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Satisfaction with the Birth Process in Women Undergoing Induction of Labor

Satisfacción con el proceso del parto en mujeres sometidas a inducción del parto
Satisfação com o Processo de Parto em Mulheres Submetidas a Indução do Parto

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Abstract
Background: Induction of labor often results in complicated childbirths and increased interventionism, which can lead to frustration and anxiety.
Objective: To analyze satisfaction with the birth process in women undergoing induction.
Methodology: Observational study. Non-probabilistic convenience sampling. Inclusion and exclusion criteria were established. The sample consisted of 46 participants. A sociodemographic and obstetric questionnaire and the Spanish version of the Mackey Childbirth Satisfaction Rating Scale.
Results: Global satisfaction was good. The newborn subscale had the highest score, while the dilatation and expulsion subscales had the lowest scores. Satisfaction with the partner and comfort was higher in women aged 30-34 years than in women aged ≥ 40 years. Global satisfaction was higher among women who had received prior information about the induction process and whose expectations had been met.
Conclusion: Global and subscale-level satisfaction were high. The results provide evidence for effective quality care to improve satisfaction levels of induced women.

Keywords: labor; labor, induced; newborn; pregnancy; satisfaction

Resumen
Marco contextual: La inducción del parto suele ocasionar partos complicados y mayor intervencionismo, lo que puede conllevar frustración y ansiedad.
Objetivo: Analizar la satisfacción del proceso de parto en mujeres sometidas a inducción.
Metodología: Estudio observacional. Muestreo no probabilístico por conveniencia. Se establecieron criterios de inclusión y exclusión. La muestra fue de 46 participantes. Se utilizó un cuestionario sociodemográfico, obstétrico y la versión española de la *Mackey Childbirth Satisfaction Rating Scale*.
Resultados: La satisfacción global fue buena. La subescala mejor valorada fue la relacionada con el recién nacido, las peor valoradas las relacionadas con las fases dilatación y expulsivo. La satisfacción del acompañante y confort de las mujeres entre 30-34 años fue mayor que en ≥ 40 años. La satisfacción global fue mayor en mujeres que recibieron información previa sobre el proceso de inducción y que habían cumplido sus expectativas.
Conclusión: La satisfacción global y por subescalas fue alta. Los resultados aportan evidencia para una atención eficaz de calidad que mejore los niveles de satisfacción de mujeres inducidas.

Palabras clave: parto; parto inducido; recién nacido; embarazo; satisfacción personal

Resumo
Enquadramento: A indução do parto resulta frequentemente em partos complicados e numa maior intervenção, o que pode levar à frustração e ansiedade.
Objetivo: Analisar a satisfação com o processo de parto em mulheres submetidas a indução.
Metodologia: Estudo observacional. Amostragem não probabilística e de conveniência. Foram estabelecidos critérios de inclusão e exclusão. A amostra foi constituída por 46 participantes. Foi utilizado um questionário sociodemográfico e obstétrico e da versão espanhola da *Mackey Childbirth Satisfaction Rating Scale*.
Resultados: A satisfação global foi boa. A subescala melhor classificada foi a relacionada com o recém-nascido e as dimensões com pior classificação foram as relacionadas com as fases de dilatação e expulsão. A satisfação com o parceiro e o conforto foi maior em mulheres com idade entre 30-34 anos do que em mulheres com idade ≥ 40 anos. A satisfação global foi maior nas mulheres que tinham recebido informação prévia sobre o processo de indução e cujas expectativas tinham sido satisfeitas.
Conclusão: A satisfação global e por dimensão foi elevada. Os resultados fornecem evidências de cuidados de qualidade para melhorar os níveis de satisfação de mulheres induzidas.

Palavras-chave: parto; trabalho de parto induzido; recém-nascido; gravidez; satisfação pessoal

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Introduction

Induction of labor is the process of initiating labor using pharmacological or mechanical procedures before the onset of labor occurs naturally with the aim of achieving a vaginal delivery (Maroto Martín et al., 2023). It is one of the most common obstetric interventions today, with rates having increased significantly in recent decades, and accounts for more than 20% of all births at full term in many countries (Fernández Fernández et al., 2025). Induction rates vary considerably between developed and developing countries, with the highest rates observed in developed countries. In Spain, 34% of births were induced in 2022 (Puertas et al., 2022).
Induction of labor is associated with a less efficient, more prolonged, and more painful labor process than spontaneous labor. It also requires more interventions during the process and its completion. Furthermore, more than one-third of cases end in instrumental delivery or cesarean section. This process necessitates a higher level of oversight of the fetus's well-being compared to spontaneous labor and also entails a more substantial involvement by midwives and gynecologists during the dilation process (Sociedad Española de Ginecología y Obstetricia, 2015). In some cases, the non-physiological nature of childbirth can result in a loss of control for the mother during the process and lead to feelings of frustration and anxiety, which can negatively impact the progression of the birth (Evans et al., 2021). It is essential to understand the factors involved in women's satisfaction in order to make optimal selections and provide precise care to enhance induction outcomes (Ramlee et al., 2023).

Background

Some authors have found that satisfaction with the birth process decreases as the number of interventions increases at each stage of labor. Induction of labor is an intervention that can lead to other interventions, depending on hospital protocols. These interventions may include continuous fetal monitoring, restricted mobility, frequent vaginal exams, restricted solid and liquid intake, and amniotomy. The induction process itself has been significantly associated with lower levels of maternal satisfaction compared to spontaneous labor (Çalik et al., 2018).
In Spain, women who go into spontaneous labor are more satisfied than those whose labor is induced. The latter group reports longer labor, more pain, and more complications. This is exacerbated by the lack of information women receive from the professionals attending them when their labor is induced (Antón-Pastor et al., 2019). A systematic review aimed at exploring the experiences and perceptions of women undergoing induction for post-term pregnancy revealed that women who were informed about the procedure and involved in the decision-making process had more positive experiences (Lou et al., 2019). Participating in decisions about the birth process positively impacts the birth experience. In this sense, midwives are most involved in encouraging women's participation and autonomy in the process (Deherder et al., 2022). Rahman et al. (2022) conducted a clinical trial to assess whether an educational video improves women's knowledge of induction of labor and, consequently, their outcomes and satisfaction. The results showed that the educational intervention had a positive impact on induction management and the women's experience of induction.
This study aimed to analyze women's satisfaction with the birth process when undergoing induction of labor and to identify ways to improve the induction process for future reference.

Research question

What is the level of satisfaction with the birth process among women whose labor is induced?

Methodology

Study design and population

A cross-sectional, correlational study was conducted in a hospital in southern Spain with women undergoing induction of labor in 2023.

Selection criteria

The study population included full-term pregnant women scheduled for induction due to prolonged labor, premature rupture of the membranes, or obstetric, medical, or fetal pathology. The study excluded pregnant women induced prior to 37 weeks of gestation, those induced subsequent to caesarean section, those under 18 years of age, and those induced with a dead fetus.

Sample

The hospital performs approximately 2,000 deliveries annually, with approximately 70 of these being induced during the study period. This convenience sample included all women with induced labor during the specified period, given the low number of inductions. The sample was composed of women who met the inclusion criteria and were willing to participate in the study and complete the questionnaires.

Data collection

During the fieldwork period, we conducted a site visit to the hospital in the afternoon to collect information from all pregnant women whose labor had been induced the previous day. Two instruments were used to collect the data: a sociodemographic and obstetric characterization questionnaire and the MCSRS scale, which contains different factors to assess satisfaction with the labor and birth experience. For the sociodemographic and obstetric characterization, the questionnaire used by López-Mirones et al. (2017) was taken as a reference. Both questionnaires were self-administered in print format. The data were extracted into an Excel spreadsheet and subsequently loaded into a database using IBM SPSS Statistics software, version 22.0.

Study variables

The sociodemographic variables included in the study were age, education level, marital status, current employment status, and country of origin. The obstetric variables considered in this study include childbirth preparation, number of pregnancies, number of miscarriages, number of deliveries, number of previous inductions, number of caesarean sections, number of weeks of gestation, use of epidural anesthesia, reason for induction of labor, previous information about the induction process provided by the physician, and met or unmet expectations. The dependent variables analyzed were the global score and dimension-level scores of the Spanish version of the MCSRS.

The MCSRS is a tool used to assess women's satisfaction with the experience of labor and birth. It encompasses several components involved in satisfaction with the labor and birth experience and has been used in numerous studies in European countries. This is a self-completed questionnaire that should be administered to the woman prior to her discharge from the hospital (Mas-Pons et al., 2012; López-Mirones et al., 2017). The MSCRS was developed in the United States and subsequently translated and adapted for the Spanish population. The scale consists of 36 items grouped into six subscales: dilation, expulsion, newborn, nurse, physician and partner. It also includes a global satisfaction subscale. Each item is assigned a value from 1 to 5, using a Likert-type scale (ranging from very dissatisfied to very satisfied). The final score on the satisfaction scale is determined by adding the values assigned to each item, with higher scores indicating greater satisfaction. In the same way, it is possible to obtain partial scores for each subscale (Mas-Pons et al., 2012).

Data analysis and processing

Statistical processing and analysis were carried out using IBM SPSS Statistics, version 22.0 for Windows. Descriptive analysis was performed for all the variables studied to identify extreme values and characterize differences between subgroups of individuals. Quantitative variables are represented by medians and percentiles, and qualitative variables by absolute (n) and relative (%) frequency distribution for each of their categories. Data distribution was evaluated using the Shapiro-Wilk test, which is appropriate for samples of less than 50. The Mann-Whitney and Kruskal-Wallis tests were used to contrast hypotheses. Spearman's correlation coefficient was used to assess the correlation between the quantitative variables. The level of significance was established with a $p < .05$, and a confidence level of 95%.

Ethical aspects

The study is subject to the Organic Law 3/2018 on Personal Data Protection and guarantee of digital rights, which ensures the anonymity of the data and the confidentiality of the participants, as well as the rules established in the Declaration of Helsinki, which governs ethical research with human subjects.

Prior to commencing the study, the participants were informed of its objectives, potential implications, and associated risks and benefits through both verbal and written means, including the information sheet. They were also asked to sign the informed consent form. The data were anonymized, with each pregnant woman assigned a code. Approval was obtained from the Research Ethics Committee of the University of Seville, with internal protocol code PEIBA.

Results

The women in the sample were of Spanish nationality and had a mean age of 32.5 years. A significant majority of the respondents, 95.7%, were either married or in a civil partnership, 45.7% held a higher education degree, and 69.6% were employed prior to pregnancy.

The results on obstetric variables indicate that only 43.5% of the participants attended childbirth preparation classes. Of the women, 43.5% were multiparous, 8.7% had a previous caesarean section, and 30.4% of them had already undergone induction in a previous delivery. All women received epidural analgesia during induction, and the most common reason for induction was obstetric indication (52.2%). In 82.6% of the postpartum women, prior information about the induction process was provided, and only 8.7% of the total did not meet their expectations about the induction process. The main sociodemographic and obstetric data are presented in Table 1.

Table 1

Sociodemographic and obstetric variables

Variables	No.	%
Age (years)		
25-29	8	17.4
30-34	26	56.5
35-39	7	15.2
≥ 40	5	10.9
Education level		
Elementary school	10	21.7
Secondary school	15	32.6
Higher education	21	45.7
Marital status		
Married/civil partnership	44	95.7
Single	2	4.3
Work situation		
Employed	32	69.6
Unemployed	14	30.4
Childbirth preparation	20	43.5
Previous births	28	60.9
Previous abortions	15	32.6
Previous inductions	14	30.4
Previous caesarean sections	4	8.7
Use of epidural anesthesia	46	100
Reason for induction		
Maternal indication	13	28.3
Fetal indication	9	19.6
Obstetric indication	24	52.2
Information about the process	38	82.6
Met expectations	42	91.3

An analysis was conducted to assess women's satisfaction, incorporating both the overall scale score and the scores from the subscales that comprise the MCSRS. Due to the differences in the ranges of the satisfaction subscales, as each is composed of a different number of items, satisfaction averages (out of 10) were calculated to facilitate comparison. The median global satisfaction score was 168 points. A comparison of the average global satisfaction and the factors of the MCSRS revealed that factors III and IV (satisfaction with dilation and expulsion stages) received the lowest scores (9 points each), while factor V (satisfaction with the newborn) received the highest score (10 points). Regarding satisfaction with the health professionals attending the delivery, the nurse received the highest score (9.66 points), followed by the physician with 9.33 points. Table 2 shows the total scores for global satisfaction and subscale-level satisfaction. The scores have also been converted to a scale of 10 for the purpose of facilitating comparison between scales.

Table 2

Global and subscale-level satisfaction

Satisfaction	*Mdn* (P25–P75)	Mean (out of 10)
Global	168 (146-179)	9.33 (8.11-9.94)
Physician (Factor I)	42 (33-45)	9.33 (7.33-10)
Nurse (Factor II)	58 (55-60)	9.66 (9.16-10)
Dilation (Factor III)	18 (15-20)	9 (7.5-10)
Expulsion (Factor IV)	18 (13,7-20)	9 (6.88-10)
Newborn (Factor V)	15 (15-15)	10 (10-10)
Partner and comfort (Factor VI)	19.5 (15.7-20)	9.75 (7.88-10)

Note. *Mdn* = Median; *p* = Percentile.

Statistically significant differences were found in global satisfaction scores based on marital status. The median global satisfaction was higher among single women (180 points) compared to women who were married or in a civil partnership (167 points), with a statistical significance of $p = .039$. Statistically significant differences were also identified in satisfaction with the partner and comfort regarding the age groups studied ($p = 0.021$). Women aged 30 to 34 years reported higher levels of satisfaction with their partners and greater comfort than women aged 40 and over. The difference in satisfaction was 20 points, and the difference in comfort was 15 points ($p = .025$).

When comparing satisfaction categories with having received prior information about the induction process, statistically significant differences were found for global satisfaction ($p = 0.005$), satisfaction with the physician ($p = 0.002$), with the nurse ($p = .007$), with the dilation stage ($p = 0.027$), and with the newborn ($p = 00.036$). This indicates that women who received prior information about the induction process had higher satisfaction scores. No significant differences were found between having received previous information about the induction process and satisfaction with the expulsion stage, the partner, and comfort (Table 3).

Table 3

Satisfaction in relation to having received previous information about the induction process

Satisfaction	Previous information	*n*	*Mdn* (P50)	P25-P75	*p*
Global	Yes	38	172.5	(153.5-179.2)	
	No	8	145	(133.5-159.5)	**0.005**
Physician	Yes	38	45	(33-45.)	
	No	8	32	(24.25-38.25)	**0.002**
Nurse	Yes	38	59.5	(55-60)	
	No	8	51	(48.5-57.2)	**0.007**
Dilation	Yes	38	18	(16-20)	
	No	8	15	(15-16)	**0.027**
Expulsion	Yes	38	19	(14.7-20)	
	No	8	16	(13-16.7)	0.079
Partner and comfort	Yes	38	20	(15.7-20)	
	No	8	17,5	(15.2-18.7)	0.096
Newborn	Yes	38	15	(15-15)	
	No	8	13,5	(13-15)	**0.036**

Note. *Mdn* = Median; *p* = Percentile.

Statistically significant relationships were identified between meeting expectations about the induction process and various categories of satisfaction, including global satisfaction ($p < 0.001$), satisfaction with the physician ($p < 0.001$), satisfaction with the nurse ($p < 0.001$), satisfaction with the dilation stage ($p < 0.001$), satisfaction

with the expulsion stage ($p < 0.001$), and satisfaction with the partner and comfort ($p < 0.001$). These results indicate that women who met their expectations about the induction process reported higher levels of satisfaction. No significant differences were found between meeting expectations and satisfaction with the newborn (Table 4).

Table 4

Satisfaction in relation to meeting expectations about the induction process

Satisfaction	Meeting expectations	*n*	Mdn (P50)	P25-P75	*p*
Global	Yes	42	170.00	(148.25-179.00)	
	No	4	108.5	(107.25-136.75)	**< 0.001**
Physician	Yes	42	44.00	(33.00-45.00)	
	No	4	23.50	(23.00-30.75)	**< 0.001**
Nurse	Yes	42	59.00	(55.00-60.00)	
	No	4	39.00	(39.00-51.00)	**< 0.001**
Dilation	Yes	42	18.00	(16.00-20.00)	
	No	4	10.50	(10.00-14.00)	**< 0.001**
Expulsion	Yes	42	19.00	(15.75-20.00)	
	No	4	12.00	(11.25-12.75)	**< 0.001**
Partner and comfort	Yes	42	20.00	(17.00-20.00)	
	No	4	11.00	(10.00-14.25)	**< 0.001**
Newborn	Yes	42	15.00	(15.00-15.00)	
	No	4	13.00	(13.00-13.50)	0.052

Note. *Mdn* = Median; *P* = Percentile.

All participants used epidural analgesia during their induction process, so it was not possible to compare the satisfaction of these women with those who might use other methods of pain relief.
The study found that women with previous births reported higher levels of satisfaction compared to those with none ($p = 0.030$). Finally, women with no previous miscarriages reported higher satisfaction with dilation than women with previous miscarriages ($p = 0.026$). The remaining satisfaction categories did not demonstrate any substantial differences in comparison to previous miscarriages.

Discussion

The induction of labor process obtained a high global satisfaction level, with a score of 168 out of 180 points. Other authors, including Fernández Méndez et al. (2019), have reported similar findings, though their study noted a poorer evaluation during the dilation stage and a higher satisfaction with the newborn. Some authors have posited that this variability stems from differing abilities to cope with contractions, varying degrees of participation in decision-making, and emotional control during this period (Zúñiga Paredes et al., 2022). In this regard, the role of the nurse is paramount in ensuring proper monitoring of the pregnancy and in training and educating the woman for the birth process (Zabalegui, 2018). The high scores obtained in the newborn subscale may be due to skin-to-skin practices immediately after birth, the late clamping of the umbilical cord, and the promotion of breastfeeding in the first hour of extrauterine life (Orenga-Orenga et al., 2022).
The results of this study indicate that patient satisfaction with nurses is higher than patient satisfaction with physicians. The MCSRS has also been used by other researchers to obtain similar results (Ramón-Arbués et al., 2015). Similarly, Francos Pascual et al. (2022) found similar results in their study, which also used the MCSRS, although they also included women with spontaneous deliveries. Fernández Méndez et al. (2019) found that women who underwent induction of labor were less satisfied than those who had a spontaneous birth. The researchers attributed this discrepancy to the fact that induction often results in a longer, more painful, and more complicated labor. Additionally, Mauri et al. (2023) found that successful vaginal birth, shorter labor, and pain relief were associated with higher satisfaction.
The study revealed that single women reported higher global satisfaction compared to those who were in a civil partnership or married. This could be because they feel more supported by healthcare staff throughout the process. Additionally, women aged 40 and over exhibited lower levels of satisfaction with the partner and comfort compared to women aged 30 to 34. In this regard, other authors have not found such a relationship (Hamm et al., 2019; Molina-García et al., 2020).
In this study, women who received prior information

about the induction process exhibited higher global satisfaction. The childbirth preparation and pregnancy monitoring sub-programme provides a valuable opportunity for midwives to enhance their knowledge about pregnancy, childbirth, and the postpartum period, benefiting both the woman and her partner (Ruiz-Berdún, 2022). In this regard, Gould et al. (2022) determined that satisfaction with induction of labor was significantly influenced by the level of information the woman had about the induction process and technique, as well as the timing of the induction. The study found that the most satisfied women were those who were better informed and had previously undergone induction in units other than the delivery room. De Vaan et al. (2023) found that women who used cervical ripening balloons reported greater satisfaction than those who used pharmacological methods because the balloons offered greater safety for their child. It is reasonable to expect that women who have attended childbirth preparation classes should be more satisfied. However, in this study, childbirth preparation was not significantly related to greater satisfaction, although having received prior information about the induction process was positively associated with higher levels of satisfaction. Other researchers have also found that meeting expectations of the birth process is related to greater satisfaction (Camacho-Morell et al., 2018; Francos Pascual et al., 2022), results similar to this study. Similarly, a link could be established with women who present a birth plan, in which they express their wishes and expectations about their own birth process. These women tend to be better prepared and more informed about childbirth. The degree of satisfaction of these women is associated with the extent to which their expectations are met, which is influenced by the circumstances of the birth and the degree of involvement of the health professionals (Alba-Rodríguez et al., 2022).

This study provides further evidence on the level of satisfaction of women undergoing induction of labor in hospitals in Spain. This data is crucial for healthcare professionals, particularly midwives and obstetricians, as it enables them to provide more efficient and higher-quality care. It addresses crucial aspects such as information and communication with women, as well as decision-making during childbirth.

This study has several limitations. Firstly, the study was conducted in a single hospital, so it would be appropriate to conduct a multicenter study to obtain a larger sample. Secondly, the MCSRS is not designed to assess the satisfaction of women who undergo caesarean section because it assesses factors such as dilation and expulsion, which are not always present in these women. As a result, they had to be excluded from the sample.

Conclusion

In conclusion, global satisfaction with the labor and birth process was high. Satisfaction was high across all subscales, with satisfaction with the newborn obtaining the highest score, while dilation and expulsion obtained the lowest. Satisfaction with the nurse was higher than satisfaction with the physician. Single women reported higher global satisfaction compared to those in a civil partnership, and women aged 30-34 years expressed greater satisfaction compared to those aged 40 and above. Furthermore, receiving previous information and meeting expectations about the induction process were found to be significant factors in achieving higher levels of satisfaction.

It is essential for professionals in the field, particularly midwives, to have a comprehensive understanding of the degree of satisfaction of women undergoing induction of labor. This knowledge is crucial for providing higher-quality care, enhancing outcomes, and reducing stress during this process, ultimately leading to increased satisfaction. The results of this study may be of interest to the unit where the study was carried out and may serve as a starting point for further research to increase knowledge of these aspects related to induction of labor. Consequently, it is imperative to conduct a multicenter study with a larger sample size to obtain more robust results.

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