Satisfaction of Women with Labor and Delivery in Rural Punjab, Pakistan: A Cross-sectional Study

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Abstract: Women's satisfaction with the quality of care during pregnancy and childbirth can impact their access to and utilization of healthcare services. Since many women live in rural regions in developing nations, it is crucial to secure their access to and use of basic healthcare services to reduce maternal and newborn morbidity and mortality. This cross-sectional study is part of a first-time, sizeable, mixed-method study involving women and midwives' quantitative and qualitative perspectives on the quality of midwifery care in rural Pakistan. The aim was to describe women's satisfaction with the quality of midwifery care during labor and delivery at basic health units in rural Punjab, Pakistan. Simple random sampling was used to select 328 women from 96 basic health units. Data were collected between December 2020-March 2021. The Labor and Delivery Satisfaction Index measured women's satisfaction with childbirth. Data were analyzed using descriptive statistics and presented in frequencies and percentages.

Results indicated that the majority, 277 (84.5%), were satisfied with the quality of midwifery care during labor and delivery, whereas the remaining 51 (15.5%) were unsatisfied. Appropriate tools to monitor labor and delivery and non-pharmacological pain management during labor need much improvement. The women must also be treated with respect, given accurate information about their labor status, and given control over it. Midwives and other health service providers and administrators can use the findings of this study to improve services available to rural women.

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Introduction

Women's satisfaction with childbirth is a complex multidimensional phenomenon influenced by their views of quality care which provides critical feedback to improve healthcare quality.[1] Evaluating satisfaction with healthcare has appeared as a cost-effective method to estimate healthcare quality.[2] Moreover, assessing

satisfaction may contribute to improving women's childbirth experiences, which may have immediate and long-term implications on their health that may be favorable or unfavorable.[3] On the other side, it was observed that women who are unsatisfied with care tend to develop postpartum depressive symptoms, fear childbirth, have difficulties taking care of the baby and themselves, and have problems in breastfeeding.[4]

In Pakistan, women are not encouraged to visit a health facility due to the fear of losing privacy, and they have no right to decide about childbirth. These cultural norms push them to choose homebirth through trained birth attendants.[5] Less than half of the clients in a Pakistani survey that evaluated the quality of primary healthcare services were pleased with the care they received from the basic health units (BHUs).[6]

The intranatal period is critical for women's and newborns' survival. Any complication during this time can put their lives at risk. Therefore, it is crucial to provide quality midwifery care to achieve Target 3 of the United Nations' Sustainable Development Goals (SDGs) and decrease maternal and neonatal mortality. Efforts on a global scale can help ensure that mothers and their babies can survive situations of labor problems and live healthy lives.[7] Evidence has identified four dimensions of care and support a woman needs during childbirth; physical, informational, emotional, and advocacy.[8] The assistance offered by midwives can improve the birthing process. Moreover, it was observed that the communication between women and midwives is regarding assistive actions rather than encouraging women to participate.[9] Conversely, ineffective communication and a lack of support during labor increase the risk of postnatal mental health conditions such as postpartum depression and posttraumatic stress disorder.[10]

The postnatal period is crucial for the mother and baby to provide essential interventions, but it remains the most neglected. Consequently, this neglect leads to serious complications that cause maternal and neonatal deaths during this period.[11] Improvement in the uptake and quality of postnatal care and fundamental and comprehensive care during emergencies will help to reduce maternal and neonatal death. Additionally, inadequate postnatal care, especially immediately after childbirth, worsens the problem of maternal complications.[12]

Healthcare System in Pakistan

Pakistan is the sixth most populous nation in the world. According to a report, the maternal mortality rate (MMR) is 186 deaths per 100,000 live births. The MMR in urban areas is persistently lower (158/100,000) compared to rural areas (199/100,000).[13] Azad Jammu and Kashmir have the lowest MMR in Pakistan, with 104 fatalities per 100,000 live births. Punjab and Gilgit Baltistan have the highest MMR at 157, followed by Khyber Pakhtunkhwa at 165 and Sindh at 224. Baluchistan has the highest MMR at 298 deaths per 100,000. Regarding the neonatal mortality rate (NMR), overall, it is 44 per 1000 live births. In rural areas, the NMR is high at 62/1000 neonates compared to urban areas, 34/1000.[13] The high MMR is the most significant health indicator still not achieved in Pakistan as per the SDGs. Health indicators are worse in the rural population as compared to the urban population.[14]

Healthcare services are provided by two main sectors: public and private. The public health system works on three levels: the first-level care facilities include basic health units (BHUs), dispensaries, and rural health centers; the secondary-level facilities include tehsil (sub-district) headquarters hospitals; and tertiary-level facilities include district hospitals and teaching hospitals.[15] In rural areas, lady health visitors usually provide maternity services at BHUs, and they predominantly undertake midwifery care and general outpatient services. Lady health visitors are appointed after two years of training. In the first year, they train in midwifery; in the second year, they receive home-visiting training. Another cadre of

midwives is deputed to assist lady health visitors at some facilities. A midwife has one-year training in midwifery only. It was observed that these health providers have no coordination between them, significantly affecting women's health in villages.[16] Conversely, women in remote areas believe private hospitals offer higher-quality services because they always have better facilities, equipment, and doctors on call.[17] This is why most women prefer to deliver at home rather than go to public health facilities.[18] Women's satisfaction with their maternal care and birthing experiences is vital in providing quality, safe health care. Women more satisfied with the care they receive at a health facility are more likely to give birth there.[19] Therefore, exploring women's satisfaction with the quality of care at public health facilities is needed to improve access to health care during labor and delivery.

Aim of Study

This study aimed to descibe women's satisfaction with the quality of midwifery care during labor and delivery at BHUs in rural Pakistan.

Methods

Study Design: This paper reports the quantitative surveying phase in a mixed-method study. A descriptive, cross-sectional design was used. This report is written using the Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) guidelines.[20]

Sample and Setting: This study was conducted between December 2020 and March 2021 in 96 BHUs in four districts of Punjab, Pakistan. The selection of districts was made based on the rural population majority. The inclusion criteria were women who had childbirth without any complication at a BHU, were within six weeks postpartum, and lived in catchment areas of the particular BHU. Yamane's formula was used to calculate the sample size; $n = N/1+N(e)$,[2] $\alpha = 0.5$, n = sample size required, N = number of childbirths per month at BHUs, e = allowable error (5%).[21] The sample size was calculated as the average number of childbirth cases at a BHU was 19 per month, $96*19 = 1824$ women, and further calculated at a ± 5% precision level with a confidence level of 95% and p-value α 0.05. Thus, the sample size required was 328, but 426 participants were estimated after assuming a 30% (98) nonresponse rate. A simple random sampling technique was used, and the participants were selected from the logbooks at BHUs. Initially, 426 women who gave birth at BHUs and were within six weeks postpartum were selected. However, 51 (12%) of women could not be approached due to access issues, 34 (8%) were not at home, and 13 (3%) refused to participate. Finally, 328 women were included in this study.

Instruments: Two instruments were used in this study, described below:

A demographic data sheet was designed to collect personal information, including age, parity, number of children, approximate monthly household income, level of education, and occupation.

The Labor and Delivery Satisfaction Index **(LADSI)** was developed in Canada by Lomas et al.[22] and measures women's satisfaction with childbirth. It is a 38-item questionnaire. Of these items, 23 measure the caring components, while 15 measure the technical components of care. Caring components comprise different aspects of care, such as paying attention, offering help, and behaving well, for example: "The midwife gave me all the care and attention needed during labor and delivery" and "Sufficient attention was paid to comfort during labor and delivery." Technical components are based on competency and abilities required during labor and delivery. Examples are: "Sufficient attention was paid to the safety of mother and baby during labor and delivery" and "The appropriate amount of equipment was used to monitor the labor and delivery." Of 38 items in the LADSI, 21 are framed positively, 17 are negative, and the

score is reverted for the negatively worded questions. The instrument uses a 6-point Likert scale rating from 1 = strongly agree to 6 = strongly disagree. Therefore, higher scores show higher satisfaction in positive and negatively framed items. The possible range of scores is 38-228, and a score of 190 or above indicates satisfaction with labor and delivery.

The findings of two studies confirmed the construct validity of the LADSI. An Indian study has used it to compare women's satisfaction before and after an intervention related to stretching the cervix in labor.[23] Additionally, a randomized controlled trial was used in another study to evaluate satisfaction in an obstetric facility with a midwifery unit.[24] Younes et al. utilized this index to assess women's labor satisfaction and the supportive care provided by the spouse during delivery.[25] However, the internal reliability of the measure found by the instrument's authors is reasonably stable over the two-time points (r = 0.64).[22]

The LADSI was translated into Urdu (Pakistan's national language) by the principal investigator (PI) and a panel of language experts for this study. The semantic or back-translation process was used to translate the instrument, which is the most respected translation process.[26] To evaluate and assure the reliability of the Urdu version of LADSI, reliability testing was conducted after the pilot study. As a result, Cronbach's alpha of the overall LADSI Urdu version was 0.92, an acceptable level of Cronbach's alpha.

Ethical Considerations: The study was approved by the Research Ethics Committee, Faculty of Nursing, Chiang Mai University (No. 095/2019). Permission to approach BHUs to access women's data was obtained from each district's chief executive health officers in Punjab, Pakistan. All participants were informed of the study's goals and methods before the data collection, and their consent was requested for them to participate voluntarily. Informed consent was obtained from all women. Literate women signed the consent forms, whereas women who were illiterate gave their thumb impressions. Participant rights were protected throughout, and everyone could withdraw from the study whenever they wanted, without repercussion. Data confidentiality and privacy were upheld, and the study's findings were broadly conveyed.

Data Collection: Lady health visitors and midwives were requested to share the logbook at BHUs to obtain information about women who had given birth there. They were further asked to provide a facilitator to approach women in catchment areas. After gaining consent, most women were interviewed at home to complete the instruments, whereas a few were interviewed privately at BHUs during their postnatal visit. It took 20-30 minutes to complete the instruments. In addition, four LHVs were hired as research assistants from each district. They were trained about the study and assisted with information gathering and access to the women by telephone.

Data Analysis: The data were analyzed using SPSS 21, and all questionnaires were checked for completeness before entering data. Before analysis, the data were also examined for consistency and outliers. Satisfaction was determined by calculating the total score of each respondent, from 38 to 228, and a score of 190 or above was considered satisfied with care. The frequencies, percentages, means, and standard deviations of the demographic and obstetric variables were described using descriptive statistics. The results of satisfaction were also analyzed with frequencies and percentages.

Results

Of the 328 women participating in this quantitative phase, 209 (63.71%) were contacted three weeks postnatal, while 119 (36.28%) were contacted at 4-6 weeks. **Table 1** depicts the demographic statistics of childbearing women. Their mean age was 27 years, and most (231, 70.4%) were between 21 to 30 years. In terms of educational level, more than half (172, 52.43%) were illiterate, and less than half (141,

42.98%) had attended secondary school or had less education. Only a few (15, 4.57%) had participated in higher secondary school education. Regarding occupational status, most women (301, 91.76%) were housewives, while 27 (8.23%) were working. Regarding the monthly household income, the average household income was approximately 17,000 PKR ($US 63.5). Regarding parity, a few women (24, 7.31%) were primipara, while the majority (304, 92.68%) were multipara.

Table 1. Demographic and obstetric characteristics of women (n = 328)

Characteristics	*N*	%
Age (year)	Mean = 27.10, SD = 4.85	
Educational level		
Illiterate	172	52.43
Secondary or less	141	42.98
Higher than secondary school	15	4.57
Occupation		
Housewife	301	91.76
Working	27	8.23
Household income PKR or US$ (Monthly)	Mean = 17272, SD = 7688	
Postnatal weeks		
0–3 weeks	209	63.71
4–6 weeks	119	36.28
Parity		
1	24	7.31
2–3	178	54.26
≥4	126	38.41

Satisfaction of women

Regarding the results of the LADSI questionnaire, most participants (277, 84.5%) were satisfied with labor and delivery services at BHUs provided by midwives. The remaining 51 (15.5%) were unsatisfied since they scored below 190. The frequencies and percentages of LDSI are presented in **Table 2.** The participants were most unsatisfied with the following items: their wishes being respected 58 (17.7%), the information provided about the progress of labor 54 (16.5%), the staff helping them to feel like this was a special event 50 (15.2%), the midwife paying them sufficient attention 50 (15.2%), and labor and delivery experience 43 (13%). Nineteen participants (5.8%) thought the staff were rude toward them. Some items achieving the highest satisfaction were: 308 (93.9%) women being able to hold their baby as soon as they wanted, 293 (89.3%) being satisfied that the healthcare provider stayed with them as much as they wanted, and 292 (89%) saw their midwife as much as they wanted. Meanwhile, the lowest scored items for technical components were: 77 (23.5%) women did not feel the labor and delivery were in their control, 73 (22.3%) were unsatisfied with the amount of equipment that was used to monitor the labor and delivery, 63 (19.2%) thought the position that was chosen for delivery was not comfortable, and 64 (19.5%) were unsatisfied with the way the pain was managed during labor and delivery. High satisfaction was observed with the number of vaginal examinations 319 (97.3%) and the things done to the baby immediately after birth 306 (93.3). Additionally, 301 (91.8%) were satisfied because sufficient attention was paid to the safety of the mother and baby during labor and delivery. More detailed results regarding the LADSI are given in **Figures 1** and **2.**

Table 2. Score and percentage of satisfaction and unsatisfaction with labor and delivery for each item (n = 328)

Items	Statement	Satisfied		Unsatisfied	
		n	%	n	%
Item 1	I was very satisfied with the care we received during labor and delivery.	288	87.8	40	12.2
Item 2	Sufficient attention was paid to the safety of the mother and baby during labor and delivery.	301	91.8	27	8.2
Item 3	The staff gave us all the care and attention they could during labor and delivery.	279	85.1	49	14.9
Item 4	Some unnecessary interventions were carried out on the mother or baby during labor and delivery.*	310	94.5	18	5.5
Item 5	My wishes were always respected during labor and delivery.	270	82.3	58	17.7
Item 6	I feel happy about this labor and delivery experience.	285	86.9	43	13.1
Item 7	I felt in control of what happened during labor and delivery.	251	76.5	77	23.5
Item 8	I felt that some mistakes were made in the care received from the staff during labor and delivery.*	309	94.2	19	5.8
Item 9	If the staff had been more capable during labor and delivery, I would have been happier with the care received.*	300	91.5	28	8.5
Item 10	I would be feeling better now if the staff had been more considerate during labor and delivery.*	294	89.6	34	10.4
Item 11	The midwife gave me all the care and attention needed during labor and delivery.	291	88.7	37	11.3
Item 12	The midwife gave me all the care and attention I wanted during labor and delivery.	308	93.9	20	6.1
Item 13	I would have liked the staff to have responded to me differently during labor and delivery.*	300	91.5	28	8.5
Item 14	Sufficient attention was paid to comfort during labor and delivery.	278	84.8	50	15.2
Item 15	I would have liked the management of labor and delivery to have been done differently.*	291	88.7	37	11.3
Item 16	There was too much equipment used during labor and delivery.*	291	88.7	37	11.3
Item 17	The staff was sometimes rude to me during labor and delivery.*	309	94.2	19	5.8
Item 18	There were too many staff or students involved in the labor and delivery.*	325	99.1	03	0.9
Item 19	The staff treated me as if this was just one more delivery.*	300	91.5	28	8.5
Item 20	The staff helped me to feel like this was a very special event.	278	84.8	50	15.2
Item 21	The appropriate amount of equipment was used to monitor the labor and delivery.	255	77.7	73	22.3
Item 22	There were occasions when no one explained to me what was going on.*	312	95.1	16	4.9
Item 23	There were unnecessary restrictions on mothers walking around during labor.*	318	97	10	3.0
Item 24	The most comfortable position was used for the actual delivery.	265	80.8	63	19.2

Table 2. Score and percentage of satisfaction and unsatisfaction with labor and delivery for each item (n = 328) (Cont.)

Items	Statement	Satisfied		Unsatisfied	
		n	%	n	%
Item 25	The things done to the baby immediately after birth were all necessary.	306	93.3	22	6.7
Item 26	I held the baby as soon as I wanted.	308	93.9	20	6.1
Item 27	They tried to deliver the placenta too quickly.*	312	98.5	16	1.5
Item 28	I was given all the information needed about progress in labor.	274	83.5	54	16.5
Item 29	The healthcare provider was with me as much as I wanted.	293	89.3	35	10.7
Item 30	I saw the midwife as often as I wanted.	292	89	36	11.0
Item 31	I was satisfied with the way pain was relieved during labor.	264	80.5	64	19.5
Item 32	I was dissatisfied with the way pain was relieved during labor.*	309	94.2	19	5.8
Item 33	There were too many vaginal examinations.*	319	97.3	09	2.7
Item 34	My birth plans were ignored.*	307	93.6	21	6.4
Item 35	Recovery time in labor and delivery was too rushed.*	300	91.5	28	8.5
Item 36	The health care provider made the labor and delivery a better experience.	300	91.5	28	8.5
Item 37	I wish all midwives were as good as mine.	306	93.3	22	6.7
Item 38	The midwife made the labor and delivery a better experience.	303	92.37	25	7.6

*Score was reversed for negatively framed items (A higher score shows strong disagreement which means high satisfaction).

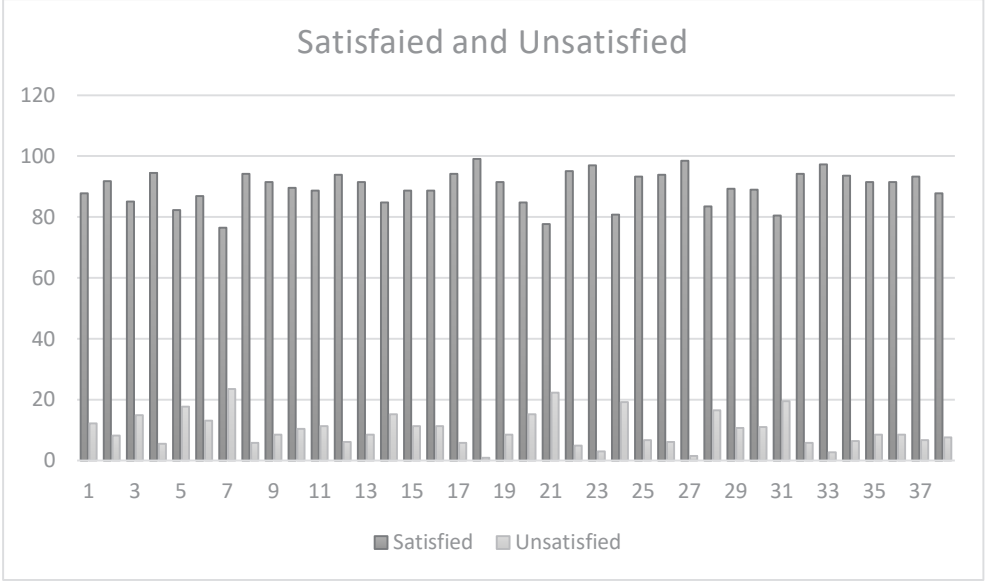

Figure 1. Graph showing the percentages of satisfaction and unsatisfaction with labor and delivery for each item (n = 328)

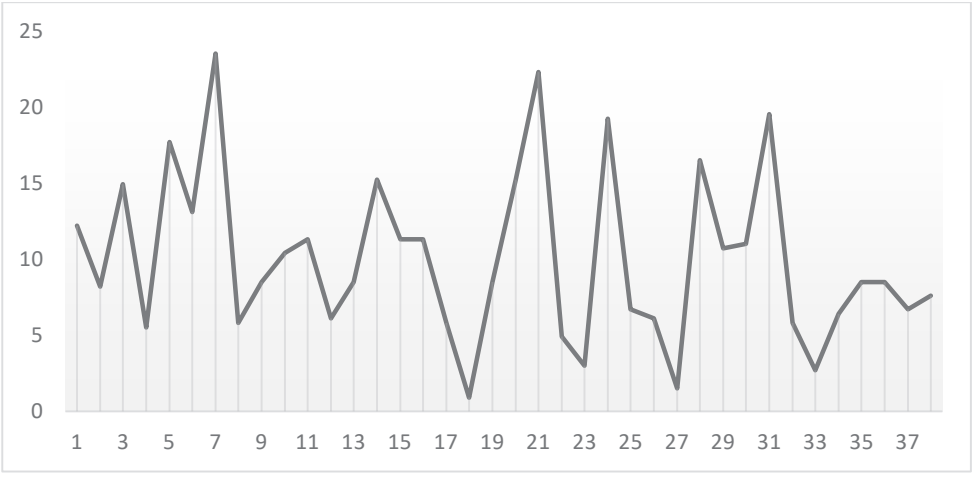

Figure 2. Unsatisfaction with labor and delivery (n = 328)

Discussion

This study found that most women were satisfied with labor and delivery services at basic health units in rural Punjab, Pakistan. The results are consistent with the original study reported by Lomas et al.[22] However, the results of our study were slightly lower than research from America that used the LADSI to measure labor and delivery satisfaction[27] and the scores are higher than a study from Norway evaluating women's satisfaction with the midwifery unit versus the obstetric unit using the same tool.[28] Some other studies have used different tools to evaluate women's satisfaction. Evidence from Ethiopia states that the overall satisfaction of mothers with their delivery service was 81.7%.[28] However, another African study from Swaziland evaluated women's level of satisfaction with the quality of intranatal care, and their findings were slightly lower than ours.[19] However, our research findings do not concur with the European research conducted in Slovakia, which observed the overall satisfaction level of women with childbirth was 56.56%, which is relatively lower than our study.[29] Furthermore, a local study from Lahore, another district in Punjab, found only 20% of women were happy with the childbirth experience at maternal and child health centers.[30]

Our study found that the satisfaction level reported by rural women in Pakistan was relatively high. However, this may be because the women overestimated the quality level, as over half were illiterate. High satisfaction ratings have been attributed to several reasons, such as women from rural areas do not have much exposure to different care settings and lack awareness regarding standard care.[31] It was also observed that mothers who gave birth in basic health facilities tended to be more satisfied than mothers who gave birth in hospitals.[31]

Caring components identified in the study include caring for women and newborns during labor and delivery, respecting women's wishes during labor and delivery, paying attention during labor and delivery, and provision of information regarding the progress of labor. These attributes are very vital to make the childbirth experience happy. According to studies, the delivery of technical care relies on these caring components, which also determine how well it will work.[19]

Women and their families need information regarding their labor progress, as inadequate or delayed information can lead to dissatisfaction or postpartum depression.[32] According to a study from Ethiopia, 27% of mothers were unsatisfied with the healthcare

providers' explanation.[28] These findings are higher than the results of this study. However, a local study from another district in Punjab found higher results, as 61.12% of women complained that the midwives did not allow them to ask questions.[30] Additionally, a recent study from Malaysia found one-third of the women reported it was not explained to them what was going on during labor which is slightly higher than this study.[33]

Our results show that the midwives at BHUs were caring. However, 16.5% of the women thought the staff were not helpful, and a study from Ethiopia reported similar findings.[28] The present study's findings are higher than a local study from Sindh, Pakistan, which found health care providers' behavior could only satisfy 16% of the women in their services at public health facilities.[34]

The women in our study thought during labor, a midwife should respect their wishes and that they planned for their childbirth. They also demand autonomy from healthcare providers during this process. In this regard, some midwives met the women's expectations, although others fell short. The findings of our study are congruent with a local study that noted more than 80% of the women were happy with the midwife and thought they positively contributed to their care.[18] While less than 6% of women felt that the midwife was rude sometimes, this is a matter for midwives to reflect on and address.

Women in labor want a qualified health professional that can continuously monitor the whole process and could pay attention to their needs. Our findings present that most women felt satisfied with the availability of midwives as required and the attention midwives provide during labor and delivery, which is congruent with a recent study from Malaysia.[33]

Technical components: These include women feeling in control during labor and delivery, the appropriate amount of equipment used, comfortable positioning, and pain management during labor and delivery. Midwives with adequate skills can ensure high-quality maternity care for the women in their care.

Control during labor depends on women's behavior during childbirth. This control determines how satisfied a woman is with her behavior, and this focuses on controlling labor pain.[29] A sense of control during labor satisfies women, but in our study, some women did not feel this control. Similarly, some previous studies show dissatisfaction among women in this regard. For example, in an African study, women were offended during labor by repeated vaginal examinations and the absence of privacy.[28] Another African study reported that half of the women in their study felt upset for being left alone while needing attention and verbal and physical abuse.[31] Additionally, a recent study from Malaysia reported almost one-third of the women felt that things were not in their control.[33]

Adequate supply and equipment at basic health facilities also contribute to the high satisfaction of women. A previous study from rural Sindh shows a lack of supplies and equipment for labor and delivery in public hospitals.[18] Although many women were satisfied with the equipment used during their care, this item was among the lowest-scored items in this study. The score of our study was lower than the previous study from Africa, where 90% of the women were satisfied with the availability of supplies and equipment.[28]

During childbirth, women change position as their labor progress. Changing positions makes them feel comfortable and relaxed and think their labor is in control. Moreover, changing position helps reduce the duration of labor.[35] In our study, some women were unsatisfied with the position of their choice used during labor and delivery, like in a previous study.[29] It is suggested that women should be educated about the benefits of changing positions and be assisted with appropriate posture during labor.[36]

Pain during labor is normal, but managing pain is a complex task currently. Pain can be managed with pharmacological and non-pharmacological methods. Research suggests that women's satisfaction with birthing increases as labor pain intensity reduces.[37] A knowledgeable and expert midwife can manage this

time.[38] This study found some women were unsatisfied with how pain was relieved, although it was not determined how pain was managed. It is suggested that non-pharmacological management of pain during labor can be managed by reassurance, changing position, rubbing off the back and giving a massage, relaxation, cold or warm bathing, and providing information about the progress of labor.[39]

Limitations

There were some limitations; the main one was data collection. Since all the women surveyed had normal childbirth without complications and healthy babies, they might not have been as critical during the midwives' labor and delivery processes and care. In such a case, they might have ignored unsatisfactory circumstances. Moreover, women in rural areas may find it difficult to report negative experiences as they live in the same vicinity where healthcare providers such as midwives live. In addition, being interviewed within their home might have caused women not to respond freely. In a cultural sense, they might have wanted to greet the researcher as a guest, as it is valued in villages when someone comes from a distance. Further, this study was conducted in four districts of Punjab, Pakistan. Thus, the results of this study might not apply to other provinces of Pakistan, which deserve further exploration in future studies to confirm the results.

Conclusion and Implications for Midwifery Practice, Policy, and Research

Women's satisfaction with childbirth is a crucial indicator for evaluating the quality of maternal health services. Thus, assessing how satisfied they were with the care given during labor and delivery has emerged as a critical factor in evaluating healthcare services and policy standards. The current study revealed that women's overall satisfaction was high with the labor and delivery services provided by midwives at basic health units. However, there is still a need for improvement, such as the availability of proper equipment to monitor labor and delivery and non-pharmacological management of pain during childbirth. It is also necessary that the women are provided respect and appropriate information about the labor progress and that they have control over their labor.

Our findings have implications for countries other than Pakistan because many women reside in rural areas where pregnancy care is compromised. Governments must ensure women's access to high-quality primary health facilities to provide quality maternal and neonatal health care. The development and implementation of appropriate cultural strategies for effective measures to enhance mother satisfaction with labor and delivery will be improved by identifying the structure and process of women's satisfaction with childbirth at BHUs. Nursing and midwifery leaders and researchers are vital in gathering evidence regarding maternal satisfaction with care and drawing this to government and health policymakers' attention. Further research on women's satisfaction with maternal and infant care is vital in Pakistan to affect health policy and investment. Midwives and nurses have a critical role and must include women in research and policy processes.

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ความพึงพอใจของสตรีเกี่ยวกับการเจ็บครรภ์และการคลอดบุตรในชนบทของแคว้นปัญจาบ ปากีสถาน: การศึกษาแบบภาคตัดขวาง

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บทคัดย่อ: ความพึงพอใจของสตรีที่มีต่อคุณภาพการดูแลระหว่างตั้งครรภ์และการคลอดบุตรอาจส่งผลต่อการเข้าถึงและการใช้บริการด้านสุขภาพ เนื่องจากสตรีเป็นจำนวนมากในประเทศที่กำลังพัฒนามักอาศัยอยู่เขตพื้นที่ชนบท การดูแลให้สตรีเข้าถึงการใช้บริการสุขภาพขั้นพื้นฐานจึงเป็นสิ่งที่สำคัญยิ่งที่ช่วยลดอัตราการเจ็บป่วยและการเสียชีวิตของผู้เป็นมารดาและทารกแรกเกิด การศึกษาแบบภาคตัดขวางนี้เป็นส่วนหนึ่งของการศึกษาแบบผสมผสานครั้งแรกในกลุ่มตัวอย่างขนาดใหญ่ที่มีการเก็บและวิเคราะห์ข้อมูลเกี่ยวกับมุมมองในเชิงปริมาณและเชิงคุณภาพของสตรีและผดุงครรภ์เกี่ยวกับคุณภาพของการผดุงครรภ์ ในชนบทปากีสถาน โดยมีวัตถุประสงค์เพื่อศึกษาความพึงพอใจของสตรีที่มีต่อคุณภาพการผดุงครรภ์ในช่วงที่เจ็บครรภ์และคลอดบุตรที่หน่วยสุขภาพพื้นฐานในพื้นที่ชนบทของแคว้นปัญจาบ ประเทศปากีสถาน ใช้การสุ่มตัวอย่างอย่างง่ายเพื่อเลือกสตรี 328 คนจาก 96 หน่วยสุขภาพพื้นฐาน เก็บข้อมูลระหว่างเดือนธันวาคม 2020 ถึงมีนาคม 2021 วัดความพึงพอใจของสตรีเกี่ยวกับการคลอดบุตรโดยใช้ดัชนีความพึงพอใจเกี่ยวกับการเจ็บครรภ์และการคลอดบุตร วิเคราะห์ข้อมูลโดยใช้สถิติเชิงพรรณนา นำเสนอในรูปความถี่และร้อยละ

ผลการศึกษา พบว่า สตรีส่วนใหญ่ 277 คน (84.5%) พึงพอใจกับคุณภาพการผดุงครรภ์ที่ได้รับระหว่างเจ็บครรภ์และคลอดบุตร ในขณะที่ 51 คนที่เหลือ (15.5%) ไม่พึงพอใจ ความพร้อมและเหมาะสมของเครื่องมือที่ใช้ในการประเมินติดตามการเจ็บครรภ์และการคลอด ตลอดจนการจัดการความเจ็บปวดโดยไม่ใช้ยายังเป็นส่วนที่ยังต้องปรับปรุง สตรีต้องได้รับการปฏิบัติด้วยความเคารพ ให้ข้อมูลที่ถูกต้องเกี่ยวกับการเจ็บครรภ์คลอดและการควบคุมการเจ็บครรภ์ ผดุงครรภ์และผู้ให้บริการด้านสุขภาพอื่น ๆ และผู้บริหารสามารถใช้ผลการวิจัยนี้เป็นแนวทางเพื่อปรับปรุงการบริการสำหรับสตรีในชนบท

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