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Sadiqa Shafiq
Research Scholar at Institute of
Home Science, University of
Kashmir, Hazratbal, Srinagar,
Jammu and Kashmir, India

Satisfaction of women with care during labour and childbirth: A study

Sadiqa Shafiq

Abstract

Women's satisfaction with maternity services, especially care during birth and labor, has become increasingly important to health care providers, administrators, and policy makers. Research shows that women's satisfaction with childbirth is partly related to the health and well-being of the mother and her baby. The current study aims at finding whether women are satisfied with care during labor and birth in Kashmir. For the current study 100 women who had recently experienced childbirth and were still admitted in hospital were selected from both the rural and urban areas of Kashmir region. 50% women had normal delivery, while as, 5%, & 45% had forceps and caesarean delivery respectively. Rural woman 51.2% (n=43) are satisfied with cleanliness and comfort in the hospital as compared to urban women 48.8% (n=41). However, a higher number of women (n=62) were not satisfied with the drug and equipment and (n=76) were not satisfied with accessibility of toilets, out of which 47.4% (n=36) belong to rural areas and 52.6% (n=40) belong to urban areas. (n= 77) report that staff assists in breast feeding, out of which 53.2% (n=41) belong to rural area and 46.8% (n=36) belong to urban area. It can be concluded that we get a mixed response from the subjects, most of the rural women in Kashmir are quite satisfied with Care during Labor and Childbirth as compared to urban women, however, certain areas need prompt action and attention especially in supplies and equipment in birth centers and the amenities and interpersonal aspects in the public hospital.

Keywords: labour, satisfaction, delivery, hospitals, care

1. Introduction

Woman refers to a person's gender identity. Women with typical genetic development are usually capable of giving birth from puberty until menopause. Throughout history women have assumed or been assigned various social roles. Womanhood is the period in a female's life after she has passed through childhood and adolescence, generally around the age of 18. Pregnancy is a time of tremendous physiological changes and these changes demand healthful dietary and lifestyle choices. (Coatingius 1998) [3]. This 40-week period is often divided into three trimesters of 13 or 14 weeks each; however, this division does not reflect specific stages in fetal development. Following fertilization of the egg (ovum) comes the blastogenic stage-a period of rapid cell division. As these cells divide they begin to differentiate. The inner cells in this growing mass will form the fetus; the outer layer of the cells will become the placenta. During this stage which lasts about two weeks, the fertilized ovum implants himself in the wall of its mother's uterus. Extends from the end of the second week through the eighth week after conception. The placenta the vital organ that serves as a conduit between mother and child forms in the uterine wall during this stage. Attached to the placenta by the umbilical cord the embryo now receives its nourishment from its mother, and nearly everything the mother eats, drinks, or smoke reaches the embryo. The embryonic stage also is a period of organogenesis. By the time the embryo is 8 weeks old, all of the main internal organs have formed, along with the major external body structures. Because nutrient deficiencies or excesses and intake of harmful substances can result in congenital abnormalities (birth defects) or spontaneous abortion (miscarriage) this stage is critical period of development. (Cnatinguis S., *et al.*, 1996) [2]. Childbirth is also known as labor, delivery, birth, partus, or parturition, is the culmination of a period of pregnancy with the expulsion of one or more newborn infants from a woman's uterus. The process of normal childbirth is categorized in three stages of labor: the shortening and dilation of the cervix, descent and birth of the infant, and the expulsion of the placenta.

Correspondence
Sadiqa Shafiq
Research Scholar at Institute of
Home Science, University of
Kashmir, Hazratbal, Srinagar,
Jammu and Kashmir, India

Each year about 500,000 women die due to pregnancy and childbirth, 7 million have serious long term complications, and 50 million have negative outcomes following delivery. Most of these issues occur in the developing world. Few things in life are more exciting than the birth of a new baby. This has been the case throughout human history, but child birth options for new mothers have advanced to make the experience safer. Since 1900, trends have changed dramatically with the increase of technology and modern medical practices. For instance, in 1900 almost all U.S births occurred outside a hospital. But by 1940, more than half of births were taking place in hospitals. The trend continued exponentially and by 1969 only 1% of births occurred outside a hospital. (WHO 2008). Different kinds of child birth and delivery methods:

Vaginal Delivery: In vaginal birth, the baby is born through the birth canal.

Cesarean Section: a cesarean section is the delivery of a baby through a surgical incision in the mother's abdomen and uterus. In certain circumstances, a C-section is scheduled in advance. In others, it is done in response to an unforeseen complication.

Vacuum Extraction: A Vacuum extraction is a procedure sometimes done during the course of vaginal child birth. During vacuum extraction, a health care provider applies the vacuum (a soft or rigid cup with a handle and a vacuum pump) to the baby's head to help guide the baby out of the birth canal.

Forcep's Delivery: A forceps delivery is a type of operative vaginal delivery. It is sometimes needed in the course of vaginal child birth. In a forceps delivery, a health care provider applies forceps (an instrument shaped like a pair of large spoons or salad tongs) to the baby's head to help guide the baby out of the birth canal.

Satisfaction is one of the most frequent reported outcome measures for quality of care and enhanced satisfaction has been identified as a goal for improvement in health care. Women's satisfaction with maternity services, especially care during birth and labour, has become increasingly important to health care providers, administrators, and policy makers. Research shows that women's satisfaction with childbirth is partly related to the health and well-being of the mother and her baby (Stizia J., 1997) [10]. For example, dissatisfaction is associated with poorer postnatal psychological adjustment, a higher rate of future abortions, preference for a caesarean section, more negative feeling towards the infant and breast-feeding problems. However, the concept of satisfaction is complex and poorly defined. A definition suggested by waldebstrom *et al.*, (2004) [12]. Is that an individual's satisfaction with health care is a personal evaluations of health care services and providers. These evaluations reflect the personal preferences of the individual, the individual's expectations, and the realities of the care received. (Andaleeb SS 2001) [1]. Christiaens and Bracke (2007) [13]: Examined that the fulfillment of expectations, labor pain, personal control and self-efficacy determine the postpartum evaluation of birth. However, researchers have seldom considered the multiple determinants in one analysis. To explore to what extant results can be generalized between countries. We analysis data of Belgium and Dutch women. Although Belgium and the Netherlands share the same language,

geography and political system and have a common history, their health care system diverges. The Belgium maternity care system corresponds to the ideal type of the medical model, whereas the Dutch system approaches the midwifery model. In this paper we examine multiple determinants, the fulfillment of expectations, labour pain, personal control and self-efficacy, for their association with satisfaction with childbirth in a cross-national perspective. Two questionnaires were filled out by 605 women, one at 30 weeks of pregnancy and one within the first 2 weeks after childbirth either at home or in a hospital. Of these, 560 questionnaires were usable for analysis. Women were invited to participate in the study by independent midwives and obstetricians during antenatal visits in 2004-2005. Satisfaction with childbirth was measured by the Mackey Satisfaction with Childbirth Rating Scale, which takes into account the multidimensional nature of the concept. Labor pain was rated retrospectively using Visual Analogue Scale. Personal control was assessed with the Wijma Delivery Expectancy/Experience Questionnaire and Pearlin and Scholars mastery scale. A hierarchical linear analysis was performed. Satisfaction with childbirth benefited most consistently from the fulfillment of expectations. In addition, the experience of personal control buffered the lowering impact of labor pain. Women with high self-efficacy showed more satisfaction with self, midwife and physician-related aspects of the birth experience. After concluding we conclude that the findings focus the attention toward personal control, self-efficacy and expectations about childbirth. This study confirms the multidimensionality of childbirth satisfaction and demonstrates that different factors predict the various dimensions of satisfaction. The model applies to both Belgium and Dutch women. Cross-national comparative research should further assess the dependence of the determinants of childbirth satisfaction on the organization of maternity care.

The importance of assessing satisfaction when evaluating healthcare services means it is also imperative that reliable and valid measures are used. Surveys are the common method of assessing individual's experiences of the care in research, evaluation, and audits. Although satisfaction surveys are vital tools for assessing a person's views, and can form an integral part of assessing the quality of care and informing service planning. Patient satisfaction has been increasingly recognized as an important outcome for the health care delivery system and is increasingly studied in developing countries (Redshaw M., 2008) [9]. Following the 1994 International Conference on Population and Development, researcher's interest in reproductive health expanded to include satisfaction with reproductive and maternal health care. The World Health Organization (WHO) promotes skilled attendance at every birth to reduce maternal mortality, and recommends that women's satisfaction be assessed to improve the quality and effectiveness of health care. WHO further emphasizes ensuring patient satisfaction as a means of secondary prevention of maternal mortality, since satisfied women may be more likely to adhere to health provider's recommendations? (Hodnett ED 2002) [4].

Material and Method

In this valley of seven million, there are not enough nursing homes to cater the need. All the hospitals in the valley grapple under the huge influx of patients. The number of patients in the hospitals is around three times more than the actual capacity. In this crises it is not possible for the hospitals to provide good maternal care. Therefore, an attempt is made to

find whether women are satisfied with care during labor and birth in Kashmir. For the current study 100 women who had recently experienced childbirth and were still admitted in hospital were selected from both the rural and urban areas of Kashmir region. A questionnaire was used to collect information from respondents. The questionnaire was divided into four sections. Socio-demographic characteristics which include age, marital status, dwelling, family-income, type of family, educational Status. Obstetric characteristics which include age at first pregnancy, parity status, antenatal checkups, reason for antenatal checkups, type of delivery, duration of labour, and condition after delivery, time passed since delivery. satisfaction on health facility and staff which include satisfaction with cleanliness and comfort, overall cleanliness of the hospital, satisfaction with the availability of transport, supplies of basic drugs, accessibility and cleanliness of toilets, waiting time seen by the health worker, helpful of staff, healthcare provider, opportunity to ask about treatment, involvement in decision making, staff willing to hear patient problems content about drug prescribed, delivery choice. Maternal satisfaction it will study the facility available for pediatric checkups available at hospitals, immunization facilities available at hospital and breast feeding. The data collected was carefully condensed into an excel sheet where all the information was brought into proximity, then tabulated, analyzed and interpreted as per the need of study.

Socio-Demographic Characteristics

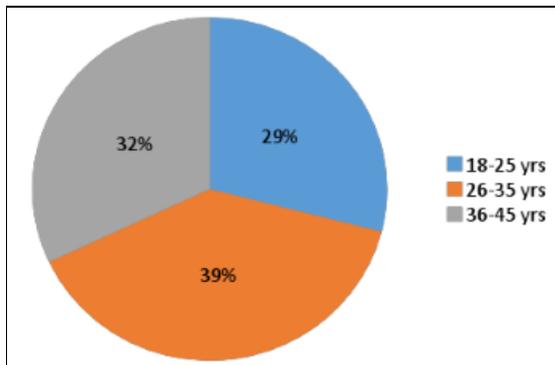


Fig 1: Age-wise comparison of the respondents

The above table shows that the majority of the respondents i.e. 39 per cent (n=39) are in the age group of 36-45 years, 32 per cent (n=32) of the respondents are in the age group of 26-35years and 29 per cent (n=29) of the respondents are in the age group of 18-25 years.

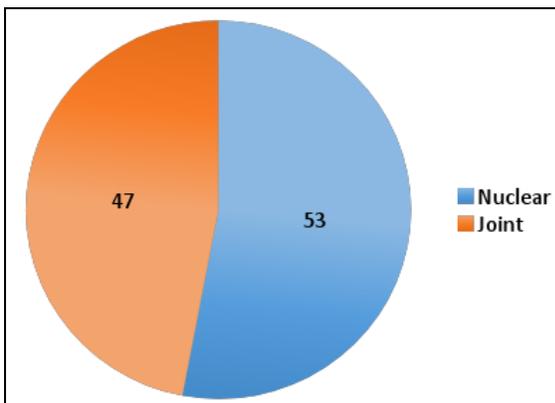


Fig 2: Type of family of the respondents

Majority of respondents i.e. 53 % (n=53) belong to nuclear and 47 % (n=47) belong to the joint family.

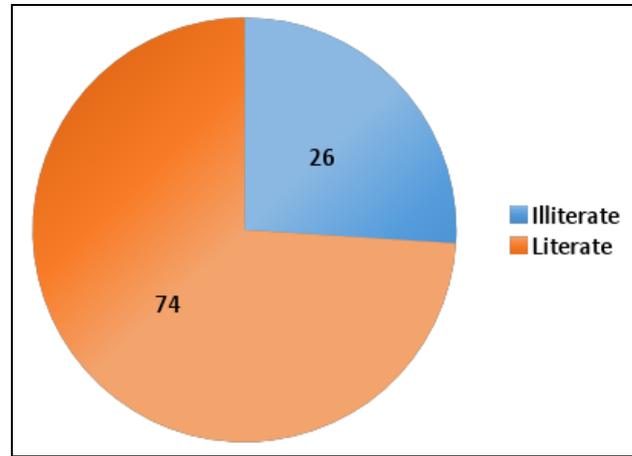


Fig 3: Educational status of the respondents

The above figure states the educational status of the respondents. Majority of respondents i.e. 26 % (n=26) are illiterate and 74 % (n=74) are literate in both the rural as well as urban areas.

**Results
Obstetric Characteristics**

Table 1: Age at first pregnancy

Dwelling	15-25 yrs.		26-35 yrs.	
	F	%age	F	%age
Rural	30	50.8	20	48.8
Urban	29	49.2	21	51.2
Total	59	100.0	41	100.0

A majority of respondents i.e. (n=59) belong to age group of 15-25 years out of which 50.8% (n=30) belong to rural and 49.2% (n=29) belong to urban areas. Whereas (n=41) are in the age group of 26-35 years, out of which 48.8% (n=20) belong to rural and 51.2% (n=21) belong to urban areas.

Table 2: Parity Status of the respondents

Dwelling	Two		Three		Four	
	F	%age	F	%age	F	%age
Rural	21	40.4	21	56.8	8	72.7
Urban	31	59.6	16	43.2	3	27.3
Total	52	100.0	37	100.0	11	100.0

The above table reveals that the majority of respondents (n=52) have parity status two out of which 40.4% (n=21) belong to rural areas and 59.6% (n=31) belong to urban areas. Whereas (n=37) have parity status three, out of which 56.8% (n=21) belong to rural areas and 43.2% (n=16) belong to urban areas and 11 has parity status four, out of which 72.7% (n=8) belong to rural and 27.3% (n=3) belong to urban areas.

Table 3: Antenatal check-ups taken by respondents

Dwelling	One		Two		Three		Four	
	F	%age	F	%age	F	%age	F	%age
Rural	7	35.0	14	48.3	19	55.9	10	58.8
Urban	13	65.0	15	51.7	15	44.1	7	41.2
Total	20	100.0	29	100.0	34	100.0	17	100.0

A good number of respondents i.e., (n=34) took three antenatal check-ups, out of which 55.9% (n=19) and 44.1% (n=15) were rural and urban respectively. 29 respondents took only two antenatal check-ups, out of which 48.3% (n=14) and 51.7% (n=15) belong to rural and urban areas respectively. 20 of the respondents 35.0% (n=7) and 65.0% (n=13) belong to rural and urban areas respectively. And only (n=17) of the respondents went for four antenatal check-ups, out of which 58.8% (n=10) belong to rural and 41.2% (n=7) belong to urban areas.

Table 4: Practice of antenatal check-ups

Dwelling	Planned		Referral	
	F	%age	F	%age
Rural	26	49.1	24	51.1
Urban	27	50.9	23	48.9
Total	53	100.0	47	100.0

The table exhibits that the majority of the respondents i.e., (n=53) went for planned antenatal check-ups, out of which

Table 6: Duration of labour

Dwelling	<6 hours		6-12 hours		12-24 hours		Above 24 hours		Not applicable	
	F	%age	F	%age	F	%age	F	%age	F	%age
Rural	6	60.0	4	66.7	7	50.0	8	40.0	25	50.0
Urban	4	40.0	2	33.3	7	50.0	12	60.0	25	50.0
Total	10	100.0	6	100.0	14	100.0	20	100.0	50	100.0

The table depicts that (n=50) went for caesarean section, therefore no labour pain. A majority of respondents i.e. (n=20) had long labour pain above 24 hours, out of which 40.0% (n=8) are belonging to rural areas and 60.0% (n=12) belonging to urban areas. Only 14 had 12-24 hours of duration of labour, out of which 50% (n=7) are belonging to rural areas and 50.0% (n=7) belonging to urban areas. (n=10) had <6 hours' duration of labour, out of which 60.0% (n=6) are belonging to rural areas and 40.0% (n=4) were belonging to urban areas.

Table 7: Condition after delivery

Dwelling	Without complication		With complication	
	F	%age	F	%age
Rural	33	53.2	17	44.7
Urban	29	46.8	21	55.3
Total	62	100.0	38	100.0

The table emphasises that the majority of the respondents i.e. (n=62) has good condition after delivery without any complications, out of which 53.2% (n=33) belong to rural areas and 46.8% (n=29) belong to urban areas. Whereas (n=38) have complications, out of which 44.7% (n=17) belong to rural areas and 55.3% (n=21) belong to urban areas.

Section C

Satisfaction on Health Facility and Staff

Table 8: Satisfaction with cleanliness and comfort

Dwelling	Yes		No	
	F	%age	F	%age
Rural	43	51.2	7	43.8
Urban	41	48.8	9	56.2
Total	84	100.0	16	100.0

The results indicate that the majority of the respondents i.e. (n=84) are satisfied with cleanliness and comfort in the

49.1% (n=26) belonged to rural areas and 50.9% (n=27) belonged to urban areas and 47 were referred to antenatal check-ups, out of which 51.1% (n=24) belonged to rural area and 48.9% (n=23) belonged to urban areas.

Table 5: Type of delivery

Dwelling	Normal		Forceps		Caesarean	
	F	%age	F	%age	F	%age
Rural	25	50.0	0	0.0	25	55.6
Urban	25	50.0	5	100.0	20	44.4
Total	50	100.0	5	100.0	45	100.0

The results of the above table depict that the majority of respondents i.e. (n= 50) opted for normal delivery, out of which 50.0% (n=25) belong to rural and 50.0% (n=25) belong to urban areas. Whereas (n=45) opted for caesarean delivery, out of which 55.6% (n=25) belongs to rural and 44.4% (n=20) belong to urban areas. Only (n=5) have forceps delivery and 100.0% (n=5) belong to urban areas. The present study reveals that most of the deliveries are C-section

hospital, out of which 51.2% (n=43) belong to rural areas where as 48.8% (n=41) belong to urban areas. Only (n=16) are not satisfied with the cleanliness and comfort in the hospital, out of which 43.8% (n=7) belong to rural areas and 56.2% (n=9) belong to urban areas.

Table 9: Satisfaction with overall cleanliness

Dwelling	Yes		No	
	F	%age	F	%age
Rural	44	58.7	6	24.0
Urban	31	41.3	19	76.0
Total	75	100.0	25	100.0

The table states the satisfaction of the respondents with overall cleanliness of the hospital. The table shows that the majority i.e. (n=75) respondents are satisfied with overall cleanliness of the hospital, out of which 58.7% (n=44) belong to rural areas and 41.3% (n=31) belong to urban areas. Whereas (n=25) are not satisfied with the overall cleanliness of the hospital, out of which 24.0% (n=6) belong to rural areas and 76.0% (n=19) belong to urban areas.

Table 10: Satisfaction with the availability of transport

Dwelling	Yes		No	
	F	%age	F	%age
Rural	34	59.6	16	37.2
Urban	23	40.4	27	62.8
Total	57	100.0	43	100.0

The table highlights that the majority of respondents i.e. (n=57) are satisfied with availability of transport, out of which 59.6% (n=34) are belong to rural areas and 40.4% (n=23) belong to urban areas. Only (n=43) are not satisfied with the availability of transport, out of which 37.2% (n=16), 62.8% (n=27) belong to rural and urban areas respectively.

Table 11: Satisfaction with drug and equipment

Dwelling	Yes		No	
	F	%age	F	%age
Rural	16	42.1	34	54.8
Urban	22	57.9	28	45.2
Total	38	100.0	62	100.0

A majority of the respondents i.e. (n= 62) are not satisfied with the drug and equipment available at hospital, out of which 54.8% (n=34) belong to rural area and 45.2% (n=28) belong to urban areas. Whereas (n=38) are satisfied with the drug and equipment available at hospital, out of which 42.1% (n=16), 57.9% (n=22) belong to rural and urban areas respectively.

Table 12: Satisfaction with accessibility of toilets

Dwelling	Yes		No	
	F	%age	F	%age
Rural	14	58.3	36	47.4
Urban	10	41.7	40	52.6
Total	24	100.0	76	100.0

The table states the majority of the respondents i.e. (n=76) are not satisfied with accessibility of toilets, out of which 47.4% (n=36) belong to rural areas and 52.6% (n=40) belong to urban areas. Whereas (n=24) are quite satisfied with accessibility of toilets, out of which 58.3% (n=14) belong to rural areas and 41.7% (n=10) belong to urban areas.

Table 13: Satisfaction with time given by health worker

Dwelling	Yes		No	
	F	%age	F	%age
Rural	9	45.0	41	51.2
Urban	11	55.0	39	48.8
Total	20	100.0	80	100.0

The table depicts that the majority of the respondents i.e. (n=80) are not satisfied with the satisfaction with time given by health worker, out of which 51.2% (n=41) belong to rural areas and 48.8% (n=39) belong to urban areas. Whereas (n=20) are satisfied with the time given by health worker, out of which 45.0% (n=9) are rural and 55.0% (n=11) are urban.

Table 14: Satisfaction with helpfulness of staff

Dwelling	Yes		No	
	F	%age	F	%age
Rural	25	64.1	25	41.0
Urban	14	35.9	36	59.0
Total	39	100.0	61	100.0

The table indicates the majority of the respondents i.e. (n=61) are not satisfied with helpfulness of staff, out of which 41.0% (n=25) belong to rural and 59.0% (n=36) belong to urban areas. However, (n=39) are satisfied with helpfulness of staff, out of which 64.1% (n=25) are rural and 35.9% (n=14) are urban

Table 15: Satisfaction regarding health care provider

Dwelling	Yes		No	
	F	%age	F	%age
Rural	22	61.1	28	43.8
Urban	14	38.9	36	56.2
Total	36	100.0	64	100.0

The results depict the majority of the respondents i.e.(n=64) are not satisfied with health care provider, out of which 43.8% (n=28) belong to rural and 56.2%(n=36) belong to urban. Whereas (n=36) satisfied with health care provider, out of which 61.1% (n=22) belong to rural and 38.9 % (n=14) belong to urban areas.

Table 16: Opportunity to ask for treatment

Dwelling	Yes		No	
	F	%age	F	%age
Rural	30	52.6	20	46.5
Urban	27	47.4	23	53.5
Total	57	100.0	43	100.0

The table depicts that the majority of respondents i.e. (n=57) were satisfied and reported that they had enough opportunity to ask for treatment, out of which 52.6% (n=30) belong to rural areas and 47.4% (n=27) belong to urban areas. Whereas (n=43) of the respondents were dissatisfied and reported that they had not any opportunity of asking for treatment, out of which 46.5% (n=20) belong to rural area and 53.5% (n=23) belong to urban areas.

Table 17: Satisfaction with involvement in decision making

Dwelling	Yes		No	
	F	%age	F	%age
Rural	33	50.8	17	48.6
Urban	32	49.2	18	51.4
Total	65	100.0	35	100.0

The table evaluates the satisfaction of respondents with involvement in decision making.it is revealed that the majority of respondents i.e. (n=65) are satisfied with involvement in decision making, out of which 50.8% (n=33) belong to rural and 49.2% (n=32) belong to urban area. Whereas (n=35) were not satisfied with involvement in decision making, out of which 48.6% (n=17) belong to rural and 51.4% (n=18) belong to urban areas.

Table 18: willingness of staff to address problems of patients

Dwelling	Yes		No	
	F	%age	F	%age
Rural	31	64.6	19	36.5
Urban	17	35.4	33	63.5
Total	48	100.0	52	100.0

The results of the table illustrate that the majority of the respondents i.e. (n=52) said that the staff is not willing to hear the problem of patient, out of which 36.5% (n=19) belong to rural area and 63.3% (n=33) belong to urban area. However, (n=48) of the respondents reported that the staff is helpful and willing to hear the problem of patients, out of which 64.5% (n=31) belong to rural and 35.4% (n=17) belong to urban area.

Table 19: Contentment regarding prescription of drugs

Dwelling	Yes		No	
	F	%age	F	%age
Rural	17	45.9	33	52.4
Urban	20	54.1	30	47.6
Total	37	100.0	63	100.0

The above table indicates that the majority of respondents i.e. (n=63) are not contented about drugs prescribed, out of which 52.4% (n=33) belongs to rural and 47.6% (n=30) belongs to

urban area. Whereas (n=37) respondents were quite contented with the drugs prescribed, out of which 45.9% (n=17) and 54.1% (n=20) belonged to rural and urban area respectively.

Section D: Maternal Satisfaction

Table 20: Paediatric check-ups available at hospital.

Dwelling	Yes		No	
	F	%age	F	%age
Rural	46	54.8	4	25.0
Urban	38	45.2	12	75.0
Total	84	100.0	16	100.0

The results of the table show that the majority of the respondents i.e. (n=84) reported the availability of paediatric check-ups, out of which 54.8% (n=46) belong to rural areas and 45.2% (n=38) belong to urban areas. Whereas (n=16) reported that there was no facility of paediatric check-ups, out of which 25.0% (n=4) belong to rural and 75.0% (n=12) belong to urban areas.

Table 21: Immunization facilities available at hospital

Dwelling	Yes		No	
	F	%age	F	%age
Rural	34	59.6	16	37.2
Urban	23	40.4	27	62.8
Total	57	100.0	43	100.0

The results of the table emphasises that the majority of respondents i.e. (n=57) reported that hospital provide immunization facilities, out of which 59.6% (n=34) belong to rural area and 40.4% (n=23) belong to urban areas. The other (n=43) respondents reported that hospital does not provide immunization facilities, out of which 37.2% (n=16) belong to rural area and 62.8% (n=27) belong to urban area.

Table 22: Assistance of staff in breast feeding

Dwelling	Yes		No	
	F	%age	F	%age
Rural	41	53.2	9	39.1
Urban	36	46.8	14	60.9
Total	77	100.0	23	100.0

The results of the table show that the majority of respondents i.e. (n= 77) say, yes staff assists in breast feeding, out of which 53.2% (n=41) belong to rural area and 46.8% (n=36) belong to urban area. Whereas, (n= 23) respondents said that staff does not assist in breast feeding, out of which 39.1% (n=9) belong to rural area and 60.9% (n=14) belong to urban area.

Discussion

Majority of respondents fall in the age group of 36-45 yrs. of age. The majority of respondents have nuclear type of family in both. The majority of respondents are literate in both the communities. The age at first pregnancy of respondents belonging to rural and urban areas fall in the age group of 15-25 yrs. Most of respondents have parity status 2 in both the communities. One of the most striking finding of the study is that the majority of respondents go thrice for antenatal checkups. The majority of respondents in both areas have caesarian type of delivery; similar findings are reported by (Pahari and Ghosh, 1997) [7]. Kambo *et al.*, (2002) [5], Sreevidya and Sathiyasekaran (2003) [11] that India is witnessing increased C-section deliveries. The condition of

majority of respondents has been reported as without complications after delivery. Majority of respondents rural (51.2%) and urban (48.8%) were satisfied with the cleanliness and comfort of the hospital. Majority of respondents rural (58.7%) and urban (41.3%) were satisfied with the overall cleanliness of the hospital. Majority of respondents were satisfied with the availability of transport in the hospital. Most of the respondents complained about the accessibility of toilets and were not satisfied with the helpfulness of the staff in the hospital. Furthermore, were not happy with drug and equipment available. These results are in accordance with the findings of Karkee *et al.*, (2014) [8] who in his study reported that most of the respondents were not satisfied with the supplies and equipment in birth centers and the amenities and interpersonal aspects in the public hospital. Most of the respondents were not satisfied with the time and attention given by health worker, satisfaction on the aspect of helpfulness of the staff too is rated low, concurrent findings are reported by Christiaens and Bracke (2007) [13] who in his findings focus the attention of personals toward personal control, self-efficacy and expectations about childbirth. This study confirms the multidimensionality of childbirth satisfaction and demonstrates that different factors predict the various dimensions of satisfaction. Majority of respondents felt that the delivery position was of their choice. Respondents were not mostly satisfied with the prescription of drugs and were satisfied with the availability of pediatric checkups and immunization facilities, these results are supported by the findings of Emelumadu *et al.*, who in his study reported a high level of satisfaction with the quality of maternal health services among antenatal attendees and highlights the need to strengthen interventions that increase uptake of formal MHC services.

Conclusion

It can be concluded that government has kept various services available at hospitals, however, proper execution is lacking. Majority of respondents were in 15-25 years of age at first pregnancy and have parity status two, which can be attributed to sound knowledge about the family planning. A healthy trend can be seen that most of the respondents go for three times to the hospital for antenatal checkups. Majority of respondents have better condition after delivery without complication. Rural respondents are much satisfied with the overall cleanliness of the hospital as compared to urban areas. Majority of respondents belonging to rural areas are much satisfied the helpfulness of the staff. Majority of respondents were satisfied with the availability of transport in the hospital. Most of the respondents complained about the accessibility of toilets and were not satisfied with the helpfulness of the staff in the hospital. Furthermore, were not happy with drug and equipment available. Training of staff is needed for the better satisfaction of patients. It can be concluded that the rural women in Kashmir are quite satisfied with Care during Labor and Childbirth as compared to urban women, however, certain areas need some attention to make this beautiful journey of motherhood safe and beautiful.

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