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Women's Health Science Journal

ISSN: 2639-2526

Women's Expectations and Experiences of Childbirth: A Cross-Sectional Study

Hirwa P[1] and Nazik E[2]*

[1]Department of Nursing, Institute of Health Sciences, Cukurova University, Turkey
[2]Department of Obstetrics and Gynecological Nursing, Faculty of Health Sciences, Cukurova University, Turkey

***Corresponding author:** Evsen Nazik, Department of Maternity and Gynecological Nursing, Faculty of Health Sciences, Cukurova University, 01330, Adana, Turkey, Tel: 05054525263; Email: eceevsen_61@hotmail.com

Research Article
Volume 8 Issue 2
Received Date: August 20, 2024
Published Date: September 20, 2024
DOI: 10.23880/whsj-16000234

Abstract

This study was carried out with the aim of determining the expectations and experiences of women during childbirth. This cross-sectional study was conducted with 117 women. The data were collected in two stages (before and after childbirth). Data were collected from using Personal Information Form, obstetric Information Form and The Thai Childbirth Expectation & Experience Questionnaire (TCEEQ). It was found that 76% of the TCEEQ items that each woman expected to happen did happen (fulfilled expectations), whereas 24% of these items did not happen (Unmet expectations). Of the items each woman did not expect to happen, 35% of the items actually did happen (Unexpected experiences) and 65 % of these items did not happen (Null experiences). It was found that there was a significant correlation between mean score of fulfilled expectation and satisfaction with the birth. (p=0.000). In this study, it was found that the women were satisfied with intrapartum care and most of their expectations were met. Overall, while there is a significant amount of research on this topic, there is still much to be learned about women's expectations and experiences during childbirth, particularly from their perspectives.

Keywords: Birth Expectation; Birth Experience; Nursing Care

Abbreviations

TCEEQ: Thai Childbirth Expectation & Experience Questionnaire.

Introduction

Childbirth is a significant event in a woman and her family's life and it encompasses all types of feelings from excitement and happiness to stress and tiredness. In addition, it may include unanticipated outcomes [1-3]. This makes expectations about this process very complex and dynamic. Women's birth expectations are commonly about delivery type and labor duration, idealized baby, obstetric outcomes, breastfeeding, support, control and pain management during labor. In addition, studies have found that women also have different expectations about the relationship with their spouses, baby care, housework, emotional support and economic support [4,5]. In a study conducted by Uzel HY, et al. it was determined that 84% of women wanted to eat, 97.8% wanted to be supported emotionally, 96.6% wanted to have a relative or companion during the birth process. It was found that 95% of women did not want their birth to be induced, 95.1% did not want fundal pressure application, 92.6% of participants did not want enema and 95.1% of women did not want episiotomy [6]. In another study by Aktaş S, et al. it was found that women expected nurses and midwives to be friendly, to be duly informed, to be listened

to, to be encouraged, and their privacy protected [7].

The expectations of women about birth are influenced by past birth experiences, prenatal classes and risky pregnancies, family, society, cultural values and traditions of their communities [4,5]. Birth experience is defined as a woman's personal feelings and interpretations of the birth process. The birth experience can be perceived as positive or negative.1 a positive birth experience is defined as one that results in a healthy baby born in a clinically and psychologically safe environment. Positive birth experience incorporates birth companion of choice, control, effective communication, respect, participation of patient in the informed decision-making process, use of pain relief methods, oral fluid and food intake, freedom of movement and position, continuity of care, referral plan, the personal and sociocultural beliefs of patient and expectations during labor been met. A positive birth experience improves the woman's sense of accomplishment, self confidence and self-esteem. Also, it facilitates the transition to motherhood, and strengthens the mother-baby bond [1,4,8,9]. Lack of support, feeling of being under duress during labor, and neglect of the mother's needs by health professionals while catering for that of the newborn only, fear, severe pain, ineffective communication, lack of intimacy or privacy and obstetric complications lead to a negative birth experience [10].

Negative birth experience affects women and baby health and is associated with postpartum depression, post-traumatic stress disorder, interpersonal relationship problems, weak mother-baby bond, child abuse and neglect, breastfeeding problems, fear of childbirth, sexual problems, widened intervals between pregnancies, increase in elective cesarean operations and an increase abortion rate [2,11-15]. Studies on expectations and experiences of childbirth show that women have different expectations and that there is a correlation between birth expectations and birth experiences. It has been shown that determining and meeting women's birth expectations is associated with a positive birth experience and a high level of birth satisfaction. As a consequence, dissatisfaction with birth leads to postpartum psychological adjustment difficulties, higher abortion rates, increase in the rates of elective cesarean births, and breastfeeding problems [4,5,16,17].

Today, patient satisfaction is a significant measure of the quality of health services and plays an important role decision making in health care services [14,15,18,19]. Intrapartum care; aims not only to reduce both maternal and infant mortality and morbidity rate but also to provide a positive and satisfactory birth experience. Therefore, satisfaction with intrapartum care has become an important issue for healthcare providers, administrators, and policy makers [8]. So it is important to determine women's birth expectations and to evaluate whether these expectations are met or not. Healthcare professionals should ensure that these expectations are met in order to improve the quality of provided health care services. Nurses and midwives have a strong influence on the birth experience as they are the healthcare professionals who spend the most time with women during childbirth. Nurses/midwives should determine the expectations of women and ensure that they have a positive birth experience [20,21]. In order to provide a quality obstetric care service, obstetrical nurses and midwives should determine and consider women and their families' birth expectations and experiences during care, and ensure that they have a positive birth experience [22]. This research was conducted to determine women's birth expectations and experiences.

Methods

Study Design and Setting

A descriptive and cross-sectional research design was used for this study. In this study, it was aimed to determine women's expectations and experiences with regards to childbirth. It was conducted at a state hospital in the southern part of Turkey between January and July, 2021.

Participants

Participants were recruited using random sampling method. The inclusion criteria were women who were 18 years or above, had vaginal delivery, had singleton pregnancy, had no pregnancy complications, mental and psychological problems, had no communication difficulties and understood and spoke Turkish fluently and participated in the research of their own volition. Power analysis was performed in the G-Power program for the sample size. Based on the Birth Expectations and Experiences Scale-2 total score (2.3±0.4) found in Muslu and Yanıkkerem study, the total sample size was calculated at 90% power and alpha=0.05 error level was found to be 117 [23]. The study was carried out with 119 women, taking into account the women's desire to leave the study and incomplete filling of the questionnaires. However, 2 participants were excluded from the study because they underwent cesarean section due to non-progressive labor and fetal distress. The study was completed with 117 women.

Data Collection

Data were collected using Personal Information Form, Birth-Related Characteristics Information Form and The Thai Childbirth Expectation & Experience Questionnaire (TCEEQ).

Personal Information Form: The personal information form prepared in line with the literature information, includes the socio-demographic (age, education status, employment status, economic status, family type, etc.) and obstetric characteristics (week of gestation, number of pregnancy, desire for pregnancy, etc.) of the pregnant women [23-27]. It consists of 18 questions.

Birth-Related Characteristics Information Form: This form prepared in line with the literature is a form consisting of 5 questions including healthcare professionals who assisted in the delivery process, duration of labor, medical interventions applied during birth, the development of complications during the birth process and the availability of social support [23-27].

The Thai Childbirth Expectation & Experience Questionnaire – (TCEEQ): This scale, which was developed by Tanglakmankhong in 2008, consists of two parts [28]. The first part (questionnaire-1) evaluates women's expectations of childbirth and consists of 36 items with item in questionnaire-1 being a binary Likert type scale that can be answered as "Yes" or "No". Answering yes means women had expectation regarding the item; Answering No means women did not have expectation regarding the item. The second part (questionnaire-2) evaluates women's experience and satisfaction of the birth process and consists of 37 questions. The first 36 items evaluate women's experience of childbirth with each item being a binary likert type that can be answered as "Yes" or "No". Answering Yes means women experienced the item; Answering No means women did not experience the item. In item 37, the woman is asked to evaluate their overall satisfaction with the birth experience. It is answered on a four-point Likert scale as "not satisfied, low satisfied, moderately satisfied, and very satisfied". The average of birth expectations is calculated by adding the first 36 items in questionnaire-1. The average of birth experience is calculated by adding the first 36 items in questionnaire-2, item 37 is not included in calculating that average. Match /mismatch between expectations and experiences are evaluated as "Fulfilled expectation", "Unmet expectation", "Unexpected experiences" and "null experiences".

Fulfilled Expectations occur when what a woman expected about her upcoming childbirth actually happened during childbirth.
Unmet Expectations occur when what a woman expected about her upcoming childbirth did not actually happen during childbirth.
Unexpected Experiences occur when what a woman did not expect about her upcoming childbirth actually happened during childbirth.
Null Experiences occur when what a woman did not expect about her upcoming childbirth did not actually happen during childbirth.
Match/Mismatch between women's expectations and experiences of childbirth.

$$\text{Fulfilled Expectation} = \frac{\text{Questionnaire 1 Yes} + \text{Questionnaire 2 Number of Yes} \times 100}{\text{Total Number of Yes}}$$

$$\text{Unmet Expectation} = \frac{\text{Questionnaire 1 Yes} + \text{Questionnaire 2 No Number} \times 100}{\text{Total Number of Yes}}$$

$$\text{Unexpected Reception} = \frac{\text{Questionnaire 1 No} + \text{Questionnaire 2 Yes Number} \times 100}{\text{Total No}}$$

$$\text{Unexpected Reception} = \frac{\text{Questionnaire 1 No} + \text{Questionnaire 2 No} \times 100}{\text{Total No}}$$

The Cronbach alpha value of the original scale was found to be 0.94.28 In the Turkish reliability study of the scale by Muslu and Yanikkerem, the Cronbach alpha value was found to be 0.89 [23]. In this study, the Cronbach alpha value was found to be 0.95.

Procedure

The data were collected by the researchers in two stages through face-to-face interviews. The first part of the interviews was conducted after women were admitted to the delivery unit. In this interview, the Personal Information Form and part 1 of the TCEEQ (questionnaire-1/ expectations) was filled. The participants were interviewed again while the women were in the obstetrics ward after delivery as the second part of data collection. In this interview, the Birth-Related Characteristics Information Form and part 2 of the TCEEQ (questionnaire-2/ experience) was filled. Each interview lasted between 20 and 30 minutes.

Data Analysis

Statistical tests such as Frequency tables, descriptive statistics and logistic regression were conducted using SPSS (IBM SPSS Statistics 24) to analyse data. Logistic regression [Binary: Backward LR] model was used to evaluate the level of dissatisfaction with birth.

Ethical consideration

The research proposal of this study was approved by the Non-Interventional Clinical Research Ethics Committee of XX University Faculty of Medicine. In addition, official permission letter was obtained from the institution where the research was conducted and informed consent was obtained from all participants.

Results

It was determined that the mean age of participants was 26.47±5.69 (years) and 33.4% of them were between ages 21 and 25. It was determined that 29.9% of the pregnant women were secondary school graduates, 89.7% were unemployed, 82.1% of women had spouses who were employed and 53% had no social security. It was determined that 51.3% of participants had family income values equivalent to their expenses, 80.3% of them lived at a city centre and 76.9% of them lived in a nuclear family (Table 1).

Variable (N=117)	n	%
Age [X±S.S.→26,47±5,69(Y1l)]≤20	18	15,4
21-25	39	33,4
26-30	30	25,6
>30	30	25,6
Education level Illiterate	6	5,2
literate	4	3,4
Primary school	26	22,2
Middle School	41	35,0
High school	22	18,8
University and above	18	15,4
Spouse education level Illiterate	2	1,7
Literate	3	2,6
Primary school	24	20,5
Middle school	34	29,1
High school	35	29,9
University and above	19	16,2
Employment status		
yes	12	10,3
No	105	89,7
Spouse employment status		
Yes	96	82,1
No	21	17,9
Social security		
Yes	55	47,0
No	62	53,0
Income rate		
Income less than expenses	55	47,0
Income equals to expenses	60	51,3
Income more than expenses	2	1,7
Place of residence		
Countryside	9	7,7
Town	14	12,0
City center	94	80,3
Family type		
Nuclear family	90	76,9
Extended family	27	23,1
Town	14	12,0

Table 1: Distribution of socio-demographic characteristics of women.

The distribution of obstetrical characteristics of pregnant women in labor is given in (Table 2). It was determined that 29.1% of the women were primigravida, a gestational week of ≥38 were reported for 88.9% of participants. It was determined that 82.1% of the pregnancies were wanted, 32.5% were nullipara, and 34.2% had no living child. It was determined that 73.5% of the pregnant women had no abortion/curettage history, 99.1% received information about prenatal care and 91.4% received information from a doctor and nurse and midwife (Table 2).

Variable (N=117)	N	%
Gravidity		
primigravida	34	29,1
multigravida	83	70,9
Gestational week		
<38 weeks	13	11,1
≥38 weeks	104	88,9
Previous pregnancy time interval		
No previous pregnancy	34	29,1
Less than 24 months	19	16,2
More than 24 months	64	54,7
Wanted pregnancy		
Yes	96	82,1
No	21	17,9
Parity		
nullipara	38	32,5
Primipara	33	28,2
Multipara	46	39,3
Living children number		
None	40	34,2
One	32	27,4
Two	22	18,8
Three	19	16,2
≥four	4	3,4
Abortion/curettage number		
None	86	73,5
One	23	19,6
≥Two	8	6,1
Obtaining information about birth		
Yes	116	99,1
No	1	0,9
Information resource		
Doctor	10	8,6
Nurse and Midwife	106	91,4

Table 2: Distribution of obstetric characteristics of women.

In this study, it was determined that 52.1% of deliveries were carried out by midwives, 75.2% of deliveries occurred within a labor period under 16 hours, and 65.8% of pregnant women did not take oxytocin during delivery. It was observed that episiotomy was performed in only 12.8%, 99.1% of deliveries did not involve the use of forceps/vacuum extraction. Whiles the 91.5% of the participants received social support, 52.2% of this support came from midwives. Only 8.5% cases reporting postpartum hemorrhage. None of the cases recorded was classified as a prolonged labor, whiles 95.7% of the cases recorded no fetal distress during delivery and 79.52% of the cases were reported as non-difficult delivery (Table 3).

Variable (N=117)	N	%
Professional in charge of baby delivery		
Midwife	61	52,1
Doctor	5	4,3
Doctor and Midwife	51	43,6
Duration of Labor		
<16 hours	88	75,2
≥16 hours	29	24,8
Administration of Oxytocin		
Yes	40	34,2
No	77	65,8
Episiotomy		
Yes	15	12,8
No	102	87,2
Forceps/vacuum application		
Yes	1	0,9
No	116	99,1
Use of Social support		
Yes	107	91,5
No	10	8,5
Social support Provider		
Nobody	10	8,5
Midwife	61	52,2
Doctor	4	3,4
Doctor and Midwife	42	35,9
Hemorrhaging during labor		
Yes	10	8,5
No	107	91,5
Prolonged labor		
Yes	-	-
No	117	100,0
Fetal distress		
Yes	5	4,3
No	112	95,7
Dystocia		
Yes	24	20,5
No	93	79,5

Table 3: Characteristics of participants related to delivery.

When the expectations of women are examined; It was determined that the expectation was very high in the 4,11,12,13,16, 19, 20, 22, 25, 28, 29, 30, 33, 34, 35 and 36 items of the scale. 97.4% of participants expected to be informed immediately when something goes wrong with them or the baby, while 98.3% expected nurses/midwives will take good care of the baby after birth, 99.1% expected to be involved in making decisions about treatments and care during the birth process, 99.1% expected to a doctor be available to help when something goes wrong during birth and all of them (100%) expected the baby and themself to be safe during birth (Table 4).

Items	Expected %	Experienced %
1. I got medication to reduce pain.	7,7	39,3
2. I got medication to induce labor	26,5	34,2
3. I had special instruments for checking my baby's health.	79,5	96,6
4. I had a vaginal examination for checking cervix dilatation.	90,6	100,0
5. I had intravenous fluids	74,4	97,4
6. I had food and fluids withheld during labor and birth.	66,7	94,0
7. I had other laboring women stay in the same room during labor	23,1	1,7
10. I was able to contact my family during labor	70,9	67,5
11. I got supportive care from nurses/midwife during labor.	95,7	89,7
12. I received information from nurses/midwife about methods of pain relief.	91,5	88,9
13. I received information from nurses/midwife about my progress of labor.	96,6	90,6
14. I had my legs strapped on metal stirrups during delivery.	71,8	13,7
15. I was in a private delivery room during delivery	80,3	100,0
18. I was delivered by a doctor.	49,6	47,9
19. I was informed immediately when something is wrong with me or my baby.	97,4	11,1
20. I was involved in decision making about my care and treatments during the delivery process.	99,1	94,0
23. I had an episiotomy	65,0	12,8
24. I had anesthetic medication before the episiotomy	62,4	53,8
25. Doctor was ready to help at any time if something was wrong with me during delivery	99,1	98,3
26. Student nurses took care of me during my labor and birth.	74,4	73,5
27. Nurses/midwife spoke to me politely.	87,2	84,6
28. Nurses/midwife treated my family politely.	94,0	88,9
29. Nurses/midwife helped me talk with the doctor.	94,9	96,6
30. Nurses/midwife contacted the doctors for me if I wanted to consult the doctors.	94,0	96,6
31. Nurses/midwife were happy to help me	88,9	86,3
32. Nurses/midwife were busy and may not have time to take care of me	40,2	13,7
33. Nurses/midwife brought my baby to me immediately after birth.	92,3	93,2
34. Nurses/midwife took very good care of my baby after birth.	98,3	88,9
35. My baby and I were safe during labor and birth.	100,0	93,2
36. My husband and my family had a chance to hold my baby after birth.	94,0	92,3

* The scale items of TCEEQ -1 include the future tense. The scale items of the TCEEQ -2 include the past tense.
Table 4: Percent of women who expected and experienced each item-TCEEQ*.

It was determined that women experienced the 3, 4, 5, 6, 13,15,17, 20, 25, 29, 30, 33, 35 and 36 items of the scale at a high rate. When the experiences of women were examined; It was determined that 96.6% of women had special devices

used in checking baby's health distress, 96.6% received help from "Nurses/midwives in communicating with doctors, 97.4% of women were given IV fluids, 98.3% of the cases had a doctor available to help if something went wrong during delivery, all women (100%) had a vaginal examination to check cervical dilatation and all deliveries were carried in non-shared private rooms (Table 4).

	Happened During Childbirth	
	yes	no
Women expected to happen	Fulfilled expectations M =75,69 % SD=10,87	Unmet expectations M =24,31% SD=10,87
Women did not expect to happen	Unexpected experiences M=34,86% SD=20,02	Null experiences M =65,14% SD=20,02

Table 5: The average percent and standard deviation for the four measures of match/mismatch between a woman's expectations and experiences in childbirth.

(Table 5) shows the average percent and standard deviation of the four types of matches/mismatches in expectations and experiences about childbirth. On average 76% of the items that each woman expected to happen did happen (fulfilled expectations), whereas 24% of these items did not happen (Unmet expectations). Of the items each woman did not expect to happen, 35% of the items actually did happen (Unexpected experiences) and 65 % of these items did not happen (Null experiences). It was found that the mean satisfaction scale score of TCEEQ (item 37) was 3.36±0.75. It was also determined that 54.7% of participants were very satisfied with intrapartum care.

As a result of the Backward logistic regression analysis based on dissatisfaction with the birth, The model was established with the scores of met expectation, unmet expectation, unexpected satisfaction, unexpected unmet scores and some parameters. Accordingly, it was determined that the expectation scale score met significantly affected the dissatisfaction with intrapartum care ($p=0.000<0.05$). When the fulfilled expectation scale scores increase by 1 unit, the risk of dissatisfaction with intrapartum care will decrease by 11.6% (OR=0.884<1) (Table 6).

	B	S.H.	Wald	sd	p	OR	95% Confidence Interval(OR)	
							Alt	Ust
Fulfilled expectations	-0,124	0,034	13,191	1	0,000	0,884	0,826	0,945
Unexpected experiences	0,006	0,016	0,134	1	0,714	1,006	0,975	1,037
Constant	6,535	2,536	6,638	1	0,010	68,874		
CCR=92,3% $\chi 2$=8,647; p=0,373								

Table 6: Determining the factors affecting satisfaction with intrapartum care.

Discussion

This study, which was conducted to determine the expectations and experiences of women's birth, is discussed below in line with the relevant literature. In the study, it was determined that the health professionals who conducted the deliveries were generally midwives. The rate of medical interventions (oxytocin, episiotomy, forceps) applied during birth was low, and the participants received support in various ways from a midwife/nurse during birth. This result is in line with the WHO's intrapartum care recommendations for positive birth experience and the mother-friendly hospital program [8]. In the intrapartum care model, it emphasizes the importance of providing a satisfactory birth experience, as well as preventing the development of birth complications in women and babies [8]. The mother-friendly hospital program aims to increase the quality and quantity of maternal health services, and to ensure that expectant mothers have access to safe and quality delivery services [29]. This result was expected since the hospital where the research was conducted is appraised to be a mother-friendly hospital by the national health ministry and can serve as a model for other maternal health clinics in the country and beyond.

The expectations of most expectant mothers included accessibility of health personnel when necessary, getting information from health personnel (self, baby, birth process, etc.), food/beverage restrictions, having a relative by their side, receiving supportive care, being in contact with the family and staying in an unshared private room during labor and delivery. Other expectations of the women

included inclusive decision- making process, respect, no ill-treatment, immediate access to the baby right after delivery, and a feeling of safety. In the study of Aktaş S, et al. during the birth process, expectant mothers stated that they expected nurses and midwives to be friendly to them, to be duly informed, to be listened to, to be encouraged, and their privacy protected [7]. Uzel HY, et al. in their study reported the following expectations of expectant mothers: no food intake restriction, emotional support and a relative by their side during childbirth. It was found that women do not want the application of induced labour, fundal pressure, enema and episiotomy procedures [6]. In the review by Marques et al. and Webb et al. it was determined that women generally have expectations for conditions such as obtaining information about the mode and duration of delivery, having a healthy baby, breastfeeding, provision of support during birth, control, and pain reduction [4,5]. With the exception of the study by Uzel HY, et al. in which women did not expect food intake restriction running contrary to the expectations of women in our study, the findings in our study was compatible with those of reviewed literature presenting a picture of generally similar expectations among expectant mothers. The participants stated that they were part of the decision making processes throughout labor and birth, had vaginal examinations, vascular access procedures, food/beverage restriction, and contact with their family, supportive care from a midwife/nurse, information updates, and the privacy of giving birth in a room without the presence of other patients. They also reported that they felt safe, health personnel were accessible, respectful, and they were allowed to see their babies immediately after birth. From these findings we can infer that the expectations of the women were met in most cases. The study finding is similar to those of Muslu A, et al. [23] and Tanglakmankhong K [28]. The reason for this is thought to be due to the fact that the hospital where the research was conducted is a mother-friendly hospital, the health professionals working in the maternity unit and obstetrics service attach importance to the care of pregnant women and take into account the expectations of expectant mothers. In addition, considering that the data of the study were collected under the constraints of the COVID-19 pandemic, the hospital's obstetrics unit can be considered to be in good standing.

It was established that most of the women participating in the study were satisfied with the birth process. We arrived at this conclusion in light of the fact that the birth expectations of the participants were fulfilled in almost all the cases. The current literature shows that fulfilling the wishes and applicable expectations of women in labor increase general satisfaction level [30-32]. Cases of normal vaginal deliveries under the guidance of midwives that did not involve obstetric interventions and did not result in any complication recorded higher levels of satisfaction in various related studies. Cases of planned normal vaginal deliveries that eventually required an interventions such as the use of the help of forceps or vacuum devices and emergency cesarean sections resulted in negative birth experiences and decreased satisfaction levels [15,33,34]. It has been reported that women who gave birth in units with midwives had a more positive birth experience and a higher level of satisfaction with care [15,35-38]. Receiving support at birth was associated with a high level of satisfaction [8,9,14,39-41]. Control in labor provides positive emotion and a high level of satisfaction [15,42,43]. Mei JY, et al. in a study found that the fulfillment of women's wishes was associated with birth experience, general satisfaction and the sense of control during birth [44]. Application of obstetric interventions to the mother and baby and the development of complications negatively affect the level of satisfaction with the birth experience [14,45-47]. In the study of Sandall J, et al. it was reported that women who took midwife-led continuous care models were less likely to have an obstetric intervention and were more likely to be satisfied with care [48].

It was determined that the expectation score met in the study significantly affected the state of being dissatisfied with the birth. When the fulfilled expectation scores increase by 1 unit, the risk of being dissatisfied with the birth decreases. Similarly, Webb R, et al. found that inconsistency between birth expectations and experiences reduces satisfaction with the birth experience [5]. Patient satisfaction is the most common concept used to evaluate the quality of care [49]. It is important to determine the birth expectations of expectant mothers and to appraise the level of fulfillment of these expectations in terms of improving the quality of health services and care provided.

Conclusion

Most of the birth expectations of the women in this study were markedly met and there was general expression of satisfaction with the birth process. It was found that there is a significant relationship between met expectations and birth satisfaction level. Positive birth experience affects satisfaction positively. Satisfaction plays an important role in evaluation of a quality obstetric care service. Taking the results of this study and those of similar studies into consideration, it is important for nurses, midwives and other health professionals to take into account the expectations of expectant mothers so as to ensure positive experience during birth and increase the level of satisfaction with the entire birth process.

Funding

This research did not receive any specific grant from funding agencies in the public, commercial, or not-for-profit sectors.

Research Ethics

This study was approved by the Clinical Research Ethics Committee (number: 2020/105-42, date: October 6, 2020) of the Cukurova University. Each participant provided voluntary written informed consent. This study was conducted in accordance with the principles of the Helsinki Declaration.

Disclosure Statement

No potential conflict of interest was reported by the authors.

Authorship Statement

All listed authors have contribution to this work. PH and EN designed the study, collected the data, conducted the analysis and prepared the draft. All authors approved the final version of the manuscript for submission.

Acknowledgements

This is a master thesis. We wish to thank the women who participated.

Data Availability Statement

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

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