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Mother's Childbirth Experiences Impacting Satisfaction and Prospective Service Utilization at A tertiary Health Centre in Benue State, North-Central, Nigeria: A Mixed Methods Approach

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ABSTRACT

Background: Women's experiences which impacts on the level of satisfaction with institutional childbirth services is crucial as it influences utilisation of care offered at health facilities. This study aimed to assess mothers' satisfaction with delivery services in Federal Medical Centre Makurdi in Benue State and their intention for future utilisation of the facility. **Methodology:** A cross-sectional survey using both quantitative and qualitative methods was conducted among postnatal clinic attendees. Data were collected using questionnaires from 200 eligible women and in-depth focused group discussions. Quantitative data were analysed using SPSS version 25, while qualitative findings were presented thematically. **Results:** The average age of respondents was 30.49 ±5.36 years. Most were married (98.0%), of Tiv ethnicity (55.5%), urban dwellers (94.5%), and educated to tertiary level (57.0%). Multiparous women formed 70.5%. About 35.5% attended antenatal care (ANC) fewer than eight times, while 64.5% attended eight or more times. Most deliveries were spontaneous vaginal (65.0%), with no complications to newborns (86.0%) and mothers (85.0%). Overall satisfaction was 37.6 %, while 62.4 % were dissatisfied. Dissatisfaction with cleanliness was rated as 60%, interpersonal relationship (61.0%), information provided (53.5%) and technical aspect of care (60.5%). Areas of concern (dissatisfaction) were uncleanliness of toilets, scarcity of water, non- availability of necessary medicine & supplies and poor interpersonal relationships. Despite the displeasure expressed, 75% of the women were willing to use the facility for future childbirth. **Conclusion:** Satisfaction was poor but intention to use facility in future was high. Infrastructural rehabilitation, equipping and provision of commodities are essential for improvement in quality of childbirth services. Training and re-training of skill birth attendance will solve the aspect of poor interpersonal relationship and inadequate provision of information to client during childbirth.

Keywords: Childbirth, Experiences, Mortality, Mother, Satisfaction, Skill Birth Attendant

INTRODUCTION

Childbirth is a natural process that almost every married woman dreams of experiencing during her reproductive life. Unfortunately, some women who embarked on this journey of human reproduction do have a sad experience [1]. Worldwide, it has been reported that over 13 million women have an unpleasant experience and eventually die due to complications arising during and or following delivery[1]. It is reported that approximately 800 parturient would die daily from

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causes related to childbirth that are actually preventable[1]. Sadly, about 99% of all these maternal deaths occur in less developed nations of the world [2,3].

Figures in sub-Saharan Africa and Asia are more abysmal [4]. In some parts of Africa, these unacceptable maternal mortality ratios (MMR) are reported to be astronomically high. For instance, the MMRs in Ethiopia and Kenya have been reported as 420 and 676 per 100,000 live births respectively [5,6]. Nigeria has one of the worse maternal health indices typically reflecting the poor health indicators in developing countries of the world [2].

Country categorisation of the World Health Organization (WHO) estimates on maternal mortality show that three countries had extremely high maternal mortality ratios that exceeded 1000 deaths per 100 000 live births in Africa in the year 2020. These countries are; South Sudan (1223), Chad (1063), and Nigeria (1047) [7]. The lifetime risk of a Nigerian woman dying during pregnancy, childbirth, postpartum or post-abortion is said to be 1 in 22, in contrast to the lifetime risk in developed countries estimated at 1 in 4900 [8].

The world health organization (WHO) recommends that women should deliver in health facilities where skilled birth attendants render services to clients [6]. It is believed that utilization of delivery services at the hospital will reduce these unacceptably high maternal complications and deaths especially in sub-Saharan Africa [2, 9-11]. Aside from the availability of skilled birth attendants, the hospital environment is expected to have the minimal medical standards that will guarantee good health. Availability of basic tools/equipment, medicine/supplies and effective referral system where the need arises, makes institutional births most acceptable especially in LMICs [6].

Studies have shown that the availability of health institutions with well-equipped gadgets for the delivery of essential maternity services that are also manned by skilled birth attendants does not always translate to satisfactory utilisation of services for delivery by clients [12]. For instance, the Nigeria Demographic Health Survey (NDHS) report of 2018, stated that although 67% of women utilise antenatal care (ANC) services, only 39% of them deliver in a health facility where there is a skilled birth attendant [12,13].

Women's perception of satisfaction with existing labour and delivery service which is anchored on their experience at the facility is the best predictor for their choice of health facility, compliance with service provided, follow-up and early detection of complications and its management before, during and after childbirth [14]. Therefore, this study on mother's experience with childbirth services that impacts on satisfaction and prospective utilisation of services in a tertiary health institution such as the Federal Medical Centre (FMC) Makurdi in Benue State, Nigeria is valuable research.

METHODOLOGY

Study setting: This work was done at the maternity wing of the Federal Medical Centre Makurdi in Benue State, North-Central, Nigeria. This facility is one of the tertiary health centres located in Makurdi the State capital and serves as a referral facility for health care centres within the state and neighbouring states.

Study design: This was a descriptive cross-sectional survey using the quantitative approach that is supplemented with a qualitative methodology.

Study population: The quantitative approach utilized postnatal attendees who had delivered at the health institution and were admitted to the postnatal ward and were also seen at the postnatal clinic of the facility in the first week of childbirth. The qualitative approach utilised women organized in focused groups. They had delivered in the facility and presented in the sixth week postnatal clinic. This later group of 20 women were further divided into 2 groups of 10 each. Participants in each focused group were recruited based on age and parity. It took six (6) months to complete data collection.

Inclusion criteria: Consented women who were stable physically and mentally and had delivered in the study centre.

Exclusion criteria: Non consented women who were physically and mentally unstable and had delivered elsewhere. Those who had hysterectomy and bilateral

tubal ligation (BTL) were also excluded.

Sample size determination: This was determined using the Cochran's formula of proportion (Panth & Kafle, 2018) studies in which it is assumed that z (level of significance, 5%=1.96); P (the proportion of satisfied mothers with delivery care services: P= 86.7% (previous study done in Jos University Teaching Hospital, Jos, plateau State, North-Central Nigeria by Ali et al, 2022. Therefore, q=1-p; d (marginal error, 5%=0.05), and 10% of the calculated sample size was added to compensate for non-responses.

Then, the sample size based on the above assumptions was:

$N= pqz^2/d^2$

$N= 0.87x0.13x (1.96)^2/ (0.05)^2= 174 \{(N_{initial})\}$

For expected attrition rate of 10%; $N_{adjusted}=n_{initial}$ /1-(attrition rate/100)

$N_{adjusted}= n_{initial}$ / (10/100), = 174/1-0.10 =174/0.90 = 193. This figure was rounded up to 200. For the qualitative approach, 20 women divided into 2 FGDs of 10 women each, based on age and parity. They were selected by a purposive sampling technique. They did not participate in the quantitative interview.

Sampling technique: This was a simple non-probability purposive sampling technique in which deliberate effort was made to recruit woman at the postnatal clinic who gave birth at the hospital and returned for the post-natal care clinic.

Tool for Data Collection: A standardized and validated normal birth scale for measuring maternal satisfaction for childbirth (Patient satisfaction questionnaire) developed by John E. Ware Jr was structured to include the various components of the maternal satisfaction expressed in the conceptual framework. This research tool for data collection was divided into various parts. Part I was basically focus on socio-demographic characteristics of the clients. Part II focused on some obstetric characteristics of clients. Part III focused on levels of satisfaction using the five-point Likert scale. Scores were allotted for each statement as follows: 5 was given for very satisfied, 4 for satisfied, 3 for neither satisfied nor dissatisfied, 2 for dissatisfied, 1 for very dissatisfied.

In this scale there were four domains namely; health facility-related statements (6 questions), interpersonal aspects of care (11 questions), informative aspects of care (10 questions), and technical aspects of care (9 questions).

Overall satisfaction score was obtained by summing all the 36-item. The total score ranged from 36-180. The mean overall scores obtained was (145.36) Those whose scores were less than the mean was categorized "Dissatisfied", while those who scores were greater than or equal to the mean was categorized "Satisfied". The respective domain scores were obtained by summing up all the various item regarding a given domain. The mean scores were computed for each of the domains. Those who scores were less than the mean was categorized as "dissatisfied" while, those who scores greater than or equal to the mean was categorized "satisfied" on all the domains of satisfaction about the institutional delivery services. In order to determine the reliability of the 36-item scale, Cronbach's Alpha coefficient test was conducted. This scale has been ascertained to be a good measure of reliability. The overall Cronbach's Alpha coefficient of the satisfaction to institutional delivery services scale was 0.956. The Cronbach's Alpha coefficient of the four domains was also assessed. Cronbach's Alpha coefficients for the four domains were; satisfied with healthcare facility was 0.738, satisfied with interpersonal aspect of care was 0.922, satisfied with information provided was 0.912 and satisfied with technical aspect of care was 0.877 respectively.

Part IV was focused on intention to utilise delivery services in these health facilities by the clients in the future.

Focused Group Discussion

Twenty (20) women were chosen through a purposive sampling method. They were divided into 2 groups of 10 per group. Each sub-group was to either represent a population of younger/primiparous women or older/multiparous women. In-depth interviews using

questionnaire guidance developed in English language were used (deductive approach) for data collection and this was recorded using audio tape recorders and eventually transcribed. Also, the inductive approach was allowed due to emerging themes during the discussions. Again, a co-researcher was designated to also take notes which complemented the audio tape recording.

Validity and Reliability (Quantitative): So, the validity of the data collection tool was established by extensive literature review, discussion with experts based on established theory or findings of previous studies as well as by peer review.

Reliability: was enhanced by translating the tool into the local language and back to English. Pretesting of the tool was done in 10% (20 participants) of the study population of mothers at the postnatal clinic of another hospital for clarity and comprehensibility of the tool. After pre-testing the instrument was revised and finalized for use in data collection.

Data collection procedure: The data was collected by the researcher and 2 well trained research assistants with the pre-tested and revalidated tool. Consent was sought from the mothers; they were assured of confidentiality and care; even if they chose to opt out, their welfare and rights shall be safeguarded.

Trustworthiness of data (Qualitative): Adequate time of not less than 45 minutes was spent with each group of participants centres. Secondly, there was triangulation with the quantitative analysis, and findings were also cross-checked. There was also a peer debriefing with colleagues. Thirdly, the transferability of the data was enhanced by the provision of study setting, participants, and processes involved. The Dependability was ensured by audit trail of research steps which included-data collection, coding and analysis and colleagues also helped in reviewing the processes. Notes taken and audiotapes during the research as well as analytical documents were kept for confirmability.

Dependent and Independent variables: Dependent variable was mother's satisfaction. Independent variables were maternal characteristics; obstetric variables and the four domain factors associated with satisfaction.

Analysis of data: The data was analysed along the line of the research objectives and research questions. Collected data was checked for accuracy, completeness, and consistency. Thereafter, it was properly coded, and entered into SPSS version 25 for further analysis.

Ethical Clearance: Ethical approval was obtained for this research. Also, participants gave their consent. Data collection was done in confidence and transferred immediately. Data was reported in thematic areas. FMC Ethical clearance-FMC/CMAC/HREC/108/Vol.1.

RESULTS

Description of socio-demographic characteristics of participants showed that the mean age was 30.49±5.36 years. The majority of the participants (n=65, 32.5%) had their age 30-34 years. Most of the participants were married (n=196, 98.0%) and above one-third of the participants were traders (n=85, 42.5%). Majority of the participants reside in urban centres (n=189, 94.5%) with more than half (n=114, 57%) having tertiary education (see table 1 below).

Maternal obstetric variables of participants showed that more than two-third (n=141, 70.5%) were multiparous. two-third of the participants had two or more living children (n=142, 70.5%). Concerning sex of last child, (n=106, 52.5%) were females and (n=96, 47.5%) were males. More than half of the participants visited the antenatal clinic more than or equal to eight times (n=129, 64.5%). Majority of the participants (n=130, 65.0%) had SVD and majority did not have complications in baby (n=172, 86.0%) or mother (n=170, 85.0%). The most single complication for the newborn was LBW (n=7, 25.0%). Similarly, among the participants who had maternal complications, majority (n=13, 43.3%) had genital tear *(see table 2 below).*

In all the four domains assessed, there were higher dissatisfaction than satisfaction; facility (60% vs 40%), interpersonal relationship (61.5 % vs 38.5%), information provided (53.5% vs 46.5%), and technical aspect of care (60.5% vs 39.5%) (see table 3).

Areas of concern (dissatisfaction) were uncleanliness of

toilets, scarcity of water, non- availability of necessary medicine & supplies and poor interpersonal relationships.

Most women 62.4% were dissatisfied with childbirth services while only 37.6% were satisfied (figure 1). As many as 150(75.0%) want to utilize the facility for future childbirth services and 50(25.0%) will not (figure 2). For those who will use facility in future, most of them gave satisfaction as the reason, while for those who will not, poor attitude of staff was the common reason. There was no statistical relationship between socio-demographic characteristics and satisfaction. However, concerning maternal Obstetric characteristics, there was a significant relationship between complications in mother and satisfaction (P<0.001).

Table 1: Socio-demographic characteristics

Variable	N	%
19	3	1.5
20 - 24	22	11.0
25 - 29	62	31.0
30 - 34	65	32.5
35 - 39	48	24.0
means ± SD	**30.49±5.36**	
Marital Status		
Single	3	1.5
Married	1 96	98.0
Widowed	1	0.5
Ethnicity		
Tiv	111	55.5
Idoma	39	19.5
Igede	8	4.0
Others	42	21.0
Occupation		
Trading	85	42.5
Farmers	13	6.5
Housewife	48	24.0
Civil servant	42	21.0
Student	12	6.0
Area of Residence		
Urban	189	94.5
Rural	11	5.5
Level of Education		
No formal education	1	0.5
Primary	6	3.0
Secondary	79	39.5
Tertiary	115	57.0

Table 2: Maternal Obstetric variables

Variables	N	%
Parity		
Primiparous	59	29.5
Multiparous	141	70.5
Number of living children		
1	59	29.4
≥2	141	70.6
Sex of Child		
Male	94	47.5
Female	106	52.5
Number of ANC visit		
<	71	35.5
≥	129	64.5
Mode f delivery		
SVD	130	65.0
CS	68	34.0
Instrumental	2	1.0
Complication (newborn)		
Yes	28	14.0
No	172	86.0
Type of Complication		
Foetal distress	5	17.9
Neonatal Jaundice	5	17.9
Infection	0	0.0
LBW	7	25.0
Others	11	39.2
Complication (mother)		
Yes	30	15.0
No	170	85.0
Type of complication		
PPH	5	16.7
Genital Tear	13	43.3
Genital sepsis	0	0.0
Breast disorder	6	20.0
Puerperal pyrexia	0	0.0
Others	6	20.0

Table 3: Satisfaction with the four domains assessed

Variables	N	%	Mean Score
Facility			
Satisfied	80	40.0	22.47±3.71
Dissatisfied	120	60.0	
Interpersonal relationship			
Satisfied	77	38.5	44.17±7.21
Dissatisfied	123	61.5	
Information Provided			
Satisfied	93	46.5	7.86±7.64
Dissatisfied	107	53.5	
Technical aspect of care			
Satisfied	79	39.5	35.73±6.09
Dissatisfied	121	60.5	

Figure 1: Overall satisfaction with child birth services at the facility

Table 4: Relationship between maternal socio-demographic characteristics and maternal satisfaction with services

Variables	Satisfied n (%)	Dissatisfied n (%)	χ^2	df	p-value
Age (years)			27.68	24	0.274
<30	74 (82.2)	16 (17.8)			
≥30	94 (85.5)	16 (14.5)			
Marital status			0.68[f]	1	0.409
Currently married	166 (84.3)	31 (15.7)			
Currently not married	2 (66.7)	1 (33.3)			
Ethnicity			1.98	4	0.739
Tiv	92 (82 .9)	19 (17.1)			
Idoma	32 (82.1)	7 (17.9)			
Igede	8 (100.0)	0 (0.0)			
Others	36 (87.8)	5 (12.2)			
Occupation			2.67	4	0.615
Trader	68 (80.0)	17 (20.0)			
Farmer	11 (84.6)	2 (15.4)			
Housewife	43 (89.6)	5 (10.4)			
Civil servant	35 (83.3)	7 (16.7)			
Student	11 (91.7)	1 (8.3)			
Area of residence			0.04[f]	1	0.839
Urban	159 (84.1)	30 (15.9)			
Rural	9 (81.8)	2 (18.2)			
Level of education			1.96	3	0.581
Primary	6 (100.0)	0 (0.0)			
Secondary	64 (81.0)	15 (19.0)			
Tertiary	97 (85.1)	17 (14.9)			
No formal education	1(100.0)	0(0.0)			

Table 5: Relationship between maternal Obstetric variables and satisfaction with services

Variable	Category	Satisfied n (%)	Dissatisfied n (%)	Test statistic	p-value
Parity	Primiparous	50 (84.7)	8 (13.6)	$\chi^2 = 1.19$	0.757
	Multiparous	115 (81.6)	24 (17.0)		
Number of living children	1	51 (86.4)	7 (11.9)	$\chi^2 = 1.88$	0.599
	≥2	114 (80.9)	25 (17.7)		
Number of ANC visits	<8	55 (77.5)	14 (19.7)	$\chi^2 = 3.29$	0.349
	≥8	110 (85.3)	18 (14.0)		
Mode of delivery	SVD	105 (80.8)	22 (16.9)	$\chi^2 = 3.91$	0.689
	CS	59 (86.8)	9 (13.2)		
	Instrumental	1 (50.0)	1 (50.0)	Fisher's	1.000
Newborn complication	Yes	20 (74.1)	7 (25.9)	$\chi^2 = 2.91$	0.405
	No	145 (84.3)	24 (14.0)		
Maternal complication	Yes	17 (68.0)	5 (20.0)	$\chi^2 = 23.82$	**0.001***
	No	147 (85.0)	26 (15.0)		

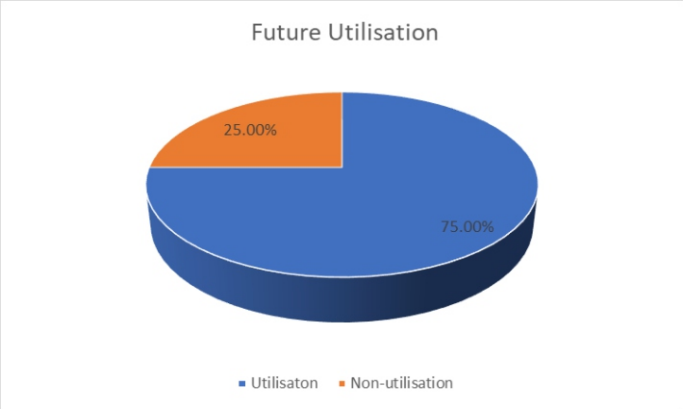

Figure 2: Prospective childbirth services utilization at the facility

Table 6: Reasons for future utilization of facility for childbirth

Reason	Frequency	Percentage (%)
Satisfied with care	128	85.3
Referred	1	0.7
Near my residence	9	6.0
Cost is affordable	7	4.7
Others	5	3.3

Table 7: Reasons for no intention to utilize facility in future

Reason	Frequency	Percentage (%)
Dissatisfied	9	18.0
Cost is high	11	22.0
Poor attitude of staff	17	34.0
Lack of cleanliness	7	14.0
Others	6	12.0

DISCUSSION

Socio-demographic characteristics of these women showed that majority of them were young and in the prime reproductive age that health education and support is of essence [15]. Failure of this education can lead to dissatisfaction with services [15]. No wonder one of the mothers had to say: *"So when I came here, I had no idea about delivery or anything, but they did not even say anything to me. They did not even say push like this, do like this. If not for the help from the internet that I went through, it would have been very difficult for me. They did not even show me how to push or do anything. They only kept saying "push, push!!" and it's not right. A first-time mother, you should know that this person has not gone through this before"*. This finding is similar to the reports of Hagos and co-workers [16].

The study finds most of the women married which is in keeping with the culture of the inhabitants of the state in

which marriage is a norm; if a woman is going to be socially free in bearing children. Secondly, in the contest of satisfaction with childbirth, married women might have stronger family support systems, which could influence their level of satisfaction and their ability to access healthcare services. The few single women amongst them, represent a potentially vulnerable group whose satisfaction might differ based on their unique challenges, such as financial constraints or social stigma.

Traders and urban residents usually would have higher expectation for satisfaction. Those who are more economically empowered would expect value for their investment and the urban dwellers would have similar expectation because of their exposure. Also, most of the women had tertiary level of education. This high level of education among clients may contribute to higher expectations for information sharing, respect, and overall care.

Educated women are more likely to demand better quality services, which might push the facility to maintain higher standards of care [16]. Moreover, studies have shown that these categories of women utilize orthodox facility for childbirth more and this is what reproductive health experts seeks to promote [16-18]. This also clearly brings to bear the need to educate the girl child. The more educated, the more they are informed of their rights, better health seeking behaviour and health practices that mitigate against wrong decisions that puts their lives in jeopardy.

Most of the women are multiparous, meaning they have experienced childbirth multiple times, which might suggest that they have prior experiences to compare the current facility's services with. First-time mothers may require more personalized attention and guidance, affecting their satisfaction. Similarly, majority of respondents have two or more children. Women with more children might be more familiar with the childbirth process and might have different needs compared to primiparous women. Their past experiences will heavily influence their expectations and perceptions of service quality [16,17].

A large number 129(64.5%) of participants had attended ANC either eight or more times which satisfies the recommendation of WHO for ANC attendance. Increase or adequate ANC attendance is linked to better health outcomes for both mother and child [19-21] and that was seen in the study. Studies had shown that women who attend ANC more frequently had a better chance of attending hospital for delivery. They also have better satisfaction[1].

The majority of women had spontaneous vaginal deliveries (SVD), which generally require less medical intervention and fewer resources compared to caesarean sections (CS). This also reflects on the facility's capability to handle more complex deliveries, and the outcomes here can significantly influence satisfaction. Those who deliver vaginally are likely to breastfeed earlier, ambulate quicker, bond with their babies faster and also spend less on medical bills. There is the possibility of less morbidity and mortality from anaesthesia related complications. They also feel their womanhood is not taken away from them which is the cultural belief in many parts of Nigeria.

Regarding postpartum complications, only 14.0 % of newborns experienced complications, with conditions such as foetal distress and low birth weight (LBW) being the most common. These complications, though relatively low in percentage, may have a lasting impact on client satisfaction if not adequately addressed. Similarly, 15.0 % of mothers reported complications, with the most common being genital tears. The occurrence of maternal complications could contribute to dissatisfaction, especially if pain management and follow-up care were inadequate. However, it is important to note that the majority did not experience complications, indicating that the facilities perform well in most cases. Minimizing complications will increase satisfaction and enhance hospital delivery [22].

Findings from this study suggests that; the perception of the clients on satisfaction with childbirth services which could be considered as the degree of quality attributed to the facility by the client whether its delivery was regarded as effective, useful or beneficial [23,24] was far from expected.

Less than half 75(37.5%) were satisfied with childbirth services while 125(62.5%) were dissatisfied. Whereas reports of other studies done at health institutions in Nigeria showed high satisfaction figures such as 86.7% in Jos and 81.5% in Akure. Although, the level of satisfaction in the study is comparable with the reported 49.4% from Chile [25], it is higher than the reported 17.8% from Jordan.

Considering the various domains of assessment, dissatisfaction with the facility environment was high (60%). The women were concerned about issues of electricity and water especially during night periods. This mother had this to say- *"We have water but sometimes there'll be shortage of water".* Similarly, there were complaints of poor electricity supply, *"In my own case, truly, there wasn't any light and all the nurses' phones were off. So even for me, it was my phone's light that was used during my delivery".* Another consequence of this scarcity was a recurring complaint of severe mosquito bites due to lack of consistent lighting, which heightened discomfort for patients.

Most of the women were satisfied with promptness of care while a few were not. Responses on staff responsiveness and behavior indicate mixed experiences with the hospital staff. Some mothers praised the nurses for their attentiveness and support, even mentioning staff who stayed beyond their shift to provide care. Others, however, shared experiences of neglect and insensitive behavior. For instance, some nurses were perceived as dismissive or rude, and patients felt that certain medical staff did not show adequate empathy during labor.

Many participants noted a lack of necessary supplies and medications within the hospital. Several mothers reported having to source medicines outside, especially for critical post-delivery needs, which caused additional stress. The high cost of delivery-related items was also a concern, with mothers expressing frustration about being charged for items that were either unused or retained by the hospital staff. Mrs. AT said; "*Actually sir, in my own case, on the day I came to deliver, it was through C/S so when they brought me out of the theatre, and they prescribed the drugs but they weren't available in the hospital at all so they had to go outside to buy the drugs".*

On adequacy of doctors and nurses on duty, majority of the women were satisfied**.** "*Me, the day I came there were enough of them promptly attending to us that were in the labour room.*

On overall cost of treatment**:** The women were satisfied with the cost of treatment but some had this to say about delivery items*: "In terms of delivery items, the cost is very much. And this scares others away from coming to deliver in the hospital. Sometimes even when these items are not exhausted, the health workers keep the remainder without returning them to you, and things are hard right now".*

Most of the women said they were warmly received into admission. They were also given orientation and their privacy guaranteed. The feedback on privacy and dignity was also mixed. While some mothers appreciated the sense of privacy, others felt that staff disregarded their dignity, particularly when addressing labor pains. For example, mothers reported being asked to "keep quiet" while in pain, which they found disrespectful and insensitive. *"The first time I came, the nurse that attended to me was just shouting at me as if we had an issue before. She said that if I don't stop shouting, she would leave me there. So, I had to ask her that have we had an issue before? She said why am I shouting here anyhow, that am I the only one in labour? I felt so bad. And even after my delivery, they didn't give me any drugs. It was when my baby was having issues and I came back and was complaining of pains that they had to prescribe drugs for me to go and buy".*

The lack of informational support, especially for first-time mothers, was a recurring theme. Some participants felt uninformed about labor procedures, which contributed to feelings of anxiety and helplessness. Additionally, they reported inconsistent guidance on newborn care, breastfeeding, and postnatal health, which could lead to avoidable health complications.

Pain relief was a significant issue. Mothers reported that they were often denied painkillers, with explanations that such medications are standard practice only abroad.

This created a perception that their comfort during labor was not a priority, leading to dissatisfaction. They were also not allowed to assume comfortable positions in labour but were asked to lie in only one position. However, regular monitor of fetal heart rate, maternal vital signs and progress of labour was satisfactorily done.

The overall satisfaction and future intentions suggested that the general sentiment towards returning to the hospital was split. While some mothers valued the expertise and presence of multiple doctors, others were dissuaded by their negative interactions with certain staff members and inadequate resources. A few respondents stated outright that they would not return due to their experiences. Some of the decisions here included*: "Sir me o, they tried. This is my third child. My sister came here and said the hospital is very dirty that she can't give birth here again. So, for this baby, she directed me to another hospital but I said no because this is not my first time so let me continue where I've been delivering before".*

Despite the degree of dissatisfaction and unpleasant experiences reported by some women 75% would utilize the facility for future childbirth purposes and only 25% would not. This is encouraging considering the fact that hospital delivery would certainly minimize morbidity and mortality for both the mother and baby. However, it may also be true to say that, their intention to use the facility in future is not only due to satisfaction with services but other factors such as; their inability to identify suitable alternatives, unaffordability of cost of services in other facilities, distance of other health centers from their place of residence and referral to the study center amongst other reasons.

Others emphasized number and professionalism; *"For me this is my first time but I'd advice someone to come here because when you are in the labour room, several doctors would be checking on you, but in other hospitals sometimes it's just one doctor checking on you and they are also professional in their work"*. Others felt the health workers were kind to them*; "For my own, this is my first time too but I will come back here because they were really nice to me and they really tried (performed well). But it's those delivery items that scare me. But they were really nice to me"*. So, there were divided reasons for their intention to utilize the facility in the future.

CONCLUSION

Data obtained from this research reveals poor satisfaction, but high intention for future utilization of facility in future. Underlying issues in the hospital's service delivery basically focused on infrastructure, emotional, physical, and logistical support provided to patients. Themes like staff empathy, commodity availability, and patient dignity emerged as being pivotal to mothers' satisfaction levels, indicating areas for potential improvement to enhance maternal care at the facility.

Limitation of the study: The participation of the researchers in the data collection could have introduced bias. The small number of the participants for FGD could have narrowed the opinions that might have been a larger representation of the study group. Some participants who do not want to utilize the facility for future childbirth might have in the actual sense completed their family sizes.

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REFERENCES

1. Niguise A, Azale T & Yitaya M. Institutional delivery service utilization and associated factors in Ethiopia: a systematic review and META-analysis. BMC Pregnancy and Childbirth, 2020; 20: 364. https://doi.org/10.1186/s12884-020-3032-5
2. Chizoma N, Tobiloba O & Chigozie, N. Factors influencing the choice of health care provider

during childbirth by women in Ibadan, Oyo State, Nigeria. *Int. J of Caring Sci, 2017; 10*(1): 511–521.

3. Darebo T D, Abera M & Abdulahi M. Women's satisfaction with intrapartum care and associated factors among mothers who gave birth at public health facilities in Hawassa city, Southern Ethiopia. *J of Med Physiol and Biophysics,2016; 25*: 19–28.
4. Esan D T, Sokan-Adeaga A A & Rasaq M O. Assessment of satisfaction with delivery care among mothers in selected health care facilities in Ekiti State, Nigeria. *J of Pub Health Res,2022; 11*(4):1–10.https://doi.org/101177/22799036221127572
5. Gitobu C M, Gichangi P B, & Mwanda W O. The effect of Kenya's free maternal health care policy on the utilization of health facility delivery services and maternal and neonatal mortality in public health facilities. *BMC Pregnancy and Childbirth, 2018; 18*, 77. https://doi.org/10.1186/s12884-0118-1708-2
6. Bitew K, Ayichiluhm M, & Yimam K. Maternal satisfaction on delivery service and its associated factors among mothers who gave birth in public health facilities of Debre Markos Town, Northwest Ethiopia. *BioMed Research International, 2015*, Article 460767. https://doi.org/10.1155/2015/460767
7. WHO. Maternal mortality: The urgency of a systemic and multisectoral approach in mitigating maternal deaths in Africa. *Analytical fact sheet 2023*. aho.afro.who.int.
8. Ope BW. Reducing maternal mortality in Nigeria: addressing maternal health services perception and experience. J Global Health Reports. 2020; 4: e2020028.
9. Babure Z K, Assefa J F & Weldemarium T D. Maternal Satisfaction and Associated Factors towards Delivery Service among Mothers Who Gave Birth at Nekemte Specialized Hospital, Nekemte Town, East Wollega Zone, Oromia Regional State, Western Ethiopia, 2019: A Cross-sectional Study Design. *Journal of Women's Health Care, 2019; 9:* 489. https://doi.org/10.35248/2167-0420.20.9.489.
10. Darebo T D, Abera M, & Abdulahi M. Women's satisfaction with intrapartum care and associated factors among mothers who gave birth at public health facilities in Hawassa city, Southern Ethiopia. *Journal of Medicine, Physiology and Biophysics,2016; 25:* 19–28.
11. Edaso A U, Teshome G S. Mothers' satisfaction with delivery services and associated factors at health institutions in West Arsi, Oromia Regional State, Ethiopia. *MOJ Women'sHealth,2019; 8*(1), 110–119.https://doi.org/10.1546/mojwh.2019.08.00222.
12. Okonofua F, Ogu R, Agholor K, Okike O, Abdus-salam R, Gana M et al. Qualitative assessment of women's satisfaction with maternal healthcare in referral hospitals in Nigeria. *Reprod Health.* 2017; 14: 44.
13. Dahiru T, Oche MO. Determinants of antenatal care, institutional delivery and postnatal care services utilization in Nigeria. Pan Afr. Med J. 2013; 21: 321.
14. Demis A, Getie A, Wondmieneh A, Bimerew M, Alemnew B & Gedefaw G. Women's satisfaction with existing labour and delivery services in Ethiopia: A systematic review and meta-analysis. *BMJ Open, 2020; 10* (e036552). https://doi.org/10.1136/bmijopen-2019-036552
15. Irinyenikan T A, Aderoba A K, Fawole O, Adeyanju O, Mehrtash H, Adu-Bonsaffoh et al.). Adolescent experiences of mistreatment during childbirth in health facilities: secondary analysis of a community-based survey in four countries *BMJ Global Health, 2022; https://doi.org/101136/bmjgh-2021-007954.*
16. Hagos S, Shaweno D, Assegid M, Mekonnen A, Fantahun A A & Ahmed S. Utilization of institutional delivery service at Wukro and Butajera districts in Northern and South-Central Ethiopia. *BMC Pregnancy and Childbirth,2014; 14*: 178.

https://doi.org/10.1186/1471-2393-14-178.

17. Ijeoma N O, Ifenyinwa C A, Johnbosco I M, & Chika N O. Determinants, reasons for choice, and willingness to recommend birthing facility among mothers in public and private health facilities in Ebonyi, Nigeria. *Pan African Medical Journal, 2021; 38* (289). https://doi.org/10.11604/pamj.2021.38.289.24437
18. Ogunyemi A O, Ogunyemi A A, Olufunlayo T F, & Odugbemi, T O. Patient satisfaction with services at a public and faith-based health facility in Nigeria. *Journal of Clinical Sciences*,2019;16: 75-80.
19. Fikre A A, & Demisie M. Prevalence of institutional deliveries and associated factors in Dodota Woreda (district), Oromia Regional State, Ethiopia. *Reproductive Health, 2012; 9*(33): 1–6. https://doi.org/10.1186/142-4755-9-33
20. Moore B M, Alex-Hart B A, & George I O. Utilization of health care services by pregnant mothers during delivery: A community-based study in Nigeria. *Journal of Medicine and Medical Sciences, 2011;2*(5): 864–867.
21. Njuguna J, Kamau N & Muruka C. Impact of free delivery policy on utilization of maternal health services in county referral hospitals in Kenya. BMC Health Services Research, 2017;17:429. https://doi.org/10.1186/sl2913-017-2376-z
22. Karmacharya M, Jasienska G, Bissell P, Wasti S P & Bajracharya L. Factors influencing the utilization of health facilities for childbirth in a disadvantaged community of Lalitpur, Nepal. *Journal of Gynaecology, 2016;1*(1).
23. Wu Wu Y, Mu J and Zhang S. Evaluating Patient Satisfaction in Township Hospitals in the Cold Regions of China. Health Environments Research & Design Journal, 2020; 1-16.
24. Taqdees Fatima, Shahab Alam Malik, Asma Shabbir. "Hospital healthcare service quality, patient satisfaction and loyalty: An investigation in context of private healthcare systems", International Journal of Quality & Reliability Management, 2018; Vol. 35 Issue: 6:1195-1214. https://doi.org/10.1108/IJQRM-02-2017-0031
25. Bulto GA, Demissie DB, Tasu TL and Demisse GA. Mother's satisfaction with the existing labour and delivery care services at public health facilities in West Shewa zone, Oromia region, Ethiopia. BMC Pregnancy and Childbirth (2020). 20:303. https://doi.org/10.1186/s12884-020-02998-6.