = 199; 22.87%), Group 3 – women felt stressed before delivery (N = 92; 10.57%), Group 4 – women felt fear/anxiety and stress (N = 26; 2.99%). The total CZ-BSS-R scale and its subscales showed a statistically significant effect of the psychological state before childbirth on women's satisfaction with childbirth ($p < 0.05$). Women who felt calm and balanced before childbirth were statistically significantly more satisfied with childbirth than women who felt fear, anxiety, and/or stress before childbirth. There are also statistically significant differences in women's satisfaction with childbirth between women in Group 4 (fear, anxiety, stress) and women in Groups 1, 2, and 3. Women's satisfaction with childbirth in the group of women who felt both fear/anxiety and stress before childbirth is statistically significantly lower than women in the other groups. There is a significant association between CZ-BSS-R scores and subjectively perceived psychological state before childbirth.

Women's satisfaction with childbirth and the presence of a close person at the birth

We compared the satisfaction of 667 women (76.67%) who had a close person present at delivery, and 181 women (20.80%) who had no close/known person present at delivery. A statistically significant effect of the presence of a close person at delivery was found for the total CZ-BSS-R scale and its subscales WA and QC ($p < 0.05$). The results of the CZ-BSS-R and these two subscales indicate that women who had a close person present at delivery were significantly more satisfied with their delivery than women who did not have a close/known person present. For the subscale SE, the effect of the presence of a close/acquaintance person was not statistically significant.

Satisfaction with the birth and the presence of a private midwife or doula

22 women (2.53%) who had a private midwife or doula present at delivery and 181 women (20.80%) who had no close/known person present at delivery were included. According to the total CZ-BSS-R scale and all its subscales, the effect of having a private midwife or doula present at delivery was statistically significant ($p < 0.05$). The results of the CZ-BSS-R indicate that women who had a private midwife or doula present at delivery were significantly more satisfied with their delivery than women who did not have a close/known person present.

Women's satisfaction with childbirth in relation toundisturbed contact with the baby after delivery

The sample included 550 women (63.22%) who had uninterrupted contact with the newborn after delivery (the baby was placed on the mother's chest, skin-to-skin, for at least 30 minutes after birth), and 320 women (36.78%) who did not have uninterrupted contact with the baby after delivery. Acording to the total CZ-BSS-R scale and all its subscales, the effect of uninterrupted contact with the newborn after delivery was statistically significant ($p < 0.05$). The results of the CZ-BSS-R and its subscales indicate that women who had uninterrupted contact with their baby after delivery were significantly more satisfied with their delivery than women who did not have uninterrupted contact with their newborn after delivery.

Discussion

We investigated the effect of selected psychosocial factors on women's satisfaction with childbirth. The results may be of benefit to practicing medical staff, as a number of these factors can be influenced by midwives through their care and contribute to a positive birth experience for women.

Primiparity is more often associated with dissatisfaction with childbirth (Nystedt and Hildingsson, 2017; Poikkeus et al., 2014), while multiparity is more often associated with a positive birth experience (Hauck et al., 2007; Mattison et al.,

2018). This may be related to the fact that primipara have higher expectations of childbirth than multipara who have already experienced childbirth (Chabbert et al., 2021). At the same time, however, our findings suggest that the quality of the experience of the previous birth is important. 38 women in our cohort described their previous experience as poor or very poor. These women were also significantly less satisfied with their next birth. Women's negative experience of childbirth tends to be associated with fear of childbirth, unexpected and dramatic birth complications, little social support, and experience of pain and loss of control (Gottvall and Waldenström, 2002). The first negative experience of childbirth affects a woman's reproductive health, including subsequent negative birth experiences.

A woman's antenatal preparation for childbirth is generally considered beneficial. In relation to satisfaction with childbirth, the relationship is not clear. Our study showed no statistically significant difference between the satisfaction of women who attended a professionally supervised antenatal course and those who did not prepare for childbirth. An Italian study (Nespoli et al., 2021) found that women who attended antenatal courses had lower satisfaction on the subscale 'stress experienced during labour' ($p < 0.001$) than women who did not attend courses. The information gained in the course may change or increase women's expectations of their birth experience. The same may be true for women who have prepared birth plans/wishes for their birth. A high number of birth wishes in the birth plan was associated with higher dissatisfaction with the birth experience among women (Mei et al., 2016). In our research, women with a birth plan were less satisfied in terms of the quality of care provided than women without a birth wish/plan. Similarly, in a study by Afshar et al. (2018), women with a birth plan were significantly less satisfied with their birth experience. Their expectations of birth were less often met, and they felt less in control of the situation compared to women who did not have a birth plan. Women's satisfaction with childbirth is related to their expectations and perceptions; a greater discrepancy between the planned and actual experience of childbirth predicts women's lower satisfaction (Preis et al., 2019). It is important for health professionals to discuss expectations with women before birth, tailor interventions to their needs, and support women whose expectations diverge from their experience. Respecting individual preferences while reducing feelings of guilt in women whose expectations have not been met can improve women's health and well-being.

Women's satisfaction with childbirth is also related to their personality and psyche. Anxious women are prone to negative expectations associated with childbirth and may be more anxious about giving birth. In a study by Schaal et al. (2020), anxiety and neuroticism were negatively associated with several dimensions of the birth experience (perceived safety, participation, professional support). Women who scored higher on neuroticism had lower scores on a factor involving their own capacity (success using breathing and relaxation methods, confidence and feeling in control during labour). More neurotic women may be more likely to be uncertain about their decisions, tend to feel more anxious, and have less confidence in their abilities overall (Conrad and Stricker, 2018). In our study, women who had already experienced anxiety, fear, and/or stress before giving birth were significantly less satisfied with their birth experience than women who felt calm and balanced. Women's personality characteristics, such as optimism and positive life adjustment, are associated with greater satisfaction with childbirth (Preis et al., 2022).

Women's satisfaction with the birth experience is influenced by the degree of social support, both from professionals and those close to them (usually the partner). Prenatal perceptions of social support (from partner, family, or friends) and the number of people providing support during labour are positively associated with women's satisfaction with their birth experience (Preis et al., 2022). The importance of social support from the partner during labour was fully demonstrated during the Covid-19 pandemic, when, particularly in the early stages, the availability of support was reduced for many women. The limitation of the presence of the women's attendants at the birth was one of the main concerns women reported.

An important finding from our research is the positive effect of the presence of a private midwife or doula on women's satisfaction with birth. Bohren et al. (2017) report the results of a systematic review in the Cochrane Database on continuous support for women during labour. This support was found to reduce the likelihood of pain medication, operative vaginal delivery, cesarean delivery, and a 5-minute Apgar score of less than 7. Continuous support was also associated with a modest reduction in the length of labour. The basic determinants of quality maternity care include respectful care, communication with the partner, meeting the woman's personal expectations, high professionalism, support from health professionals, involvement of the woman in decision-making, and respect for her choice (Wilhelmová et al., 2022).

Bonding, the uninterrupted skin-to-skin contact between mother and newborn after birth, is also mentioned in the research in relation to satisfaction with childbirth. The relatively simple technique of skin-to-skin contact is already known to benefit both mother and baby (Brubaker et al., 2019; Ghanbari-Homayi et al., 2020). The high number of women in our cohort ($N = 320$; 36.78%) who did not get undisturbed contact with their baby after delivery is striking. This cannot be explained by the number of preterm births ($N = 84$; 9.66%). It is possible that bonding after cesarean section or other operative delivery is uncommon in the Czech Republic. The number of women who experienced operative delivery in our cohort is 247 (28.39%). However, all babies should have access to immediate skin-to-skin contact after vaginal birth, and after cesarean section as soon as the woman is awake and responsive (Stevens et al., 2014). Yet, other studies have also found that skin-to-skin contact is used much less frequently after operative deliveries than non-operative deliveries (Brubaker et al., 2019; Chalmers et al., 2010). This may be due to issues such as lack of nursing staff, outdated routines, and/or lack of knowledge about the benefits of skin-to-skin contact. Skin-to-skin contact is a significant predictor of women's satisfaction with the birth (Mazúchová et al., 2020).

Several limitations of this study need to be addressed. First, the sample was obtained online and was not representative. The advantage of online research is obtaining a large sample of women in a short period of time. However, the sample is then limited to those respondents who have access to social media and technology. Our sample mainly had high school and university education. Another limitation is the cross-sectional study design as we cannot draw conclusions about causality. Another limitation may be the retrospective assessment of births up to 2 years apart. However, Simkin (1992) reports that women recall their childbirth very vividly even after 20 years.

Conclusion

Our research results provide several findings that may be crucial for good practice:

- The first negative birth experience negatively affects women's satisfaction with the subsequent birth. Thus, the negative experience can be chained.
- Woman's antenatal preparation for childbirth and birth wishes are important. Responding to women's expectations and trying to meet them is essential for women's satisfaction.
- Midwives should focus their attention on women who are already experiencing anxiety, fear, and/or stress before birth, providing counselling, support, and possibly contact with professional psychological help.
- The level of social support is important for women's satisfaction with the birth. The presence of a known private midwife or doula has a positive influence.
- Midwives should advocate bonding, *i.e.*, uninterrupted skin-to-skin contact, for all women after childbirth, including women who have had an operative delivery.

Research shows that women's experience of childbirth and birth is highly individual and dependent on several factors. The entire birth process is preceded by some preparation and information, and these experiences shape a woman's expectations of birth, wishes, and plans. Healthcare professionals should know these expectations and wishes, be able to discuss them with the woman, provide evidence for certain practices during labour, ease fears and anxieties, and guide the woman to be flexible and allow for changes that may occur during labour. Women need reassurance, physical contact, an undisturbed environment, a sense of safety, and closeness. Woman-centred care is often considered synonymous with midwifery care. This means that midwifery care is focused on the unique individual needs, expectations, and aspirations of the woman, rather than on the routine needs of the profession or institution.

Ethical aspects and conflict of interest

The authors have no conflict of interest to declare.

Psychosociální faktory ovlivňující spokojenost žen s porodem

Souhrn

Úvod: Spokojenost žen s porodem lze definovat jako retrospektivní hodnocení porodu rodičkou, které odráží její celkovou úroveň spokojenosti, pohody a emocionální reakce na porodní proces.

Cíl: Cílem tohoto výzkumu bylo hledat významné psychosociální faktory, které ovlivňují spokojenost žen s porodem.

Metodika: Byla provedena retrospektivní průřezová studie s využitím online dotazníku. Získali jsme 870 řádně vyplněných dotazníků od žen po porodu. Hlavním měřicím nástrojem byla česká verze revidované Škály spokojenosti s porodem (CZ-BSS-R).

Výsledky: U celkové škály CZ-BSS-R a jejích dílčích škál byl zjištěn statisticky významný vliv předchozí zkušenosti žen s porodem, vliv psychického stavu ženy před porodem a vliv nerušeného kontaktu ženy s novorozencem po porodu ($p < 0,05$). Významně spokojenější s porodním zážitkem byly ženy, které měly u porodu přítomnou blízkou osobu ($p < 0,05$), ale také ženy, které doprovázela při porodu soukromá porodní asistentka nebo dula ($p < 0,05$). Ženy s porodním plánem byly významně méně spokojené s kvalitou péče během porodu než ženy bez porodního plánu ($p > 0,05$).

Závěr: Zdravotníci, zejména porodní asistentky, mají možnost pozitivně ovlivnit porodní zkušenosti žen. Klíčovými prvky péče zaměřené na ženy jsou respekt k jedinečnosti, znalost toho, co ženy od porodu očekávají, věnování pozornosti psychickému stavu žen před porodem, umožnění ženám nerušený kontakt s novorozencem bezprostředně po porodu, právo volby a nepřetržitá péče porodních asistentek.

Klíčová slova: péče orientovaná na ženy; porodní asistence; psychosociální faktory; spokojenost s porodem; Škála spokojenosti s porodem – revidovaná

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