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Satisfaction and Cooperativeness of Parturients Regarding Their Medical Informedness

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ABSTRACT

Most women experience pregnancy and childbirth several times in their lives. There is data that such an experience is remembered for a long time. Whether positive or negative, the experience of childbirth can affect the desire for another pregnancy and the relationship between mother and child. With the aim of determining what is related to the mother's satisfaction with childbirth, research was conducted on interventions before, during and after childbirth. The aim of this paper was to present the results of research related to the satisfaction of the mother with childbirth. Methodologically, it is a narrative review article for the creation of which "Standards for reporting qualitative research: a synthesis of recommendations" were used, and the review of published articles had no language barrier. PubMed and Google Scholar databases were reviewed. Relevant articles regardless of the time period of publication were taken into account. Most papers report that certain socio-demographic characteristics and the psychological state of the woman in labor as well as sense of uncontrol of the woman in labor over her own birth, can affect the fear of childbirth or dissatisfaction with it. Research is needed that would more clearly explain the association between individual factors and satisfaction with childbirth, especially variable factors.

Key words: *childbirth, patient satisfaction, tokophobia, interventions, antenatal care, cooperativeness, medical informedness*

Introduction

The dizzying pace of medical progress, especially in the last few decades, has greatly contributed to the improvement of perinatal outcomes. The care that is available to pregnant women today, especially in the countries of the developed world, often manages to save the lives of mothers and children in cases of complications and manages to prevent a large number of unwanted outcomes. Nevertheless, the dominant focus on the mechanism of the procedure might lead to the unintentional neglect of the fact that the woman giving birth is a human being in a special state, with all her fears, insecurities, doubts, and desires.

The aim of this paper was to analyze the previous findings, assumptions and results obtained by conducting several studies aimed at defining the determinants of maternal satisfaction with childbirth. Some of the studies examined interventions before, some during and after childbirth, and most of them aimed to determine which factors are related to satisfaction with childbirth and how much influence each factor has.

Research by Mazúchova et al.[1] investigated psychosocial factors, the approach and empathy of health personnel during childbirth (vs. superiority and disinterest), then physical comfort and quality of service, and the mother's feeling that she participates in the control of her own birth (participation in decision-making and providing information). As for the mentioned psychosocial aspects, the approach of health personnel had the greatest impact on the level of satisfaction, while the least was attributed to the control and participation of the mother in decision-making. Perception of the course of childbirth and skin-to-skin contact (of mother and child) immediately after childbirth were found to be significant predictors of women's satisfaction with childbirth. The research points to the impor-

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tance of strengthening interventions in the area of women's participation in decision-making and supporting the natural course of childbirth whenever possible so that women associate childbirth with a positive experience.

Materials and Methods

In the period from January 1, 2020 to December 31, 2022, a retrospective, analytical study was conducted of the results of the research on the relationship of medical staff towards mothers immediately before and during childbirth, as well as the frequency of carrying out certain interventions, the psychological preparation of the mother for the birth itself, and the potentially necessary interventions related to psychological mothers' health in the weeks and months after childbirth. Databases were searched: PubMed, Google Scholar and texts published in English, German, Spanish and French, regardless of the time period of the published papers (until 2022). The research included the results obtained from surveys of pregnant women and midwives using validated questionnaires, systematic review articles, and results obtained from interviews. Considering the small number of published papers related to the topic, an effort was made to include as many papers as possible that were carried out in a sufficiently repeatable and clearly described manner and without doubt of the existence of bias. All papers that made logical sense with regard to the topic and keywords of the search were taken into consideration for the analysis, and papers with clear outcomes were selected. We assessed bias across studies and outcomes. This research was done in accordance with "Standards for reporting qualitative research: a synthesis of recommendations (SRQR)"[2].

Results

Satisfaction and cooperation of mothers in labor depending on prenatal interventions

The group of prenatal interventions can include all those actions undertaken by the healthcare team during the pregnancy itself. The aim of the chapter was to pay attention to all additional interventions carried out as part of the studied research during pregnancy that are not part of standard medical care for pregnant women, such as birth plan and support and education via telephone conversation, but also with regard to socio-demographic determinants.

Birth plan

Several studies have been conducted on the subject of processing data on the satisfaction of mothers in childbirth related to adherence to a previously established birth plan. A birth plan is defined as a written document in which a pregnant woman expresses her preferences regarding care during childbirth. Such a document was filled out by the respondents during the pregnancy period so that it could be found in the hands of the medical staff during the actual delivery.

Research by Swedish authors Lundgren et al.[3], used as comparable parameters evaluation in five different categories: relationship with midwife, doctor and sexual partner, fear of childbirth, pain during childbirth, feeling of having control over the situation and fear for the life of the child[3]. The Swedish study included two hundred and seventy-one pregnant women who were divided into two categories: women who had the option of using a birth plan and those who received standard care. The mother's satisfaction was assessed immediately after delivery and one week later. In Lundgren's study, no statistically significant difference was observed in satisfaction with the birth experience.

The Egyptian study[4] included a questionnaire composed of thirty-four questions with the possibility of rating from five to one, two open questions and four questions for which the scale varied from four to one. The aforementioned research included two hundred and sixty first-time mothers. Also, two groups were formed, one of which included test subjects with a birth plan, while the other group, without a birth plan, represented the control group. The respondents had the opportunity to fill out a questionnaire on satisfaction with the experience during the first week after giving birth. The result was quite different in Farahat's study compared to the Lundgren's one, because the group of subjects who received an intervention in the form of a birth plan rated their satisfaction significantly higher than the control group.

In a study conducted in Taiwan[5], a scale of five to one was used on which women in labor could express their satisfaction with their experience, with the number five representing the most positive rating. The Taiwanese study included three hundred and thirty primiparous women who were randomly divided into an intervention and a control group. Their satisfaction with the experience was measured the day after the birth itself. The results of Kuo's research largely correspond to Farahat's, because even in the Taiwanese study, women in the intervention group showed a significantly higher level of satisfaction with the experience.

A high risk of bias was assessed for all three mentioned studies. The authors compared the results through a discussion, which, of course, led to the inevitable raising of certain questions. The premise of the paper/article to explain the difference in the results of the Swedish study compared to the Egyptian and Taiwanese studies includes the consideration of the wishes of the birthing mother themselves, which are included in the birth plan. Namely, the authors theorize that it is possible that some of the requests of the respondents were unrealistic within the context of the situation itself, that the implementation of the birth plan gave them a false sense of control, and that their satisfaction decreased accordingly in cases when the course of the birth could not take place exactly as planned. They conclude that the aforementioned research did not produce sufficiently strong evidence that could justify the

use or rejection of the birth plan and propose further research of such a nature in order to reach further, more concrete knowledge.

A team of researchers from Hawaii[6] had a somewhat different idea. They also used a birth plan as the backbone of the research, but in this case the plan was standardized, i.e. it was drawn up by health workers employed in the relevant institution where the research was conducted, and was adapted to the existing conditions of the institution and the same for all research participants. Expectant mothers had the opportunity to mark which options they wanted to include in their birth plan, and they had the opportunity to complete their own plan at a regular check-up at the mentioned institution after the 24th week of gestation. The authors state that care was taken to ensure that the questionnaire was compiled in such a way that a person with a completed primary school would have no problem filling it out. Additional data on the test subjects, such as information on age, education, race, number of previous pregnancies and the use of birth plans in the past, were obtained by the researchers during examinations before the birth itself. On a ten-centimeter scale, pregnant women had the opportunity to mark how satisfied they think they will be, whether they think they will be able to communicate well with the medical staff present during childbirth, and whether they trust the doctors.

Eighty-one patients were included in the study. Ninety percent of women stated that they had never used a birth plan before, 78% of respondents received epidural analgesia, while half of the women in labor used oxytocin. A low incidence of complications before delivery was observed (5%) and 1% of newborns were admitted to the neonatal intensive care unit. Approximately 6% of patients had postpartum complications, primarily in the form of postpartum hemorrhage.

The researchers asked the respondents to fill in the attitudes about trust, communication, and satisfaction before and after the birth itself, which left room for comparing the results. The authors state that the increase in the evaluation of trust, communication and satisfaction on the scale is statistically significant. Also, 84% of respondents expressed the opinion that they would also use a birth plan during their next birth. The greater difference of the clinical studies explained in the research of Lundgren et al and Anderson et al. is in the existence of a control group in the study by Lundgren et al. A study by Anderson et al. could not compare how satisfied women would be with their experience in the event of a lack of a birth plan, however, they showed and reported the success of their standardized plan in the desire of a large number of respondents (84%) to use this form of intervention again. Furthermore, in the case of research by Lundgren et al.[3], Farahat et al.[4] and Kuo et al.[5] a dose of autonomy was given when creating the plan, which was not present in Anderson et al.'s[6] research, but the latter had the potential to result in wishes and requests that the competent institution and employees were unable to provide, which probably had a significant impact on the parturients' general satisfaction with the experience. Also, it is important to note that the satisfaction rating of a new mother can always be slightly higher than the realistic objective one, mainly due to the feeling of happiness and success due to bringing a healthy child into the world.

Support and education via phone call

Australian researchers, Fenwick et al.[7] published an article on the impact of education and psychological support provided by midwives over the phone during pregnancy. Empirically, during the years of clinical work, they noticed that the need to perform a Caesarean section is more often indicated in women who show high doses of fear of the experience of childbirth. They assumed that a conversation with a medical professional, in this case a midwife, could have an effect on reducing nervousness and worry in future parturients.

During the second trimester, pregnant women who came for regular check-ups at their institutions were asked to fill out a questionnaire, which the researchers could use to assess their level of fear of the expected delivery experience (Wijma Delivery Expectancy/Experience Questionnaire). All women who scored higher than or equal to the number 66 on the questionnaire were included in the research (a total of 339 respondents). The subjects were divided into two groups, intervention and control. The return of information by the respondents within the given time limit was recorded for 184 women. The condition for women's participation in the research was that they were over 16 years old, that they were able to read, write and understand the English language and that they signed an informed consent.

The subjects placed in the intervention group were contacted by midwives by phone for two agreed sessions, one of which took place in the 24th week of gestation, and the other in the 34th week. Sessions lasted an average of one hour. Women in the control group were cared for by usual procedures without the addition of an educational interview with the midwife.

The authors report the following results: in women in the intervention group, a lower percentage of Cesarean sections was observed compared to the control group (intervention 34%, control 42%), with special emphasis on cases of emergency Cesarean sections (intervention 18%, control 25%). Six weeks after giving birth, a lower percentage of respondents from the intervention group compared to the control group had the desire to end the next pregnancy with a Caesarean section (18% vs. 30%). The researchers report that there was no difference between the groups in the use of certain standard interventions during labor such as epidural analgesia and labor induction. Also, no difference was observed in the frequency of postpartum depressive symptoms, nor in the woman's self-confidence in her ability to fulfill her role as a mother. A lower incidence of recalling traumatic scenes of childbirth was reported among subjects in the intervention group.

In conclusion, the researchers believe that the obtained results are clinically significant, although not statistically. Women who were part of the intervention group reported after giving birth that the midwife's involvement in education and psychological support was a significant factor in lowering their level of fear. The authors believe that the study emphasizes the importance of medical information and satisfaction of the mother, as well as the key role of midwives in this process.

The satisfaction and compliance of the parturient depends on the interventions undertaken during childbirth

The aim of this section is to present the impact of interventions undertaken during childbirth on the satisfaction of the parturient, to consider how certain actions of medical professionals affect the compliance of woman, and to present the conclusions of the authors of various studies on the significance and applicability of the obtained results to the advancement of the profession.

Research published in 2018 by Çalik et al.[8] dealt with the need for routine implementation of a greater number of medical interventions during childbirth and the way in which taking such actions reflects on the parturient's satisfaction with the experience. The authors begin the article by explaining the importance of carrying out the necessary interventions but emphasize that a large number of interventions for which there is no conclusive medical indication can lead to the complete opposite effect: disruption of the physiological course of childbirth and the emergence of dissatisfaction of the parturient with the lived experience.

The study was conducted in a medical institution in Turkey and included 351 parturients between the ages of 19 and 45 whose delivery took place on time, who had no chronic diseases and gave birth to healthy children. In order to assess women's satisfaction, questionnaires, observation forms and the "Scale for measuring maternal satisfaction with vaginal delivery" (SMMSVB) were used. The questionnaires contained questions about the socio-demographic and obstetric characteristics of the parturient, while the observation forms were used to record the interventions undertaken during childbirth. The SMMSVB satisfaction assessment scale was handed over to parturients a day after giving birth, i.e. immediately before their discharge from the hospital. The possible number of points achieved on the SMMSVB scale varied between 43 and 215. The researchers obtained verbal and written consent from the subjects to conduct the research.

The satisfaction of the parturient was evaluated with regard to the performed interventions, among which in the first stage of labor were: shaving of the perineum, administration of enemas, induction of labor, fetal cardiography (CTG), palpation of contractions on the fundus, fetoscopy, restriction of movement, amniotomy, application of analgesia, intravenous administration of fluids and restriction of intake food and liquids. During the second stage of labor, the following were applied: episiotomy, pressure on the fundus, pushing techniques, vacuum/forceps, vaginal irrigation with chlorhexidine, early ligation of the umbilical cord and early skin-to-skin contact. The third stage of labor was marked by removal of the placenta, control of bleeding and uterine massage. The obtained results indicated the mothers' dissatisfaction with the experience. The average score was 139.59 ± 29.02, while the lower limit was 150.5.

The authors concluded that the mothers' dissatisfaction with the experience most likely resulted from the routine use of most of the mentioned interventions. They believe that additional, not necessarily necessary interventions interfere with the physiological course of childbirth. Furthermore, they note that the medical staff who did not adequately inform the parturient can also be one of the reasons for the dissatisfaction of the woman in labor. The same was established for the absence of seeking women's approval for performing the mentioned interventions. Researchers recommend obstetric teams to work on communication both with parturients and among themselves, so that the number of unnecessary intrapartum interventions can be reduced to a minimum, which would enable women to have an easier and more natural birth experience.

Fumagalli et al.[9] evaluated the influence of socio-demographic characteristics, obstetric history and intrapartum care variables on the satisfaction of the parturient. The researchers note that there is a lack of similar research in Italy, although their increase has been observed at the global level, and as the purpose of the research they present an attempt to bridge such a disparity at least partially.

The study was conducted in an obstetric unit dealing with low-risk pregnancies. The indicated frequency of Caesarean sections in the case of the mentioned unit is 14.7%, which is significantly lower than the national average (35.4%). 277 women were included in the research. The subjects completed the Italian version of the Childbirth Satisfaction Scale (I-BSS-R). The I-BSS-R included various statements related to the parturient's satisfaction with the experience, which the respondents rated on a Likert scale from one to five. Three subcategories were included in the study: the quality of the care provided, the personal characteristics of the mother and the stress suffered during childbirth. Socio-demographic specifics and obstetric information (gestational age, onset of labor, analgesia used, use of oxytocin, length of the passive phase of labor, length of the active phase of labor, CTG, midwifery care, preservation of the perineum) were recorded in the form of electronic documentation.

The obtained results showed that, in the case of this research, socio-demographic characteristics had no influence on the satisfaction of the patrurient with the experience. The authors note that such an outcome could have been influenced by the fact that all the subjects involved spoke and read Italian and that it was a fairly homogeneous sample consisting of almost 97% of Italian citizens. Furthermore, the researchers note that multiparous women expressed a higher level of satisfaction than primiparous women. The author's assumption is as follows: births of multiple births are often shorter and, in the absence of

complications, require fewer medical interventions during childbirth. Also, it was recorded that women who attended pregnancy courses were generally more dissatisfied with their experience. The researchers offer two possible explanations. First, the frequency of attending courses is higher among first-time mothers. Second, the information obtained while attending the courses could have led to higher expectations that remained unfulfilled. Also, the use of epidural analgesia in this study was shown to have a negative impact on mothers' satisfaction. The assumption is that the parturients felt like they had less control over the situation in that case. As part of the described study, episiotomy had no effect on the experience of childbirth. In conclusion, the authors recommend the continuation of similar research and the use of the I-BSS-R in order to collect as much data as possible and potentially determine in the future how best to provide care to expectant mothers.

It is important to mention a study conducted in Brazil. Magnus Martins and colleagues reported that satisfaction with childbirth is influenced by previous satisfaction with antenatal care, understanding of information provided by health professionals, not experiencing disrespect and abuse during childbirth, and the first delivery of a newborn within the first hour of life[10].

Satisfaction and compliance of parturients depending on socio-demographic determinants

Tocchioni et al.[11] wrote about the influence of the socio-demographic characteristics of the parturients on their general satisfaction with the prenatal care provided and the interventions carried out during the birth itself. The research was conducted in the Italian region of Tuscany.

Data collection and analysis were conducted for 4,598 respondents in the form of childbirth experience, and 131 women who do not live in Tuscany were excluded from prenatal care records. During the research, the medical staff questioned the women about their experience of the prenatal care provided to them, as well as about their satisfaction with the experience of childbirth itself. A scale with five different ratings was used to evaluate both aspects: excellent, very good, good, bad, and very bad.

The researchers considered various variables, primarily socio-demographic (age, level of education, citizenship, previous pregnancies) and additionally women's experiences related to the provided medical care that could influence the outcome of the research (number of ultrasound examinations, existence of a pathological pregnancy, attendance at pregnancy courses, informing the patient about pregnancy). Regarding the end of the pregnancy, the patients were questioned about the type of delivery (vaginal or Caesarean section), the date of delivery, the information the mother had received so far about breastfeeding, satisfaction with the applied analgesia, the time she was able to spend in the hospital with the newborn, and the parturient' s confidence in the medical staff.

By analyzing the collected data, the authors came to the following conclusions: women's satisfaction increased with age; women whose citizenship does not belong to the countries of the Western world were generally more satisfied with the experience; there is a positive relationship between women's satisfaction with the experience and their education; the number of previous pregnancies had no influence in the evaluation of satisfaction with the experience by the respondents; delivery by Caesarean section had a negative effect on the satisfaction of the mother.

Although women with a higher level of education were mainly more satisfied with the care provided, their experiences largely depended on the staff's ability to provide them with the expected care, which in some respondents, in case of absence, led to an increase in dissatisfaction. Furthermore, the authors hypothesize that mothers who are not citizens of Western countries were more satisfied with the experience due to the higher quality of care than they would otherwise receive in their own countries. Also, it is possible that the satisfaction of older mothers is more pronounced in the aspect of antenatal care due to the fact that Tuscany offers special care to mothers over thirty-five years old (free prenatal tests).

The researchers note that the study did have its limitations. As an example, they cite several missed questions that they believe would have further enriched the study (questions about the health of the mother and child, partner relationship and length of stay in Italy). Nevertheless, the authors consider the research useful and welcome, and express hope for a larger number of closely focused research so that in the future, by collecting more data, more solid knowledge can be obtained.

There is one observational multicenter longitudinal study by Spanish authors led by Miriam Donate-Manzanares on sociodemographic variables and satisfaction with childbirth[12]. The relationship between satisfaction with childbirth and the place of birth and level of education, the type of work women performs, the way childbirth begins and ends, and the type of perineal trauma is shown. The most satisfied were those mothers whose labor began and ended naturally and who received epidural analgesia. A few sentences should be extracted from the discussion of that research. One is that a negative experience such as pain has an impact on the assessment of satisfaction with childbirth, but also that postpartum care plays an important role. It should be mentioned that many interventions during childbirth are carried out in the said maternity hospital.

A similar study was conducted by Ahmed in Iraq, using a questionnaire that included sociodemographic and obstetrical data of the birth mother and 28 items related to verbal and nonverbal communication with the health care team[13]. Only less than 30% of women were satisfied with the level of communication, and satisfaction with communication was higher among multiparous women. More educated women were less satisfied. Age as a factor did not significantly affect satisfaction with communication.

The results also highlight non-verbal staff communication as an important factor.

In a multicenter study by Kabakian-Khasholian et al.[14] (area of Egypt, Lebanon, and Syria) on maternal satisfaction, an adapted version of the Mackey scale was used and the parturient's perception of control during childbirth was assessed. The results are similar – control of the parturient during childbirth is important and contributes to satisfaction. But again, it turned out that women with a lower level of education were more satisfied with childbirth.

Another study is important to mention because of the results on women's education, the one from Ghana by Adjei at al[15]. Compared to women with no education, those with secondary or lower secondary education were less satisfied with the overall services provided during childbirth. The authors offer high expectations of more educated women as one of the possible explanations, but with that study the authors showed that women's dissatisfaction was primarily influenced by the behavior of health workers, which more educated women are probably more aware of.

Tokophobia

Fear of childbirth can range in intensity, and influence daily functioning[16]. There are results that say that tokophobia can appear in almost half of women who are about to give birth[17]. Given that the multifactorial association of tokophobia with different psychological states of women is assumed, there is an interest in clarifying what can influence the greater frequency and intensity of tokophobia. Thus, for the purpose of their research, Slovenian researchers[18] wanted to determine the prevalence of tokophobia in women in labor and establish risk factors for the development of fear of the experience of childbirth.

The study was conducted in 2014 in Ljubljana. 191 pregnant women from the 21st to the 38th week of gestation were included in the research. The authors contacted the respondents during their pregnancy course and asked them to solve several questionnaires related to depression (CES-D), anxiety (STAI X1 and X2), life satisfaction (SWLS), expectations from the birth experience (W-DEQ) and specific fears. Most of the respondents were first-time mothers (90%). The recorded age of the women ranged from 18 to 44 four years. More than half of the expectant mothers involved in the research had a univeristy/high education.

The obtained results indicated (the fact to the authors) that more than half (53.4%) of the respondents felt moderate fear. A high level of fear was observed in 23.1% of expectant mothers, while 1.6% of them suffered from a pathological fear of childbirth. Fear of episiotomy was recorded as the most dominant specific fear related to the experience of childbirth, followed by fear of losing control over the situation and fear of pain. Although the majority of parturients (86%) would choose a vaginal delivery in the event of a repeat pregnancy, the authors observed a positive correlation between the highest levels of fear achieved in the tests and the preference for Cesarean section as a method. Furthermore, the study confirmed depression and anxiety as risk factors for the development of a high degree of tokophobia, with a special emphasis on depression. But the fact that the fifth most frequent reason for tokophobia was fear of unprofessional medical staff is worrying. On the other hand, this may indicate the importance of communication between healthcare staff and patients. In conclusion, the researchers note that regardless of the fact that tokophobia is a frequently used argument for the justification of performing an elective Caesarean section, the international point of view considers that there is no evidence that would indicate the advantage of performing a caesarean section without an indication. The authors believe that their research, as well as other studies conducted with the aim of studying the determinants of tokophobia, could help to more easily identify groups of women for whom vaginal birth is unthinkable due to great fear, and to try to provide them with psychological help in time in order to overcome said fear or at least bring it under control. They also note that the early identification of such parturients could be helpful in shaping the behavior of the medical staff present during childbirth in order to avoid unnecessary confrontations and all the consequences that could arise from them.

A group of Italian authors[19] also tried to determine the frequency of tokophobia and to investigate obstetrical and psychological variables related to the fear of childbirth and to determine whether there are independent factors for the development of tokophobia. In the research, 98 women filled out questionnaires about tokophobia and perceived social support, as well as depression and anxiety. Almost four out of ten women in the study reported probable or potential tokophobia. The authors found that epidural analgesia as well as the intensity of pre-traumatic stress symptoms were independently associated with fear of childbirth.

One Swedish longitudinal study carried out in three hospitals in the north of Sweden and with almost seven hundred respondents dealt with monitoring women before and after childbirth and reporting on the frequency of fear of childbirth[20]. It is interesting that the frequency of fear associated with childbirth even increased after childbirth compared to the period around mid-pregnancy. In that research, vaginal birth is cited as preferable due to a greater sense of control over one's own birth and obtaining information during the birth itself. Moreover, the respondents more often declared vaginal delivery as recommended for the next delivery. The authors concluded that the fear of childbirth can be reduced by more informed mothers and their greater sense of control over their own childbirth. The research is also interesting from the point of view that the measurements were carried out on several occasions, while the majority of research studies were carried out at one point in time and did not include changes in the frequency of the development of fear of childbirth.

One of the studies with a better quantification than the above is that of Barut et al[21], which compared the levels of anxiety, depression, and satisfaction of the parturient in

childbirth based on the parturient's traumatic perception of childbirth. By collecting data in the pre- and post-partum phase, the authors determined that test subjects with a high level of traumatic perception of childbirth also had a higher average score of anxiety and depression symptoms and vice versa. This confirms the expected clinical belief that high levels of traumatic perception in childbirth can lead to anxiety and depression, while satisfaction with childbirth increases the lower the level of traumatic perception of childbirth.

Discussion

It is important to note that there are data that speak in favor of the long-term memory of childbirth as such a great experience in life. According to Simkin's results[22], some memories related to childbirth go back twenty years. The same research points to another fact - women's memories were quite strong and precise. Other results show that over time this experience can become negative, that is, it tends to have a more negative view of the birth experience itself[23]. In their research, the same authors showed that a depressed mood at the beginning of pregnancy can negatively affect the experience of childbirth. Thus, women who felt that they had insufficient support from their partners were less satisfied with childbirth, as were those who had negative thoughts more often during pregnancy. Interestingly, not attending pregnancy courses was associated with a lower risk of developing dissatisfaction with childbirth, but the authors explain this with the data that most pregnancy courses are attended by first-time mothers who have a higher frequency of fear of childbirth. It is also interesting that almost all medical procedures during childbirth were associated with lower satisfaction of childbirth, with the exception of elective Caesarean section.

Trying to explain the comprehensiveness of the change that the process of pregnancy and the act of childbirth bring to a mother's life seems almost impossible. The research described in the previously elaborated text dealt with very different aspects of preserving the mother's health. Attempts to understand and calm the mother's growing concern and the desire for the woman to go through the complete experience of childbirth with an adequate understanding of current changes were added to the consideration of the influence of prenatal care on the fulfillment of the functions of interventions that are primarily dedicated to the detection of the potential existence of pathology and its treatment. Some authors, for the purposes/aims of their works, emphasized the importance of respecting the physiology of normal childbirth and tried to reconsider the justification of routinely performing a large number of interventions, thus highlighting the very backbone of medicine in its entirety - first do no harm. Some authors emphasized the importance of respecting the physiology of normal childbirth for the goals of their work and tried to reconsider the justification of routine performance of a large number of interventions, thus emphasizing the very backbone of medicine in its entirety - first do no harm. The existence of studies that dealt with a woman's mental health in the weeks and months after childbirth has to a certain extent raised the stakes related to childbirth, because it really cannot be seen as a one-time event that lasts a few hours and leaves no consequences behind. Defining the socio-demographic determinants and their influence on the experienced satisfaction of the parturient has a chance in the future to help adjust the approach to women at the individual level, whose trust in the medical staff can have far-reaching consequences and even advantages. Noticing and acknowledging tokophobia as a serious fear that can result in unexpected difficulties has opened the door to future research that can only help adjust the attitude of professionals towards a certain group of women.

A woman's satisfaction with the experience of childbirth is a very important item. Honestly satisfied women who feel that they have been treated correctly and that they have been heard and experienced as human beings with their fears and problems have a significantly greater chance in the future of experiencing childbirth as an inherently positive experience, which can also result in an increase in the desire for a future pregnancy if it has been the main obstacle so far represented the fear of reliving a difficult situation. Mothers who did not experience the birth of their own child as a trauma will be able to connect with their child more easily and nurture a sense of success and fulfillment in their new life role. Also, the compliance of the parturient in the obstetric unit represents a significantly lower risk of endangering one's own health and the life of the newborn, and it is precisely this cooperation that is strived for that is built through respect and trust between the parturient and the medical staff.

Conclusion

Some aspects of childbirth, such as too many prenatal interventions, especially routine ones and by the opinion of parturients not necessarily necessary ones, can have a negative impact on the satisfaction of childbirth. For other items such as having a birth plan, the results are conflicting, although some favor that following a birth plan can result in greater satisfaction for the mother. Moreover, there are results that show that most pregnant women would be happy to use a birth plan for their next delivery. Social support from the environment seems to have a positive effect on a woman's satisfaction with childbirth. Women whose labor begins and ends naturally and who also receive epidural analgesia are more commonly satisfied with the delivery, unlike women whose pregnancy had to be completed surgically.

Although it seems that many attempts and ideas are still in their infancy, 21st century medicine shows a considerable desire to turn to the individual in the form of care for several different aspects of health, and regardless of the increasingly pronounced specialization in certain fields, the need for multidisciplinary cooperation comes to the fore.

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ZADOVOLJSTVO I SURADLJIVOST RODILJA S OBZIROM NA NJIHOVU MEDICINSKU INFORMIRANOST

SAŽETAK

Većina žena doživi trudnoću i porođaj svega nekoliko puta u životu. Postoje podaci da se takvo iskustvo dugo pamti. Bilo pozitivno ili negativno, iskustvo porođaja može utjecati na želju za sljedećom trudnoćom i na odnos majke i djeteta. S ciljem utvrđivanja što je povezano sa zadovoljstvom majke porođajem, provedeno je istraživanje o intervencijama prije, tijekom i nakon porođaja. Cilj ovog rada bio je prikazati rezultate istraživanja o zadovoljstvu majki porođajem. Metodološki je riječ o narativnom preglednom članku za čiju su izradu korišteni "Standards for reporting qualitative research: a synthesis of recommendations" te pri pregledu objavljenih članaka nije bilo jezične barijere. Pregledane su baze podataka PubMed i Google Scholar. U obzir su uzeti relevantni članci bez obzira na vremensko razdoblje objavljivanja. Većina radova navodi da određene sociodemografske karakteristike i psihičko stanje rodilje, kao i osjećaj nekontrole rodilje nad vlastitim porođajem mogu utjecati na strah od porođaja ili nezadovoljstvo njime. Potrebna su istraživanja koja bi jasnije objasnila povezanost pojedinih čimbenika i zadovoljstva porođajem, posebice onih na koje možemo utjecati.