

Research



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Mothers' satisfaction with free maternity services at Kalemba Mulumba Secondary Hospital, Democratic Republic of Congo

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Abstract

Introduction: in the Democratic Republic of Congo, healthcare coverage remains insufficient, and service quality is a major challenge, particularly for women. To address this, the government implemented Universal Health Coverage, emphasizing free maternal and neonatal care. However, recurring complaints from women giving birth in healthcare facilities have raised questions about the effectiveness of this policy. In this context, the present study aimed to assess the satisfaction level of postpartum women. **Methods:** a descriptive cross-sectional study was conducted from July 10 to December 13, 2024, among 233 women discharged from the maternity ward at Kalemba Mulumba Secondary Hospital after at least 24 hours of stay. The study adapted the Saphora-Médecine, Chirurgie, Obstétrique model to assess satisfaction with care. The questionnaire included 50 items across 8 key factors, excluding sociodemographic variables. Scores were calculated for each factor to determine the specific and overall levels of satisfaction. **Results:** participants had a median age of 25 years (interquartile range = 10), 93.5% lived with a partner, and 59.7% had incomplete secondary education. A total of 39.9% were referred after incomplete care elsewhere. The average length of stay was 3.9 ± 1.1 days. Overall, 76.8% of women reported being satisfied with the care received. **Conclusion:** while the majority of women were satisfied with free maternal care, improvements are needed in stay conditions and provider availability. Regular monitoring and evaluation of

free care policies are essential to meet women's expectations and ensure quality maternal services.

Introduction

In the Democratic Republic of the Congo (DRC), inadequate healthcare coverage and poor service quality remain major challenges. In 2022, 38.7% of women were excluded from family planning services, primarily because of financial barriers [1]. That same year, total household health expenditures accounted for 40%, with out-of-pocket payments estimated at 92% [2]. According to the 2023-2024 Demographic and Health Survey (DHS III), the maternal mortality rate was 746 maternal deaths per 100,000 live births (LBs) over the seven years preceding the survey — far above the target of 70/100,000 LBs [3].

In an effort to reduce the financial burden of healthcare, several African countries, including the DRC, have implemented policies aimed at improving access to quality healthcare without requiring direct payment [4,5]. However, these measures are sometimes introduced in electoral contexts without prior consultation with local providers and managers, which limits their effectiveness [6,7]. Overall, the literature has reported positive effects of these policies on healthcare utilization [8-10] and healthcare providers' working conditions [11,12]. Nonetheless, persistent issues have been noted, such as medicine stockouts and declining quality of care, attributed to poor policy preparedness, reimbursement delays, and insufficient government funding [13-15].

Several studies have reported improvements in the quality of care; however, the satisfaction of women who have given birth remains variable. It depends on multiple factors, including infrastructure quality, staff training, patient-provider communication, pain management, the comfort provided, and sociocultural context [16-20]. In Togo, for example, the quality of reception (94.7%) and respect for dignity and

privacy (96.7%) were identified as major determinants of mothers' satisfaction [21].

In the DRC, the policy of free maternal healthcare was introduced to improve access to and quality of services, yet beneficiary satisfaction remains a key indicator of its effectiveness. Since the removal of user fees for maternal care, postpartum women's perceptions of service quality have shown considerable variation across several dimensions, including professional support, fulfillment of expectations, birth environment, pain management, early contact with the newborn, and family support. For example, an evaluation conducted by the Patrick Kayembe Research Center [22] revealed complaints from mothers regarding the quality and effectiveness of free maternal care in several health facilities, particularly concerning emotional support, personalization of the care environment, and pain management. These complaints reflect irregularities in the provision of obstetric care in the area. To the best of our knowledge, no study has been conducted in health facilities in Kananga to assess the satisfaction of women receiving free maternal care. Yet, such studies are essential to guide the implementation and improvement of the free maternity care policy in the region. Therefore, this study aimed to evaluate the satisfaction level of postpartum women at the maternity ward of Kalemba Mulumba Secondary Hospital (KM SH), with the objective of formulating evidence-based recommendations to enhance the quality of maternal care and strengthen the effectiveness of the free maternity care policy in the region.

Methods

Study site: the study was conducted at the maternity ward of Kalemba Mulumba Secondary Hospital (KM SH), a second-level facility integrated into the healthcare network of the Tshikaji Health Zone. This hospital is located approximately 9 kilometers from the Central Office of the Health Zone, along the road connecting the city of

Kananga to Tshikaji. It serves an estimated population of 80,033 out of the 163,607 people covered by the entire health zone. The selection of this maternity ward was based on its integration into the free maternal healthcare policy and the high demand for obstetric services it records, making it the most frequent health facility for maternal health within the HZ.

Study design: we conducted a descriptive cross-sectional study targeting women who had given birth and received free maternal care at the KM SH maternity ward over a five-month period, from July 10 to December 13, 2024.

Sample size: the sample size for this study was determined via a single population proportion formula, considering the following assumption: the percentage of mothers who were satisfied with hospital delivery care services was 90% ($p = 0.90$) [23]. The level of significance was 5% ($\alpha = 0.05$), $Z_{\alpha/2} = 1.96$, and the margin of error was 5% ($d = 0.05$). By adding a 10% nonresponse rate, the minimum sample size was 151 mothers who delivered free of charge.

Sampling strategy: to increase the precision of the results and reduce the risk of Type II errors, exhaustive sampling was preferred. All women who gave birth at the KM SH maternity ward during the data collection period were included. A total of 237 postpartum women were identified. Of these, four were excluded because major medical complications could affect their perception of the care they received. In the end, 233 women provided informed consent and participated in the study (Figure 1).

Study variables: the data collection instrument was a structured, closed-ended questionnaire. The items related to satisfaction with delivery services were derived from the Saphora-MCO model [24], which is used to assess patient satisfaction. This model was further adapted on the basis of its application in a patient satisfaction survey conducted in Bourkina-Faso [21]. All questions were presented on a 5-point Likert scale (1 — very

dissatisfied, 2 — dissatisfied, 3 — neutral, 4 — satisfied, and 5 — very satisfied). Excluding overall satisfaction and participant identification, the questionnaire comprised 50 items grouped into eight domains, covering the main aspects of postpartum women's satisfaction: reception (7 items), communication and relationships with healthcare providers (9 items), privacy (2 items), hospitalization conditions (10 items), waiting times for care (3 items), medical and paramedical care (9 items), pain management (3 items), and information provided at discharge (7 items). The instrument was pretested with 20 postpartum mothers at Pax Polyclinic one month prior to the actual data collection.

Data collection: data were collected by four independent interviewers who were not affiliated with the maternity ward under study. These interviewers received two days of training (one day theoretical and one day practical) on data collection procedures. Data were obtained through face-to-face interviews with postpartum women via smartphones equipped with the KoboCollect application. The interviews were conducted both inside the hospital (70% of the cases) and outside (30%), depending on the participants' availability and preferences. In the field, interviewers initiated the process with administrative procedures, followed by the identification of eligible participants and the verbal acquisition of their informed consent. Each interview took place in a location mutually agreed upon with the participant, ensuring privacy and comfort. The interviews lasted approximately 30 minutes. The questionnaires were administered in French, with simultaneous translation into Tshiluba (the locally spoken national language) when necessary to ensure full comprehension and reliability of the responses. A systematic quality control check was performed before the forms were submitted to a secure server.

Data analysis: to ensure optimal data quality, additional verification procedures were implemented following the quality control procedures conducted during the data collection

phase. These verifications, carried out during the analysis phase, aimed to identify and correct any potential inconsistencies. Data cleaning was performed via Microsoft Excel, and statistical analyses were conducted with STATA software, version 18. The distribution of quantitative variables was assessed via the Kolmogorov-Smirnov test. Variables following a normal distribution are summarized as the means with standard deviations, whereas nonnormally distributed variables are presented as medians with interquartile ranges (IQRs). Qualitative variables were described using absolute and relative frequencies.

The assessment of specific satisfaction levels among postpartum women was based on eight overarching dimensions of satisfaction. The corresponding items were rated on a four- or five-point Likert scale. For each factor, the mean score was calculated via the following formula: $Mean\ Score = (5 \times n\ Very\ Satisfied) + (4 \times n\ Satisfied) + (3 \times n\ Neutral) + (2 \times n\ Dissatisfied) + (1 \times n\ Very\ Dissatisfied)$. The percentage score was then obtained by dividing the mean score by the maximum possible score for the given dimension and multiplying the result by 100. In line with the methodological approaches adopted in several similar African studies, a 50% threshold was applied to classify the results: scores $\geq 50\%$ were considered *satisfactory*, whereas scores $< 50\%$ were considered *unsatisfactory* [21]. Overall satisfaction was calculated via a similar approach, assigning a value of 1 to respondents who were "satisfied" and 0 to those who were "unsatisfied." The resulting mean score was divided by the maximum possible score (eight), multiplied by 100, and categorized using the same 50% threshold.

Ethical considerations: this study was conducted in accordance with the Declaration of Helsinki and was approved by the Ethics Committee of the Kinshasa School of Public Health (reference: ESP/CE/17/205). In addition, favorable authorization was obtained from the administrative authorities of the hospital under

study. Verbal informed consent was also obtained from all participants prior to the interviews.

Results

Sociodemographic characteristics of postpartum women: the study included 233 postpartum women with a median age of 25 years (IQR = 10 years). The ages of the participants ranged from 18-43 years. The vast majority (93.5%) were living with a partner, and more than half (59.7%) had not completed secondary education. Approximately two out of five women (39.9%) had been referred to the maternity ward following incomplete initial care at a health center. The average length of hospital stay was 3.9 ± 1.1 days, and 73% of the women had been hospitalized for 2 to 4 days at the time of the survey (Table 1).

Mothers' satisfaction with delivery care: the analysis of scores obtained from the validated variables (Table 2, Table 2.1, Table 2.2) presents the levels of satisfaction reported by postpartum women for each of the factors studied. According to Figure 2, 75.5% of the women reported being satisfied with their reception and communication with providers. The respect for privacy was considered satisfactory by 76.8% of the participants. The conditions of the hospital stay were deemed satisfactory by 61.8% of the respondents, whereas 71.2% expressed satisfaction with the waiting time for care. In terms of medical care, 76.8% of the women reported a favorable level of satisfaction. Pain management received a satisfaction rate of 82.0%, and approximately 80% of the postpartum women expressed satisfaction with the information they received upon discharge from the maternity ward. Overall, 76.6% ($n = 179$) of the postpartum women were satisfied with the free maternal care provided at the KM SH (Figure 2).

Discussion

The primary objective of this study was to assess the satisfaction level of postpartum women

receiving free maternal care at the KM HS. To achieve this, a modified version of the Saphora-MCO model was employed, comprising 50 items distributed across eight key dimensions of patient satisfaction. Each dimension was evaluated via 4- or 5-point Likert scales, allowing for a detailed and nuanced analysis of user experiences within the maternal care-free service program. The findings revealed an overall satisfaction rate of 76.6%, indicating a generally positive perception of the care received. This level suggests a degree of acceptance of the free care initiative within the facility and supports the continuation and strengthening of this policy. However, compared with other African countries, such as Togo (94%) [21] and Burkina Faso (90%) [23], this satisfaction rate is relatively lower.

This discrepancy may be attributed in part to the increased workload on healthcare personnel following the introduction of free care [25]. Indeed, the surge in patient volume was not matched by a proportional reinforcement of human and infrastructural resources, which may compromise care quality. These observations align with those of Fasoi *et al.* [26], who noted that staff overload can deteriorate service quality and negatively impact patient satisfaction. Furthermore, the rapid deployment of free care without adequate human, material, and financial support likely exacerbated these limitations, although this relationship was not directly measured in our study [27]. It is also important to contextualize the reported satisfaction scores. As highlighted by Boudreaux *et al.* [28], surveys conducted in resource-limited settings may underestimate true dissatisfaction due to internalized low expectations, reluctance to criticize healthcare workers, or the absence of events perceived as overtly negative. Consequently, high satisfaction scores do not necessarily reflect optimal quality but rather complex perceptions influenced by sociocultural context, education level, and patients' informational capital.

Despite an overall favorable satisfaction level, notable dissatisfaction was identified in several specific dimensions. The most concerning factor was the conditions of stay, which received the lowest score (61.8%). Although often overlooked in evaluations, accommodation conditions play a fundamental role in patients' perceptions of care quality. These findings corroborate those from studies in other African countries, where environmental factors such as hygiene, comfort, and infrastructure status significantly influence patient experience [19]. This underscores the urgent need to rehabilitate care environments to ensure a dignified and respectful setting for women during childbirth.

Additionally, other dimensions received low ratings, including staff availability, patient flow management, and respect for privacy. These shortcomings resonate with the recommendations of the World Health Organization (WHO) [29], which emphasize confidentiality, respect for privacy, and empathetic communication as pillars of patient-centered maternal care. The reception service, often the patients' first contact with the health system, was also identified as a major source of dissatisfaction. The quality of this initial interaction strongly shapes overall perceptions of care. Similarly, the quality of caregiver-patient relationships—encompassing listening, empathy, and responsiveness—has been shown to be a critical determinant of satisfaction [30]. Addressing these gaps requires a systemic approach that combines capacity building, restructuring of care pathways, and the implementation of standardized protocols aimed at embedding a culture of respectful and humanized care.

In a broader context, these results highlight the challenges of institutionalizing free care policies within fragile health systems. While free care undeniably improves financial access to services, it may also produce unintended negative effects, such as deterioration in service quality, if not supported by concurrent investments in systemic resources [30,31]. These findings call for a

strategic rebalancing of health policies: beyond financial equity, ensuring equity in quality and dignity of care is essential [29]. Moreover, the data underscore the importance of integrating social accountability mechanisms, particularly through user involvement in monitoring and evaluating received care [32]. Such an approach would not only promote continuous service improvement but also strengthen trust between communities and providers—an essential condition for the success of any public health policy [33].

Limitations and strengths of the study: to our knowledge, this study is among the first to explore the satisfaction of women who gave birth in the context of free maternity care in the DRC. While it provides relevant insights into the perception of obstetric care, it has some methodological limitations that may influence the interpretation of the results. First, the physical proximity of healthcare providers during data collection may have introduced social desirability bias. Some participants, interviewed within the maternity ward itself, may have felt compelled to provide responses that aligned with the presumed expectations of the healthcare providers, thereby compromising the authenticity of their testimonies. To mitigate this bias, several measures were taken: the anonymity of the responses was ensured, the questions were formulated in a neutral and nonsuggestive manner, and the majority of the interviews were conducted outside the healthcare facility. The few interviews conducted within the hospital premises were carried out under conditions ensuring confidentiality, with no healthcare staff or other patients present.

Second, the variability in care provided by different healthcare teams and during various time slots represents another significant limitation. The quality of services received can differ on the basis of the competence, availability, or workload of the healthcare providers present at different times of the day. This heterogeneity could lead to contrasting perceptions among postpartum women. To reduce the impact of this

variability, the data were collected over different time slots and with various healthcare teams, thus allowing a more comprehensive and nuanced representation of the women's lived experiences. Finally, the awareness of healthcare staff regarding the conduct of the study may have resulted in a Hawthorne effect, where staff may have consciously or unconsciously adopted more favorable behaviors toward patients to project a positive image. To limit this influence, interviews were conducted by external, trained, and independent interviewers who acted unexpectedly and in the absence of healthcare staff.

Conclusion

The free maternity care provided at the KM SH is generally perceived as satisfactory by the majority of the women surveyed. However, this overall satisfaction conceals certain notable shortcomings, particularly regarding the conditions of stay, the availability of healthcare staff, the quality of medical and paramedical care, and the management of pain and other forms of discomfort. These areas highlight the need for corrective actions to increase the quality and sustainability of free maternity care. This suggests the implementation of regular and continuous satisfaction surveys to ensure constant evaluation of service quality and the ability to adapt practices quickly on the basis of feedback from women. Regular feedback meetings with healthcare staff are also essential to discuss the experiences shared by women, enabling concrete adjustments in care practices.

What is known about this topic

- *In the Democratic Republic of Congo, access to quality maternal health services remains limited, and high healthcare costs are a major barrier for women;*

- *The Congolese government introduced free maternal and neonatal care within the Universal Health Coverage framework to reduce maternal and neonatal morbidity and mortality;*
- *Despite this policy, several reports highlight persistent challenges such as inadequate infrastructure, shortage of healthcare providers, and dissatisfaction among beneficiaries.*

What this study adds

- *At Kalembe Mulumba Secondary Hospital, 76.8% of mothers reported being satisfied with the free maternity services they received, highlighting the positive impact of this policy on women's perception of care;*
- *However, significant gaps remain in terms of conditions of stay and availability of healthcare providers, which were key sources of dissatisfaction;*
- *The study underscores the need for continuous monitoring and evaluation of free maternity services to improve quality, strengthen patient-centered care, and ensure the sustainability of Universal Health Coverage in the DRC.*

Competing interests

The authors declare no competing interests.

Authors' contributions

Bonard Djongesongo Djamba: conceived the study, developed the methodology. Bonard Djongesongo Djamba and Pascaline Muelu Mikobi: supervised the data collection. Bonard Djongesongo Djamba and Paulin Nkolamoyo Musungula: performed the data analysis. Bonard Djongesongo Djamba: drafted the original manuscript. Paulin Nkolamoyo Musungula: reviewed the manuscript and revised the discussion. Bonard Djongesongo Djamba and Pascaline Muelu Mikobi: review of the revised

manuscript. John Ditekemena Dinanga: contributed substantially to the methodology and supervision. All authors read and approved the final manuscript.

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Tables and figures

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Table 2.1: satisfaction of women giving birth at the maternity ward

Table 2.2: satisfaction of women giving birth at the maternity ward

Figure 1: selection flowchart of mothers who gave birth

Figure 2: degree of specific and overall satisfaction among postpartum women

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Table 1: sociodemographic characteristics of postpartum women

Variables	Frequency (n=233)	%
Age		
Young mothers	94	40.3
Mothers of intermediate age	102	43.8
Older mothers	37	15.9
Median and IQR	25 and IQR 10 years	
Marital status		
Married	218	93.5
Single	6	2.6
Divorced	3	1.3
Widowed	3	1.3
Separated	3	1.3
Level of education		
Incomplete primary	6	2.6
Complete primary	8	3.4
Incomplete secondary	139	59.7
Complete secondary	71	30.5
Incomplete university	3	1.3
Complete university	6	2.6
Other levels of education	0	0.0
Residence		
Urban	216	92.7
Rural	17	7.3
Religion		
Catholic	17	7.3
Protestant	25	10.7
Revival church	145	62.2
Kimbanguist	3	1.3
Jehovah's Witness	18	7.7
Message	25	10.7
Mode of admission		
Came directly	100	42.9
Followed up at KM SH	40	17.2
Referred	93	39.9
Length of hospital stay		
2 to 4 days	170	73.0
4 to 7 days	63	27.0
Mean ± Standard deviation (SD)	3.9 ± 1.1 days	

IQR: interquartile range; SD: standard deviation

Table 2: satisfaction of women giving birth at the maternity ward

Satisfaction dimensions	Appreciation of deliveries				
	Very dissatisfied	Dissatisfied	Neutral	Satisfied	Very satisfied
Admission reception					
Reception by the administrative staff	33 (14.2)	39 (16.7)	30 (12.9)	95 (40.8)	36 (15.5)
Reception by midwives	30 (12.9)	36 (15.5)	38 (16.3)	96 (41.2)	33 (14.2)
Benefits of free services	No advantage	Few advantage	Neutral	Some advantages	Many advantages
	29 (12.5)	51 (21.9)	38 (16.3)	46 (19.7)	69 (29.6)
Time taken for administrative procedures	Not reasonable at all	Slightly reasonable	Neutral	Reasonable	Very Reasonable
	27 (11.6)	36 (15.5)	29 (12.5)	111 (47.5)	30 (12.5)
Courtesy of the admission staff	Very dissatisfied	Dissatisfied	Neutral	Satisfied	Very satisfied
	30 (12.9)	33 (14.2)	30 (12.9)	111 (47.5)	29 (12.5)
General impression upon entry	Very poor	Poor	Neutral	Good	Very good
	27 (11.6)	27 (11.6)	32 (13.7)	120 (51.5)	27 (11.6)
Communication and relationships with providers					
Clarity of medical explanations	Not clear at all	Slightly clear	Neutral	Clear	Very clear
	36 (15.5)	33 (14.2)	38 (16.3)	99 (42.5)	27 (11.6)
Satisfaction with answers provided	Not satisfactory at all	Slightly satisfactory	Neutral	Satisfactory	Very satisfactory
	33 (14.2)	33 (14.2)	46 (19.7)	94 (40.3)	27 (11.6)
Informed about rights and available services	Not informed at all	Slightly informed	Neutral	Informed	Very well informed
	41 (17.6)	36 (15.5)	42 (18.0)	87 (37.3)	27 (11.6)
Providers' attitude	Very negative	Negative	Neutral	Positive	Very positive
	27 (11.6)	39 (16.7)	30 (12.9)	105 (45.1)	32 (13.7)
Communication difficulties with caregivers	Very often	Often	Neutral	Rarely	Never
	54 (23.2)	29 (12.5)	32 (13.7)	48 (20.6)	70 (30.0)
Annoying remarks from the doctor	27 (11.6)	27 (11.6)	27 (11.6)	48 (20.6)	104 (44.6)
Annoying remarks from the midwives	33 (14.2)	39 (16.7)	27 (11.6)	36 (15.5)	98 (42.1)
Politeness of the staff	Very rude	Rude	Neutral	Polite	Very poly
	27 (11.6)	27 (11.6)	30 (12.9)	113 (48.5)	36 (15.5)
Help with daily activities	Not at all	Slightly	Neutral	Yes	Absolutely
	66 (28.3)	30 (12.9)	42 (18.0)	68 (29.2)	27 (11.6)

Table 2.1: satisfaction of women giving birth at the maternity ward

Satisfaction dimensions	Appreciation of deliveries				
	Not respected at all	Slightly respected	Neutral	Respected	Very respected
Privacy					
Respect for privacy	27 (11.6)	27 (11.6)	29 (12.5)	120 (51.5)	30 (12.9)
Data confidentiality	27 (11.6)	32 (13.7)	29 (12.5)	118 (50.6)	27 (11.6)
Satisfaction with accomodation conditions	Very dissatisfied	Dissatisfied	Neutral	Satisfied	Very satisfied
Cleanliness of the hospital room	36 (15.5)	53 (22.8)	30 (12.9)	87 (37.3)	27 (11.6)
Cleanliness of sanitary facilities	32 (13.7)	63 (27.0)	32 (13.7)	76 (32.6)	30 (12.9)
Cleanliness of the bed linens	Not clean at all 51 (21.9)	Slightly clean 42 (18.0)	Neutral 56 (24.0)	Clean 57 (24.5)	Very clean 27 (11.6)
Adequacy of cleaning schedule	Not adequate at all 60 (25.8)	Slightly adequate 42 (18.0)	Neutral 36 (15.5)	Adequate 68 (29.2)	Very adequate 27 (11.6)
Satisfaction with the hospital room	Very dissatisfied 63 (27.0)	Dissatisfied 27 (11.6)	Neutral 86 (36.9)	Satisfied 27 (11.6)	Very satisfied 30 (12.9)
Number of visitors received yesterday/today	Less than 5 people 175 (75.1)		More than 5 people 58 (24.9)		
Disturbed by noise during the day	Very often 33 (14.2)	Often 30 (12.9)	Neutral 34 (14.6)	Rarely 85 (36.5)	Never 51 (21.9)
Disturbed by noise at night	33 (14.2)	27 (11.6)	29 (12.5)	41 (17.6)	103 (44.2)
Comfort of the bed	Very uncomfortable 33 (14.2)	Slightly uncomfortable 64 (27.5)	Neutral 36 (15.5)	Comfortable 70 (30.0)	Very comfortable 30 (12.9)
Comfort of room temperature	44 (18.9)	91 (39.1)	30 (12.9)	41 (17.6)	27 (11.6)
Satisfaction with waiting time for care	Not reasonable at all	Slightly reasonable	Neutral	Reasonnable	Very reasonable
Reasonable wait time for assistance	27 (11.6)	45 (19.3)	48 (20.6)	80 (34.3)	33 (14.2)
Waiting time to receive assistance	Very dissatisfied 26 (11.2)	Dissatisfied 42 (18.0)	Neutral 51 (21.9)	Satisfied 79 (33.9)	Very satisfied 35 (15.0)
Informed about waiting times	Not informed at all 42 (18.0)	Slightly informed 37 (15.9)	Neutral 46 (19.7)	Informed 70 (30.0)	Very well informed 38 (16.3)
Satisfaction with medical and paramedical care	Very dissatisfied	Dissatisfied	Neutral	Satisfied	Very satisfied
Courtesy of healthcare providers	30 (12.9)	27 (11.6)	30 (12.9)	119 (51.1)	27 (11.6)

Table 2.2: satisfaction of women giving birth at the maternity ward

Satisfaction dimensions	Appreciation of deliveries				
Respect by carers	Not respectful at all	Somewhat respectful	Neutral	Respectful	Very respectful
	27 (11.6)	27 (11.6)	33 (14.2)	119 (51.1)	27 (11.6)
Competence of carers	Very dissatisfied	Dissatisfied	Neutral	Satisfied	Very satisfied
	27 (11.6)	30 (12.9)	33 (14.2)	111 (47.6)	32 (13.7)
Availability of carers	27 (11.6)	36 (15.5)	38 (16.3)	100 (42.9)	32 (13.7)
Clarity of information on care received	27 (11.6)	30 (12.9)	53 (22.8)	91 (39.1)	32 (13.7)
Clear instructions on health management after childbirth	33 (14.2)	42 (18.0)	54 (23.2)	75 (32.2)	29 (12.5)
Moral support from caregivers	27 (11.6)	36 (15.5)	31 (13.3)	109 (46.8)	30 (12.9)
Prompt responses provided	27 (11.6)	36 (15.5)	40 (17.2)	103 (44.2)	27 (11.6)
Number of times verification of the condition	Once a day	Twice a day	Three times a day	More than three times a day	Mean ± SD
	45 (19.3)	81 (34.5)	60 (25.8)	47 (20.2)	2.3±1.0
Pain management pain management	Yes		No		
Experienced pain	233 (100.0)		0 (0.0)		
Pain intensity	Very mild	Mild	Moderate	Intense	Extremely intense
	27 (11.6)	27 (11.6)	27 (11.6)	84 (36.1)	68 (29.2)
Effectiveness of interventions to relieve pain	Very dissatisfied	Dissatisfied	Neutral	Satisfied	Very satisfied
	36 (15.5)	51 (21.9)	41 (17.6)	99 (42.5)	6 (2.6)
Effectiveness of measures to relieve other discomforts	27 (11.6)	48 (20.6)	46 (19.7)	82 (35.2)	30 (12.9)
Assessment of information received					
Quality of information on side effects	30 (12.9)	53 (22.7)	53 (22.7)	70 (30.0)	27 (11.6)
Implications for decisions	27 (11.6)	39 (16.7)	53 (22.7)	87 (37.3)	27 (11.6)
Quality of information on health status	27 (11.6)	39 (16.7)	45 (19.3)	95 (40.8)	27 (11.6)
Clarity of information received	30 (12.9)	40 (17.2)	106 (45.5)	30 (12.9)	30 (12.9)
Quality of information on taking medication	33 (14.2)	39 (16.7)	58 (24.9)	76 (32.6)	27 (11.6)
Quality of information on resumption of activities	30 (12.9)	36 (15.5)	62 (26.6)	75 (32.2)	30 (12.9)
Quality of information on signs of readmission	30 (12.9)	30 (12.9)	63 (27.0)	80 (34.2)	30 (12.9)

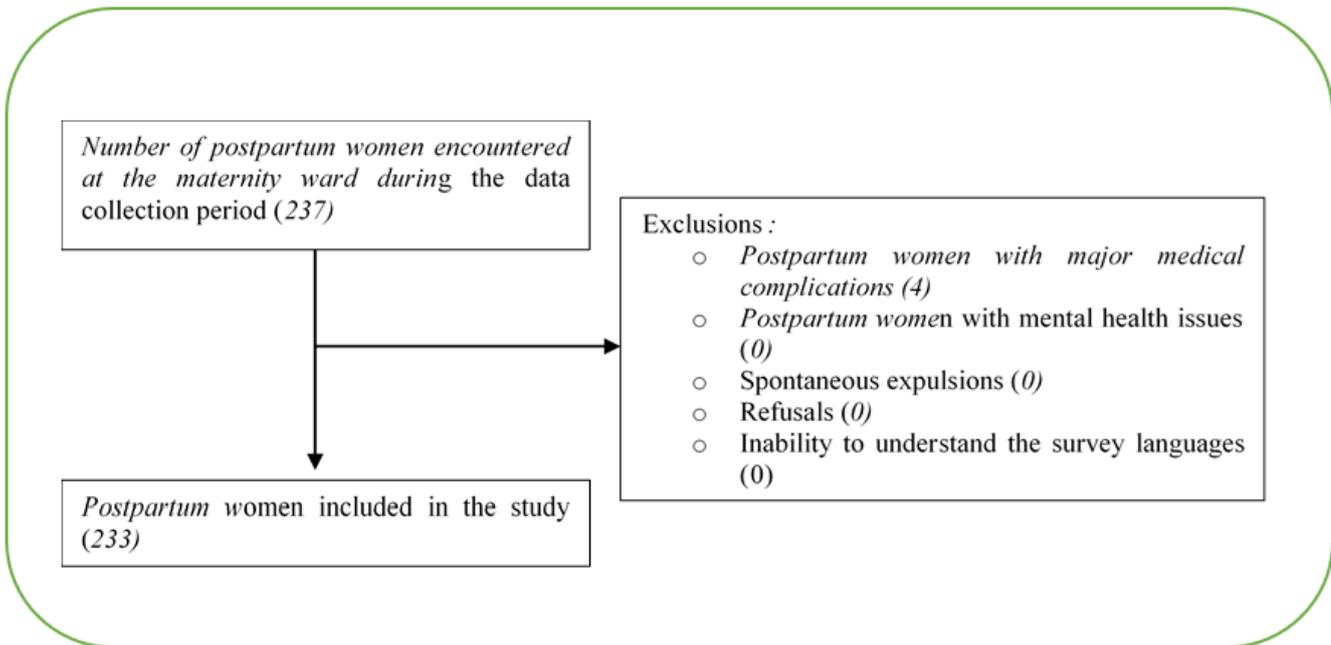


Figure 1: selection flowchart of mothers who gave birth

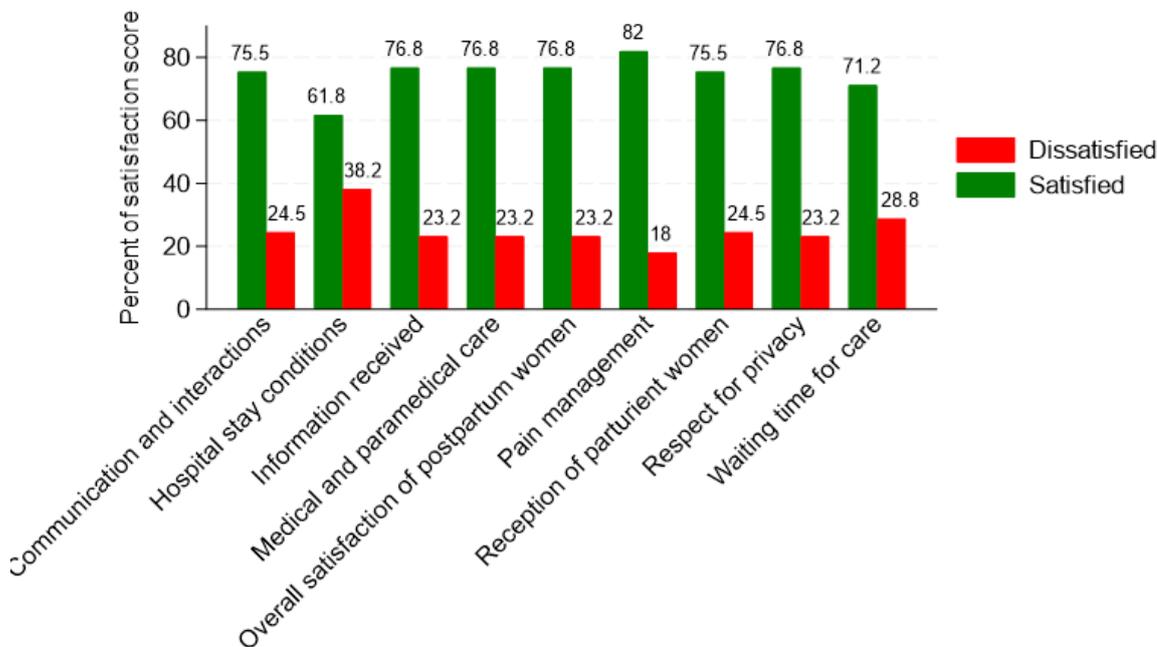


Figure 2: degree of specific and overall satisfaction among postpartum women