UKR Journal of Medicine and Medical Research (UKRJMMR)
Homepage: https://ukrpublisher.com/ukrjmmr/
Email: submit.ukrpublisher@gmail.com
Volume 2, Issue 2, March-April 2026
ISSN: 3107-5061 (Online)

Women's experiences of decision-making choices and control of the labour care

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DOI: *https://doi.org/10.5281/zenodo.19767398*

Article History
Original Research Article
Received: 05-03-2026
Accepted: 10-04-2026
Published: 25-04-2026

Citation: Okorie Amarachi Onuka, Prof. Ngozi Orazulike, Prof. Faith Diorgu. (2026). Women's experiences of decision-making choices and control of the labour care. UKR Journal of Medicine and Medical Research (UKRJMMR), 2(2), 65-71.

Abstract

Introduction
Decision-making choices and the experience of control are essential components of care during labour. Choice is a fundamental element of quality childbirth care, and birthing women desire to have choices when receiving labour care. Components of control comprise of access to information, personal safety, decision-making, and physical functioning. This study aims to unravel women's experiences of decision-making choice and control of the labour care.

Method
The study is qualitative study and descriptive phenomenology was employed to undertake the study. The sample comprised of 21 women who were purposively selected. In-depth interviews were conducted to collect data and thematic analysis was done.

Result
Three themes were generated from the data: being involved, diverse experience of control and paying attention.

Conclusion
Most women participated in decision-making and experienced the feeling of being in control of their labour care. However, a few women were not involved in decision making during birth and another few women felt they experienced a loss of control over the labour care. Opportunity should be provided for women to be actively involved in their care.

Keywords: *labour care, decision-making, maternal autonomy, childbirth experience, perceived control, qualitative study, phenomenology, women's experiences*

Introduction

Decision-making choices and the experience of control are essential components of care during labour (Mazuchova et al., 2020). Health policies demand that maternity care be delivered in a manner that empowers women to make choices for themselves (American College of Nurse-Midwives, 2022). Choice is a fundamental element of quality childbirth care, and birthing women desire to have choices when receiving labour care (Phipps, 2020). The White Ribbon Alliance (2023) noted that every birthing woman has the right to information, respect for preferences and choices as well as the right to request or refuse medical interventions.

The childbirth continuum has two ends with the normal or natural birth method on one end and the medicalized birth method on the other end, and between both extremes, there are several birth options from which women could state their birth choices. This includes mode of birth, place of birth, birth companion, care provider, birth positions, pain relief measures, umbilical cord clamping time, and birth interventions such as induction of labour. Borrelli et al. (2020) studied women's involvement in decision-making in

labour. Although the focus was on women's choice of epidural analgesia, the findings revealed that women expect to actively participate in the decision-making process. Women expect midwives and other healthcare professionals involved in their care to provide advice and support the choices they make.

Meyer (2013) outlined four components of control, which comprise of access to information, personal safety, decision-making, and physical functioning. The identified components of control by Meyer (2013) are four key areas of care that could be adequately addressed for women to have a feeling of being in control of their labour care. The nature of the care received by a woman during labour may determine whether the woman will experience the feeling of being in control of her labour care. Birthing women wish to gain a feeling of personal accomplishment and control by being part of decision-making during birth. Besides, having a sense of control during labour could be a key contributor to a woman's childbirth experience (Chabbert et al., 2021). Previous studies have explored women's experiences of decision making or experience of control independently (Johansson et al., 2022; Colley et al., 2018). Snowden (2011) studied choice and control. However there is no identified current study that explored decision making choices and control of labour care. Therefore this study aims to unravel women's experiences of decision making choice and control of labour care. The research question to be considered is: What are women's experiences of decision making choices and control of labour care?

Statement of Problem

Concepts such as decision making choices and control of the labour care are increasingly becoming subjects of interest in maternity care. Women believe in their inherent ability to participate in their childbirth care. World Health Organisation (2018) intrapartum care guidelines emphasize the need to communicate treatment options to women and the need for women to make decisions for themselves. Husckle (2021) reported that it might be claimed that healthcare providers involve women in decision-making about the choice of treatment, but sometimes women are not really involved in decision-making; women are merely informed about what to do and what will happen to them. Previous studies have explored decision-making and control in labour independently. This study seeks to uncover women's experiences of decision-making choices and control in labour.

Method

The research design for this study is descriptive phenomenology, which offers an in-depth description of life experiences (Holloway & Galvin, 2016). This study was undertaken in infant welfare clinics in three health facilities in Umuahia, Abia state, Nigeria. The selected facilities are Federal Medical Center Umuahia, the primary healthcare facilities at Ojike Street and Adelabu Street, Umuahia. The facilities were chosen for the study because these clinics were well attended by mothers with infants. The eligibility criteria include women who were up to 18 years of age, who attend infant welfare clinics in public healthcare facilities whose infants were not more than twelve months of age.

Women whose infants were less than twelve months of age but were critically ill at the time of the study were excluded as they may not be emotionally stable to share their birth experiences. Purposive sampling was employed to derive the sample of 21 women for this study. The sample for this study was derived from the sample for the quantitative study that was conducted alongside this study. Women who met the inclusion criteria and participated in the quantitative study and indicated the willingness to be interviewed were enrolled for the qualitative study. Ethical approval was received from the University of Port Harcourt ethics committee. A total of 21 interviews were conducted. The data collection began in June 2024 and ended in December 2024. The interview was audio recorded. The Interview was conducted by the researcher in the side room of the clinic in Federal Medical Centre, while in the other two facilities, the interview was held in a quiet office. Twelve women were interviewed at the Federal Medical Centre, six women were interviewed at the Ojike Primary Healthcare Facility, and three women were interviewed at the Adelabu Health Facility. The audio recordings were manually transcribed. Thematic analysis as described by Barun and Clarke (2006) was employed for data analysis. The generated codes were merged to form ten sub-themes and three main themes emerged from the sub-themes.

Result

The demographic data of the participants are as represented in table 1.1. Of all the women who participated in the study, 71% of the participants were between the age range of 22-29, while 29% of the respondents were within the age range of 30-37 years. The women were all Igbos, and 88% of the women had tertiary education, 8% had only senior secondary school education, while 4% had only primary school education. A total of 64% of the women were self-employed, 20% were civil servants, 6% were employed by private institutions, while 10% of the women were unemployed. All the women were married, and they were all Christians.

Table 1.1: Demographics of respondents.

Interview participant (Ip)	Age	Tribe	Marital status	Religion	Level of education	Employment status	Number of Children
1	24	Igbo	Married	Christianity	Tertiary	Unemployed	2
2	30	Igbo	Married	Christianity	Tertiary	Unemployed	4
3	27	Igbo	Married	Christianity	Secondary	Self employed	3
4	23	Igbo	Married	Christianity	Primary	Employed	2
5	26	Igbo	Married	Christianity	Tertiary	Self employed	2
6	35	Igbo	Married	Christianity	Secondary	Employed	4
7	37	Igbo	Married	Christianity	Tertiary	Employed	3
8	29	Igbo	Married	Christianity	Secondary	Employed	4
9	25	Igbo	Married	Christianity	Tertiary	Self employed	2
10	28	Igbo	Married	Christianity	Tertiary	Self employed	1
11	24	Igbo	Married	Christianity	Secondary	Self employed	2
12	23	Igbo	Married	Christianity	Secondary	Self employed	2
13	25	Igbo	Married	Christianity	Tertiary	Self employed	1
14	30	Igbo	Married	Christianity	Tertiary	Self employed	3
15	22	Igbo	Married	Christianity	Secondary	Self employed	2
16	28	Igbo	Married	Christianity	Secondary	Self employed	2
17	27	Igbo	Married	Christianity	Secondary	Self employed	4
18	35	Igbo	Married	Christianity	Tertiary	Employed	4
19	26	Igbo	Married	Christianity	Secondary	Unemployed	1
20	28	Igbo	Married	Christianity	Primary	Unemployed	3
21	30	Igbo	Married	Christianity	Secondary	Employed	2

Thematic analysis was employed for the analysis of the data, codes were identified and sub- themes and themes were generated. Three themes emerged from the analysis of the women's verbal reports as indicated in table 1.2.

Table 1.2 Themes and sub-themes

Themes	Sub-themes
Being involved	Part of decision making
	I was involved
	Limited options
	Cared for as an individual
Diverse experience of control	Experienced loss of control
	Control is mutual
	I took charge
Paying attention	Able to communicate
	Listen to women

Being involved

An important theme running throughout the verbal report of women was their expectation and experience of being involved in decision-making. Majority of the women expected to be part of the decision-making during labor and be actively involved in their own care to enable them to make meaningful contribution to their labour care. A woman stated that it is expected of the healthcare providers to involve a woman in any decision-making before reaching out to any of her family members, and that women should be able to choose a birth position and should be able to choose to have or refuse to have an intervention, for example:

"…I expect that if there's need for episiotomy, I should be alerted first and I expect that my birthing position should be my decision to make" (IP 20).

Some women also reported that during labor they made decisions for themselves without being compelled. Some women affirmed that consent was sought from them and obtained before procedures and interventions were carried out by healthcare providers, while a few women felt the decision-making was mutual as they discussed with their care providers to arrive at a decision. Therefore, the women felt a sense of involvement in decision making.

"…I was able to make decisions, but in other way round. They would tell you, then after they must have educated you on your decision then you now have to decide whether to go ahead with your own decision or their own idea" (IP 17).

Among the women who reported being involved in decision making, a woman who had a vaginal birth eagerly expressed that it was her decision to have a vaginal birth, therefore, she felt she was involved in decision making:

"…I was involved, they are not the ones that decides for me. I was the one that decided that I will take birth by myself" (IP 3).

Another minority of women reported not making any contribution in deciding their care as their opinion was not sought during decision making but decision making was undertaken by healthcare professionals:

"…The doctors and the nurses, they were the ones that told me what to do and didn't ask for my decision or opinion" (IP 16).

"...There was no involvement" (IP 13).

A few other women expect that their care providers should be sufficiently knowledgeable to know what to do for women. For example a woman stated:

"…I was expecting that the nurses would know what to do, each person in the field should do what they are supposed to do so that everybody will be happy, this is a big hospital, a teaching hospital for that matter" (IP 7).

Women reported the need for varied care options to be offered to women. When the care options in labor are limited, women may not experience decision making choices and may be compelled to make decision within the limited options:

"…Options were limited, I had to choose from the limited options" (IP 9).

"….I was supposed to be informed about of pharmacological pain relief but I was not. If a woman does not have knowledge of it, the physician did not inform her or the nurses, she won't be able to request that and that cannot be provided for her because it was not initially requested or agreed upon" (IP 9).

In addition, there were instances where women's preferred care options were honored, a woman reported that she wished to maintain mobility and assume an upright position during the first stage of labor and she convinced her care providers to allow her to move about.

Meanwhile there are instances where the preferences of a woman may not be honored by her care providers because it may adversely affect the health of the woman, For instance, one of the participants requested to drink water shortly after a caesarean section but the nurse could not honour her request but the nurse explained why she will not have a drink.

"…I told the nurse that is in charge, the one that is taking care of me…… I told her that I want to drink water. So she said no, that I will stay on for a while before taking water" (IP 1).

Diverse experience of control

The feeling of control varied among the women. Firstly, a few women reported that they had the feeling of loss of control during labor when they were confined to bed and were unable to change position as they wanted as well as when they were compelled to accept treatment. For example, a woman reported that:

"…I felt lack of control in the second stage of labor when I couldn't stand up again" (IP 21).

"…If they want to do anything to you, they don't seek your consent, they just tell you they want to do something. So comply, may be even if you are complaining about your contraction, you shut up and do whatever they have asked you to do. However, provided what me (they) want to do is in my favor, I will succumb after all baby alive, mother alive, that's my aim" (IP 15).

Secondly, another set of women reported that they were partly in control while their care providers were also partly

in control of the labor care. The women believed that they cannot be in total control since they were not trained as healthcare professionals therefore they lack the necessary knowledge to exercise complete control

"… I wouldn't say I was in total control, let me say I was partially in control" (IP 9).

"…You can't have100% control because you are not the caregiver, you are not the doctor" (IP 2).

Thirdly, it was reported by another woman that control of the labour care is mutual, the woman reported the need for women to cooperate with the healthcare provider.

"…The control of it (labour) is mutual, as in the nurses, the doctors and yourself, you cooperate, not only you or only them, yes it is mutual, yes mutual" (IP 8).

Fourthly, a few women were pleased to report that they felt they were in control of the labor care. A woman expressed that she had the feeling of being in control when her decisions were respected, the woman also reported that her experience of feeling in control of the labor care made her feel important that the health worker could listen to her and she felt more reassured that the outcome of her labor will be positive:

"…I was doing what I was supposed to do and I have a little knowledge about childbirth and what is happening with it so they didn't control me. I took charge" (IP 7).

"…Actually my experience of feeling in control during the whole labor process gave me joy, that actually I felt important, them listening to what I said, it made me feel important and at peace that the outcome of labor was going to be successful" (IP 20).

Lastly, another minority of women never desired to have control over their childbirth care. They were pleased to completely cede their right to exercise control over their labour care to the healthcare providers:

"… I never wished to have control over my destiny because this is my first experience. So hence the doctors and the nurses are doing their work. My only wish is to follow their order and what they are leading" (IP 4).

Paying Attention to Women:

The account of most women explained the need for healthcare workers to actively listen to the women and communicate with women in a respectful manner.

"…I think they should listen to women when they are in labor. During childbirth, because that time is severe, is a pitiful time" (IP 16).

The majority of the women expect the care provider to be polite and friendly as the women whom they are caring for are under the stress of labor,

"…there are some that are hostile. In fact, the kind of words they will be saying to the person is not good. So let them change some pattern and try to be friendly to pregnant women. It will help calm contraction or the labor before the person will give birth" (IP 15).

In addition to listening to women, majority of the women expressed the need for care providers to answer the call of women in labour. Although the women appreciate that the care providers may experience work pressure they still desire response from the care providers each time they call. Furthermore, ignoring the call of women was a common experience reported by some women. Ignoring the call of women at the time they were in pains left the women with negative emotions. Some women noted that their care provider did not respond to their call to assess their labour progress.

"…I called the nurse in charge that she should come, that my water broke. She didn't listen to me" (IP 1).

"…Sometimes you will call them they will just ignore you as if maybe you don't know what is happening" (IP 4).

On the other hand, a few women reported that the midwives responded to their call and reassured them by explaining that it was not yet time to birth the baby. The women felt satisfied with their birth experience when they had healthcare providers who adequately communicated with them:

"…It was a successful one because they always make sure that …ehh you are communicating with them, making you to feel free, making you laugh, making you to see the reason that you can make it, come out with joy, no matter the pain, no matter everything, so it was very nice one" (IP 19).

"…Like me, when you know, as a woman, sometimes you shout, shout, shout, you are calling the midwife, they tell you, that is not yet time, you should relax, it is just contractions that the baby is not coming. When I called them they will come and answer, check and say you are okay, they would encourage you" (IP 2)

Discussion

This study tends to unveil women's experiences of decision-making choices and control of the labour care. The key findings shows that most women wish to be involved in decision making about their care therefore they made decisions for themselves during labour. However, a few women were comfortable to jointly make decisions with health care providers. Another minority did not enjoy the privilege to be involved in decision making. This is consistent with the findings of Coates et al (2021) that women desire to actively participate in decision making and most of women felt involved in their care though a few women reported that they were not involved in their care.

Jackson (2022) reported that women felt left out in contributing to their labour care when decision making was staff-led. On the other hand, a few women expect the health care professional to make decisions about their care. This aligns with the findings of a study conducted by Bibeau (2014) that noted that some women were comfortable to follow the decisions of the healthcare providers in order to minimize the risk associated with childbirth. There is need for care providers to effectively engage women in discussions about their care to empower women to actively participate in decision making during labor.

In addition, women expressed the need to be offered varied care options as well as the need for their preferences to be respected as active participation in decision making could be limited when care options are limited. Lopez-Toribio et al. (2021) noted that 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. However, when it is difficult to respect women's preference for safety reasons, it should be clearly and respectfully communicated to women.

Further findings from this study reveal that women had diverse experiences of control, some women reported that they were happy to have a sense of being in control of their care, but a few women reported that they had the feeling of loss of control of the labor care when consent was not sought from them and when they could not be involved in decision making. This aligns with the findings of a study on women's appraisal of traumatic birth by Baptie et al. (2021) which identified that some women felt empowered during their birth while others felt powerless, women who felt powerless during birth reported that they had no choice and they lacked control over their childbirth care. This implies that women may experience the feeling of being in control of their labour care if they were empowered to make decisions for themselves.

Another minority felt that the control of the labour care was mutual implying that the birthing woman and the care provider should jointly be in control of the labour care. Doherty et al (2023) studied the experience of control in relation to birth satisfaction and women reported that having a trusted midwife facilitated their experience of choice and control. This implies that care providers such as midwives could support women to experience the feeling of being in control of their labour care.

Further findings from this study show that some women were pleased when the care providers were polite to them and listened to them when they called for the attention of the care provider. However, a few women were displeased by the poor attitude of some of the health care providers who were hostile to the women and ignored the women when they sought for attention. Dorairajan et al. (2020) studied the felt needs of women during birth and the findings suggest that a few women still experience disrespectful care in health facilities. Disrespectful care is unacceptable, care providers should uphold the rights of birthing women and support women to experience optimal satisfaction with their childbirth care as this could potentially impact the well being of the mother in the post partum period and beyond.

Conclusion

This study unveiled women's experiences of decision-making choices and control of the labour care. Most women were actively involved in decision making concerning their care while a few others were not involved in decision making. Another minority were happy to either make decisions with their care provider or rely on the care provider to make decisions for them. Some women experienced a sense of control over their labour care but a few women felt they experienced loss of control. The findings reveal the need for all birthing women to be adequately supported to actively participate in decision making and experience control over their childbirth care.

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