



# The Interrelationship Between Women's Expectations, Experiences of Decision-Making Choices and Control of Labour Care Among Women Attending Infant Welfare Clinics in Public Health Facilities in Umuahia

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## ABSTRACT

## Original Research Article

**Introduction:** The availability of decision-making choices and the exercise of control are crucial aspects of care during labour. Healthcare regulations for maternity services demand that decision-making choices be made available to women, and women should be given adequate support to actively participate in decision-making. The study aims to determine the relationship between women's expectations and experiences of decision-making choices as well as the experience of decision making choices and control of the labour care.

**Method:** The study design is the cross-sectional design. Convenience sampling was employed to enroll 471 women who were eligible for the study. Data was collected with a questionnaire and analysed with SPSS version 30 and Excel.

**Result:** The findings shows that there is a relationship between women's expectation and experience of decision-making choices. Further findings also shows that there is a relationship between the experience of decision-making choices and the experience of control in labour.

**Keywords:** Decision-making in labour, Maternal autonomy, Labour care experience, Women's expectations, Control during labour, Shared decision-making, Maternity care quality, Informed consent in childbirth, Maternal healthcare services.

## Introduction

The availability of decision-making choices and the exercise of control are crucial aspects of care during labour (Mazuchova et al., 2020). Healthcare regulations for maternity services demand that decision-making choices be made available to women, and women should be given adequate support to actively participate in decision-making

(International Confederation of Midwives, 2014). Choice is an integral component of quality childbirth care, and women desire to have choices when receiving maternity care (Phipps, 2020). The key elements of care in labour are adequate communication, support, respect for choices, and autonomy in decision-making (World Health Organisation, 2020). Birth choices are women's preferences, which are important to

women during childbirth. There are a variety of choices to be made with respect to labour; women need to make choices about type of birth, place of birth, birth companion, model of care to adopt, care provider, pain management approach, use of interventions and birthing positions. Bergendahl and Wendel (2024) noted that pregnant women are sometimes regarded as part of the vulnerable population and healthcare providers tend to feel the need to protect women from the stress and risk during pregnancy and labour with the aim of shielding the women and their unborn babies. The presumed vulnerability of pregnant women provides the rationale for pregnant women and women in labour to be treated as if they need to be protected from the difficulties associated with making choices or providing consent for certain interventions. In other healthcare circumstances, the idea of protecting patients from making choices could be viewed as a threat to women's autonomy (Bergendahl & Wendel, 2024). In the same light, protecting women from making choices during labour should be viewed as a threat to women's autonomy. There is a need to offer adequate information to women in labour, and women should have the opportunity to make informed decisions.

A previous study on factors that influence women's choices revealed that about 45% of women were aware of the type of birth they desired before the onset of the pregnancy. However, the women continued to modify their choices as they gained additional information. Their choices showed that some women want to avoid more invasive interventions, such as episiotomy and epidural analgesia (Regan et al., 2023).

Yuill et al. (2020) noted that it is generally believed that choice is obtainable when relevant and balanced information is available. Choice demands careful weighing of benefits and risks; therefore, women make choices when information has been gathered and weighed against other options, and they tend to opt for decisions that align with their values (Yuill et al., 2020).

Kloester (2022) reviewed midwives' facilitation of decision-making in developed countries; it was revealed that during childbirth, women may not always be presented with choices, women sometimes receive insufficient information, or information may be presented in a manner that presumed consent and undermined a woman's liberty to make a choice.

Meyer (2013) identified four aspects of control, which include access to information, decision-making, personal safety, and physical functioning. Although the identified four aspects of control Meyer is an older work, it also identified four key areas of care that could be adequately addressed for women to experience control of their labour care. During labour, the nature of the interaction between the woman and her maternity care provider may determine whether the woman will experience the feeling of being in control. Women desire to retain a feeling of personal accomplishment and control by being part of decision-making during birth (Downe et al., 2018). Moreover, having a sense

of control during labour is a major contributor to a woman's childbirth experience (Chabbert et al., 2021). Women who planned to have a natural birth may have experienced a loss of control when they had medical interventions such as induction of labour and the use of epidural analgesia for pain management in previous birth.

Evidence suggests that the concept of decision-making choices and control during childbirth are closely related. A previous study analysed choice and control using the qualitative approach but the relationship between choice and control was not assessed (Snowden et al., 2011). In addition, Rauch et al. (2022) studied the different birth preferences but did not evaluate its association with the experience of control of the labour care. Thus, what remains unclear is the nature of the inter-relationship between women's expectations, experiences of decision-making choices, and control in labour. The aim of the study is to determine the relationship between women's expectations and experiences of decision-making choices as well as the relationship between the experience of decision-making choices and control of the labour care.

## Method

The cross-sectional research design was employed to undertake this study. This study is a multicenter study, the study was undertaken at the infant welfare clinics of three facilities. The first, second and third health facilities for the study were the Federal Medical Center, Ojike health center and Adelabu health office respectively. The three selected facilities are located in Umuahia, which is the capital city of Abia state, Nigeria. The study population comprised of mothers who attend the three selected infant welfare clinics in public healthcare facilities in Umuahia. Women who were eighteen years old and above whose infants were not more than one year old were included in the study.

Women with severe illness at the time of data collection and women whose infants were critically ill at the time of the study were excluded as they may not be psychologically stable to complete the questionnaire appropriately. The Cochran (1977) formula for sample size calculation for mean was utilized to derive the sample size.

$$n^0 = \frac{z^2 pq}{e^2}$$

Where:

$n^0$  = initial sample size for an unknown population

$Z$  = standard normal value at 95% confidence level = 1.96

$p$  = estimated proportion of the population with the attribute (0.5 used because it maximizes sample size)

$q$  = 1 -  $p$  = 0.5

$e$  = margin of error = 0.05

$Z$  = ( $Z_{2\alpha/2}$ ) the standard normal deviate at the desired level of confidence (e.g., 1.96 for 95% confidence level). A previous study on factors affecting women's perception of control in pregnancy and childbirth revealed that 29.6% of

women reported that they had a feeling of control in labour (Leahy-warren, 2021).

Therefore,

The standard deviation of 29.6% is 0.82

E is the desired margin of error = 0.05

$N = 1.962 \times 0.822 / 0.052$

$N = 1.96 \times 1.96 \times 0.82 \times 0.82 / 0.05 \times 0.05$

$N = 2.427 / 0.0025 = 970$

Owing to the large sample size, the finite population correction factor (FPC) was utilized to adjust the sample size.

Finite population correction factor FPC =

$$\sqrt{\frac{N-n}{N-1}} = \sqrt{\frac{1300-970}{1300-1}} = \sqrt{\frac{330}{1299}} = \sqrt{0.254} = 0.5$$

FPC = 0.5

Adjusted sample size =  $970 \times 0.5 = 485$ .

A total of 485 questionnaires were given out to 485 women who were enrolled for the study. However, on retrieving the questionnaires for analysis 14 questionnaires were not properly completed therefore, questionnaires from 471 respondents that were properly completed were analysed. Thus, the sample size for this study became 471.

The convenience sampling method was adopted for this research. Data was collected with the aid of a questionnaire. A pilot study was conducted with 20 women at the infant welfare clinic at a General Hospital in a semi-urban area of Umuahia. The questionnaire was administered twice to the same respondents at four-week intervals, and the results were measured using Cronbach's Alpha in SPSS. The initial test shows Cronbach's alpha of .0726, and subsequent administration gave a Cronbach's alpha of 0.832, which is an indication of internal consistency. Data collection began in June 2024 and ended in December 2024. The collected data was entered in an Excel sheet and saved in a folder on a computer with a password. The data was statistically analysed using correlation and regression analysis. SPSS version 30 was employed for the analysis.

Ethical approval was received from the research ethics committee of the University of Port Harcourt.

## Result

The study on the Interrelationship between women's expectations, experience of decision-making choices, and control of labour care among women attending public infant welfare clinics in Umuahia was designed to elicit women's expectations and experiences of decision-making choices, women's experiences of control in labour.

Additionally, the study was undertaken to ascertain the relationship between women's expectation and experience of decision-making choices in labour as well as to identify the relationship between the experience of decision-making choices and control in labour. Questionnaires from 471 respondents that was properly completed were analysed. Thus, the sample size for this study is 471. The quantitative data was analysed with SPSS version 30 and Excel. Statistical methods that were employed for data analysis include percentages, pearson correlation, regression analysis and hypothesis testing.

The report showed that majority of the women 90.5% were between the age of 18-39 years, 8.7% were between 39-49 years while 0.8% were 50 years and above. Greater part of the participants (91.5%) belong to the Igbo tribe, 3.8% were Yorubas, 1.9% were Hausas while 2.8% were from other tribes in Nigeria. Interestingly, most of the respondents were tertiary education graduates (72.6%), 24.2% were secondary school leavers, 1.9% had primary education, and 1.3 % had no formal education, as noted in Table 4.0.

Most of the participants (93.8%) are married, 3.8% are single mothers, 1.3% are divorced while 1.1% are widows. 50.1 % of the respondents were self-employed, 21% are civil servants, 11.7% are unemployed, while 17.2 % are employed in the private sector. 85.1% of the respondents had 1-3 children, while 14.9% had four children and above. 71.5% had 1-3 birth experiences, 18.3% had four birth experiences, while 0.2% had five birth experiences. The majority of the respondents delivered in the government hospital (67 %), 22.7% in private hospitals, 7% in primary health care centers, and 1.5% delivered at home, as indicated in Table 4.0.

**Table 4.0** Demographic data and some obstetrics characteristics.

Age	Frequency	Percentage %
18 – 29	200	42.5
30 – 39	226	48
39 – 49	41	8.7
50 and above	4	0.8
Ethnicity		
Igbo	431	91.5
Hausa	9	1.9
Yoruba	18	3.8
Others	13	2.8
Educational level attained		
Primary	9	1.9
Secondary	114	24.2
Tertiary	342	72.6
No formal education	6	1.3
Marital status		
Single	18	3.8
Married	442	93.8
Seperated/divorced	6	1.3
Widow	5	1.1
Employment status		
Private sector	81	17.2
Self employed	236	50.1
Civil Servants	99	21
Unemployed	55	11.7
Number of living Children		
1	149	31.6
2	142	30.1
3	110	23.4
4 and above	70	14.9
How many child births have been experienced		
1	140	29.7
2	136	28.9
3	108	22.9
4	86	18.3
5	1	0.2
Which of the following was the place of your childbirth		
Home	7	1.5
Government hospital	318	67.5
Private hospital	107	22.7
Primary health centre	33	7
Others	6	1.3

Table 4.1 represents the birth experiences of women during labour and interventions they received. During the women's last childbirth, the greater part of the women (61.6%) received care from a team of doctors and midwives, 6.4% received care from doctors, 3.0% of women received childbirth care from Nurse/Midwives, and 6.4% 0.8 received care from other healthcare workers. Also, majority of the respondents (74.5%) had spontaneous vaginal birth, 21.0% had Caesarean section. 2.5% had vaginal breech birth while a

minority of 1.9% had vacuum/forceps delivery. Women essentially prefer spontaneous vaginal birth because there is a conceptual belief that it is natural with minimal intervention. More so the result revealed the percentage of women who experienced complications. The majority of the women (85.6%) had no complications during labour, while 14.2% experienced complications.

Furthermore, the result indicated various complications and problems experienced by women during childbirth. The

highest complication was bleeding (3.7%), followed by waist pain (2.2%), prolonged labour (1.9%), and pre-eclampsia (1.1%). 1.1% of the respondents had hypertension, 1.1% obstructed labour, placenta praevia 0.6% and 0.4% poor descent. Likewise, 0.4% had cord prolapse, 0.6% breech presentation, while the least complication was big baby, which had 0.2% and is indicated in Table 4.1

Additionally the result showed the type of birth intervention experienced by women. Greater part of the women did not experience any intervention. 36.1% of the women received birth intervention, 11.9% received an oxytocic agent for induction of labour, 9.3% received oxytocic agent for augmentation of labour, 10% had episiotomy, 1.9% had vacuum/forceps delivery while 1.9% had vaginal breech delivery.

**Table 4.1** Experiences of women during labour and birth intervention received.

Who was the birth attendant at your last childbirth		
	Frequency	Percentages%
Nurse/Midwives	146	31.10
Physician	30	6.40
A team of nurse/midwives and physicians	290	61.70
Other Health care workers	5	0.90
Indicate mode of birth		
	Frequency	Percentages%
Spontaneous vaginal delivery	351	74.50
Caesarean section	99	21
Vacuum/Forceps assisted delivery	9	1.90
Vaginal breech birth	12	2.50
Experience of any complication.		
	Frequency	Percentages%
Yes	67	14.20
No	404	85.80
If yes specify		
	Frequency	Percentages%
Bleeding	17	3.70
Pre-eclampsia	6	1.30
Prolonged labour	9	1.90
Hypertension	5	1.10
CPD	1	0.20
Placenta praevia	3	0.60
Waist pain	10	2.20
Poor descent	2	0.40
Obstructed labour	5	1.10
Headache	3	0.60
Cord prolapse	2	0.40
Breech presentation	3	0.60
Big baby	1	0.20
Type of birth intervention received, if yes indicate birth intervention		
	Frequency	Percentages%
Use of oxytocic agent for induction	56	11.90
Use of oxytocic agent for augmentation of labour	44	9.30
Episiotomy	47	10
Vacuum/Forceps delivery	9	1.90
Vaginal breech delivery	9	1.90
No intervention	306	65

Table 4.2. revealed that the majority of the respondents expected 28.20% expected only good quality care, 11.7% expected only adequate attention, 4.7% anticipated respect for preferences while 2.3% expected to be part of the decision making. Also the expectations of women before going into labour were varied. 45.5% of the women had

mixed expectations of making decisions about their care, support from the care provider, receipt of adequate attention from the caregiver, good quality care, respect for preferences, and receiving adequate information as noted in Table 4.2. However, among the 45.5% of the women with mixed expectations, some were limited to two or three expectations.

**Table 4.2** Expectations about labour care.

Before going into labour what were your expectations about the labour care	Frequency	Percentages %
Receive support from the care provider	23	4.9
Receive adequate attention from the care giver	55	11.7
Respect for your preferences	22	4.7
Good quality care	133	28.2
To make decisions about my care	11	2.3
To receive adequate information	10	2.1
Others	217	45.5
Total	471	100

Table 4.3 showcases women with written birth plans, adherence to birth plan, and care options offered. The majority of the respondents (74.5%) had no written or discussed birth plan, while 25.5% had a written or discussed birth plan. Also, with respect to adherence to birth plan, 25.5% had a written plan or discussed their birth plan with

healthcare providers. Additionally, the birth plan of 23.4% of the women was closely followed, while the birth plan of 3.6% were not adhered to. Reflecting on the offer of choices or care options to women during labour, the result revealed that the majority of the respondents (60.9%) were not presented with choices or care options for managing the birth process. However, 39.1% were presented with birth choice

**Table 4.3** Women with written birth plans, adherence to birth plan and care options offered.

Women with written birth plan.		
	Frequency	Percentage %
Yes	120	25.5
No	351	74.5
If yes was it closely followed		
	Frequency	Percentage %
Yes	110	23.4
No	17	3.6
No answer	344	73
Women presented with various choices or care options during labour.		
	Frequency	Percentage %
Yes	184	39.1
No	287	60.9

Table 4.4 reflects the choices and options given to the women before and during labour; The results showed that the majority of the clients, 59.1 %, did not respond to any of the options, which implies that they were not given any option. 10.6 % were given a pain management option, 4% were given the choice of birth companion and birthplace, while the least given option was cord clamping time. Additionally, the

options and choices given to women during labour were wide-ranging. 8.6% of the women presented with mixed options, such as pain management options, use of birth position, use of intervention, choice of birth companion, choice of birthplace, and Cord clamping time. However, some were limited to two or three options among the 8.6% that were given varied decisions or options as noted in table 4.4

**Table 4.4** Choices/options offered to women.

Choices/options you were given	Frequency	Percentages%
Type of birth	50	10.6
Pain management options	32	6.8
Use of birth position of your choice	21	4.5
Use of intervention	19	4
Choice of birth companion	10	2.1
Choice of birthplace	12	2.6
Cord clamping time	6	1.3
No answer	278	59.1
Others	42	8.9
Total	471	100

Table 4.5 showed the share of information to women about available care options during labour. Respondents who often received information about the available care options during labour were 55.4%, 27.4% never received information about available care options during labour, 8.9% rarely received information about available care options during labour, while 8.3% of the respondents received information about available care options sometimes. The result also showcased whether the received information was helpful in decision making. The information received from the healthcare provider about care options was considered by 68.2% of the respondents as sufficient to enable them to make a decision. 20.6% of the respondents considered the information received from healthcare providers as insufficient for decision making. However, 7.0% of the respondents considered the information received from a healthcare professional as partially helpful in enabling them to make a decision. In comparison, a minority of 4.2% were not sure that the information received from a healthcare professional was sufficient to enable them to decide. Furthermore the result on whether women discussed with the healthcare provider on available care options

indicated from table 4.5 that a proportion of women who often had a discussion with their care provider on available care options before taking decisions 39.1%, 30.4% never had a discussion with their care provider on available care options before taking decisions, 10.4% rarely had a discussion with their healthcare provider on available care options before taking decisions, while 20.2% sometimes had a discussion with their care provider on available care options taking decisions.

Additionally, 55.6% were often given sufficient time to make a decision, 16.1% were never given sufficient time to make a decision, 7.4% were rarely given sufficient time to make a decision, while 20.8% were sometimes given sufficient time to make a decision. Table 4.5 also showcased whether women's preferences were respected by the providers. Only 47.3% often had their preferences respected by their care provider, 12.3% never had their preferences respected by their care provider, 12.7% rarely had their preferences respected by their care provider, while 27.4% sometimes had their preferences respected by their care provider.

**Table 4.5** Information sharing.

Information received from the healthcare personnel about the available care options during labour.		
	Frequency	Percentage%
Often	261	55.40
Never	129	27.40
Rarely	42	8.90
Sometimes	39	8.30
Did you consider the information you received as sufficient to enable you make a decision		
	Frequency	Percentage%
Yes	321	68.20
No	97	20.60
Partially	33	7
Not sure	20	4.20
Did you have a discussion with your health care provider on available care options before taking decisions		
	Frequency	Percentage%
Often	184	39.1
Never	143	30.4
Rarely	49	10.4
Sometimes	95	20.2
Were you given sufficient time to make decision		
	Frequency	Percentage%
Often	262	55.60
Never	76	16.10
Rarely	35	7.40
Sometimes	98	20.80
Were your preferences respected by your care provider		
	Frequency	Percentage%
Often	223	47.30
Never	58	12.30
Rarely	60	12.70
Sometimes	130	27.40

Table 4.6 represents the decision-making choices in women in labour. Minority of the women 13.2% made all the decisions about their care by themselves, 43.7% made most of the decisions with the healthcare provider, 22% made most of the decision with their partner or family member while 21.1% had decisions about their care made by healthcare provider.

Also, the report disclosed women's active involvement in decision making. A greater proportion of the women, 43.5%, were often involved in decision making in labour, 17.8% of women were never involved in decision making, 10.2% of women were rarely involved in decision making, while

28.5% were sometimes engaged in decision making. More so, the percentage of women who felt that they were often supported in advocating for their choices and needs during labour was 53.7%, 22.5% never felt they were adequately supported in labour, 4.9% were rarely supported in labour, while 18.9% were sometimes supported in labour.

The report of been pressured to make decision revealed that 8.7% of the women felt they were often pressured to make decision, 71.5% felt they were never pressured to make a decision, 7.9% felt they were rarely pressured to take a decision while a minority of 11.9% felt they were sometimes pressured to make a decision.

**Table 4.6** Decision making during labour.

Who made the decisions about the care you received		
	Frequency	Percentage
All the decisions were made by me	62	13.20%
I made most of the decisions with my healthcare provider	205	43.50%
I made most of the decision with my partner of family member	103	21.90%
Health care professionals made the decisions for me	101	21.40%
Did you feel you were actively involved in decision making during labour		
	Frequency	Percentage
Often	205	43.50%
Never	84	17.80%
Rarely	48	10.20%
Sometimes	134	28.50%
Did you feel you were adequately supported in advocating for your choices and needs during labour		
	Frequency	Percentage
Often	253	53.70%
Never	106	22.50%
Rarely	23	4.90%
Sometimes	89	18.90%
Did you feel you were pressurised to make decision		
	Frequency	Percentage
Often	41	8.70%
Never	337	71.50%
Rarely	37	7.90%
Sometimes	56	11.90%

Table 4.7 showed factors that influenced decision-making choices during labour, 22.3% were influenced by the level of pain, recommendations by health care professionals influenced 13.8%, 10.4% were influenced by Information obtained from health talks during antenatal visits, 7.2% by Personal preferences, while 5.5% were influenced by support from partners. Moreover, factors that influenced decision-making choices during labour were mixed for most of the

participants. Majority of the respondents (40.8%) were influenced by recommendations made by healthcare professionals, personal preferences, level of pain, Information obtained from health talk during antenatal visits, Support from partner, family and friends. However, some of the respondents among the 40.8% had limited factors of two or three that influenced their decisions-making choices during labour.

**Table 4.7** Factors that influenced your decisions-making choices.

What are the factors that influenced your decisions-making choices during labour select all that apply	Frequency	Percentages
Recommendations made by healthcare professionals	65	13.8
Personal preferences	34	7.2
Level of pain	105	22.3
Information obtained from health talk during antenatal visits	49	10.4
Support from partner, family and friends	26	5.5
Others	192	40.8
Total	471	100

Table 4.8 shows whether consent was sought from women before the commencement of procedures and the ceding of rights for decision making. The greater percentage of women whose consent was sought before the commencement of procedures and interventions were 66.5%, consent was never sought from 9.6% before the commencement of procedures, consent was rarely sought from 6.2% of women before the commencement of procedures. In comparison, consent was sometimes sought from 17.7% of women before the commencement of any intervention.

Also, only 29.5% of women often ceded their right to make decisions to women, 25.9% never ceded their right to make

decisions to their healthcare provider, 11.9% rarely ceded their right to make decisions to their healthcare provider. In comparison, 32.7% sometimes ceded their right to make decisions to their healthcare provider. Furthermore, Table 4.8 showed women's decision to cede their right to make decisions to a relative, husband, partner, friends, or support person. The percentage of women who often ceded their right to make decisions to a relative or support person was 29.3%, and 27.2% never ceded their right to make decisions to a relative or support person. A minority of 10.8% rarely ceded their right to make decisions to a relative or support person, while 32.7% sometimes ceded their right to make decisions to a relative or support person.

**Table 4.8** Consent before commencement of procedures and ceding of right for decision making.

Was consent always sought from you before the commencement of procedures and interventions		
	Frequency	Percentage
Often	313	66.50%
Never	45	9.60%
Rarely	29	6.20%
Sometimes	84	17.80%
Did you ever cede your right to take decisions to your health care provider		
	Frequency	Percentage
Often	139	29.50%
Never	122	25.90%
Rarely	56	11.90%
Sometimes	154	32.70%
Did you ever cede your right to take decisions to a relative, husband, partner, friends or support person		
	Frequency	Percentage
Often	138	29.30%
Never	128	27.20%
Rarely	51	10.80%
sometimes	154	32.70%

Table 4.9 represents women's feeling of being in control in labour and overall satisfaction with the level of control. The percentage of women who often had the feeling of being in control of labour care was 26.5%, another 26.5% never had the feeling of being in control, 14.9% rarely had the feeling of being in control, while 32.1% sometimes had the feeling of being in control. The result also revealed the overall

satisfaction with the level of control they experienced during labour. Only 22.6% of women were delighted with the level of control they experienced during labour, another 64.5% of women were satisfied with the level of control they experienced in labour, 8.7% were dissatisfied with the level of control they experience in labour while 4.3% were very dissatisfied with the level of control they experienced in labour.

**Table 4.9** Feeling of being in control in labour and overall satisfaction with the level of control.

During labour I had the feeling of being in control of the labour care		
	Frequency	Percent
Often	125	26.50%
Never	125	26.50%
Rarely	70	14.90%
sometimes	151	32.10%
What rating will you ascribe to your overall satisfaction with the level of control you had during labour		
	Frequency	Percentage
Very satisfied	106	22.50%
Satisfied	303	64.30%
Dissatisfied	41	8.70%
Very dissatisfied	21	4.40%

Table 4.10 showed that 28.20% were affected by timely response to their needs, 13.2% were affected by participating in decision making while 10.20% were affected by request for consent before the commencement of procedures. However, factors that affected the feelings of respondents as being in control were wide-ranging and mixed. A total of

30.6% of the participants felt in control of the labour by participating in decision making, respect of care providers for personal preferences, timely response to patients' needs, and request for consent before the commencement of procedures. However, a few women among the 30.6% of women were limited to two or three of the factors that influenced the feeling of being in control.

**Table 4.10** Factors affecting the feeling of being in control.

What factors affected your feeling of being in control	Frequency	Percentages
Participating in decision making	62	13.2
Respect of care providers for personal preferences	84	17.8
Timely response to your needs	133	28.2
Request for consent before the commencement of procedures	48	10.2
Others	144	30.6
Total	471	100

Table 4.11 shows women's expectation about participating in decision making and how it matches the actual experience of decision making. Majority (68.2%) of the women's expectation about decision making matched with the

experience of decision making, 13.6% of the women's expectation was not met, 7.6% had experience that was worse than expectation, while 10.6% had experience that was better than expectation.

**Table 4.11** Match of expectation and experience of decision making.

Reflecting on your birth experience, did your expectations about participating in decision making match your actual experiences of decision making		
	Frequency	Percentage
Expectation matched with the experience	321	68.2%
Expectation was not met	64	13.6%
Experience was worse than expectation	36	7.6
Experience was better than expectation	50	10.6
Total	471	100

Table 4.12 shows women's expectations about being in control of their labour care and how it matches the actual experience of control over their labour care. The majority (65.4%) of the women's expectations about being in control of the labour care matched with their actual experience of

being in control of the labour care. Only 18.5% of women's expectations of being in control of their labour care were unmet. A minority of 5.7% had experience of being in control of the labour that was worse than their expectation. In comparison, 10.4% had an experience of being in control that was better than their expectation.

**Table 4.12** Match of expectations and experience of being in control of your labour.

Reflecting on your birth experience, did your expectations about being in control of your labour care match your actual experience of control over your labour care		
	Frequency	Percent
Expectation matched with the experience	308	65.4
Expectation was not met	87	18.5
Experience was worse than expectation	27	5.7
Experience was better than expectation	49	10.4
Total	471	100

## Correlation Analysis

Considering the correlation between feeling of being in control of the labour care and expectations about the labour care, table 4.13 shows a Pearson correlation of -0.28 which depicts a strong negative relationship between the feeling of being in control of the labour care and expectations about the

labour care, which implies that the higher the women's expectation the lower the feeling of being in control over the labour care. Also, the p-value depicts the statistical validity, which suggests if the correlation is real and trustworthy. The p-value is 0.543, greater than 0.005; hence, it is not statistically significant and indicates a strong negative correlation.

**Table 4.13** Correlation analysis of expectations and feeling of being in control of labour.

Correlations			
		Feeling of being in control of the labour care	Expectations about labour care
Expectations about labour care	Pearson Correlation	1	-.028
	Sig. (2-tailed)		.543
	N	471	471
Feeling of being in control of the labour care	Pearson Correlation	-.028	1
	Sig. (2-tailed)	.543	
	N	471	471

\*\* . Correlation is significant at the 0.01 level (2-tailed).

Table 4.14 shows the correlation between being actively involved in decision making and control of the labour care. The Pearson correlation coefficient  $r$  is .331 and  $p$  value is <.001 which indicates a positive relationship between being actively involved in decision making and control in labour

care. The  $p$  value of <0.001 which is statistically significant implies that the correlation is valid and trustworthy. Hence there is a strong and significant relationship between being actively involved in decision making and control of labour care.

**Table 4.14** Correlation analysis of being actively involved in decision making and feeling of being in control of labour.

Correlations			
		Actively involved in decision making during labour	Feeling of being in control of the labour care
Actively involved in decision making during labour	Pearson Correlation	1	.331**
	Sig. (2-tailed)		<.001
	N	471	471
Feeling of being in control of the labour care	Pearson Correlation	.331**	1
	Sig. (2-tailed)	<.001	
	N	471	471

\*\* . Correlation is significant at the 0.01 level (2-tailed).

## Regression Analysis

The relationship between the independent variable and multiple independent variables can be measured using

regression analysis. The regression analysis depicts how changes in the independent variable affect the dependent variable. The model for simple linear regression is  $Y = a +$

$bX + e$ . The regression analysis was used to ascertain the association between being in control of labour care (dependent variable) and other independent variables such as discussion with your health care provider on available care options before taking decisions, preferences respected by your care provider, pressurised to make decision, cede your right to take decisions to a relative, husband, partner, friends or support person and expectations about participating in

decision making match your actual experiences of decision making. The result in Table 4.15 shows standard coefficients of the variables as indicated. The four independent variables had p values of <0.001, <0.001, <0.003, <0.001, <0.001, while one of the variables had a p value of -8.85. The four variables with a p-value less than 0.005 are statistically significant and they are good predictors of being controlled in labour.

#### 4.15 The predictors of control in labour.

Coefficients						
Model		Unstandardized Coefficients		Standardized Coefficients	T	Sig.
		B	Std. Error	Beta		
1	(Constant)	.760	.191		3.985	<.001
	Did you have a discussion with your health care provider on available care options before taking decisions	.158	.047	.151	3.343	<.001
	Were your preferences respected by your care provider	.132	.044	.143	3.034	.003
	Did you feel you were pressurised to make decision	.239	.067	.154	3.574	<.001
	Did you ever cede your right to take decisions to a relative, husband, partner, friends or support person	.251	.043	.257	5.898	<.001
	Reflecting on your birth experience, did your expectations about participating in decision making match your actual experiences of decision making	-.009	.049	-.008	-.188	.851

a. Dependent Variable: During labour I had the feeling of being in control of the labour care

In determining the relationship between women's expectations of decision-making and experience of decision-making choices, as well as the relationship to control in labour, the collected data were used to test the hypothesis between the two variables. The z-test was used for testing the hypothesis in Excel. The z-test is preferred over the t-test because the sample size is greater than 30, though the hypothesis testing can also be done with SPSS. The process involved activating the analysis function in Excel, entering the variables, and determining and entering the variances of the two variables. The dialogue box label is ticked to reflect the headings of the two variables.

The null hypothesis states that there is no relationship between women's expectation of decision-making choices

and experience of decision-making choices. The result in Table 4.16 is the z-test for two samples for means. It shows the average mean for the two variables as 1.023 and 2.235, while the known variances calculated from the Excel table using the variance sum formula are 0.02 and 1.62. The z calculated is 20.5 while the z tabulated is 1.95. Since the z calculated is greater than the z tabulated, the null hypothesis is rejected, which implies that there is a relationship between women's expectation of decision-making choices and experience of decision-making choices. More so, the p-value  $P = 0$ , which is below the 0.05 threshold and signifies a significant relationship between women's expectation of decision-making choices and experience of decision-making choice

**Table 4.16** Hypothesis testing.

z-Test: Two Sample for Means	Expectation of decision making choices during labour	Active involvement in decision making during labour
Mean	1.023354565	2.23566879
Known Variance	0.02	1.62
Observations	471	471
Hypothesized Mean Difference	0	
z	-20.54488576	
P(Z<=z) two-tail	0	
z Critical two-tail	1.959963985	

For the second null hypothesis which state that there is no relationship between the experience of decision-making choices and feeling of being in control of the labour. Table 4.17 shows the mean of the two variables as 2.52 and 2.24, respectively, while the known variances are 1.42 and 1.62. The z calculated is 3.5 while the z tabulated is 1.95. Since the z calculated is greater than the z tabulated, the null hypothesis

will be rejected, which implies that there is a relationship between the decision-making choices and the feeling of being in control of the labour. Furthermore, the p value,  $p = 0$ , which is below the 0.05 threshold and signifies a significant relationship between women being actively involved in decision making during labour and feeling of being in control of the labour care.

**Table 4.17** Hypothesis testing.

z-Test: Two Sample for Means		
	During labour I had the feeling of being in control of the labour care	Did you feel you were actively involved in decision making during labour
Mean	2.524416	2.23566879
Known Variance	1.42	1.62
Observations	471	471
Hypothesized Mean Difference	0	
z	3.594112	
P(Z<=z) two-tail	0.000325	
z Critical two-tail	1.959964	

## Discussion

The findings from the study revealed that women's expectations varied from receiving support from the care provider to adequate attention from the caregiver, respect for preferences, good quality care, and sufficient information. However, others had a combination of diverse expectations. Excerpts from the study revealed that being actively involved in decision-making was part of women's expectations during labour. This is congruent with the findings of another study on shared decision making in the United Kingdom by Jackson et al. (2022) which reported that women expect to be involved in decision making and they hope that their expectations will be turned to reality.

Furthermore, the findings of this research reveal that greater percentage (60.9%) of women were not always presented with choices during labour. Offering choice to women in labour is a key component of good quality care. The WHO (2018) intrapartum care guideline support that choices should be offered to women in labour. With respect to the women who were offered care options to make choices, only a small minority of 8.9% were offered multiple care options from which they could make their choices. Offering women a wide variety of care options is ideal and this could be appreciated by women. Lopez- Toribio et al. (2021) noted that women were pleased to make choices for themselves. However, there is the need to ensure that all birthing women are offered care options to enable them make decisions, it should not be limited to a few women.

The study unearthed variation of respect for women's preferences. Findings from the study show that most of the women's preferences were respected. Although a few women reported that their preferences were not honoured and a few others indicated that their preferences were not sought. Vanden-Berg (2023) grouped women's preferences into need-

based and personal preferences and maintained that preferences are personal. This was supported by Nakphong, (2023) findings that efforts should be made to respect women's preferences for pain control, information sharing and support from relatives. The variation of respect for preferences unearthed by this study suggests the need for care providers to respect women's autonomy.

The result also show that greater proportion of the women made decisions about their care with their health care provider. The practice of making decision with care provider is laudable and is congruent with the model of shared decision making. On the other hand, Jackson (2022) studied decision making during birth and found that the contribution of some women in decision making was insignificant, the decision-making was staff-led, making women feel left out in contributing to their care and urging for more women's involvement in decision making. The shared decision making model should be adopted in maternity settings as it provides opportunity for women to discuss care options with their care provider and gain better understanding of care options before a decision is made.

With respect to the experience of control, the findings from the study revealed that 26.50% of the women felt in control of the labour care, while another 26.50% of the women never felt in control of the labour. The rest of the women sometimes or rarely had the experience of being in control of the labour care. Reflecting on the rating of the overall satisfaction level of control of women during labour shows that the majority of the women were very satisfied with the level of control they experienced. However, a smaller percentage of the women were dissatisfied and very dissatisfied with the level of control. This was noted by Konieczka (2025) that reported that women's highest level of satisfaction during labour was facilitated by women's interaction with the healthcare

providers, listening to music, and conversely, the introduction of pharmacological pain relief reduced their feeling of being in control and satisfaction.

Furthermore, the excerpts from the correlation analysis of the study on expectations about decision making and experience of decision-making choices revealed a negative correlation between women's expectation of decision making and the experience of decision making. This implies that most of the women's expectations with respect to decision making in labour were unmet and experience of decision making decreases with high expectations. This is supported by Preis (2019) findings which showed a negative association between women expectations of minimal interventions and medicalised birth experience as labour progresses. Also as noted by Grylka-Baesclin (2023) the experiences of women was far from their expectation as most women felt being ranked second in feeling of being in control during labour opting for individualised approach in labour care. Similarly, as noted by Combellic (2023) to reduce the disparity between expectations about labour care and feeling of being in control of the labour care patients satisfaction and respect should be prioritized

Findings from the study revealed that some of the women felt in control of labour, while the majority of the women never felt in control of the labour. However, a fraction of the women were uncertain if they were actually in control or not. Reflecting on the rating of the overall satisfaction level of control of women during labour shows that the majority of the women were very satisfied with the level of control they experienced. However, a smaller percentage of the women were dissatisfied and very dissatisfied with the level of control. This was noted by Konieczka (2025) in his finding that the highest level of satisfaction during labour was facilitated by the interaction with the healthcare providers, listening to music, and, conversely, the introduction of pharmacological pain relief reduced their feeling of being in control and satisfaction.

The testing of the first hypothesis noted a significant relationship between women's expectation of decision-making choices and experience of decision-making choices. This implies that women's expectation of being actively involved in the decision making was met. This is in line with Doherty (2023) findings that revealed women reported that they were actively involved in decision making during labour. According to the study the women were highly satisfied with their involvement in decision making and level of care as well as the cordial relationship offered by the caregivers and urged for the development of policy document that will guide the care of women during labour.

The testing of the second hypothesis showed and significant relationship between the experience of decision-making choices and the feeling of being in control of the labour care. This implies that when women are actively involved in decision-making women may experience the feeling of being

in control during labour. This is supported by a review by Egenberg (2025), who demonstrated a relationship between the experience of decision-making choices and feeling of being in control of the labour care, emphasizing that the feeling of being in control was predicated on quality care, desire for non pharmacological intervention, and consent before any intervention. This is in line with a related study by Mazuchova (2020) that noted that the feeling of being in control was mainly due to women's active involvement in decision making, respect of preference, and quality of care.

Furthermore, the finding of Pearson's correlation of being actively involved in decision-making during labour and having a feeling of being in control of the labour care shows a positive correlation between the two variables. Also, the p-value was significant, which indicate, a positive and significant relationship between being actively involved in decision making and a feeling of being in control in labour. This suggests that when women are given the opportunity to be actively involved in decision-making during labour, women may experience the feeling of being in control.

## Conclusion

This study examined the relationship between women's expectation, experiences of decision making choices and control of the labour care. The findings suggest that there is a relationship between expectations and experience of decision making choices. Further findings also reveal that there is a relationship between decision making choices and control of the labour care. Healthcare workers are encouraged to offer choices to women and support women to be actively involved in decision making during labour to provide opportunity for women to exercise control over their childbirth care as this may contribute to maternal wellbeing in the post partum period.

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