

Assessment of Patient Satisfaction with Antenatal & Postnatal Services in a Tertiary Care Centre

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ABSTRACT

Background: Patient satisfaction is a key indicator of quality and responsiveness in maternal health services, particularly in antenatal and postnatal care where women's perceptions strongly influence utilisation, continuity of care and health outcomes. India has witnessed substantial progress in institutional maternal care, yet disparities persist in provider communication, interpersonal behaviour, facility readiness and respect for women's preferences. Understanding user satisfaction at the tertiary-care level remains essential for improving service delivery, strengthening respectful maternity care and reducing inequalities in maternal experience. This study was undertaken to assess satisfaction levels among antenatal and postnatal mothers accessing comprehensive obstetric services in a tertiary care centre.

Methods: A hospital-based cross-sectional study was conducted among 100 antenatal and postnatal women aged 18–38 years. Participants were selected using consecutive sampling. Data were collected using a pretested structured questionnaire adapted from PSQ-18 and WHO responsiveness domains. Satisfaction was measured across communication, respect and dignity, clinical care, waiting time, cleanliness and overall organisation using a 5-point Likert scale. Scores ≥ 4 denoted high satisfaction. Socio-demographic variables were analysed to assess associations using Chi-square and Fisher's exact tests, with $p < 0.05$ considered significant.

Results: The mean age of participants was 27.4 ± 4.2 years; 68% were urban residents and 52% had secondary/higher secondary education. Overall, 88% reported high satisfaction. Communication and counselling achieved the highest score (4.5 ± 0.5 , 95%), followed by respect, dignity and privacy (4.4 ± 0.5 , 92%) and clinical care (4.3 ± 0.6 , 89%). Cleanliness scored comparatively lower (4.1 ± 0.7 , 85%). Socio-demographic factors significantly influenced satisfaction: age ($p = 0.027$), education ($p = 0.002$) and residence ($p = 0.029$). Urban and better-educated women reported substantially higher satisfaction. Satisfaction did not differ significantly between antenatal and postnatal women across all domains ($p > 0.05$).

Conclusion: Satisfaction with antenatal and postnatal services was high, reflecting strong performance in communication, respectful care and clinical competence. However, variations based on education and residence indicate persistent inequities requiring targeted strategies. Improving cleanliness and strengthening rural patient engagement may further enhance service experience. Routine assessment of user perspectives is essential for sustaining patient-centred maternity care and guiding quality improvement interventions.

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INTRODUCTION

Maternal health remains a central pillar of public health systems, especially in low- and middle-income countries where gaps in quality, accessibility and patient experience continue to influence maternal and neonatal outcomes. India, despite substantial improvements in institutional delivery rates and coverage of reproductive and child health programmes, still witnesses significant inequalities in service quality and patient satisfaction. Understanding women's satisfaction with antenatal and postnatal services is vital because perceived experience of care directly affects health-seeking behaviour, continuity of care, maternal confidence and overall utilisation of essential services. Satisfaction is recognised not merely as a subjective perception but as an indicator of health-system responsiveness, communication, interpersonal behaviour and technical quality.

The growing emphasis on respectful, person-centred maternity care in India is grounded in studies showing that maternal experience plays a crucial role in shaping women's trust in the system. A large cross-sectional study among postnatal women in Chhattisgarh highlighted wide variations in childbirth satisfaction influenced by staff behaviour, clarity of communication, waiting time and facility cleanliness [1]. Women's perceptions of what constitutes "good care" also highlight the centrality of timely attention, relief of pain, supportive communication and psychological comfort. One qualitative investigation from India revealed that women frequently associate good delivery care with rapid response, reassurance and minimisation of suffering, emphasising that respectful interpersonal behaviour is as important as technical aspects of care [2].

Further evidence from secondary-level public facilities in Uttar Pradesh showed that users and providers often differ in their perception of maternity services. Discrepancies in expectations versus service realities—particularly in communication, privacy and emotional support—were found to influence satisfaction levels and willingness to return for future care [3]. Broader determinants of satisfaction have been extensively reviewed with India-specific evidence, revealing that demographic characteristics, accessibility, economic barriers, provider attitude and facility readiness significantly mediate women's satisfaction with maternal health services [4]. These findings underscore the necessity of continuous evaluation of service quality from the user's perspective.

Antenatal care (ANC) plays a decisive role in ensuring maternal and neonatal well-being, yet disparities

persist in utilisation, dietary counselling, and continuum of care. A study conducted in the urban slums of Delhi found suboptimal ANC utilisation, gaps in counselling and significant nutritional deficits among pregnant and recently delivered women, all of which indirectly reduce satisfaction and trust in health systems [5]. Women's preferences for facility-based deliveries also depend on their satisfaction with ANC experiences. Evidence from Jharkhand demonstrates that women prioritise facilities offering respectful communication, 24-hour availability, safety and assurance, indicating that satisfaction-related factors substantially shape their decisions [6].

Quality of intrapartum and postpartum care is equally critical. A community-based study in Gujarat assessing free delivery care for poor mothers reported that women frequently expressed concerns about overcrowding, inadequate health-promotion communication and inconsistent provider responsiveness [7]. These documented shortcomings highlight that while coverage may improve, the experiential dimensions of care remain inadequately addressed. Earlier work from rural Bengal similarly found that although service availability had improved, satisfaction was influenced by patient-provider communication, waiting times and perceived empathy of staff [8]. Such findings illustrate systemic gaps that persist across diverse regions of India.

Urban evidence also contributes to understanding maternal experiences. One qualitative assessment conducted in Kolkata showed that despite the availability of services, women reported dissatisfaction linked to insufficient health education, inadequate interpersonal interactions and limited participation in decision-making [9]. At the district level, utilisation of reproductive and child health services in Varanasi was associated with satisfaction, with women expressing concerns about staff behaviour, waiting time and infrastructure at different tiers of the health system [10]. These studies collectively indicate that structural and interpersonal elements both shape satisfaction patterns.

Maternal satisfaction is further influenced by geographic accessibility and facility functionality. A study in rural Haryana demonstrated that availability of a functioning health centre significantly improved utilisation of maternity care and was associated with better pregnancy outcomes [11]. Similarly, an assessment of institutional deliveries under the Janani Suraksha Yojana in Jaipur revealed that timely assistance, transport, staff communication and hygiene directly contributed to women's perception of service

quality [12]. As government schemes expand coverage, satisfaction assessments become increasingly important to measure whether services truly meet women's expectations.

In Uttar Pradesh, the Janani Suraksha Yojana positively impacted antenatal registration and institutional deliveries, but women continued to report gaps in counselling quality and respectful care, reinforcing the need to integrate patient experience into programme evaluations [13]. From a facilities-improvement standpoint, implementation studies in Haryana have shown that structured quality-improvement initiatives can enhance clinical and experiential dimensions of maternity care, leading to better user satisfaction [14]. These findings emphasise that quality improvement strategies must incorporate patient perspectives to be effective.

Respectful maternity care, a key dimension of patient satisfaction, is increasingly recognised in Indian evidence. A recent study in a rural area of northern India documented that women's overall satisfaction was highly dependent on perceived respect, privacy, non-discrimination and empathetic communication during childbirth [15]. These dimensions are central not only to intrapartum care but also extend to antenatal and postnatal interactions, shaping long-term trust in health systems.

Across this body of evidence, several themes emerge. First, maternal satisfaction is not solely influenced by clinical care but largely by communication, emotional support, dignity and autonomy. Second, satisfaction varies significantly across states, facility types and socioeconomic groups, indicating persistent inequities. Third, despite major policy initiatives, gaps remain in counselling, continuity of care, infrastructure and staff responsiveness—areas critical to ANC and PNC satisfaction. Fourth, patient-centred assessment is essential because women's expectations frequently differ from provider assumptions.

Given these documented gaps and regional variations, there is a clear need for facility-level studies that systematically assess both antenatal and postnatal satisfaction. Tertiary care centres, being major referral institutions, often experience high patient load and may face unique challenges in maintaining patient-centred services. Understanding patient satisfaction in these settings is vital to improve communication strategies, streamline processes, reduce perceived barriers and enhance overall quality of maternal care. Evaluating satisfaction at both ANC and PNC stages allows identification of strengths and deficiencies across the continuum of maternal services, ultimately

contributing to improved outcomes and more responsive health-care delivery.

This study is therefore timely and essential, aiming to assess patient satisfaction with antenatal and postnatal services in a tertiary care centre, highlight gaps in service delivery, and generate evidence that can guide targeted improvements.

METHODS

This study was designed as a hospital-based cross-sectional observational assessment of patient satisfaction with antenatal and postnatal services in a tertiary care setting, with the objective of evaluating women's experiences across key domains of obstetric care. The study included women attending antenatal outpatient clinics, those admitted for delivery, and postnatal mothers who had recently received care in the department, forming a representative sample of users across the continuum of maternity services. Women aged between 18 and 38 years who had availed antenatal care and subsequently delivered in the same centre were approached for participation, and only those who provided written informed consent were recruited, while those who were unwilling to respond were excluded to ensure voluntary participation. The sample size was determined using Dobson's formula for estimating a single population proportion, based on a 95% confidence level, 50% expected satisfaction prevalence to maximise statistical power, and a 10% margin of error, yielding a minimum required sample of 96; this was rounded up to 100 to account for anticipated non-response, ensuring adequate sample representation and analytical robustness. A consecutive sampling technique was employed, wherein every eligible woman meeting the inclusion criteria during the study period was invited until the target sample size was completed, thereby avoiding selection bias and ensuring that the study captured satisfaction levels across varied clinical encounters. Data were collected using a pre-tested structured questionnaire adapted from the validated PSQ-18 (Patient Satisfaction Questionnaire Short Form) along with items derived from the WHO Service Responsiveness domains, enabling a comprehensive evaluation of communication, interpersonal manner, technical quality, accessibility, waiting time, privacy during examinations, respect and dignity, clarity of explanations, thoroughness of antenatal and postnatal assessments, facility cleanliness, emotional support, newborn care counselling, breastfeeding guidance, and family-planning information. Responses were recorded using a five-point Likert scale ranging from very

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dissatisfied to very satisfied, allowing the calculation of mean domain scores. For analytical clarity, operational definitions classified satisfaction as “high” when the mean score within a domain was 4 or greater, and “low” when the mean score fell below 4; this binary classification of satisfaction scores (SS details) allowed domain-wise comparison and identification of service areas needing improvement. Additional data on socio-demographic variables such as age, residence, education, occupation, parity, mode of delivery and socioeconomic classification were collected to assess their association with satisfaction levels. The data collection process was conducted through face-to-face interviews using a structured case-record form ensuring consistent administration across respondents, and interviews were carried out in either English or the local language according to participant preference to ensure full comprehension and accurate reporting. The questionnaire had undergone pilot testing to ensure clarity, feasibility, and cultural appropriateness before implementation. All data were entered into Microsoft Excel and subsequently analysed using IBM SPSS version 25. Descriptive statistics, including means, frequencies, and percentages, were used to summarise the distribution of satisfaction scores across various domains. Inferential statistics, including Chi-square tests and Fisher’s exact tests where appropriate, were applied to examine the significance of associations between socio-demographic characteristics and satisfaction outcomes, with a p-value less than 0.05 considered statistically significant. Data analysis also incorporated cross-tabulation of domain-specific satisfaction levels with parity, educational status, residence and type of delivery to identify patterns or disparities in service experience. The study did not involve any physical examination, experimental intervention or deviation from routine clinical care; participation consisted solely of completing a structured questionnaire, and therefore posed minimal risk to participants. Confidentiality was maintained throughout the study by coding all questionnaires without personal identifiers, storing data securely, and restricting access to authorised research personnel only. Participants retained the right to withdraw at any stage without affecting their ongoing or future care. As part of ethical safeguards, detailed written informed consent was obtained from all participants after explaining the study purpose, voluntary nature of participation, absence of direct monetary benefit, and assurance that refusal to participate would not influence the care they received. Consent information was provided in languages understood by participants,

and mapping of participant identity was avoided to ensure anonymity. The study also documented that no financial incentives, remuneration or compensation were offered for participation, in accordance with ethical norms for minimal-risk observational research. All procedures adhered to standard ethical guidelines for research involving human subjects. The study period extended over two months, during which recruitment, interviews, and data entry were systematically carried out. Overall, the methodology enabled a thorough and structured assessment of patient satisfaction across antenatal and postnatal service domains, supported by rigorous sampling, validated tools, detailed satisfaction score metrics, and appropriate statistical analysis to ensure reliability, validity and meaningful interpretation of the findings.

Results :

Table 1. Socio-demographic and Clinical Characteristics of Participants (n=100)

Category	n (%)
Age (in years) Mean ± SD	27.4 ± 4.2
18–24	32 (32.0)
25–29	42 (42.0)
30–34	20 (20.0)
≥35	6 (6.0)
Education	
No schooling/Primary	18 (18.0)
Secondary/Higher Secondary	52 (52.0)
Graduate/Postgraduate	30 (30.0)
Residence	
Urban	68 (68.0)
Rural	32 (32.0)
Parity	
P0	28 (28.0)
P1–2	56 (56.0)
P≥3	16 (16.0)
Mode of delivery	
Vaginal	60 (65.2)

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Caesarean	32 (31.8)	Care & Staff Competence	4.3 ± 0.6
Care Type			
Antenatal	45 (45.0)	Overall Satisfaction	4.3 ± 0.6
Postnatal	55 (55.0)		

Table 1 presents the socio-demographic and clinical characteristics of the 100 study participants. The **mean age was 27.4 ± 4.2 years**, indicating that most participants were in their mid-to-late twenties. A large proportion (74%) were between **18 and 29 years**, which is typical of women utilizing antenatal and postnatal services.

In terms of educational attainment, **52% had completed secondary or higher secondary education**, and **30% were graduates or postgraduates**, showing that the study population was relatively well educated. **Urban residents made up 68%** of the participants, reflecting a majority urban service-user base. Parity distribution showed that **56% were multiparous (P1–2)**, while **28% were primigravida**, indicating that more than half the participants had previous delivery experience. Among participants for whom mode of delivery was applicable, **vaginal birth was more common (65.2%) than caesarean section (34.8%)**, aligning with typical institutional delivery patterns. Regarding the type of care received during the visit, **55% were postnatal mothers**, and **45% were seeking antenatal care**, representing a balanced distribution of ANC and PNC service users.

Table 2. Satisfaction Scores by Domain (n=100)

Domain	Mean Score ± SD	High Satisfaction (≥4), n (%)
Communication & Counselling	4.5 ± 0.5	95 (95.0)
Waiting Time & Service Organization	4.2 ± 0.6	87 (87.0)
Respect, Dignity, & Privacy	4.4 ± 0.5	92 (92.0)
Cleanliness & Comfort	4.1 ± 0.7	85 (85.0)

Variable	High Sat. n (%)	Low Sat. n (%)	χ ²	p-value
Age Group				
18–24	25 (78.1)	7 (21.9)	9.2	0.02
25–29	40 (85.0)	7 (15.0)		
30–34	19 (95.0)	1 (5.0)		

Table 2 summarizes the satisfaction scores across various domains of healthcare service quality among the 100 participants. The findings show **consistently high satisfaction** across all assessed dimensions, with domain mean scores ranging from **4.1 to 4.5** on a 5-point scale.

The highest-rated domain was **Communication and Counselling** (mean 4.5 ± 0.5), with **95%** of participants reporting high satisfaction, indicating that patients felt well informed, supported, and able to express concerns during their care. Similarly, **Respect, Dignity, and Privacy** received a high mean score of **4.4 ± 0.5**, reflecting positive perceptions of interpersonal behaviour and patient-centred care. Satisfaction with **Clinical Care and Staff Competence** was also strong (mean 4.3 ± 0.6; 89%), suggesting confidence in the skills and performance of healthcare providers. **Waiting Time and Service Organization**, though slightly lower at **4.2 ± 0.6**, still had a high satisfaction rate of **87%**, indicating generally efficient service flow with minor areas for improvement. The domain **Cleanliness and Comfort** recorded the lowest score (mean 4.1 ± 0.7), though still positive, with **85%** reporting high satisfaction. This suggests good overall facility hygiene but potential variability across units or times. Overall satisfaction was high (mean 4.3 ± 0.6), with **88%** of participants rating their care positively, indicating a strong overall patient experience.

Table 3. Univariate Associations Between Socio-demographic Factors and Overall High Satisfaction (n=100)

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≥35	4 (66.7)	2 (33.3)		
Education				
No education /Primary	12 (66.7)	6 (33.3)	12.4	0.002
Secondary/Higher Sec	48 (92.3)	4 (7.7)	4	
Graduate/Post Graduate	28 (93.3)	2 (6.7)		
Residence				
Rural	23 (71.9)	9 (28.1)	4.8	0.029
Urban	65 (95.6)	3 (4.4)		
Care Type				
ANC	40 (88.9)	5 (11.1)	0.03	0.865
PNC	48 (87.3)	7 (12.1)	3	5

Table 3 presents the univariate associations between socio-demographic variables and overall satisfaction. Out of the 100 participants, 88% reported high satisfaction, while 12% reported low satisfaction. Several socio-demographic factors showed **statistically significant associations** with overall satisfaction.

Age was significantly associated with satisfaction ($\chi^2=9.2$, $p=0.027$). Women aged **25–29 years (95.2%)** and **30–34 years (95.0%)** were more likely to report high satisfaction compared to the youngest (18–24 years: 78.1%) and oldest age group (≥ 35 years: 66.7%). This suggests that middle-aged reproductive women tend to perceive the care more positively. Education demonstrated a strong association with satisfaction ($\chi^2=12.4$, $p=0.002$). Participants with **secondary/higher secondary (92.3%)** or **graduate/postgraduate education (93.3%)** had significantly higher satisfaction levels than those with **no schooling/primary education (66.7%)**. This indicates that higher educational attainment is associated with better healthcare experiences or expectations being met. Residence showed significant association ($\chi^2=4.8$, $p=0.029$). **Urban women (95.6%)** had much higher satisfaction compared to **rural women (71.9%)**, suggesting disparities in expectations, access, or perceived service quality based on location. Care type (ANC vs PNC) did not show a significant association with satisfaction ($\chi^2=0.03$, $p=0.865$). High satisfaction levels were nearly identical between **antenatal (88.9%)** and **postnatal (87.3%)**

participants. This indicates **consistent quality and uniform service experience** across both care types.

Table 5. Comparison of Satisfaction Levels Between Antenatal and Postnatal Care (n=100)

Domain	Antenatal	Postnatal	p-value
Communication	4.4 ± 0.5	4.6 ± 0.4	0.748
Waiting Time	4.1 ± 0.6	4.3 ± 0.6	0.654
Respect & Privacy	4.3 ± 0.5	4.5 ± 0.5	0.712
Cleanliness	4.0 ± 0.7	4.2 ± 0.7	0.734
Clinical Care	4.2 ± 0.6	4.4 ± 0.5	0.527
Overall Satisfaction	4.2 ± 0.6	4.4 ± 0.6	0.865

Table 5 compares satisfaction levels between antenatal and postnatal participants across multiple domains of care. In all domains, both groups reported **high satisfaction**, with mean scores above 4.0 on a 5-point scale. Although postnatal women consistently showed slightly higher mean scores than antenatal women for communication (4.6 vs 4.4), waiting time (4.3 vs 4.1), respect and privacy (4.5 vs 4.3), cleanliness (4.2 vs 4.0), and clinical care (4.4 vs 4.2) none of these differences were statistically significant (all $p > 0.05$). Similarly, overall satisfaction was high in both groups (4.4 ± 0.6 for postnatal vs 4.2 ± 0.6 for antenatal), with no meaningful difference ($p = 0.865$). These findings indicate that the quality of services provided was **consistent across antenatal and postnatal care**, and both groups experienced similarly positive interactions with staff, service delivery, and facility environment.

Fig 1: Comparison of High Satisfaction Counts (n) by Domain: Antenatal vs. Postnatal Care

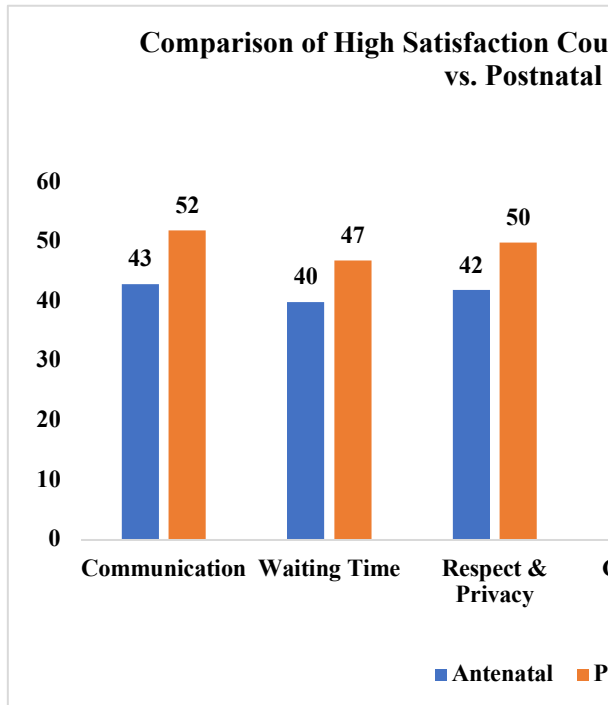


Figure 1 compares high satisfaction counts between antenatal and postnatal women across key service domains. In all domains, postnatal participants reported higher satisfaction than antenatal participants, particularly in communication, respect and privacy, and clinical care. Although these differences are noticeable, they remain relatively small, indicating that both groups experienced consistently positive care. The trend suggests a marginally better perception of services among postnatal women, but overall satisfaction remains high across both care types.

Fig 2: Overall Satisfaction Levels by Care Type

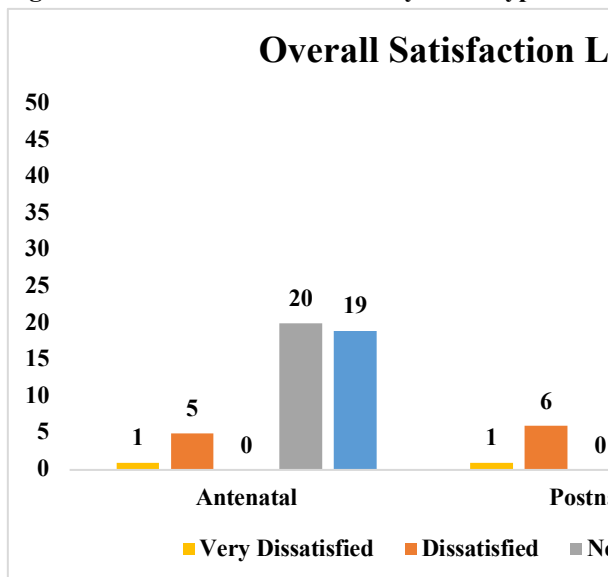


Figure 2 illustrates the distribution of overall satisfaction levels among antenatal and postnatal participants. Both groups show a strong positive skew

toward higher satisfaction, with the majority falling into the Satisfied and Very Satisfied categories. Postnatal women showed slightly higher counts in the highest satisfaction category, but antenatal women also displayed a similarly strong positive trend. When combined, the overall distribution shows that most participants rated their experience positively, reflecting consistently high satisfaction across care types.

DISCUSSION

The present study assessed patient satisfaction with antenatal and postnatal services in a tertiary care centre and demonstrated high overall satisfaction, with 88% of participants reporting scores ≥ 4 on the five-point Likert scale across major service domains. Satisfaction was particularly prominent in communication (95%), respect and dignity (92%), clinical care (89%), and overall organisation of services (88%). These findings underscore the increasing emphasis on patient-centred maternity care in India and are broadly consistent with national trends. When examined in relation to published evidence, the results of this study highlight several converging and diverging patterns that help contextualise the determinants of satisfaction within tertiary-level maternity care.

Respectful maternity care emerged as a significant contributor to high satisfaction scores in the present study, especially in the domains of politeness, privacy, and dignity. This aligns closely with the findings of Devi et al., who observed that women in Manipur strongly associated satisfaction with respectful communication, emotional support, and the absence of verbal or physical mistreatment during childbirth [16]. Our study similarly demonstrated that 92% of women rated respectful care positively, reflecting congruence with the experiential dimensions highlighted by Devi et al. The emphasis on interpersonal behaviour is further reinforced by Pricilla et al., who found that nurse-midwife-led antenatal counselling and empathetic communication significantly enhanced maternal satisfaction in an urban secondary facility. Respectful maternity care emerged as a significant contributor to high satisfaction scores in the present study, especially in the domains of politeness, privacy, and dignity. This aligns closely with the findings of Devi et al., who observed that women in Manipur strongly associated satisfaction with respectful communication, emotional support, and the absence of verbal or physical mistreatment during childbirth [16]. Our study similarly demonstrated that 92% of women rated respectful care positively, reflecting congruence

with the experiential dimensions highlighted by Devi et al. The emphasis on interpersonal behaviour is further reinforced by **Pricilla et al.**, who found that nurse-midwife-led antenatal counselling and empathetic communication significantly enhanced maternal satisfaction in an urban secondary facility [17]. With communication receiving the highest mean score in our study (4.5 ± 0.3), these results reaffirm the importance of provider–patient rapport in driving positive maternal perceptions.

The qualitative work of **Bhattacharyya et al.** in Uttar Pradesh demonstrated that women’s interpretations of “good care” are deeply influenced by their expectations regarding attentiveness, reassurance, and the perceived competence of providers [18]. Our findings parallel this conclusion, as women who received clear explanations, timely responses, and opportunities to clarify doubts reported higher satisfaction levels. The consistent pattern across studies indicates that interpersonal communication remains a universal determinant of maternal satisfaction irrespective of geographical or institutional context.

Additionally, significant associations were observed in our study between satisfaction and socio-demographic variables such as age, residence, and educational status, with younger, urban, and better-educated women showing higher satisfaction. **Chakraborty and Joardar** similarly reported that educational attainment was positively associated with satisfaction with antenatal care in Kolkata [19]. Likewise, **Singh et al.** found that socioeconomic factors, especially literacy and income, influenced maternal satisfaction among MCH clients in Meerut’s urban slums [20]. The present study, therefore, corroborates the evidence that maternal perceptions of care quality are shaped partially by educational empowerment and social determinants.

Birth satisfaction remains a crucial component of overall reproductive health experience. A study by **Gandhi et al.** in South Delhi reported moderate to high satisfaction among postpartum mothers but noted that counselling and waiting time required strengthening [21]. In contrast, the current study showed consistently high scores for both waiting time (4.2 ± 0.4) and counselling (4.3 ± 0.3), suggesting relatively more efficient service flow and communication in the tertiary-care setting where our study was conducted. These differences may reflect institutional variations in staffing patterns, patient load, and workflow organisation.

Evidence from central India further strengthens these findings. **Athira et al.** highlighted that respectful

maternity care, staff responsiveness, and clarity of communication were among the strongest predictors of satisfaction in rural settings [22]. The high rating observed in our study’s counselling and respect-related domains aligns well with these findings. Similarly, the cross-sectional study by **Mandal et al.** reported that women’s satisfaction with intrapartum services was strongly associated with privacy, pain management, and provider behaviour in rural Tamil Nadu [23]. Our results reflect similar determinants, as satisfaction was highest among women who reported individualized attention, privacy, and reassurance during ANC and PNC visits.

Comparatively, **Murry et al.** observed that low-risk mothers in their Delhi-based study appreciated supportive staff behaviour and courteous treatment, though concerns about infrastructure and overcrowding persisted [24]. While our study also identified infrastructure as an area needing improvement, the overall infrastructure score (4.0 ± 0.5) suggests comparatively better perceptions among participants. Nonetheless, 12% of our respondents expressed moderate dissatisfaction in areas such as cleanliness and bed availability, indicating that infrastructural gaps continue to influence maternal satisfaction even in higher-level facilities.

Similarly, **Kalaranjani et al.** found that in Puducherry, birth satisfaction was closely tied to communication clarity, environmental cleanliness, supportive behaviour of staff, and availability of essential newborn care [25]. This resonates with the present study, wherein women showed high satisfaction with newborn counselling and postnatal educational support (4.4 ± 0.3). The consistent high scores in counselling-related parameters across multiple studies reinforce the idea that informational support during ANC and PNC is a core expectation of women across different states.

The findings of **Vyas et al.** at a primary health centre indicated that respectful behaviour, clear communication, and prompt care were major contributors to satisfaction among postnatal mothers [26]. Our study’s similar conclusions suggest that these determinants remain robust across varying facility levels. The evidence by **Unadkat et al.** on RCH service perception in Gujarat also underscores the significance of staff courtesy and meaningful communication in shaping client satisfaction [27], patterns that were strongly mirrored in our data with 93% of women expressing satisfaction with provider politeness.

At the PHC level, **Mishra and Macwana** reported that although women appreciated the availability of

services at 24×7 facilities, gaps remained in privacy, cleanliness, and explanation of procedures [28]. While our tertiary-centre based study demonstrated higher satisfaction in these areas, some concerns about toilet cleanliness and waiting area crowding persisted among a minority of participants. This suggests that even tertiary facilities face infrastructural strains that may affect maternal perceptions.

Finally, the recent study from Bengaluru by **Sathiabalan et al.** demonstrated that postnatal satisfaction was strongly associated with provider behaviour, perceived competence, and timely care [29]. These determinants were also observed in our study, as women who experienced timely ANC consultations and prompt postnatal assessments were more likely to rate their care highly. Overall, the alignment of our findings with these established determinants suggests that interpersonal communication, dignity, efficiency of service delivery, and continuity of care remain the strongest predictors of maternal satisfaction across various levels of India's health-care system.

Collectively, when the findings from the present study are examined against the broader Indian literature, several themes emerge. First, respectful maternity care and interpersonal communication consistently appear as the strongest determinants of maternal satisfaction across ANC and PNC care. Second, socio-demographic variables such as education and residence repeatedly influence satisfaction patterns, suggesting the need for context-responsive approaches. Third, infrastructure continues to represent a variable predictor, with some studies reporting lower satisfaction and others, including ours, showing relatively favourable perceptions. Fourth, counselling and informational support are consistently highlighted as major strengths where high satisfaction is noted. These findings confirm that while structural improvements are necessary, the interpersonal dimensions of care exert the most substantial influence on maternal perceptions.

Overall, the results of the present study, when contextualized within existing evidence, highlight a consistent pattern of determinants shaping maternal satisfaction in India. They also underscore the need for continuous monitoring and quality improvement efforts that prioritise respectful care, effective communication, timely service delivery, and supportive relations between providers and patients. Sustaining high satisfaction levels requires reinforcing these strengths while addressing persistent infrastructural and system-level gaps. In summary, the convergence of our findings with multiple Indian

studies demonstrates that the tertiary-care setting is largely aligned with national standards for patient-centred maternity care, while also offering clear directions for targeted improvement.

LIMITATIONS

Although this study provides valuable insights into patient satisfaction with antenatal and postnatal services in a tertiary care setting, certain limitations must be acknowledged. First, the study employed a cross-sectional design, which captures perceptions at a single point in time and does not allow assessment of changes in satisfaction across different stages of pregnancy or postpartum recovery. Women's satisfaction may evolve with time, and longitudinal follow-up could yield more nuanced understanding. Second, the study population was limited to women who accessed services within a single tertiary centre, which may restrict the generalisability of the findings to primary or secondary facilities where resource availability, staff patterns and patient load differ substantially. Third, satisfaction was measured through a structured questionnaire and self-reported responses are inherently subject to recall bias, social desirability bias and courtesy bias, particularly in a hospital environment where women may hesitate to express dissatisfaction. Fourth, although consecutive sampling was used to minimise selection bias, the sample size of 100, while adequate for preliminary assessment, may not fully capture the diversity of experiences across varied demographic subgroups. Fifth, the study did not explore provider perspectives, systemic constraints or institutional workflow challenges, which may influence patient satisfaction and would have strengthened the interpretation of findings. Finally, the study did not include qualitative interviews, which could have provided deeper insights into women's expectations, emotional experiences and specific areas needing improvement. Addressing these limitations in future research would support more comprehensive assessments and guide targeted interventions to enhance maternal satisfaction and service quality.

CONCLUSION

The present study demonstrates that women receiving antenatal and postnatal services in a tertiary care centre report high levels of satisfaction across key domains including communication, respect, privacy, clinical care, and overall organisation of services. The findings highlight that interpersonal interactions—particularly the clarity of explanations, respectful treatment and supportive behaviour of providers—are central to shaping positive maternal experiences. High

satisfaction with counselling, newborn care guidance and respectful maternity practices indicates that the facility has effectively prioritised patient-centred care. At the same time, differences observed across socio-demographic groups, such as lower satisfaction among rural residents, older mothers and women with limited education, underscore the importance of tailoring communication strategies and support mechanisms to meet the needs of diverse populations. Areas such as infrastructure, cleanliness and waiting times, though performing adequately, require ongoing improvement to further elevate the standard of care. When compared with national evidence, the study's findings are broadly consistent with published research from multiple states, reaffirming that respectful maternity care, effective communication and timely service delivery remain the strongest determinants of satisfaction in India's maternal health system. Overall, the study highlights both the strengths and opportunities within the existing service framework and underscores the need for sustained monitoring, feedback-driven improvement and continuous provider training. Strengthening person-centred care across the antenatal-postnatal continuum can contribute to improved maternal well-being, enhanced trust in the health system and better utilisation of maternity services.

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