

Assessment of Social Factors Associated with Childbirth Satisfaction among Pregnant Women in Al-Nasiriyah City

Hanadi Ali Mahnoosh^{1*}, Sarab Nasr Fadhil²

¹Mental and Psychiatric Health Nursing Specialist, MSc, Ministry of Health, Iraq

²Department of Maternal and Neonate Nursing, College of Nursing, University of Baghdad, Iraq

ABSTRACT

Background: Social factors affect women that may increase or decrease the risk of developing prenatal mental illness. These factors include poverty, lack of social support, gender and health of the child, quality of the relationship and exposure to traumatic experiences such as intimate partner violence, which are just a few of these factors

AIMS: To assess pregnant women's social factors associated with childbirth satisfaction at Al-Haboubi Hospital in Nasiriyah city, also explore its effect on women' childbirth satisfaction, and to determine the relationship between pregnant women's social factors associated with childbirth and sociodemographic and reproductive data.

Methodology: A descriptive correlational design is conducted at Al-Haboubi Hospital in AL-Nasiriya city to assess social factors associated with childbirth satisfaction among pregnant women from 19th December 2021 to 1st April 2022. The researcher designed the questionnaire to measure the purpose of the study. A convenient sample was selected consecutively from (100) pregnant women for an interview between the researcher and the pregnant woman before giving birth. In addition, communication is done by telephone after the birth for two weeks, and the discussion is conducted in the maternity hall. The data collected by use a questionnaire, which consists of four parts: the first part includes the sociodemographic characteristics: the second part includes reproductive characteristics: the third part consists of the social factors: the fourth part consists of the Mackey childbirth satisfaction scale. The information was analyzed in this study by using a statistical package for the social science program (IBM SPSS) version 24.0

Results : The result showed that social-related factors among pregnant women; (81%) of them are reported that their husbands want this pregnancy, but (51%) of them reported that their unplanned pregnancy; (85%) of them are reported they have support from their husbands and relatives; (48%) of pregnant women were fear of their husband's reaction about the newborn gender, the factor of having obstacles to visiting health centers had the highest percentage it accounted for (49%) , In addition to that there is association between social factors related to barriers of health care visits and childbirth satisfaction among pregnant women as indicated by significant difference at (p -value=.003) while no effect is seen with remaining social factors, and significant differences with the residential environment at (p -value=0.020). also the study result found that there is highly significant differences between social factors and gravida, para, and the number of a lived child at (p -value=0.001), and significant differences with the duration of labor at (p -value=0.014). While there are no statistically significant differences with leftover reproductive parameters.

Conclusion: The study found social factors related to barriers of health care visits significantly affect childbirth satisfaction among pregnant women. Also, the study found an association between social factors and some socio-demographic and reproductive characteristics.

Recommendations: Study findings and conclusions have led researchers to recommend the attempts should be made to bring change in reducing unwanted pregnancy by conducting further studies.

Key words: Assessment, Social factor, Childbirth satisfaction

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Corresponding author: Hanadi Ali Mahnoosh

e-mail ✉: mutazalharbi84@gmail.com

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INTRODUCTION

Mothers' social support is an essential source of information, emotional empathy, and understanding. Furthermore, social support impacts a woman's adjustment to her new role as a mother and her integration. Social support is significant for mothers' stress reduction, improved coping abilities, prevention of depression, and overall well-being. The importance of the baby's spouse, partner, or father, and the pregnant/postpartum woman's mother, has been documented in numerous studies to be crucial for developing the maternal role and psychological well-being. Other family members, colleagues, and health care professionals like counselors and caseworkers can also help perinatal women [1]. Husband support for pregnant women is predicted to improve their mental health, making it more straightforward for them to accept physical changes and control the emotional changes that occur throughout pregnancy. Husband support can take two forms: dynamic and instrumental. Family members, particularly husbands, who provide reasonable assistance to pregnant women, build mutual trust between family members (husbands) and pregnant women. A good connection prevents anxiety from affecting the mother's and fetus's physical and psychological health [2].

Furthermore, psychological changes are also dependent on social factors such as whether the pregnancy was planned or unplanned, desired, or unwanted, pregnancy after an extended period, the type of relationship with the partner, whether stable or transient and other factors. As a result, they have distinct effects on the pregnant woman's health, birth outcome, and fetal growth [3], some studies illustrated that refusing to accept an unwanted pregnancy might have negative repercussions during pregnancy. In other words, the nature of unwanted pregnancy may influence the pregnancy's adaption. As a result, unwanted pregnancy is a significant problem that jeopardizes women's reproductive health while also placing a significant socioeconomic burden on individuals and society. Unintended pregnancies have been linked to an increased risk of suicide and depression and poor nutrition throughout pregnancy, mental health concerns, and low birth weight infants [4].

Furthermore, other studies pointed out that women who had unintended pregnancies had poor relationships with their partners and lacked social support. Poor quality of life, postpartum depression, and high perceived stress were linked to a lack of social support [5].

Another social factor that many research focuses on, antenatal care benefits, includes the early detection of risk factors, preventive counselling and health promotion to encourage healthy lifestyles, treatment of medical conditions such as diabetes and pregnancy-induced hypertension, and referral to services such as nutritional support and smoking cessation programmes, so women who receive few or not enough prenatal visits and who start prenatal care after the first trimester have lower pregnancy outcomes, such as low birth weight and

premature birth. However, increasing the frequency of antenatal visits may not always lead to better pregnancy outcomes [6].

Also emphasized that antenatal care (ANC) is an essential health treatment to help mothers and babies live longer lives. The World Health Organization (WHO) defines adequate prenatal care as at least four health care visits throughout pregnancy for pregnant women who do not experience perinatal difficulties [7].

The mother's satisfaction during the birthing process is the most frequently reported indicator in the evaluation of the quality of maternity services [8]. Client's satisfaction is the level of satisfaction that clients experience having used a service. It therefore reflects the gap between the expected service and the experience of the service, from the client's point of view. Measuring client or patient satisfaction has become an integral part of hospital/clinic management strategies across the globe [9].

METHODOLOGY

Study design

A descriptive correlational design is conducted at Al-Haboubi Hospital in AL-Nasiriya city to assess social factors associated with childbirth satisfaction among pregnant women and explore its effect on women's childbirth satisfaction for the period women from 1st of October 2021 to 1st April 2022.

The study sample A non-probability (convenient) consisting of (100) pregnant women at Al-Haboubi Hospital in Dhi-Qar Governorate. The sample was subjected to an interview between the researcher and the pregnant woman before giving birth. In addition, communication is done by telephone after the birth two weeks, and the discussion is conducted in the maternity hall.

Study instrument

The instrument includes four parts:

Part I: Socio-demographic characteristics

This part consists of the demographic data, which comprises different items that include general information about women such as age, educational level, occupation status, monthly income, and residence environment.

Part II: Reproductive characteristics

This part is comprised of ten items, including gestational age, the date of the first day of the last menstrual period, expected date of birth, number of pregnancies (including current pregnancy), number of births, the number of abortions, number of live children, number of dead children, the length of labor for the current pregnancy, presence of complications during previous labor.

Part III: Social factors

This part consists of five sub-items. Including the desire of the husband in pregnancy, mother's plan for

pregnancy, support from the husband, relatives and family, fear of the husband's reaction to the sex of the fetus, and obstacles to obtaining visits to the health care center. These items were constructed using the two-level type of Yes and No scale, scoring (1) for Yes, and (0) for No.

Part IV: Childbirth satisfaction

The fourth parts include childbirth satisfaction. This variable was measured using the Mackey childbirth satisfaction scale consisted of 40 questions, 34 of which assessed six categories of self-satisfaction: (midwife performance, partner performance, physician performance, newborn status, and total satisfaction with delivery). These questions were answered on a 5-point Likert scale ranging from severely unsatisfied (scoring 1) to extremely satisfied (score 5). The range of scores was (34 to 170). (Low=34-79.33; Moderate=79.34-124.67; High=124.68-170) were the mean scores. The questionnaire's final six questions were open-ended (qualitative questions evaluating childbirth experiences, based on evidence-based studies using the same scale, which relies on only 34 questions as (quantitative question), thus the researcher has done the same things.

Validity and reliability

The instrument's content validity was tested by 18 nursing professionals from various specialties, and the items' reliability was through the computation of Alpha Cronbach's test (Alpha Correlation Coefficient); the internal consistency method was used to determine the reliability.

Statistical analysis

The following statistical data analysis approaches were used to analyze and assess the study's results under applying of the statistical package of social science (SPSS) version 24.0.

RESULTS

Table 1 shows that pregnant women have an average age of 30.31 ± 7.598 years, in which the highest percentage (27%) refers to (26-30) years. (21%) of them who

Table 1: Distribution of socio-demographical characteristics of (100) women.

No.	Characteristics Groups	F	%
1	Age (M ± SD=30.31 ± 7.598)	16 – 20 years	12 12
		21 – 25 years	16 16
		26 – 30 years	27 27
		31 – 35 years	15 15
		36 – 40 years	19 19
		41 – 45 years	11 11
2	Level of education	Illiterate	14 14
		Read & write	9 9
		Primary school	19 19
		Intermediate school	21 21
		Secondary school	16 16
		Diploma	7 7
		Bachelor	11 11
Postgraduate	3 3		

3	Occupation	Housewife	86	86
		Employee	14	14
4	Residential Environment	Urban	45	45
		Rural	55	55
5	Monthly income	Not enough	34	34
		Barely enough	31	31
		Enough	35	35

*F: Frequency, %: Percentage, M: Mean, SD: Standard Deviation

Table 2: Distribution of reproductive parameters of (100) women.

No.	Characteristics Groups	F	%	
1	Gravida	1 – 2	26	26
		3 – 4	43	43
		5 – 6	26	26
		7 ≤	5	5
2	Para	1 – 2	44	44
		3 – 4	41	41
		5 – 6	13	13
		7 ≤	2	2
3	Number of abortion	None	58	58
		1	28	28
		2	12	12
		3	2	2
4	Lived children	1 – 2	48	48
		3 – 4	38	38
		5 – 6	14	14
5	Dead child	None	72	72
		1	21	21
		2	4	4
		3	3	3
6	Labor duration	6 hours or less	70	70
		24 hours	24	24
		48 hours	3	3
		72 hours	3	3
7	Complications during labor	No	71	71
		Yes	29	29

*F: Frequency, %: Percentage

graduated from intermediate, (86%) is "Housewives", (55%) residence in "Rural areas, (35%) of them perceive enough monthly income.

Table 2 shows that women's gravida, (43%) reported at the second groups with range interval (3 - 4) states, 50 (25%) are at second delivery, 49 (24.5%) are nullipara, 105 (58%) "no have abortion", (48%) have at least (1-2) lived children, (72%) none have dead child", the labor duration" among pregnant women, it refers to 6 hours or less and accounted (70%). Finally, " complications during labor " most of the sample are reported at no have complications and accounted (71%) and only (29%) of pregnant women have complications as they reported.

Table 3 shows the social-related factors among pregnant women; (81%) of them are reported that their husbands want this pregnancy, but (51%) of them reported that their unplanned pregnancy; (85%) of them are reported they have support from their husbands and relatives; (48%) of pregnant women were fear of their husband's reaction about the newborn gender; and (49%) of them

had barriers for visits health care centers.

Table 4 indicates that social factors related to barriers of health care visits significantly affect childbirth satisfaction among pregnant women as indicated by significant difference at (p-value=.003) while no effect is seen with remaining social factors.

Table 5 shows the association between social factors and socio-demographic characteristics; there are significant differences between the Husband's desire for pregnancy with age, educational level, and monthly income (p-value=0.001), and significant differences with the residential environment at (p-value=0.020). While there are no statistically significant differences with occupation level. Regarding plane of pregnancy, there is a significant relationship with educational level, residential environment, and monthly income at (p value=0.039, 0.047, and 0.022) respectively, while there are no statistically significant differences between

leftover socio-demographic characteristics. Regarding Husband and relatives support, there is a highly significant relationship with age, educational level, and monthly income at (p-value= 0.001, 0.001, and 0.002), while there are no statistically significant differences with occupation level. Regarding Fear of the husband's reaction about newborn gender, there are no statistically significant differences with socio-demographic characteristics. Regarding Barriers to visits to the health care center, there is a significant relationship with educational level, occupation, residency, and monthly income at (p value=0.001), while there are no statistically significant differences with the age of women.

Table 6 displays the association between social factors and reproductive parameters; there are highly significant differences between Husband's desire about pregnancy with gravida, para, and the number of a lived child at (p-value=0.001), and significant differences with

Table 3: Distribution of social factors associated with childbirth among (100) pregnant women.

No.	Factors groups		F	%
1	Husband's desire about pregnancy	Undesirable	19	19
		Desirable	81	81
		Total	100	100
2	Plan of pregnancy	Unplanned	51	51
		Planned	49	49
		Total	100	100
3	Husband and relative support	Unsupported	15	15
		Supported	85	85
		Total	100	100
4	Fear of husband's reaction about newborn gender	No	52	52
		Yes	48	48
		Total	100	100
5	Barriers to visits to health care centers	No	51	51
		Yes	49	49
		Total	100	100

*F: Frequency, %: Percentage

Table 4: Regression analysis for effect of social factors on childbirth satisfaction among pregnant women (N=100).

Satisfaction	Unstandardized Coefficients		Standardized Coefficients			t	Sig.
Social factors	B	Std. Error	Beta				
Husband's desire about pregnancy	2.34	18.312	0.026			0.128	0.899
Plan of pregnancy	-2.565	8.45	-0.036			-0.304	0.762
Husband and relatives support	-1.511	19.786	-0.015			-0.076	0.939
Fear of husband's reaction about newborn gender	-0.951	8.413	-0.013			-0.113	0.91
Barriers to visits to the health care center	-23.854	7.678	-0.333			-3.107	0.003

a. Dependent variable: Childbirth satisfaction

Table 5: Association between social factors and women's socio-demographic characteristics.

Socio-demographic characteristics	Social Factors														
	Husband's desire about pregnancy			Plan of pregnancy			Husband and relatives support			Fear of husband's reaction about newborn gender			Barriers for visits to the health care center		
	Pearson correlation	p-value	Sig	Pearson correlation	p-value	Sig	Pearson correlation	p-value	Sig	Pearson correlation	p-value	Sig	Pearson correlation	p-value	Sig
Age	0.388	0.001	H.S	0.039	0.699	N.S	0.424	0.001	H.S	-0.19	0.058	N.S	0.087	0.39	N.S
Educational level	0.32	0.001	H.S	0.207	0.039	S	0.34	0.001	H.S	0.124	0.22	N.S	0.592	0.001	H.S
Occupation	0.195	0.051	N.S	0.181	0.071	N.S	0.169	0.092	N.S	0.016	0.873	N.S	0.395	0.001	H.S
residential environment	0.233	0.02	S	0.199	0.047	S	0.267	0.007	S	0.024	0.812	N.S	0.686	0.001	H.S
Monthly Income	0.343	0.001	H.S	0.229	0.022	S	0.309	0.002	H.S	0.181	0.071	N.S	0.421	0.001	H.S

Table 6: Association between social factors and women’s reproductive parameters.

Reproductive Parameters	Social Factors														
	Husband’s desire about pregnancy			Plan of pregnancy			Husband and relatives support			Fear of husband’s reaction about newborn gender			Barriers for visits to the health care center		
	Pearson correlation	p-value	Sig	Pearson correlation	p-value	Sig	Pearson correlation	p-value	Sig	Pearson correlation	p-value	Sig	Pearson correlation	p-value	Sig
Gravida	0.528	0.001	H.S	0.123	0.222	N.S	0.523	0.001	H.S	0.175	0.081	N.S	0.21	0.036	S
Para	0.516	0.001	H.S	0.333	0.001	H.S	0.5	0.001	H.S	0.309	0.002	H.S	0.246	0.005	H.S
Number of Abortion	-0.131	0.195	N.S	0.221	0.027	S	0.191	0.057	N.S	0.081	0.421	N.S	0.062	0.538	N.S
Number of Lived Children	0.524	0.001	H.S	0.396	0.001	H.S	0.513	0.001	H.S	0.346	0.001	H.S	0.305	0.002	H.S
Number of dead children	0.008	0.937	N.S	0.295	0.003	H.S	0.028	0.783	N.S	0.221	0.027	S	0.046	0.649	N.S
Duration of Labor	0.246	0.014	S	0.043	0.674	N.S	0.242	0.015	S	0.026	0.795	N.S	0.122	0.228	N.S
Complication during Labor	0.14	0.165	N.S	0.255	0.01	S	0.102	0.313	N.S	0.18	0.073	N.S	0.035	0.731	N.S

P: probability, Sig: Significance, N.S: Not Significant, S: Significant, H.S: High significant

the duration of labor at (p-value=0.014). While there are no statistically significant differences with leftover reproductive parameters.

Regarding Plan of pregnancy, there is a highly significant relationship with para, number of lived children, and number of dead children at (p value=0.001, 0.001, and 0.003) respectively, and significant differences with a number of abortion and complications during labor at (p-value=0.010, and 0.027). While there are no statistically significant differences in gravida and duration of labor. Regarding Husband and relatives support, there is a highly significant relationship with gravida, para, number of lived children, and at (p value=0.001). and significant differences with a duration of labor at (p-value=0.015). While there are no statistically significant differences with leftover reproductive parameters. Regarding Fear of husband’s reaction about newborn gender, there is a highly significant relationship with para, and the number of a lived child at (p value=0.002, and 0.001) respectively, and significant differences with a number of dead children at (p-value=0.027). While there are no statistically significant differences with leftover reproductive parameters. Regarding Barriers for visits to the health care center, there is a highly significant relationship with para, the number of lived children at (p value=0.005, and 0.002) respectively, and significant differences with gravida at (p-value=0.036). While there are no statistically significant differences with leftover reproductive parameters.

DISCUSSION

Several demographic characteristics of women may affect childbirth satisfaction. Therefore, the demographic characteristics and their relations to childbirth satisfaction have been studied in the Table 1, which revealed that pregnant women have an average age of 30.31 ± 7.598 years, in which the highest percentage (27%) is referred to as 26-30 years old. This finding is almost identical to one found in an Iraqi study, where most studies are between 20-and 29 years old [10].

Concerning the level of education, (21%) graduated from intermediate school. This result is close to study done in Egypt which found that the participant’s level of education is primary school and accounted (58.7%) of the total study sample [11]. Regarding the occupational status of pregnant women) 86% (are housewives. This result is like a study done in Iraq, which represents that most pregnant women were housewives accounting for (92.8%) [12]. Regarding residency is refers that 55% of pregnant women are residents in rural areas, and 45% are residents in urban areas. The results non-agreement with a study done with study documented in Iraq, which reveals that 54.4% of study sample residency in urban area [12]. Regarding monthly income) 35% (of pregnant women perceive sufficient monthly income. This result is in line with a study done in Iraq that showed the majority of the study sample with barely sufficient income and accounted for (58%) [13].

The results in a Table 2 reveal that the highest percentage (43%) of pregnant women got (3-4) pregnancies. These results disagree with a study done in Iraq, which reveals that the highest percentage of first pregnancies accounted (for 54%) [14]. Regarding parity (44%) refers to (1-2) delivery. This result agrees with a study conducted in Egypt that found that 49.5% of them delivered previously from one to three times [15]. Regarding number of previous abortion (28%) has one previous abortion. This result disagrees with a study done in Iraq, which showed that (92%) of the study sample had not had an abortion [14]. According to the number of lived children (48%) referred to (1- 2) unfortunately there, no studies were found to support this variable. Regarding stillbirth (72%), of have a non-previous stillbirth. This result agrees with a study in Saudi Arabia, which found that (74.1%) of non-still birth [15]. Regarding the labor duration among pregnant women, it refers to (6 hours or less) among more than half (53%). This result is like an international study conducted in Switzerland, which found that the median duration of the active first stage (Among nulliparous and parous women) when the starting reference point was

less than 4.5 cm ranged from (3.7–8.4) hours [16]. The complications during labor are seen among only (29%); these complications include (shoulder dystocia, post-partum hemorrhage, laceration, induction labor, and APGAR score between 5-7) this result is in agreement with a retrospective cohort study done at southeast region of Sweden that showed the most common obstetric interventions and complications that pregnant women express at labor were instrumental vaginal delivery, post-partum hemorrhage and Apgar score < 7 at five minutes. Furthermore, induction of labor, epidural anesthesia, and oxytocin augmentation found that these complications were strongly related to women's dissatisfaction with childbirth [17].

The social-related factors among pregnant women clarify in Table 3 that present (81%) of women are reported that their husbands want this pregnancy, but (51%) of them said that their unplanned this result disagreement with a study conducted in Turkey that showed that 28 (74.4%) of women stated that they planned this pregnancy, whereas 44 (25.6%) indicated that they had an unplanned pregnancy [18].

Concerning husband and relative support (85%), they have support from their husbands and relatives. This result of study disagreements with a study in Indonesia, which found that most of the husbands accompanying their wives during pregnancy examination are equal to (81.4%); meanwhile, the number of husbands attending their wives at the time of delivery is greater than (86.5%) this social factor prevents and reduce a mother's mortality rate by enhancing the active role of the family. The husband is the most responsible family member for maintaining the pregnancy and delivery process. Therefore, to care for his wife, the husband must be active. One of the significant aspects that aid the husband in making decisions about his wife's health is his active engagement in accompanying her during pregnancy and the delivery process [19]. Concerning the fear of their husband's reaction to the newborn gender (48%) were afraid. However, this result is not supported by any research findings. Regarding barriers to visits to health care centers (49%), they had a barrier. The result is in disagreement with a cross-sectional study which was conducted in the first and second primary health care sectors in Iraq in Basra city that found most the pregnant women who visit the health center frequently with a rate of (85.25%) of the total study sample where the study explained that the reason for reviewing health care centers is due to their health-care access, in addition, It seems that most of the participants need a short time to reach the health center, most of the women need 10-15 minutes to reach the health center (79.8%). In comparison, only 0.2% require more than 30 minutes to reach the health center, with a mean arrival time (of 11.3625) and (S.D=5.12560). In addition to the time each pregnant woman spends waiting or receiving intended care [20].

Results in Table 4 indicate that social factors related to healthcare visit barriers significantly affect childbirth

satisfaction among pregnant women, This finding is similar to the study done in Saudi Arabia, which showed Despite the fact that overall satisfaction with the quality of antenatal care was excellent, several areas of the treatment offered were insufficient. In addition, healthcare providers should improve their technical competence [21].

Moreover, the result agrees with a study done in Iraq in Basra city, which indicated that most of the women attending antenatal care are fairly satisfied with the care provided. Still, the level of satisfaction was mostly in the middle scale. However, a small percentage (4.5%) expressed dissatisfaction with the overall quality of care. When women were requested to suggest ways to improve care, they proposed providing the primary health care centers with ultrasonography which was the prime concern by nearly (61.25%) followed by (41.25%) regarding the crowdedness and reception, and (33.75%) provision with the dentist, increase no. of doctors (6.25%), condition of female staff at the maternal health care unit (3.75%), location of the health center and location of the maternal care unit within the center (2.5% and 5%) respectively [20].

Table 5 shows the association between social factors and some socio-demographic characteristics, which include (age, educational level, occupation, residence environment, and monthly income), except the fear of the husband's reaction to newborn gender. These findings align with an international study done in Spain, which found significant differences between the Husband's desire for pregnancy with age and educational level [22]. In addition, a study conducted in Indonesia found significantly influences the participation of husbands in accompanying wives during pregnancy and labor, which helps the husband take decisions related to the health of his wife [19].

Table 6 shows the association between social factors and reproductive parameters; there are highly significant differences between gravida, para, the number of lived children, number of dead children, number of previous abortions, duration of labor and complications during labor. These findings agree with the study conducted in Egypt that shows significant correlations were observed between satisfaction levels. Socio-demographic characteristics include (age, education, occupation, income and residence, in addition, there are significant correlations between satisfaction level and reproductive characteristics (number of gravidity, parity, abortion and type of delivery) at a p-value (0.01) [23].

According to a cross-sectional study in Iran, there was a significant relationship between reproductive characteristics and the level of income, educational and occupational status of the participants [24].

CONCLUSION

The study found the social-related factors among pregnant women are a high percentage of their husbands

want this pregnancy, but it was unplanned pregnancy; they have support from their husbands and relatives but were fear of their husband's reaction to the newborn gender; and they had barriers for visits health care centers, with this variable the study found it effect on the level of childbirth satisfaction among pregnant women. The study found an association between social factors and socio-demographic and reproductive characteristics.

RECOMMENDATION

The study suggests the following based on its findings and conclusions.

- ✓ It is recommended that attempts should be made to bring change in reducing unwanted pregnancy by conducting further studies.
- ✓ Encourage health-care professionals to participate in continuing education activities such as workshops, conferences, training programs.

REFERENCES

1. Baker B, Yang I. Social media as social support in pregnancy and the postpartum. *Sex Reprod Healthc* 2018; 17:31-34.
2. Mamuroh L, Nurhakim F. Relationship between husbands support And pregnancy control in pregnant women Sukawening Puskesmas Garut. *J Mat Care Reprod Health* 2019; 2.
3. Rajeswari S, SanjeevaReddy N. Efficacy of progressive muscle relaxation on pregnancy outcome among anxious Indian primi mothers. *Iranian J Nurs Midwifery Res* 2020; 25:23.
4. Rastad Z, Golmohammadian M, Jalali A, et al. Effects of positive psychology interventions on happiness in women with unintended pregnancy: Randomized controlled trial. *Heliyon* 2021; 7:e07789.
5. Azimi M, Fahami F, Mohamadirizi S. The relationship between perceived social support in the first pregnancy and fear of childbirth. *Iranian J Nurs Midwifery Res* 2018; 23:235.
6. Chimatiro CS, Hajison P, Chipeta E, et al. Understanding barriers preventing pregnant women from starting antenatal clinic in the first trimester of pregnancy in Ntcheu District-Malawi. *Reprod Health* 2018; 15:1-7.
7. Noh JW, Kim YM, Lee LJ, et al. Factors associated with the use of antenatal care in Sindh province, Pakistan: A population-based study. *PloS One* 2019; 14:e0213987.
8. Ali RM. Assessment of women's satisfaction with childbirth experience after utilization of pain management practices at Al-Elwya maternity teaching hospital. *Med Legal Update* 2021; 21.
9. YassenTaha T. Evaluation of clients' satisfaction towards primary health care centers services at Baghdad city. *Iraqi National J Nurs Specialties* 2017; 30.
10. Dhahi ZK, Issa SS, Hameed LA. A study on pregnant women's satisfaction with primary health care services in Basra. *Int J Res Humanit Arts Lit* 2015; 3:7-19.
11. Mahmoud Mohamed Hables R, Zaki Hassan Roma N. Factors associated with women's satisfaction during labor. *Egyptian J Health Care* 2020; 11:628-640.
12. Ahmed HM. Role of verbal and non-verbal communication of health care providers in general satisfaction with birth care: A cross-sectional study in government health settings of Erbil City, Iraq. *Reprod Health* 2020; 17:1-9.
13. Hassan IS, Omer HA. Assessment pregnant women's practices about antenatal care during pregnancy at primary health care centers in Kirkuk City, Iraq. *Annals Tropical Med Public Health* 2020.
14. Serçekeş P, Vardar O, Özkan S. Fear of childbirth among pregnant women and their partners in Turkey. *Sex Reprod Healthc* 2020; 24:100501.
15. Al-Aithan SM, Al-Ghaffli LA, Al-Shehri SZ, et al. Anxiety among multiparous women in the Al-Qatif sector of KSA: A mixed-method study. *J Taibah Univ Med Sci* 2021; 16:826-834.
16. Abalos E, Chamillard M, Díaz V, et al. Progression of the first stage of spontaneous labour. *Best Pract Res Clin Obstet Gynaecol* 2020; 67:19-32.
17. Falk M, Nelson M, Blomberg M. The impact of obstetric interventions and complications on women's satisfaction with childbirth a population based cohort study including 16,000 women. *BMC Pregnancy Childbirth* 2019; 19:1-9.
18. Sarı O, Dağcıoğlu BF, Akpak YK, et al. Planned and unplanned pregnancy and its association with coping styles and life quality. *Health Care Women Int* 2021; 1-1.
19. Rumaseuw R, Berliana SM, Nursalam N, et al. Factors affecting husband participation in antenatal care attendance and delivery. In *IOP Conference Series: Earth Environ Sci* 2018; 116.
20. Dhahi ZK, Issa SS, Hameed LA. A study on pregnant women's satisfaction with primary health care services in Basra. *Int J Res Humanit Arts Lit* 2015; 3:7-19.
21. Lamadah SM, Elsaba HA. Women's satisfaction with the quality of antenatal care at the primary health care centers in Al-Madinah Al-Menawarh, KSA. *Life Sci J* 2012; 9:4291-4299.
22. Fernández-Carrasco FJ, Rodríguez-Díaz L, González-Mey U, et al. Changes in sexual desire in women and their partners during pregnancy. *J Clin Med* 2020; 9:526.
23. Mahmoud Mohamed Hables R, Zaki Hassan Roma N. Factors associated with women's satisfaction during labor. *Egyptian J Health Care* 2020; 11:628-640.
24. Khazaeian S, Kariman N, Ebadi A, et al. Effect of socio-economic factors on reproductive health in female heads of household: A cross-sectional study in Iran. *J Clin Diag Res* 2018; 12:4.