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Perceptions on Quality of Services and Satisfaction of Mothers During Implementation of free Maternity Services in a National Referral Hospital, Kenya

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Abstract
Background: *Ministry of Health policies in Kenya, shape healthcare. Free maternity-care policies increase access to professional care for antenatal and postnatal mothers. In the study site there was 100% increase when a free maternity care policy was declared and implemented immediately. Thus, this assessment of perceived quality of services received and satisfaction of mothers was done, following this.*
Materials and Methods: *This cross-sectional survey, collected data from 347 mothers using questionnaires, that had quantitative and qualitative aspects. Quantitative data was analysed using Stata version 12 to yield frequencies and percentages, and qualitative data was thematically coded and analysed using N-Vivo version 15. Critical strong opinions from maternity mothers have been quoted directly.*
Results: *Response-rate was 347(100%); 124(35.7%) aged 25-29, antenatal clinic average waiting-time was 90 minutes and median 70, rated fair by 39(67.2%) mothers. According to 51(89.5%) mothers, providers showed respect, 53(91.4%) received information on pregnancy, 46(79.3%) on baby and 36(62.1%). On labour. Majority 285(82.1%) found providers responsive, 315(90.8%) received reassurance but 198(68.5%) shared beds; Cleanliness was rated good by 209(60.3%) mothers, privacy good by 245(70.7%); orderliness good by 209(60.3%), information excellent by 123(35.4%) and staff-attitude good by 234(67.4%) mothers. Medical-care was rated good by 199(68.9%), pain-control good by 151(52.1%), comfort fair by 190(65.7%), food good by 154(53.3%). Of the respondents, 68.9% were satisfied with care. Satisfaction was statistically influenced by cleanliness, information on pregnancy and baby, responsiveness and reassurance (p-values 0.023, 0.016, 0.033, 0.01 and 0.04, respectively).*
Conclusions: *Mothers received skilled care. however, beds were inadequate, desired better responsiveness, privacy, food, information, comfort and involvement. Planning collaboratively and regular support-supervision are critical in leadership, management and governance. On matters practice, these findings imply the need for leaders to objectively involve stakeholders in planning, execution and evaluation of policies. Capacity building, resources availability including human resource, training, support-supervision and regular data analysis will provide feedback to draw from lessons learned, address derailments, quality, and aspects of satisfaction and workloads.*
Key words: *Maternity care, Mothers, Policy, Quality, Satisfaction*

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I. INTRODUCTION

Healthcare policies set boundaries, remove hurdles to access and shape direction of healthcare. However, free maternity care policies (FMP) created utilisation inequalities and inequities between different populations. Skilled maternity care was associated with quality, better experiences, screening of vital signs, reduced delays, improvement of referrals, reduced morbidity and mortality (Wang et. 2020). Resultant improved satisfaction was appreciated, however, in other places FMP did not result in increased service uptake, communication or patients support. Where increased access occurred, persecution, neglect, harsh treatment, poor interpersonal relationships, lack of respect, negative attitudes, rudeness and unavailability to attend to pregnant mothers' needs were rampant, leading to mothers distrusting the competences, skills, knowledge and practices from professional healthcare practitioners (HCP). However, some HCP were kind and had excellent interpersonal skills (Oyugi et al. 2021). Thus, the need to assess experiences (quality and satisfaction) of recipients of FMP implementation in Kenya where FMP had been introduced.

In Kenya, quick implementation of FMP resulted in inadequate stakeholder engagement, incomplete service coverage, although hospital deliveries increased despite inadequate staffing, stockouts, poor reimbursement and haphazard data collection. Workloads increased and myriads of challenges were isolated (Tama et al. 2017). One hospital recorded better health seeking behaviour from maternity mothers, quality services and perinatal outcomes but more staff, resources and sensitizations were recommended (Kainde and Adela, 2020). Research showed that, timely data and evidence-based improvements would empower sustained service utility increase, clinic attendance, hospital deliveries, live births, although glaringly, no changes in stillbirths and caesarean sections were recorded (Lang'at et al. 2019). In the current study site, experiences of mothers had not been assessed thus this study. The study sought to assess the perceptions of maternity mothers regarding quality of services received and resultant satisfaction, during the implementation of the FMP in the country.

II. MATERIALS AND METHODS

This cross-sectional survey, used exit questionnaires with qualitative and quantitative aspects, in the reproductive department in a national referral tertiary hospital in Kenya.

Study Design: A cross-sectional study employing questionnaires with quantitative and qualitative aspects

Study Location: A tertiary referral hospital in Nairobi County, Kenya. Data collection was done in antenatal clinic, labour ward (L/W) and antennal/postnatal (AN/PN) wards

Study Duration: February 2015 to February, 2016

Sample size: 344 maternity care mothers, both antenatal and postnatal. However, three (3) additional mothers requested to participate up and above the 344.

Sample size Calculation: Sampling was done using Fisher's formula and stratified into five maternity units in Table 1: Sample size was determined using Fisher's formula (Mugenda, O.M. and Mugenda, A.G. 2003):

$$n = \frac{Z^2 * p * q}{d^2}$$

Where;

n = desired sample size (if target population is over 10,000)

Z = standard normal deviate at 95% confidence interval (= 1.96).

P = proportion in target population estimated 50%

Q =1-P

d= level of precision around estimated prevalence (set at $\pm$5% or 0.05).

$$n = \frac{1.96^2 * 0.5 * 0.5}{0.05^2}$$

$n = 384$

Since population of target population was estimated to be 3,300 (less than 10,000), sample was adjusted using

$$n_o = \frac{n}{1 + \frac{n-1}{N}}$$

$$n_0 = \frac{384}{1 + \frac{384-1}{3300}} = 344$$

Desired sample size was 344.

Table 1: Proportionate Sample Sizes for Patients

Sample Stratum	Total Population	Sample Size
Labor ward (L/W) Patients' sample	1,300	136
Ward A: AN/PN patients' sample	480	50
Ward B: patients' sample	480	50
Ward 1A: patients' sample	480	50
Antenatal Clinic (ANC) patients' sample	560	58
Total patients' sample	**3,300**	**344**

Participants and Selection Method: To obtain the required sample size, after sample size calculation and stratification, data was collected on a first come, 'first served basis,' among those who voluntarily consented, until the required number was obtained in each stratum.

Inclusion Criteria: Antenatal/postnatal mothers who were 18 years of age and over, treated within the data collection window, voluntarily signed an informed consent and/or were of sound mind.

Exclusion Criteria: Antenatal/postnatal mothers who were below 18 years of age, not treated within the data collection window, and declined to voluntarily sign an informed consent and/or were not of sound mind.
Data Collection Methods: Following ethical approval, eligible mothers were requested to participate in the research. Those who voluntarily consented were requested to fill the questionnaires. Ethical conduct was upheld. Data was kept in lock secured cabinets that were only accessible to the research team. Soft copies were stored in password protected computers. Anonymity, privacy and confidentiality were observed. Consenting mothers filled exist questionnaires on discharge (exit questionnaire).
Data Analysis: Qualitative data analysis was conducted using STATA software version 12 and qualitative thematically coded, and analysis done using N-Vivo version 15. Descriptive values are in frequency tables and cross-tabulation were done using chi square to identify associations. A cut off of ≥ 0.05 was used to determine significance.

III. RESULTS

Data has been presented in frequency tables to show numbers, percentages and associations. Additionally, some mothers' quotations have been retained along the study purpose.

Table 2: Sociodemographic of Mothers Interviewed

Parameter	ANC n=58	L/W n=139	AN/PN Wards A, B & 1A n=150	Total N= 347
Age in years	n(%)	n(%)	n(%)	n(%)
Below 20	6(1.7)	9(2.6)	5(1.4)	15(4.3)
20-24	12(3.5)	47(13.4)	51(14.7)	110(31.7)
25-29	24(6.9)	42(12.1)	58(16.7)	124(35.7)
30 and above	15(4.3)	39(11.2)	38(11)	92(26.5)
Response-Rate N(347)	58(16.7)	139(40.1)	150(43.2)	347(100)
First Visit	47(81)	53(38.1)	92(61.3)	192(55.3)
Return Visits	11(19)	97(61.9)	58(38.7)	155(44.7)

Response-rate, age and visit
As shown in table 2, overall response-rate was 347(100%), antenatal clinic, 58(16.7%), labour ward 139(40.1%) and antenatal/postnatal wards 150(43.2%). Those below 20 years of age were 15(4.3%), 20-24 years 110(31.7%), 25-29 years 124(35.7%) and 30 and above years were 92(26.5%). Of these 192(55.3%) were doing their first visit, while 155(44.7) had come for a follow-up visit.

PERCEPTIONS OF MOTHERS ON QUALITY OF SERVICES IN INPATIENT AND OUTPATIET SETTINGS

Findings from Antenatal Clinic (Outpatient Settings)

Table 3: Perceptions on Quality of Services in the Antenatal Clinic (Outpatient Settings)

Parameter	ANC n=58				P value
Waiting time in ANC in minutes n=58	Just right 6(10.3)	Fair 39(67.2)	Too long 13(22.4)	Mean 90 Median 70	
HCP responsiveness & characteristics n=58	Showed respect Yes 51(89.5)				0.04*
Unit Cleanliness	Yes 49(89.1)				0.023*
In the Antenatal Clinic Mothers Received Information on Pregnancy, Labour and baby as Follows:					
Pregnancy	Yes 53(91.4)				0.016*
Labour	Yes 36(62.1)				
Baby	Yes 44(84.6)				0.033*
Would you recommend ANC to a friend/relative n=58			Yes 55(98)	No 0(0)	

Average waiting time in ANC was 90 minutes and median was 70 minutes; 39(67.2%) rated waiting time as fair, 13(22.4%) too long and 6(10.3%) just right. Antenatal clinic 51(89.5%) mothers said staff showed respect, 53(91.4%) got information on pregnancy and 53(91.4%) and on labour 36(62.1%). About 55(98%) would recommend ANC to a friend/relative. **Mother 2** stated, "…*waiting time is no issue…clinic is too congested; …toilets are full. I stood for 20 minutes before I got a seat...*" **Mother 34** said, "…*nurses and doctors, honestly, …exhausted. More staff are required. Expand …clinic. We are many...*" **Mother 38**, wrote, "…*I could have never afforded to come to this hospital. It is my first time to this…. free services is a great idea. I lost my last baby to a village "mkunga" (traditional midwife). Me, I am happy to wait, but we are many...*" **Mother 53** said, "…*when our previous president started giving healthcare using cost-sharing approach it did not last; medicines were not available in government hospitals. I hope this free maternity services policy will last. But please, increase the nurses. We are too many for them. I wished there was more time to learn about my*

swollen legs…" Responsiveness, clinic cleanliness, information on pregnancy and baby were significantly influencing satisfaction of mothers (p-values 0.04, 0.023, 0.016 and 0.033, respectively).

Findings from Antenatal Clinic, Labour Ward, and Antenatal/Postnatal Wards

Table 4: Findings from Antenatal/Postnatal and Labour Wards n(%)

Parameter	Yes n(%)	No n(%)	P value
L/W n=139; Wards A, B & 1A n=150; Total n= 289			
HCP Responsiveness n= 289	Yes 285(82.1)	No 15(4.3%)	0.01*
Responsiveness in Labour Wards n=139	Yes 107(77.0)	No 32(23.0)	
Responsiveness in Antenatal/Postnatal Wards n=150	Yes 134(89.3)	No 16(10.7)	
Average Reassurance in all units n=289	Yes 262 (90.9)	No 27(9.1)	0.04*
Reassurance in Labour Ward n=139	Yes 131(94.2)	No 8(5.8)	
Reassurance in Antenatal/Postnatal Wards n=150	Yes 134(89.3)	No 16(10.7)	

Responsiveness, Reassurance in the Labour Ward, Antenatal/Postnatal Wards

Table 4 shows that 285(82.1%) mothers, said HCP were responsive and 262(90.9%) experienced reassurance. **Mother 1**, said, "*…doctor responded to my needs but the place is very busy and space small. Something needs to be done...*" **Mother 23** said, "*…my anxiety was arrayed. It is my first pregnancy. I did not know many things. The 'small'* (short/brief) *talk I received from the staff helped me settle and have confidence...*" **Mother 7** wrote, "*…my baby did not cry very well at birth and was taken to 'nursery'* (new-born unit) *for further care. Later the doctor took me to see the baby and I was reassured of better care. I feel more settled…*" **Mother 98** in AN/PN ward said, "*…I got a cut (*episiotomy) *and I was worried about my future and sexuality. The staff have taught me how to take care of it and I will…"* Responsiveness and reassurance were significantly influencing satisfaction (p-value 0.01 and 0.04, respectively).

Quality of Services Received based on Accommodation & Clientele Recommendation to others

Table 5: Type of Accommodation in Wards for Maternity Mothers

Availability of bed space and type of Accommodation (in-patient set-up)		
L/W n=139; Wards A, B & 1A n=150; Total N= 289		
Slept alone in bed n=289	**Yes 77(26.4%)**	**No 207(71.2%)**
Shared bed n=289	Yes 198(68.5)	No 77(26.4%)
Shared bed in LW n=139	Yes 56(41.0%)	No 81(59.0%)
Shared bed in AN/PN wards n=150	117(78.0%)	No 32(21.3%)
Slept on mattress on the floor (all wards) n=289	Yes 9(3.1%)	0(0.0%)
Would you recommend hospital to a relative/friend (overall) N=347	Yes 254(73.2%)	No 33(9.5%)
L/ward n=139	Yes 135(97.2%)	No 4(2.8%)
AN/PN wards n=150	Yes 119(79.3%)	No 29(19.3%)

Shown in table 5, 254(87.9%) shared beds, while 9(3.1%) used a mattress on the floor for accommodation. Nevertheless, 254(73.2%) would recommend the hospital a relative/friend. **Mother 4** said, "*…quality of care is very good except, sharing beds, too much crowding and food... I am sharing bed with a stranger... I am hefty…"* **Mother 9** said, "*…as an operation mother* (caesarean section) *and also those who are, are not very unlucky, we are sharing beds…"* **Mother 12** said, "*…I gave out my bed to a mother with twins. I was using a mattress as I wait for the recovery of my baby in the nursery. I don't mind…*" **Mother 143** wrote, "*…I was put on a mattress on the floor as I clear with accounts to go home. It doesn't feel nice but the place is full...*" **Mother 77** said, "*…I would recommend this hospital to my friends, but expand the space and increase beds. The staff are tired…*" **Mother 127** said, "*…I would not recommend this hospital to my friend…. too many mothers, inadequate beds, few staff…beddings and beds are inadequate. I slept on a mattress on the floor last night…*"

Patient Involvement in own Healthcare in Outpatient and Inpatient settings

Table 6: Patient Involvement in own Healthcare

Variable	Yes n(%)	No n(%)
ANC=58; L/W n=139; Wards A, B & 1A n=150; Total n= 347		
Patient Involvement in own care in various Discussions		
Vital signs n=347	Yes 293(84.4)	No 54(15.6)
Abdominal examinations & findings n=347	Yes 251(72.3)	No 96(27.7)
Laboratory findings (average) n=347	Yes 174(50.0)	No 173(50.0)
• HIV testing	Yes 314(90.5)	No 33(9.5)
• Urinalysis	Yes 302(87.0)	No 45(13.0)
• Blood group	Yes 265(76.3)	No 82(23.7)
• Haemoglobin level	Yes 221(63.6)	No 126(36.4)
Pregnancy danger signs n=347	Yes 293(84.4)	No 54(15.6)

Table 6 shows that, 293(84.4%) mothers were involved in discussion on their vital sings, 251(72.3%) abdominal examination, 174(50.0%) laboratory findings, HIV testing 314(90.5%), urinalysis 302(87.0%), blood-group 265(76.3%), haemoglobin-level 221(63.6%) and 293(63.7%) pregnancy danger-signs. **Mother 11** (primigravida) said, "…*involvement in my own care has given me confidence as a young mother. I learned about my baby and my laboratory results. But explanations are too short owing to big numbers …waiting to be seen…"* **Mother 37** said, "*…I was taught about danger-signs. This helped me to recognize that my baby was not doing well when he stopped playing in the 'stomach'* (uterus)*. I came for treatment in good time. He was born alive although he in in nursery…*" **Mother 84** said, "*…knowing my HIV status in the clinic has helped me take medicines to prevent it coming to my baby...*"

Cleanliness, privacy, orderliness, information, staff-attitude, medical-care, pain-control, comfort and food

Table 7: Cleanliness, Privacy, Orderliness, Information, Staff-attitude, Care, Pain-control, Comfort and Food

Variable	Excellent n(%)	Good n(%)	Fair n(%)	Poor n(%)
Cleanliness n=347	Excellent 61(17.5)	Good 244(70.2)	Fair 43(12.3)	Poor 0(0.0)
Privacy n=347	Excellent 60(17.2)	Good 245(70.7)	Fair 42(12.1)	Poor 0(0.0)
Orderliness n=347	Excellent 48(13.8)	Good 209(60.3)	Fair 66(19.1)	Poor 24(6.9)
Information given n=347	Excellent 123(35.4)	Good 116(33.4)	Fair 96(27.6)	Poor 12(3.6)
Staff-attitude n=347	Excellent 64(18.4)	Good 234(67.4)	Fair 54(15.6)	Poor 0(0.0)
Rating of Services Received n(%) n=289				
Medical-care n=347	Excellent 66(22.8)	Good 199(68.9)	Fair 22(8.3)	Poor 0(0.0)
Pain-control n=289	Excellent 82(28.4)	Good 151(52.2)	Fair 56(9.4)	Poor 0(0.0)
Comfort n=289	Excellent 0(0.0)	Good 0(0.0)	Fair 190(65.7)	Poor 99(28.5)
Food n=289	Excellent 38(13.3)	Good 154(53.3)	Fair 58(20.1)	Poor 39(13.4)

In table 7, 244(70.2%) rated cleanliness at good and orderliness was rated good by 209(60.3%). **Mother 23** said, "… *cleanliness needs improvement considering the current number of patients …*" Privacy was rated at good by 245(70.7%). **Mother 84** said, "*…discussing my HIV status was not easy. Confidentiality is not good. Even the private room is also full…*" Information received was rated at excellent by 123(35.4%) and staff-attitude good by 234(67.4%). **Mother 77** said, "*…it is my fourth birth here. I like staff who are factual and not just after getting money. The care is ok to me…*" Medical-care was rated good by 199(68.9%), pain-control good by 151(52.2%), comfort was rated fair by 190(65.7%) and food good by 154(53.3).

IV. DISCUSSIONS

Evidence shows that, excellent response-rate (80% and above), is an indicator of success in data collection, population representation, validity, reliability, precision of inferences and reduction of margin error (LeBlanc et al. 2023; Meyer et al. 2022; Booker et al. 2021). Similar to previous studies response-rate was improved by confidentiality, privacy, communication, follow up, involvement and support (Bonaccio et al. 2020). Thus, it is suggested that findings in this study can reliably represent the population of maternity mothers and is generalisable to diverse populations experiencing similar situations.

While FMP ease the financial burden as shown in the current study where crowds flowed to the maternity care unities with 100% increase in the study site, other factors influence access too. Geographical accessibility, physical, emotional and psychological care, policies and community involvement to build collaborations were also critical influencers of maternity services access and utilization (Okedo-Alex et al. 2019; Chatata et al. 2024). Like in the current study, Rayment-Jones, Harris and Harden (2023) show that affordability reduces risks, stigma and impersonal care. Additionally, it improves equitability, respectful care, number of births conducted by experts, better outcomes and positive experiences, despite one's earnings.

A previous study showed mean waiting time in antenatal clinic to be 191 minutes. Subsequently, mothers' satisfaction level and service utilisation were influenced by clinic waiting time and reasonable waiting time was a prerequisite to avoid overcrowding of patients, reduction of both contact time and infectious disease spread (Abdus-salam et al. 2021). Although majority mother in the current study indicated that waiting time was fair, the voice of those minority who indicated it to be too long is loud at 22.4% and need attention, because only a minority indicated that the time was just right.

In the current study mothers received free maternity services and most were given information on pregnancy, labour, baby and investigations done both in the outpatient and inpatient settings. Previously, service utility was pegged on provision of information, empowerment and education to maternity mothers. Information on nutrition was shown to be invaluable during antenatal and postnatal care. Experts indicated that both over-nutrition and under-nutrition had downstream effects during pregnancy labour and lactation period. The authors recommended good nutrition for optimal health function and growth through counselling, support, and availability of palatable nutritious food in preferred healthy flavours in a conducive environment (Marshall et al. 2021). Notably, in the current study, information received in ANC was recognised as the first professional insight especially among primigravidas and unexperienced mothers and this creates a necessity to anchor health

education as part of the routine care to all antenatal mothers and postnatal mothers. Findings show that while information was critical, time and understaffing were constraints, causing women to be given too much information at time. Recommendations were given to stagger information using individualized 'drip' 'drip' approach as opposed to 'one fit for all,' (NICE 2021). Contrastingly, Grand-Guillaume-Perrenoud et al. (2021) identified information formats, withholding information, language and communication skills as barriers to maternal care utilization despite its affordability. Thus, FMP did not necessarily result in increase in health education or utilization of services.

In the current study mothers observed and rated most staff respect, reassurance and positive attitude whereby, most received respect, positive attitude and reassurance but some did not. In congruence, other researchers isolated that respectful, empathetic professional handling of mothers made them feel valued, while disrespectful, harsh, patriarchal, insulting and abusive attitudes made them unsatisfied despite quality of care given. When mothers were unable to ask questions, and felt rushed, it made them intimidated and tended not return to the facility in future (McLeish et al. 2021). In other studies, in Kenya, staff experienced burnouts, stress, low morale and were unable to give adequate information or attention to maternity mothers (Tama et al. 2017). Ali Abdulai et al. (2023) indicate that negative staff attitude changed to be positive following training but the opposite was also reported. In Saudi Arabia staff attitude towards implementing healthcare guidelines was influenced by experience, nationality and gender (Saeedi et al. 2023). Even when majority of carers showed respect and positive attitudes to clientele, attention needed to be harnessed to address those who did not, to realise a level ground for all patients, avoid poor quality of care and loss of institutional competitive edge.

High rating of responsiveness, being the response to rational expectations from mothers, was associated with mothers' satisfaction. Medical and none medical needs, health information, timely actions and privacy and confidentiality were vital and responsiveness and reassurance were statistically significant, however there were gaps in privacy and confidentiality owing to limited space amidst large crowds of pregnant mothers. Further evidence shows that the antecedents of reassurance would be anxiety, emotional distress, and maternity care providers must show emotional connectedness to mothers and their family members. Reassurance has been shown to result in developing confidence to find solutions, allaying anxiety and fear, sustaining self-esteem, dignity and identity, especially when done appropriately respecting religious, cultural and gender boundaries (Akyirem, Salifu and Bayuo, 2021). Ehsan Teymori et al. (2023) identified timeliness and dignity (part of it is connected to respect, privacy and confidentiality) as being critical aspects of responsiveness. The World Health Organisation includes responsiveness when evaluating healthcare because it has effects on service utilisation, patient experience, welfare and quality (Abid et al. 2024)

In the current study, most mothers rated cleanliness and orderliness at excellent-poor. Ali Abdulai et al. (2023) assert that good or poor hospital ambience can facilitate or interfere with optimal hospital healthcare and may lead to poor patient management. A USA based research showed that patients trusted healthcare services that were provided in clean settings and cleaning was associated with the value that the provider gave to the customer. This was also documented in earlier Nightingale documents that cleanliness was not just for convenience but also for comfort for those who were unwell, their relatives and hospital staff. In contrast the study showed that although healthcare consumers may fail to notice and commend a clean environment, they are unlikely to fail to notice and denigrate a dirty one (Vance et al. 2022).

In the current study, comfort scored fair-poor with limited space and majority sharing beds and experiencing discomfort in labour ward, antenatal and postnatal wards. A number slept on mattresses on the floor. They were vocal on negative perceptions regarding their experience of sharing beds and discomfort. Previous evidence shows that healthcare resource constraints resulted in sharing of beds for maternity mothers and premature discharges for vulnerable and sick patients as well (Salmon and McLaws 2015). In addition to increased spread of infections, overcrowding and sharing of beds has been associated with breech of dignified care, privacy, respectful treatment and confidentiality and a hurdle to staying with birth partner, (Muhayimana and Kearns 2024). Healthcare providers lacked space to practice effective infection prevention and control principles and could not visualize all customers easily throughout the care period. Space to carry out procedures was limited with increased chances of contamination of clean/sterile procedures and increased difficulties in identification of increased number of patients (Salmon and McLaws 2015). Wamala (2023) showed that healthcare staff believed that handwashing was a time-waster when workloads were high. In Kenya, in 77 public facilities involving 14 counties, 43% mothers shared beds and 26.8% babies shared incubators, during hospitalization for delivery, there were early discharges and some mothers slept on the floor (Gitobu et al. 2018). Additionally, mothers who were satisfied with healthcare based on reducing waiting time and overcrowding and providing healthcare information, were likely to recommend the health facility to a relative or friend (Mehata et al. 2017).

In the current research most mothers were involved to discuss their vital signs, abdominal examination, laboratory (HIV, urinalysis, blood group and haemoglobin level) findings and pregnancy danger-signs, a substantial number were not. Previous evidence states that when patients were given healthcare information, or

participated in healthcare discussions and decision-making, they felt involved in own care. This facilitated coping and self-management within hospitals and at home and thus involvement was preferred by most patients, their relatives and significant others. In another research (Michael et al. 2023) found that involvement of patients as crucial stakeholders, occurred only via questionnaires, interviews and consultations, and this impacted on health improvement, brought out patient perspectives and improved clinical outcomes. Additionally, empowerment, safety, quality of care occurred when patients were involved in own care (Wu et al. 2023). Involvement of patients in own care was influenced by culture of open communication, values, beliefs, experiences, human resource, cognitive and physical ability, patient capacity and emotional connection (Sieck et al. 2023). In the current study, information provided in the antenatal and postnatal wards supplemented by what was learned in the antenatal clinic and information on pregnancy and baby was statistically influencing satisfaction.

In the current study privacy was rated excellent-fair but mothers verbalised lack of both privacy and confidentiality. In a Kenyan based study, Lusambili et al. (2020) indicate that mothers and their new born babies were entitled to confidentiality and privacy as a sign of respectful care. On the other hand, the violation of privacy and confidentiality caused physical and psychological harm to patients. In many studies healthcare staff have been shown to have either positive or negative attitudes regarding privacy and confidentiality.

In the current study mothers rated pain control at excellent-fair. Zuarez-easton et al. (2023) indicate that pain-control during labour, child-birth and post-natal period, being one of the most severe forms of pain experienced among women, should be individualised. Various forms of pain relief have been considered for effectiveness including pharmacological agents, and non-pharmacological options. The authors however, indicate that each of the pain-control options is associated with varied levels of failure rate and thus regular pain assessments and prompt interventions improve pain relief. This ought to be considered in all levels of healthcare, because pain is common, its control is a basic need and affects all the systemic parameters of the body and recovery.

In regards to satisfaction of mothers during implementation of the FMP, the mean waiting time in the antenatal clinic of 70 minutes was considered just right-fair by 77.6% of mothers, being an indicator of satisfaction. Contrastingly, Abdus-salam et al. (2021). mean waiting time was 143 minutes with more time spent on consultations, laboratory services and paying point, and this influenced service utilization and satisfaction of mothers. Reduction of time spent in the antenatal clinic was recommended. In another study mothers experienced waiting time of 338-503 minutes and 105-216 for follow-up visits with unpredictable and hard to control barriers occurring due to patient, staff and organisational factors. Some of them included staff shortage, unavailability of staff, late commencement of work, slow working speed, disregarding mothers' complaints and staff meetings scheduled during clinic time. Others were unpredictable numbers of patients, patients coming late, inconsistent patient flow, disorientation of mothers attending their first visit, gaps in queuing system leading to spaghetti process flow, referral pathway, duplicate documentations, time taken to guide students doing practical attachment, communication barriers, integrity of and unavailability of equipment and few mothers' toilets (Baron and Kaura 2021).

Additionally, perceived average provider responsiveness to needs, hospital cleanliness, information and reassurance provided antenatally, intrapartum and postnatally were rated well to the majority of mothers in the current study. Mothers were vocal regarding the usefulness of these aspects but they noted that patients were too many for especially nurses and doctors and recommended that staff numbers needed to be increased. Despite discomfort owing to limitation in space and sharing beds, most of them would still recommend the hospital to friends/relatives, and this is an indicator of satisfaction. Professionally it is unhygienic and uncomfortable for mothers and their babies, and a breach of privacy to share beds especially with strangers, and this may create a conducive environment to spread infectious disease and breeding of vermin in unhygienic conditions. Contrastingly, in a previous study unwillingness to recommend the facility to friends or relatives and return to the facility was associated with provider aggressive behaviour, abuse or discrimination to mothers (Lazzerini et al. 2020). On the other hand, evidence from four counties indicates that measuring mothers' satisfaction can be objectively based on emotional satisfaction (reassurance), provider support, respect and communication (Bohren et al. 2025). Another study showed that mothers' satisfaction with services was related to effective provider communication, timely respectful care, being listened to, being involvement and physical structures (Lazzerini et al. 2020).

V. Conclusion

This research has highlighted rating of satisfaction among antennal, intrapartum and postnatal maternity mothers. Both quantitative and qualitative data offers very good lessons for various stakeholders regarding maternity care. There is a common call to plan, implement, monitor and evaluate policies closely to increase satisfaction and service utilisation. Perceptions on quality of services received isolated pertinent patient,

health provider, institutional and governance factors, which when considered can further improve the hospital image, healthcare provider professionalism and patient experience.

VI. Recommendations

It is recommended that maternity care policies should be objective, involve stakeholders for ownership, execution and evaluation. Resources, training and support-supervision plans must be considered before policy implementation. Patient, provider, institutional factors influence maternity mothers' satisfaction and are critical alongside affordability of care. Therefore, regular data on these aspects is recommended to provide timely feedback and lessons to enable necessary adjustments to avoid derailment, increase stakeholder understanding, reduce conflicts, dissatisfaction and burnout.

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