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Perceptions and Satisfaction in Intrapartum Care among Obese and Non-Obese Women

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ABSTRACT

Background: Obesity is a major global health issue that negatively impacts pregnancy and childbirth. Maternal obesity is linked to various antenatal, intrapartum, and postpartum complications. Ensuring quality care is essential for safe outcomes for both mother and child. **Methods:** A comparative cross-sectional study was conducted among a total of 250 mothers, with 112 being non-obese and 138 being obese. These mothers gave birth in eight governmental hospitals. The study aimed to explore the factors that affect the experiences and satisfaction levels of obese and non-obese women during intrapartum care. **Results:** All non-obese women (100%) and 99.3% of obese women reported positive experiences regarding their capacity during childbirth. Most women in both weight groups felt well-supported and safe. However, both groups reported 100% negative experiences in the participation domain. Satisfaction with physical facilities was low, with 42.9% of non-obese and 38.4% of obese women satisfied. Both groups showed 100% dissatisfaction with the provision of consumables. Pain management methods were satisfactory for 63.4% of non-obese and 60.9% of obese women. Communication patterns had the lowest satisfaction rates among all participants. **Conclusion:** The study's findings underscore the critical need for improvements in various dimensions of intrapartum care. The significant dissatisfaction with participation, physical conditions, and communication strategies among both obese and non-obese women highlights the urgent areas for enhancement in maternity care facilities. This research is a crucial step towards improving the quality of care and ensuring safe outcomes for both mother and child.

Keywords: Childbirth Experience; Intrapartum Care; Obesity; Satisfaction with Intrapartum Care; Weight Bias

INTRODUCTION

Nurses, as the primary carers during the intrapartum period (Hamarash *et al*., 2023), play a pivotal role in providing care that significantly influences the birth experience and satisfaction levels for both obese and non-obese women (Abdullah & Ibrahim, 2024). Obesity is a global health epidemic, as defined by organisations like the World Health Organisation (WHO, 2000) and the National Institutes of Health (NIH) in the United States (Abelson & Kennedy, 2004). It is characterised by a body mass index (BMI) above 30 kg/m², calculated by an individual's weight in kilograms divided by the square of their height in meters (Weir & Jan 2019).

WHO categorises weight based on BMI into four groups: underweight (<18.5 kg/m²), average weight (18.5–24.9 kg/m²), overweight (25.0–29.9 kg/m²), and obesity (≥30 kg/m²). In 2016, WHO reported a significant increase in obesity, with 40% of adult women overweight and 15% obese (Devlieger *et al.*, 2016). Obesity poses a substantial threat to global health, leading to an increasing proportion of pregnant women being overweight or obese (Alkhyatt *et al*., 2012). Maternal obesity is associated with various risks and complications during pregnancy, including gestational diabetes, high blood pressure, and cesarean delivery (Simko *et al*., 2019). These complications often necessitate additional medical interventions, impacting childbirth experiences and satisfaction levels. Research indicates that healthcare services often struggle to meet the unique needs of overweight and obese women, underscoring the importance of tailored care (Shaw *et*

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al., 2016; Sulaiman *et al.*, 2023). A positive childbirth experience is crucial for the health of both the mother and the baby. Factors contributing to a positive experience include good communication, support, and respect for the mother's wishes. However, obese pregnant women often report feelings of humiliation, stigmatisation, and discomfort when discussing their weight with healthcare professionals (Dieterich & Demirci, 2020). Traumatic births can lead to post-traumatic stress disorder (PTSD) symptoms, affecting 3-4% of women in the postnatal period and 15-19% of those who experienced high-risk or complicated deliveries (Moran Vozar *et al*., 2021). Obese women are at a higher risk for induction of labour and caesarean sections compared to non-obese women (Lim & Mahmood, 2015).

Satisfaction with childbirth care is an indicator of hospital care quality. Obesity-related discrimination can negatively affect care quality, leading to reduced communication, inadequate pain management, and lower overall satisfaction (Melese *et al*., 2014). Weight stigma may result in increased anxiety, fear, and reluctance to seek necessary healthcare during pregnancy and childbirth for obese women, impacting their physical and psychological well-being (Hill & Rodriguez, 2020). Midwives and healthcare providers must consider factors affecting a woman's birth experience and tailor care accordingly. Addressing weight-related stigma is essential to improve the overall childbirth experience for obese women and promote their physical and emotional well-being (Mattison *et al*., 2018). Developing individualised care plans is fundamental in intrapartum care. For obese women, this may include monitoring for potential complications such as gestational diabetes, hypertension, and prolonged labor. Nurses must assess each patient's medical history, health status, and personal preferences to create a comprehensive care plan. This study aims to explore factors contributing to the experiences and satisfaction levels of obese and non-obese women during intrapartum care. Understanding these factors is vital for improving the quality of care for all women, regardless of their weight, and ensuring positive and safe childbirth experiences.

METHODOLOGY

Study Design

The research used a descriptive comparative cross-sectional study design from October 1, 2023, to May 28, 2024. The focus was on exploring factors influencing the differences in experiences and satisfaction between obese and non-obese women during intrapartum care in governmental hospitals in Nineveh province.

Data Collection Period

Data was collected from November 8, 2023, to March 20, 2024, across eight governmental hospitals in Nineveh province.

Study Sample

The study utilised a non-probability sampling method to select postpartum women from eight governmental hospitals' postpartum units. The sample included women from two weight groups: healthy weight and obese. The inclusion criteria required participants to have recently given birth at one of the selected hospitals and to be classified into one of the two weight groups based on their Body Mass Index (BMI).

Sampling Methodology

Selection Criteria: Women who had recently given birth and were classified as either healthy weight (BMI 18.5–24.9 kg/m²) or obese (BMI ≥30 kg/m²) were eligible to participate. These classifications were based on WHO standards (Mahmmoed, Ibrahim & Abdulgani, 2020; (Mahmood *et al*., 2022; Mohammed & Ibrahim, 2023).

Recruitment Process

Participants were recruited from the postpartum units of the eight hospitals. Hospital staff assisted in identifying eligible women, and researchers approached these women to explain the study and obtain their consent.

Sample Size

A total of 250 postpartum women were included in the study, with 112 categorised as healthy weight and

138 categorised as obese.

Sampling Diversity

Although the sample was non-random, diverse recruitment strategies ensured a broad representation of both healthy weight and obese women across the eight hospitals.

Data Collection Consistency

Standardised data collection procedures were implemented, including uniform training for data collectors and the use of a structured questionnaire, to maintain consistency across all study sites.

Data Collection

Interviewer-administered questionnaires were used, taking about 30 to 40 minutes per participant.

Inclusion and Exclusion Criteria

Inclusion Criteria: Women with expected vaginal delivery from both weight categories.

Exclusion Criteria: Women with pre-existing medical conditions, multiple pregnancies, language barriers, those who declined to participate, and those whose babies had died during delivery.

Data Collection Tools

The study employed a questionnaire divided into three parts:

Demographic Data and Obstetric Characteristics: Variables like hospital name, maternal age, educational level, BMI, gestational age, gravidity, parity, the onset of labour, and mode of delivery.

Childbirth Experience Questionnaire (CEQ): Validated in Sweden, assessing participation, own capacity, perceived safety, and professional support.

Satisfaction with Intrapartum Care Scale: Developed after a literature review and expert input, containing 20 questions rated on a five-point Likert scale.

Validity

A panel of 17 experts from various specialities confirmed the tools' validity, ensuring clarity, relevance, and applicability.

Reliability

Reliability was measured using Cronbach's alpha, yielding values of 0.9 for the CEQ and 0.92 for the satisfaction scale, indicating high reliability.

Pilot Study

Twenty-five participants participated in a pilot study from November 10 to 30, 2023, to identify potential obstacles, test reliability, and assess cooperation with the researcher.

Statistical Analysis

Data were anonymised and analysed using SPSS version 26. Descriptive and inferential statistical methods were employed to comprehensively understand the relationships between demographic and obstetric characteristics and satisfaction levels during intrapartum care. Descriptive statistics, including means, standard deviations, frequencies, and percentages, were used to summarise the demographic and obstetric characteristics of the study participants. This initial analysis provided a clear overview of the sample's composition, such as age, BMI categories, parity, and gestational age at delivery. Inferential statistics were employed to explore relationships and differences between groups.

Ethical Consideration

This study got ethical approval from the Ethical Research Committee of College of Nursing, University of Mosul, Iraq with reference number 79/CCMRE-Nur-23-21 on 13th December, 2023.

RESULTS

Table 1: Frequency and Percentage of the Total Samples (Normal Weight and Obese Weight among Women) of the Hospitals Included in the Study (n= 250)

Hospital Name	Frequency (f)	Percentage (%)
Al-Batol teaching hospital	58	23.2
Mosul general hospital	53	21.2
Al-Salam teaching hospital	53	21.2
Sheikhan general hospital	9	3.6
Tal-Afar general hospital	32	12.8
Bartella general hospital	9	3.6
Al-Hamdaniya general hospital	20	8.0
Al-Qayarah hospital	16	6.4
Total	**250**	**100**

Table 1 provides an overview of the frequency and percentage distribution of the total sample (n = 250) of women, categorised as either normal weight or obese, across eight hospitals included in the study. The highest representation of participants comes from Al-Batol Teaching Hospital (23.2%), followed closely by Mosul General Hospital and Al-Salam Teaching Hospital, each contributing 21.2% of the sample. Hospitals with smaller sample contributions include Sheikhan General Hospital and Bartella General Hospital, both at 3.6%. Other notable contributions are from Tal-Afar General Hospital (12.8%), Al-Hamdaniya General Hospital (8.0%), and Al-Qayarah Hospital (6.4%). This distribution highlights the variability in sample sizes across different healthcare facilities, reflecting the diversity and accessibility of healthcare services within the region.

Table 2: Mean and Standard Deviation of BMI, Height, and Weight of Both Groups (Normal Weight Group n=112 and Obese Weight Group n=138)

Characteristics	All Participants	Average Weight (n=112)	Obese Weight (n=138)
Height (cm)	M = 157.46	M = 156.41	
	SD = 5.72	SD = 5.8	
Weight (kg)	M = 65.25	M = 65.25	M = 83.23
	SD = 7.7	SD = 7.7	SD = 9.2
BMI	M = 26.42	M = 26.42	M = 34.33
	SD = 2.34	SD = 2.34	SD = 3.49

Table 2 summarises the mean (M) and standard deviation (SD) of height, weight, and BMI for all participants (n = 250) and the two groups: normal weight (n = 112) and obese weight (n = 138). The overall mean height is 157.46 cm (SD = 5.72 cm), slightly lower in the normal weight group (156.41 cm, SD = 5.8 cm). The mean weight is 65.25 kg (SD = 7.7 kg) for all participants and the normal weight group, while it is significantly higher in the obese group at 83.23 kg (SD = 9.2 kg). Similarly, the mean BMI for all participants and the normal weight group is 26.42 (SD = 2.34), compared to a much higher BMI of 34.33 (SD = 3.49) in the obese group. These findings underscore distinct differences in body composition, particularly weight and BMI, between the normal weight and obese groups.

Table 3 highlights the maternal characteristics of normal weight and obese women, showing notable differences between the two groups. Obese women had higher rates of primary school education (56.5%) and multigravidity (79.7%) compared to normal weight women (46.4% and 62.5%, respectively), while diploma holders were exclusively present in the normal weight group (5.4%). Term births were predominant in both groups, with similar rates (94.6% normal weight, 94.2% obese), although preterm births were slightly more frequent among normal weight women (5.4%). Obese women experienced more induced labour (55.8%) and multiparity (79%), whereas spontaneous labour (58.9%) and primiparity (41.1%) were more common in the normal weight group. Both groups predominantly had spontaneous vaginal deliveries (100% in the normal weight group, 98.6% in the obese group), with assisted vaginal delivery being rare, observed only in 1.4% of obese women. These findings suggest potential impacts of maternal weight on gravidity, parity, labour onset, and educational attainment.

Table 3: Frequency and Percentage of Maternal Characteristics in Both Groups (Normal Weight = 112, Obese Weight = 138)

Characteristics	All Participants	Normal Weight (n=112)	Obese Weight (n=138)
Education			
Uneducated	18 (7.2%)	16 (14.3%)	30 (21.7%)
Primary School	52 (20.8%)	52 (46.4%)	78 (56.5%)
Secondary School	31 (12.4%)	31 (27.7%)	25 (18.1%)
Diploma	6 (2.4%)	6 (5.4%)	0 (0%)
BSc Degree	5 (2.0%)	5 (4.5%)	5 (3.6%)
Gestational Age			
Preterm Birth	6 (2.4%)	6 (5.4%)	4 (2.9%)
Term Birth	236 (94.4%)	106 (94.6%)	130 (94.2%)
Post-term Birth	4 (1.6%)	0 (0%)	4 (2.9%)
Gravidity			
Primigravida	70 (28%)	42 (37.5%)	28 (20.3%)
Multigravida	180 (72%)	70 (62.5%)	110 (79.7%)
Parity			
Primipara	75 (30%)	46 (41.1%)	29 (21%)
Multipara	175 (70%)	66 (58.9%)	109 (79%)
Onset of Labor			
Spontaneous Labor	127 (50.8%)	66 (58.9%)	61 (44.2%)
Induced Labor	123 (49.2%)	46 (41.1%)	77 (55.8%)
Mode of Delivery			
Spontaneous Vaginal Delivery	248 (99.2%)	112 (100%)	136 (98.6%)
Assisted Vaginal Delivery	2 (0.8%)	0 (0%)	2 (1.4%)

Table 4: Frequency and Percentage of Each Variable Answers in the Childbirth Experience Questionnaire (CEQ) of Normal Weight Women (n=112)

Childbirth Experience Questionnaire (CEQ)	Disagree	Mostly Disagree	Mostly Agree	Agree
Labor and birth went as I had expected	27 (24.1%)	28 (25%)	24 (21.4%)	33 (29.5%)
I felt strong during labor and birth	0 (0%)	33 (29.5%)	69 (61.6%)	10 (8.9%)
I felt capable during labor and birth	0 (0%)	19 (17%)	49 (43.8%)	44 (39.3%)
I was tired during labor and birth	7 (6.3%)	22 (19.6%)	22 (19.6%)	61 (54.5%)
I felt happy during labor and birth	6 (5.4%)	31 (27.7%)	43 (38.4%)	32 (28.6%)
I felt that I handled the situation well	2 (1.8%)	8 (7.1%)	63 (56.3%)	39 (34.8%)
As a whole, how painful did you feel childbirth was?	No pain (0%)	Mild pain (3%)	Moderate pain (46%)	Unbearable pain (63%)
As a whole, how much control did you feel you had during childbirth?	No control (27%)	Little control (14%)	Moderate control (32%)	Complete control (39%)
My midwife devoted enough time to me	0 (0%)	11 (9.8%)	57 (50.9%)	44 (39.3%)
My midwife devoted enough time to my partner	24 (21.4%)	26 (23.2%)	47 (42%)	15 (13.4%)
My midwife kept me informed about what was happening during labor and birth	0 (0%)	15 (13.4%)	43 (38.4%)	54 (48.2%)
My midwife understood my needs	1 (0.9%)	23 (20.5%)	67 (59.8%)	21 (18.8%)
I felt very well cared for by my midwife	0 (0%)	3 (2.7%)	57 (50.9%)	52 (46.4%)
I felt scared during labor and birth	16 (14.2%)	19 (17%)	30 (26.8%)	47 (42%)
I have many positive memories of childbirth	46 (41.1%)	9 (8%)	43 (38.4%)	14 (12.5%)
I have many negative memories of childbirth	81 (72.3%)	15 (13.4%)	9 (8%)	7 (6.3%)
Some of my memories from childbirth make me feel depressed	94 (83.9%)	8 (7.1%)	8 (7.1%)	2 (1.8%)
My impression of the team's medical skills made me feel secure	0 (0%)	6 (5.4%)	32 (28.6%)	74 (66.1%)
As a whole, how secure did you feel during childbirth?	Not at all secure (4%)	Little secure (13%)	Moderate secure (38%)	Completely secure (57%)
I felt I could have a say in whether I could be up and about or lie down	22 (19.6%)	32 (28.6%)	23 (20.5%)	35 (31.3%)
I felt I could have a say in deciding my birthing position	112 (100%)	0 (0%)	0 (0%)	0 (0%)
I felt I could have a say in the choice of pain relief	112 (100%)	0 (0%)	0 (0%)	0 (0%)

Table 4 reveals mixed experiences of normal-weight women during childbirth, as assessed by the Childbirth Experience Questionnaire (CEQ). While many felt strong (61.6%) and capable (43.8% mostly agreed, 39.3% agreed), significant fatigue (54.5% agreed) and high levels of pain (63% reported unbearable pain) were common. Although 57% felt completely secure during labour, and 66.1% agreed the medical team's skills made them feel secure, autonomy in decision-making was limited, with 100% reporting no say in their birthing position or pain relief. Midwife care was generally rated positively, with 46.4% agreeing they felt well cared for and 48.2% agreeing they were kept informed, though support for partners was less emphasized. However, childbirth left many with negative emotional impacts, as 72.3% reported negative memories and 83.9% felt depressed by their memories. These findings highlight the need for greater attention to pain management, emotional support, and patient autonomy during childbirth.

DISCUSSION

The study captured data from 250 women across eight hospitals, uncovering a significant prevalence of obesity that reflects broader global health trends. This epidemic of obesity is particularly pronounced in urban settings where sedentary lifestyles and poor dietary choices are more common. High participation rates in hospitals like Al-Batol Teaching Hospital, Mosul General Hospital, and Al-Salam Teaching Hospital suggest higher healthcare accessibility or a greater incidence of obesity, which necessitates targeted healthcare interventions tailored to these regions' specific challenges and demographic realities.

The study by Chen, Xu and Yan (2018) estimates that 38.9 million overweight and obese pregnant women and 14.6 million obese pregnant women existed globally in 2014. In upper-middle-income countries and lower-middle-income countries, there were sharp increases in the number of overweight and obese pregnant women. In 2014, the percentage of females with overweight and obesity in India was %, and India had the most significant number of overweight and obese pregnant women (4.3 million), which accounted for 11.1% in the world. In the United States of America, a third of women are obese, and the number of obese pregnant women is 1.1 million.

The gap between expected and actual childbirth experiences is a significant issue that impacts a woman's psychological and emotional health, contributing to stress and anxiety that can affect their overall childbirth and postpartum experience. Prenatal education plays a crucial role in bridging this gap by preparing pregnant women not only physically but also emotionally and psychologically for childbirth, covering everything from labour processes to pain management and potential complications (Dencker *et al*., 2019).

Studies, such as those by Downer *et al*. (2018), have shown that realistic expectations can greatly enhance childbirth outcomes by making women feel more in control and less anxious. Healthcare providers are essential in this educational journey, tasked with providing medical care and ensuring women are mentally and emotionally prepared. This involves discussing potential scenarios and interventions like caesarean sections or the use of forceps and actively engaging in setting realistic expectations. Integrating family and partners in this educational process also enhances its effectiveness, creating a supportive environment that reduces the mother's anxiety and equips loved ones to be effective advocates during labor. Continuous education for healthcare providers, which keeps them updated on the latest obstetric practices and methodologies, ensures that prenatal counselling is informed by the most current best practices (Missler *et al.*, 2020). Ultimately, aligning expectations with reality through comprehensive and empathetic prenatal education significantly reduces the discrepancies women experience during childbirth, improves satisfaction levels among new mothers, and contributes to better long-term maternal health outcomes, fostering a more positive birthing experience for all involved (Modak *et al*., 2023).

Professional Support During Childbirth: Professional support during childbirth plays a critical role in shaping the childbirth experience, especially for obese women who may face unique challenges and higher risks during delivery. The variation in satisfaction levels observed among obese women underscores the necessity for healthcare providers to receive specialised training that is specifically designed to address the needs of this demographic (Marshall *et al.*, 2022). Further study supports the implementation of tailored care protocols for obese pregnant women. These protocols not only anticipate and manage the specific risks associated with obesity in pregnancy—such as gestational diabetes, hypertension, and the potential for

caesarean delivery—but also focus on the nuances of providing emotional and psychological support. For example, obese women may experience more anxiety and fear about labour and delivery, concerns about judgement from healthcare staff, or fear of complications, all of which can impact their overall childbirth experience (Alayli *et al*., 2020).

Specialised training for healthcare providers should include guidance on effective communication strategies that promote empathy, respect, and understanding. This training should also educate about the physical accommodations that might be necessary for obese patients, such as the use of specialised surgical instruments or modified delivery positions to ensure safety and comfort during labour and delivery (Lindhardt *et al*., 2015).

Furthermore, healthcare providers should be trained in the latest best practices for managing labour interventions, monitoring foetal health, and recognising the early signs of complications in obese pregnancies. This level of detailed and specific training can empower providers to deliver care that not only addresses the medical aspects of childbirth but also supports the emotional and psychological needs of obese women, ultimately leading to enhanced patient outcomes and satisfaction (Reither, Germano & DeGrazia, 2018). The need for such focused training is critical not only for improving the immediate health outcomes of mother and child but also for ensuring that the childbirth experience is positive and affirming, contributing to long-term maternal and infant health. By integrating these specialised training protocols, healthcare systems can better support obese women through their childbirth journey, fostering a more inclusive and supportive birthing environment.

Pain Management and Control: The reports of intense pain and a perceived lack of control during childbirth, particularly among obese women, underscore the urgent need for healthcare providers to revisit and enhance current pain management strategies. Obesity can complicate the administration and effectiveness of standard pain relief methods due to variations in pharmacokinetics and anatomical differences, which may necessitate adjustments in dosages and techniques. Integrating evidence-based practices specifically tailored to the needs of obese women is crucial. One such practice is the use of epidural analgesia, which has been extensively studied and proven effective in managing labour pain for this demographic (Bandyopadhyay *et al*., 2014).

Labor epidural analgesia is an increasingly used technique for pain relief in parturients. A 2011 Cochrane database review on pain management for women in labor recognized epidural analgesia as the most effective pain management technique compared to inhaled analgesia, systemic opioid and non-opioid analgesics, and non-pharmacologic interventions. It allows high maternal satisfaction rates regarding pain management, the sense of control in labor, and general childbirth experience" (Rimaitis *et al*., 2015).

Moreover, the implementation of epidural analgesia for obese women should be accompanied by training for healthcare providers in the specific technical skills required for this procedure in obese patients, who may present more challenges in needle placement due to anatomical considerations. Healthcare teams should also be prepared to monitor the effects of epidural analgesia more closely in obese women, adjusting care as necessary to optimise outcomes (Hoang & Forkner Moore, 2021).

Beyond technical adjustments, healthcare providers should foster a supportive environment that addresses the emotional aspects of childbirth pain management. This includes clear communication about pain management options and expected outcomes, which is essential for empowering women to make informed decisions about their pain management during labour (Bonapace *et al*., 2018). Therefore, revising pain management protocols to include the use of epidural analgesia tailored for obese women, along with enhanced provider training and patient education, can lead to better management of labour pain and a more positive childbirth experience for obese women.

Postpartum Care Quality: The quality of postpartum care is a critical component of the overall maternal healthcare experience, yet the dissatisfaction expressed by many new mothers regarding the facilities and services they receive during this period highlights significant areas for improvement. Effective postpartum care is essential not only for the physical recovery of the mother but also for her emotional and psychological well-being, impacting her ability to bond with and care for her newborn (Rose, Powell & Davis, 2024).

The research underscores the importance of high-quality postpartum care. For instance, a study by Webb *et al*. (2021) revealed that improvements in postpartum care facilities, including the physical environment and the availability of supportive services, can lead to markedly better health outcomes and higher satisfaction rates among new mothers. This study points to areas where enhancements are needed, such as more comfortable sleeping arrangements, better pain management protocols, and comprehensive breastfeeding support (Webb *et al*., 2021). Enhanced postpartum care also involves providing mothers with accessible and compassionate follow-up care. This includes adequate instruction on how to care for themselves and their babies, which can reduce the incidence of postpartum depression, improve infant care practices, and enhance the overall health of the mother and child. Additionally, the availability of mental health support and counselling should be standard to address any emotional and psychological issues that may arise after childbirth (Barbosa *et al*., 2016). Improving postpartum care facilities also means ensuring that staff are well-trained in postpartum care best practices. Healthcare providers should be equipped with the knowledge and skills to offer empathetic support, recognise symptoms of complications early, and respond effectively. This level of care requires a well-coordinated approach involving obstetricians, nurses, paediatricians, and mental health professionals (Chelagat, 2015).

Therefore, to address the gaps in postpartum care quality, health systems must invest in upgrading facilities, enhancing staff training, and implementing integrated care models that consider all aspects of a mother's health following childbirth. Doing so can significantly improve maternal satisfaction and contribute to better long-term health outcomes for both mothers and their infants (Duysburgh *et al*., 2015).

Limitation

This study has several limitations that may affect the generalisability and reliability of its findings. The use of nonprobability sampling means the results may not represent the larger population of women giving birth in diverse settings. Reliance on self-reported data introduces potential biases, such as recall and social desirability bias, while the cross-sectional design limits causal interpretations. Additionally, language and cultural nuances may not have been fully captured, and the focus on governmental hospitals may not reflect experiences in private or rural healthcare settings. Future research should address these limitations by using random sampling, longitudinal designs, culturally validated tools, and including diverse healthcare settings.

CONCLUSION

The analysis of intrapartum care satisfaction among 250 women, categorised into average weight and obese groups, highlights several critical areas for improvement in patient care. Key findings from the study indicate moderate dissatisfaction with physical facilities, unanimous dissatisfaction with the provision of consumables, and significant dissatisfaction with communication patterns of healthcare providers despite relatively higher satisfaction with pain management methods.

The study highlights the need for comprehensive improvements in intrapartum care to address areas of dissatisfaction among patients. Upgrading hospital infrastructure, including better cleanliness and comfort in maternity wards, is essential to enhance the birthing experience. Ensuring a consistent supply of consumables through robust supply chains is critical to meet patient needs. Personalised pain management protocols should be developed to address individual preferences, while targeted training programs for healthcare providers can improve communication skills and foster empathy. Additionally, establishing clear guidelines, regular audits, and patient feedback systems is vital for continuous improvement. Future research should explore diverse healthcare settings using mixed-method approaches to provide a deeper understanding of factors influencing patient satisfaction, ensuring equitable and high-quality care across various populations.

Conflict of Interest

The authors declare that they have no competing interests.

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