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Maternal Satisfaction with Midwifery-Led versus Physician-Led Care During Childbirth: Insights from a Mixed-Methods Study

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Background: Midwifery-led care has been associated with improved childbirth experiences in various settings; however, evidence from low-resource and culturally distinct contexts remains limited. Objective: To examine women's experiences and satisfaction with midwifery-led care during childbirth in Thi-Qar, Iraq, and to compare it with physician-led care. Methods: A convergent parallel mixed-methods study was conducted among 150 postpartum women (≤6 weeks). Quantitative data were collected using the Mackey Childbirth Satisfaction Rating Scale (MCSRS) and analyzed with descriptive statistics, independent-samples t-tests, and Pearson/Spearman correlations. Qualitative data were obtained from 15–20 semi-structured interviews and underwent thematic analysis. Results: Mean item scores for midwifery-led care ranged from 2.76 to 3.15 (1–5 scale), indicating moderate satisfaction; maternal satisfaction scores ranged 2.89–3.04. No statistically significant correlation was observed between midwifery-led care scores and overall maternal satisfaction (Pearson r = –0.085; p = 0.298). Thematic analysis revealed strong communication and information provision but identified gaps in continuous emotional support, privacy, and pain management. Conclusion: While midwifery-led care was perceived positively in terms of communication, it did not consistently translate into higher maternal satisfaction in this setting. Interventions targeting continuous emotional support, pain relief, and birth environment may enhance satisfaction.

Keywords: Parturition, Midwives, Mixed-Method, Midwifery-Led Care, Childbirth, Postpartum and Midwifery.

INTRODUCTION

For most women, childbirth is a transformative life event that leaves a profound physical and emotional imprint (World Health Organization [WHO], 2023). woman's perception of her birth experience is widely recognized as a proxy for the quality of maternity care and is closely linked to postpartum recovery, maternal–infant bonding, and attitudes toward future pregnancies (Bohren et al., 2020). Despite global progress in healthcare, many women continue to describe childbirth as stressful, overly medicalized, and emotionally detached, reflecting persistent gaps in woman-centered care (Hodnett et al., 2021).

Midwifery-led care has emerged as an evidence-based model emphasizing continuity, shared decision-making, and minimal medical intervention, thereby positioning the woman at the center of the birth process (Sandall et al., 2023). Studies in high-income settings have shown that such care can reduce unnecessary interventions and enhance maternal satisfaction (Renfrew et al., 2022; Grytten et al., 2022). However, the extent to which these benefits translate to low- and middle-income contexts remains uncertain. In many Middle Eastern and resource-limited health systems, including Iraq, childbirth services are still predominantly physician-led, and midwives often function under medical supervision rather than autonomy (El-Sayed et al., 2022). Consequently, the midwifery-led care model is only partially implemented, and its influence on maternal satisfaction and perceived quality of care has not been adequately explored

The cultural and organizational context of Thi-Qar Governorate adds further complexity. Maternity wards in the region are typically overcrowded, with limited staff continuity and strong physician authority, conditions that may constrain midwives' ability to provide sustained emotional and informational support. This unique environment raises critical questions about whether the principles of midwifery-led care—such as empowerment, trust, and continuity—can effectively operate and influence women's experiences in such settings. While several international studies have demonstrated the positive outcomes of midwifery-led models ((Team-Mamas Collaborative, 2023; Hosseini et al., 2024; Lee & Kim, 2023). Although a number of studies have shown the advantages of this model, only a few have looked closely at how it relates to women's satisfaction, especially in different cultural contexts and health systems (Leap et al., 2021). there remains a lack of empirical evidence from Iraq examining how women perceive and evaluate this model during childbirth. Addressing this knowledge gap is crucial for guiding national maternity care reforms aligned with WHO's call for respectful and evidence-based intrapartum care (WHO, 2024).

Therefore, this study aimed to explore how midwifery-led care shapes women's childbirth experiences and satisfaction within the context of Thi-Qar's public hospitals. Specifically, the study sought to : Maternal Satisfaction with Midwifery-Led versus Physician-Led Care during Childbirth: Insights from

a Mixed-Methods Study By integrating quantitative and qualitative findings through a mixed-methods approach, the study provides both statistical and narrative insights into how midwifery-led care is practiced and experienced in a culturally specific, low-resource setting.

METHODOLOGY

1. Study Design

This study employed a convergent parallel mixed-methods design, where quantitative and qualitative data were collected simultaneously, analyzed separately, and then integrated during interpretation. This design allowed for both statistical comparisons of satisfaction levels and in-depth understanding of women's subjective experiences of childbirth.

2. Setting and Timeline

The study was conducted in several maternity wards across public hospitals in Thi-Qar Governorate, southern Iraq, where both physician-led and midwifery-led services are available. Data collection was carried out between January and March 2024, following approval from the Thi-Qar Health Department Ethics Committee (Approval No. THQ/24/022).

3. Sample Size and Sampling Method

A total of 150 postpartum mothers participated in the quantitative phase of the study. Although no formal power analysis was conducted, the sample size was determined based on feasibility, accessibility, and the minimum number required to enable statistical comparison between midwifery-led and physician-led care groups. The use of n = 150 was considered sufficient for reliable mean comparison and correlation testing in small to medium effect sizes.

Participants were selected using purposive–convenience sampling: eligible women who met the inclusion criteria and were available during the data collection period were consecutively approached and invited to participate. This pragmatic approach ensured an adequate and diverse sample, though it limits generalizability beyond the study sites.

4. Inclusion and Exclusion Criteria

Participants were included if they:

- were aged 18 years or older;
- had undergone vaginal or assisted vaginal delivery within the previous six weeks;
- received either midwifery-led or physician-led care during childbirth;
- were clinically stable and able to provide informed consent.

Women were excluded if they:

- experienced severe obstetric or neonatal complications;

- had communication or cognitive impairments; or
- were unwilling to participate in either the survey or the interview phase.

5. Data Collection Instruments

Quantitative Strand

Maternal satisfaction was measured using the Mackey Childbirth Satisfaction Rating Scale (MCSRS), a validated tool widely used to assess women's perceptions of intrapartum care. The instrument consists of multiple items covering communication, emotional support, information sharing, competence of staff, pain management, and overall satisfaction. Responses were rated on a five-point Likert scale (1 = very dissatisfied to 5 = very satisfied), with higher scores reflecting greater satisfaction.

The scale was translated into Arabic using forward–backward translation to ensure conceptual equivalence and pilot-tested with ten postpartum women in Thi-Qar to confirm cultural relevance and clarity. Internal consistency reliability for the present sample was Cronbach's alpha = 0.82, indicating good reliability.

Qualitative Strand

For the qualitative component, 15 mothers were purposively selected from those who completed the questionnaire to represent diverse demographic and obstetric backgrounds. Semi-structured interviews were conducted using an open-ended guide exploring emotional support, communication, involvement in decision-making, and perceptions of safety during childbirth. Each interview lasted 30–45 minutes, was audio-recorded with permission, and supplemented by field notes to capture non-verbal cues and contextual observations.

6. Data Analysis

Quantitative Analysis

Data were entered and analyzed using SPSS version 26. Descriptive statistics (frequencies, means, and standard deviations) were computed for demographic variables and satisfaction scores. To compare satisfaction levels between the two care models, an independent samples t-test was applied after testing assumptions of normality (Shapiro–Wilk test) and homogeneity of variance (Levene's test). Correlations between satisfaction and selected maternal characteristics (age, parity, education) were examined using Pearson's correlation coefficient. A significance level of $p < 0.05$ was considered statistically significant.

Qualitative Analysis

Qualitative data were analyzed using the thematic analysis approach of Braun and Clarke (2006). The process included six steps: (1) familiarization with data through repeated reading, (2) generating initial codes, (3) searching for themes, (4) reviewing themes, (5) defining and naming themes, and (6) producing the report. Coding was performed manually by the researcher, and a second expert independently reviewed

a subset of transcripts to ensure inter-rater reliability. Discrepancies were discussed until consensus was reached. Member checking was performed with several participants to confirm the accuracy of interpretations. Data management was conducted manually without software, given the limited dataset.

Integration of Quantitative and Qualitative Data

After independent analysis, results from both strands were merged to identify areas of convergence and divergence. Quantitative findings provided measurable satisfaction levels, while qualitative insights offered explanations for those patterns, thereby deepening understanding of how care models influence maternal experiences.

7. Ethical Considerations

All participants provided written informed consent after being informed of the study's purpose, procedures, and confidentiality measures. Participation was voluntary, and participants could withdraw at any time without consequences. All data were anonymized, securely stored, and used solely for academic purposes in accordance with the Declaration of Helsinki (2013)

RESULT AND DISCUSSION

Table 1. Distribution of study sample according to socio demographic characteristics (n=150)

Variable	**(n=150)%**
Age — Mean (SD)	27.9 (4.6)
<20	14 (9.3%)
20-24	36 (24.0%)
25-29	48 (32.0%)
30-34	34 (22.7%)
>35	18 (12.0%)
Educational level	
Less than secondary	20 (13.3%)
Secondary / Diploma	60 (40.0%)
University or higher	70 (46.7%)
Residence	
Urban	105 (70.0%)
Rural	45 (30.0%)

Most participants were aged between 25 and 29 years (32%), with the majority living in urban areas (70%) and holding a university degree or higher (46.7%).

Table 2. Distribution of the study sample according to reproductive characteristic (n=150)

Variable	(n=150)
Previous births **(Mean, SD)**	1.5 (0.9)
Primiparous	60 (40.0%)
Multiparous (>1)	90 (60.0%)

Regarding obstetric characteristics, 60% of participants were multiparous, with an average of 1.5 births.

Table 3. Midwifery-Led Care(1 = Strongly Disagree to 5 = Strongly Agree):

Statement	1	2	3	4	5	Mean	SD
I felt that the midwife listened to my needs.	25 16.7	28 18.7	27 18.0	40 26.7	30 20.0	3.15	1.38
The midwife provided the emotional support I needed during childbirth.	44 29.3	18 12.0	36 24.0	34 22.7	34 22.7	2.76	1.40
The midwife respected my decisions regarding	28 18.7	38 25.3	20 13.3	31 20.7	33 22.0,	3.02	1.45

birth choices.							
I was given enough information to make informed decisions.	30 20.0	27 18.0	24 16.0	29 19.3	40 26.7	3.15	1.49
I felt safe with the midwife present during labor.	33 22.0	31 20.7	29 19.3	25 16.7	32 21.3	2.95	1.46

The mean scores for midwifery-led care items ranged from 2.76 to 3.15, indicating a moderate level of satisfaction. The highest agreement was reported for "The midwife listened to my needs" and "I was given enough information to make informed decisions" (mean = 3.15), suggesting that communication and information provision were among the strongest aspects of care.

Table 4. Maternal Satisfaction Scale (1 = Strongly Disagree to 5 = Strongly Agree):

Statement	1	2	3	4	5	Mean	SD
I am generally satisfied with my childbirth experience.	27 18.0	36 24.0	22 14.7	34 22.7	31 20.7	1.42	3.04
I felt I was the center of attention during childbirth.	26 17.3	36 24.0	32 21.3	34 22.7	22 14.7	1.32	2.93

The level of pain was managed appropriately.	32 21.3	29 19.3	31 20.7	29 19.3	29 19.3	1.42	2.96
The childbirth environment was comfortable and supportive.	34 22.7	33 22.0	25 16.7	31 20.7	27 18.0,	1.43	2.89
I would choose the same type of care for my next birth.	30 20.0	30 20.0	25 16.7	39 26.0	26 17.3	1.40	3.01

The maternal satisfaction scale also demonstrated moderate satisfaction levels, with mean scores ranging from 2.89 to 3.04. The statement "I would choose the same type of care for my next birth" had a mean of 3.01, indicating a generally positive perception of the experience.

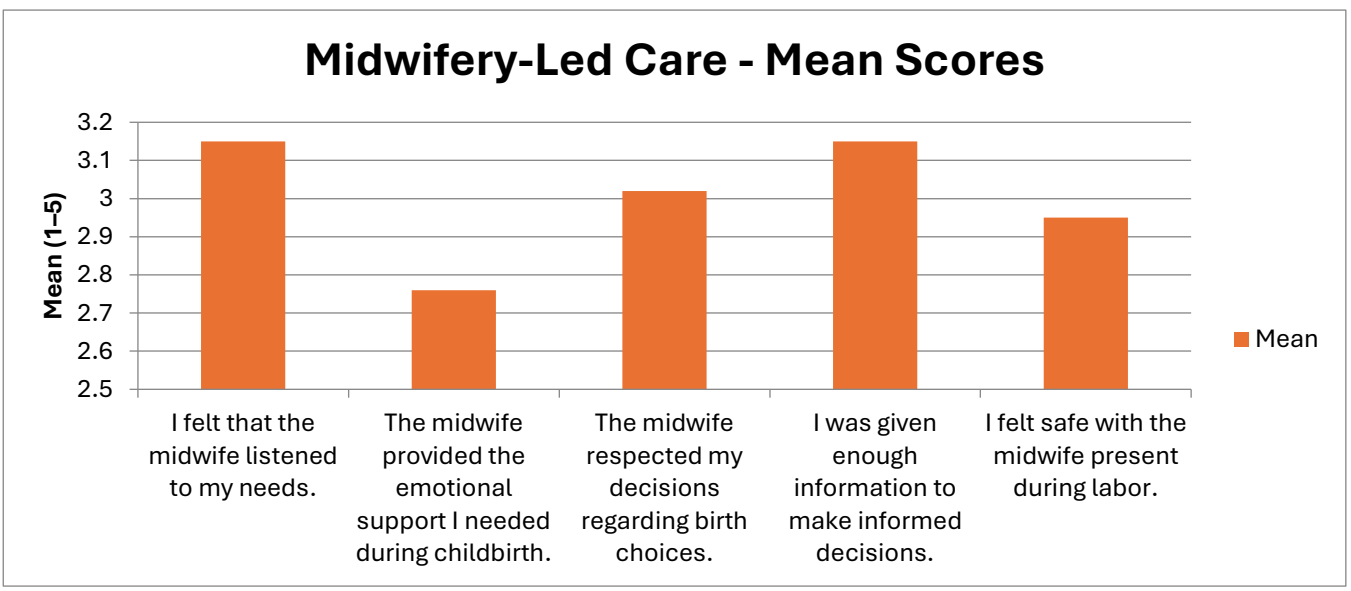

Figure 1. Midwifery-Led Care-Mean Scores

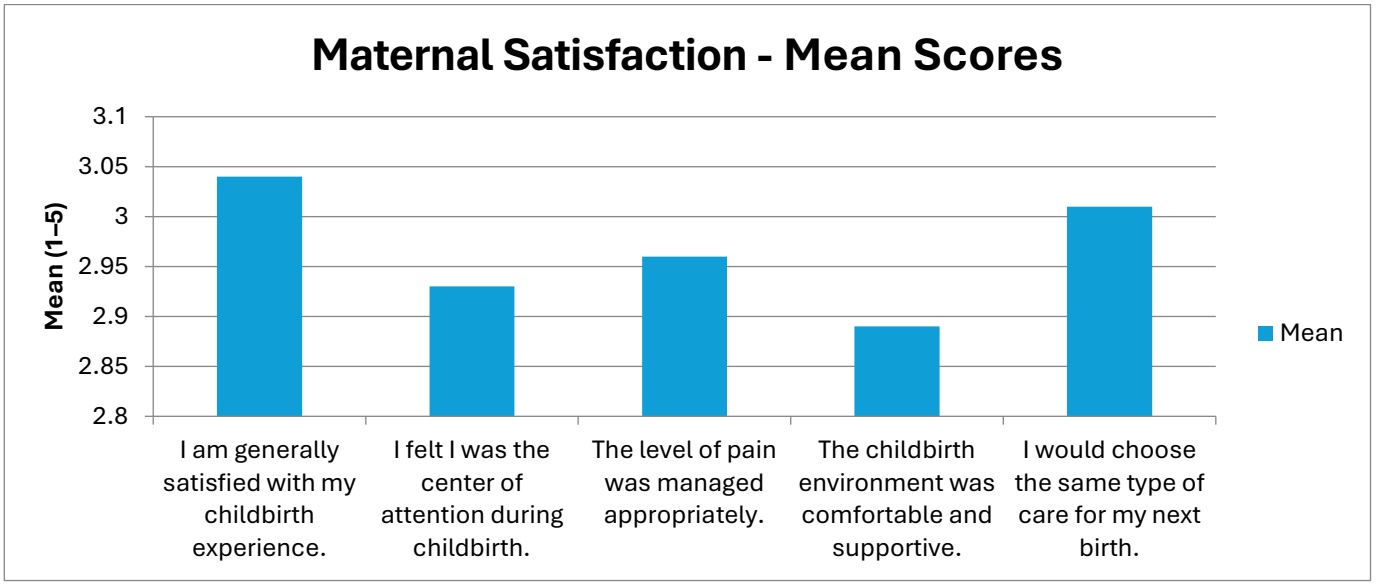

Figure 2. Maternal Satisfaction-Mean Scores

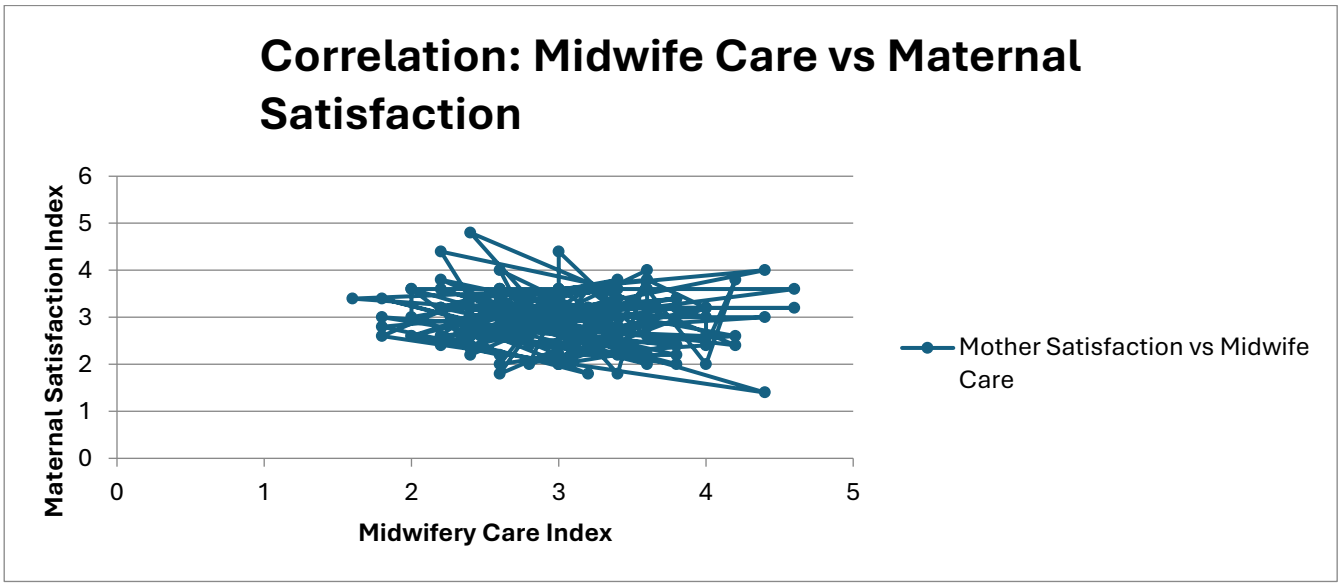

Figure 3. Correlation: Midwife Care vs Maternal Satisfaction

Table 5. Correlation between Midwifery-Led Care and Maternal Satisfaction

Method	Correlation	p-value
Pearson	-0.085	0.2984
Spearman	-0.059	0.4714

The correlation between midwifery-led care and maternal satisfaction was not statistically significant (Pearson r = –0.085, p = 0.298).

Discussion

This mixed-methods study revealed that women's overall satisfaction with childbirth care was moderate, with mean scores ranging between 2.89 and 3.15 on the five-point scale. Although women who received midwifery-led care generally appreciated the communication, respect, and information they received, statistical analysis indicated no significant correlation between midwifery-led care and overall satisfaction (r = –0.085, p = 0.298). Qualitative findings, however, provided richer insight into this weak association: participants emphasized inconsistent emotional support, limited privacy, and high workload pressures on midwives as factors influencing their perceptions of care.

Comparison with Previous Studies

The pattern of moderate satisfaction aligns with previous findings from Middle Eastern and low-resource settings. El-Sayed et al. (2022) and Hosseini et al. (2024) similarly found that although midwives were perceived as competent and compassionate, systemic constraints—such as physician dominance and limited emotional continuity—reduced women's overall satisfaction. In contrast, research in high-income settings, such as Grytten et al. (2022) and Sandall et al. (2023), reported significantly higher satisfaction levels within midwifery-led continuity models that allow for full autonomy and sustained relationships between women and midwives. The discrepancy highlights the contextual gap between well-resourced, autonomous midwifery systems and hybrid physician–midwife systems such as those in Iraq, where midwives often operate under medical supervision and resource limitations.

Possible Explanations for Weak or Negative Correlation

Several contextual and methodological factors may help explain the low, and in some cases slightly negative, correlation observed between midwifery-led care and maternal satisfaction. One possible reason relates to measurement limitations. Although the Mackey Childbirth Satisfaction Rating Scale (MCSRS) is a validated and widely used instrument, it may not fully capture the cultural dimensions of satisfaction in the Iraqi context. Women's perceptions of authority, modesty, and decision-making autonomy may differ from those embedded in Western-based measurement tools, leading to potential mismatches between the instrument's constructs and local expectations.

Another explanation lies in the heterogeneity of care models within Thi-Qar's public hospitals. Midwifery-led care often operates alongside physician-led interventions, and the overlapping responsibilities between midwives and doctors may blur distinctions between the two models. As a result,

the unique benefits of midwifery-led practice—such as emotional continuity and personalized support—could become less evident in practice.

Sample characteristics may also have influenced the results. The majority of participants were urban and relatively well-educated women, a group that tends to have more progressive expectations regarding communication and shared decision-making. When such expectations are unmet in hierarchical hospital environments, levels of reported satisfaction may naturally decline.

In addition, the study's limited statistical power—stemming from the absence of a formal power calculation—may have constrained the ability to detect small but meaningful differences between the two care models.

Finally, cultural norms likely played an important role. Within patriarchal or hierarchical healthcare systems, women often associate authoritative medical care with competence and safety. Consequently, being attended by a doctor may be perceived as more reassuring than the more participatory, collaborative model typically promoted in midwifery-led care (El-Sayed et al., 2022).

Taken together, these factors suggest that women's satisfaction during childbirth is influenced by a complex interplay of measurement, contextual, and cultural elements—extending beyond the immediate quality of clinical care itself.

Implications for Practice

To improve maternal satisfaction and optimize the implementation of midwifery-led care, several operational strategies should be prioritized. First, enhancing communication skills among midwives is crucial. Continuous professional development focused on therapeutic communication, empathy, and emotional presence during labor can strengthen the woman–midwife relationship and improve perceived support throughout childbirth (Lee & Kim, 2023).

Second, ensuring adequate staffing and balanced workloads is essential to maintain the quality of care. By increasing the midwife-to-patient ratio, midwives can provide more consistent attention and continuous presence during labor, which are central to the philosophy of midwifery-led care.

Third, hospitals should implement structured pain management protocols that integrate both pharmacological and non-pharmacological options. Clear communication about these options and obtaining informed consent can enhance women's sense of control and participation in decision-making (Bohren et al., 2021).

Moreover, improving the privacy and comfort of birthing environments should be considered a key component of quality care. Simple structural changes—such as installing partitions, reducing noise, and ensuring respectful handling—can significantly enhance women's sense of safety, dignity, and emotional well-being.

Finally, promoting a collaborative interprofessional model is necessary to bridge the traditional hierarchy between physicians and midwives. Encouraging respectful teamwork and shared accountability can help sustain a woman-centered philosophy while maintaining clinical safety and efficiency (Team-Mamas Collaborative, 2023).

Taken together, these improvements represent practical and achievable steps toward building a maternity care system that values both the technical and emotional dimensions of childbirth, thereby enhancing women's satisfaction and overall birth experience.

Limitations

This study has several limitations that should be taken into account when interpreting the results. The use of non-random purposive sampling limits the representativeness of the sample and, consequently, the generalizability of the findings beyond the participating hospitals. In addition, the absence of a formal power calculation means that small but potentially meaningful differences between the midwifery-led and physician-led care models may not have been detected. The reliance on self-reported data also introduces the possibility of recall and social desirability biases, particularly because interviews were conducted in hospital settings where participants might have felt reluctant to express dissatisfaction with their caregivers. Moreover, the study was carried out in a single province (Thi-Qar), which may not capture regional variations in hospital systems, staffing patterns, and cultural practices. Finally, a degree of cultural courtesy bias may have influenced women's responses, as participants may have been hesitant to criticize healthcare professionals due to social norms emphasizing respect and deference toward authority figures.

Future Research Directions

To further advance understanding and strengthen the evidence base for midwifery-led care, future research should adopt broader and more rigorous study designs. Multi-center or nationwide studies are needed to enhance the generalizability of findings across diverse healthcare contexts. In addition, longitudinal and intervention-based designs would allow researchers to explore causal relationships and assess the long-term effects of midwifery-led continuity models on both satisfaction and clinical outcomes. It is also important to develop and utilize context-specific measurement tools that better reflect cultural, emotional, and relational dimensions of maternal satisfaction within different sociocultural settings. Furthermore, future trials should evaluate training interventions for midwives focused on communication, emotional presence, and continuity of care, examining how these professional development initiatives translate into improved maternal experiences and perceptions of care quality.

CONCLUSION

The study found that women reported moderate satisfaction with childbirth care, with no significant difference between midwifery-led and physician-led models. Qualitative findings revealed that while mothers valued respectful and informative support from midwives, gaps remained in emotional presence, privacy, and individualized attention. Overall, midwifery-led care provides a positive foundation, but stronger emotional continuity and personalized support are needed to achieve full maternal satisfaction.

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