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Maternal Satisfaction and Quality of Life in Women with Hypertensive Disorders of Pregnancy: Findings from a Cross-Sectional Study

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Abstract

Hypertensive disorders of pregnancy (HDP) pose serious risks not only to maternal and neonatal outcomes, also impacts the psychological well-being of women. The current study aim to assess the maternal satisfaction and Quality of life of women diagnosed with HDP. A cross-sectional study was conducted among 100 women diagnosed with HDP who consented to participate. Participants were selected using purposive sampling from a tertiary care center in Bhubaneswar, Odisha. Ethical guidelines were strictly followed, and institutional approval was obtained (Ref. No: IEC/IMS.SH/SOA/2021/234). The current study has found the prevalence of gestational hypertension as 46%, out of which 21% had preeclampsia, 9% had eclampsia, and 6% having superimposed preeclampsia & eclampsia. A significant proportion of women (42%) reported a low level of satisfaction with the care received and and 35% reported a low level of Qol. The findings indicate that hypertensive disorders during pregnancy significantly impair women's quality of life and increase their vulnerability to postpartum psychological issues. The study underscores the need for midwifery-led interventions to provide comprehensive support and improve maternal well-being.

Keywords: Eclampsia, Gestational Hypertension, Hypertensive Disorders of Pregnancy, Maternal Satisfaction, Preeclampsia, Quality of Life.

Introduction

Hypertension during pregnancy is a significant high-risk condition, affecting approximately 2–3% of all pregnancies. Hypertensive disorders of pregnancy (HDP) include chronic hypertension, gestational hypertension, preeclampsia, eclampsia, and superimposed preeclampsia on chronic hypertension (1). HDP is diagnosed when systolic blood pressure is ≥140 mm Hg and/or diastolic pressure is ≥90 mm Hg on two occasions at least 4–6 hours apart. In the United States, HDP affects 13–15% of pregnancies, reflecting a substantial public health concern that requires early identification, prevention, and management (2). Globally, its prevalence ranges from 5% to 15%, with key risk factors including excessive weight gain, advanced maternal age, and metabolic disturbances. HDP is associated with maternal complications such as stroke, cardiovascular disease, diabetes mellitus, renal impairment, and long-term cognitive decline, as well as adverse fetal outcomes (3). In India, HDP contributes significantly to perinatal morbidity. Among primigravida women, prevalence is estimated at 18.6%, with a mean age of 26.34 ± 3.84 years (4). Identified risk factors include a family history of hypertension, elevated BMI, conception via in vitro fertilization, and gestational hyperglycemia. A study from Salem, Tamil Nadu, reported a prevalence of 10.4%, with primigravida women (54%) more affected than multigravida (46%). The most common age group was 18–22 years, and HELLP syndrome was the most frequently reported complication (5). The presence of any high-risk condition during pregnancy is inherently stressful and has a direct impact on the woman's quality of life (QoL). Several studies have explored this association, indicating that women experiencing high-risk pregnancies such as those complicated by abortion, antepartum hemorrhage, anemia, or cesarean section tend to report poorer quality of life compared to those with uncomplicated pregnancies (6). In Iraq, women with gestational hypertension reported moderate QoL, which declined further with complications

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such as gestational diabetes or oligohydramnios (7). Similarly, a nurse-led vascular symptom management program in Uttarakhand, India, demonstrated improvements in QoL among women with gestational hypertension, is highlighting the effectiveness of targeted interventions (8).

Maternal satisfaction is closely linked to QoL and is influenced by financial resources, quality of hospital care, family support, and the health of both mother and newborn. Women with HDP often experience anxiety and fear, perceiving the condition as life-threatening, which negatively affects coping and satisfaction (9). In Canada, a study reported that interventions such as guided imagery have been shown to reduce anxiety and improve relaxation in women with pregnancy-induced hypertension (10). Studies from Ghana and Australia further underscore the importance of respectful care, emotional support, and patient empowerment, such as self-monitoring of blood pressure, in enhancing satisfaction and confidence (11, 12). While extensive research exists globally on the QoL and satisfaction of women with HDP, there remains a dearth of context-specific studies in developing countries like India, particularly in regions such as Odisha. Unlike developed countries, where well-established protocols and infrastructure support comprehensive HDP management, India continues to face challenges in early detection, intervention, and prevention. In light of these gaps, the present study was undertaken to explore the issue in depth and contribute valuable insights toward improving maternal health outcomes in this context.

Methodology

Study Design and Participants

The current study has adopted a cross-sectional research design to assess the quality of life and maternal satisfaction with care among women diagnosed with hypertensive disorders of pregnancy. Women attending the antenatal outpatient department at IMS and SUM Hospital, Bhubaneswar, Odisha, who were diagnosed with HDP and consented to participate, were included in the study. Ethical approval was obtained from the Institutional Ethics Committee of IMS & SUM Hospital [IEC Ref. No: IEC/IMS.SH/SOA/2021/234], and written informed consent was secured from all participants in the local language.

Setting of the study

The study was conducted at IMS and SUM Hospital, a tertiary care teaching hospital located in Bhubaneswar, Odisha, with a bed capacity of 2000. The antenatal OPD receives an average of 3–4 women with HDP daily. This hospital serves as a referral center for surrounding districts, making it a purposive choice for the study setting.

Sample Size Estimation and Inclusion Criteria

A total of 100 pregnant women diagnosed with hypertensive disorders of pregnancy were included in the study. The sample size was estimated based on an expected prevalence rate of 6.2%, as reported by researchers in the past (13). Using a 95% confidence level ($Z_1-\alpha/2 = 1.96$) and an absolute precision of 5%, the required sample size was calculated using the formula:

$$n= \frac{(Z1-\alpha/2)2 \cdot p \cdot (1-p)}{d^2}$$

$$n=\frac{(1.96)^2 \times 0.062 \times 0.938}{(0.05)^2}=89.32$$

Where:

- $Z_{1-\alpha/2}$ =1.96 (for 95% confidence level),
- P= 0.062 (expected prevalence = 6.2% from past research, (13))
- (1-p) = 0.938 and
- d = 0.05 (absolute precision = 5%).

*We selected an absolute precision of 5% because this is a cross-sectional study where recruiting parameters like single-centre study, purposive sampling technique may limit sample size.

The estimated sample size was 89.32. To ensure feasibility and to allow a margin for potential non-response or incomplete data, we rounded the sample size to 100 participants.

Eligibility Criteria

The study included all pregnant women diagnosed with hypertensive disorders of pregnancy who attended the antenatal outpatient department of IMS and SUM Hospital. There were no restrictions regarding gestational age or the specific type of HDP. However, the study excluded women who declined to participate, those with twin pregnancies (to avoid potential confounding effects on adverse perinatal outcomes associated with HDP), and women with chronic medical comorbidities such as diabetes, severe anemia, renal disease, cardiac conditions, anti-phospholipid antibody syndrome, known TORCH infections, and epilepsy.

Data Collection Tool and Techniques

For data collection, the investigator utilized a total of five structured tools. The first was a socio-demographic proforma designed to capture baseline characteristics such as age, education, occupation, religion, and hemoglobin level. The second tool gathered obstetric details, including gravida, para, number of live births, history of abortion, and current gestational age. The third tool focused on complications related to hypertensive pregnancy, documenting variables such as past cesarean history, mode of delivery, type of hypertensive disorder, presence of complications, and their specific nature. To assess maternal satisfaction, the fourth tool used was the 'Satisfaction of Mothers with Midwifery Care Questionnaire,' consisting of 15 items rated on a three-point scale: 1 for dissatisfied, 2 for somewhat satisfied, and 3 for satisfied. Here higher score indicated higher satisfaction. The reliability of the tool is 0.73. Lastly, the 'WHO Quality of Life-BREF' questionnaire was used to measure quality of life. This tool contains 26 questions rated on a five-point scale: 1 indicating very poor, 2 poor, 3 neither poor nor good, 4 good, and 5 very good. The reliability of the tool is 0.86. Here higher score indicated higher quality of life.

Data collection procedure

Formal permission was obtained from the Medical Superintendent of IMS and SUM Hospital and clearance from the IEC. The data were collected for a period of seven months from 02.02.2024-02.09.2024. Eligible women diagnosed with HDP were identified from the antenatal OPD. After explaining the purpose and procedures of the study, those who agreed provided written informed consent. Participants were assured of confidentiality, voluntary participation, and their right to withdraw without affecting their treatment. To avoid missing data to affect the study accuracy, incomplete questionnaires with missing responses were excluded from the final analysis.

Method of Administration

Each eligible participant was individually interviewed in a private setting. The average time for data collection was approximately 20 minutes per participant. Responses were recorded by the investigator. After completing the interview, participants were thanked for their cooperation.

Statistical Methods

After data collection, the responses were initially entered into Microsoft Excel for cleaning and coding, followed by final analysis using SPSS version 20. Given that the study was observational and involved two main variables, both descriptive and inferential statistics were employed. The assumptions for the were "Hypertensive disorders of pregnancy may affect the quality of life and level of satisfaction among women". Descriptive statistics such as frequency and percentage were used to summarize the socio-demographic characteristics, obstetric parameters, and complication status of women diagnosed with hypertensive disorders of pregnancy. Similarly, the levels of quality of life and maternal satisfaction were also assessed using frequency and percentage. To explore the relationship between maternal satisfaction and quality of life, Karl Pearson's correlation coefficient was applied. Additionally, chi-square analysis was conducted to determine the association between quality of life and maternal satisfaction with selected socio-demographic variables. The flowcharts outlining the conceptual framework are presented in Figure 1.

Ethical Consideration

Ethical approval was obtained from the Institutional Ethics Committee of IMS & SUM Hospital (Ref. No: IEC/IMS.SH/SOA/2021/234). A convenience sampling method was used to recruit 100 eligible participants based on predefined inclusion and exclusion criteria. Written informed consent was obtained from each participant prior to data collection. Confidentiality and the right to withdraw at any point during the study were ensured.

Results

During the study period, a total of 437 women were screened for eligibility, of which 127 met the inclusion criteria. Among them, 100 women consented to participate and were included in the final analysis. These participants were all diagnosed with pregnancy-induced hypertension and fulfilled the study's inclusion criteria. The baseline data revealed that the majority of hypertensive women were aged between 25–35 years (70%), while 11% were over 35 years. Most participants were educated up to graduation and above (48%), identified as homemakers (61%),

and were predominantly Hindu (94%). Regarding hemoglobin levels, 46% had levels between 11–12 gm/dl, while 31% had anemia (Hb <11 gm/dl). Obstetric characteristics showed that 85% were gravida ≤2, and only 4% were gravida >4. A significant proportion (68%) was primigravida, while 52% had no live births. In terms of abortion history, 14% had one abortion, 2% had two, 4% had three, and 1% had four abortions before the current pregnancy. Nearly half (49%) of the women were in the gestational age range of 34–37 weeks during data collection.

With respect to hypertensive pregnancy outcomes, 17% had undergone cesarean section in a previous pregnancy. In the current pregnancy, 61% delivered via emergency cesarean, 18% by planned cesarean, 19% through vaginal birth, and 2% via assisted vaginal delivery. The distribution of hypertensive disorders was as follows: 18% had chronic hypertension, 46% gestational hypertension, 21% pre-eclampsia, 9% eclampsia, and 6% had progressed to superimposed pre-eclampsia/severe pre-eclampsia or eclampsia (Figure 2). Overall, 65% of women developed complications, the most common being endocrine (24%) and hypertension-related (15%) disorders (Table 1).

Maternal satisfaction levels showed that 42% of women had low satisfaction, 34% were moderately satisfied, and 24% were highly satisfied with the care received. Regarding quality of life, 42% reported a moderate level, 35% a low level, and 23% a high level of quality of life (Table 2). A significant positive correlation (r value 0.66, $p = 0.001$) was observed between maternal satisfaction and quality of life, indicating that higher satisfaction is associated with better quality of life (Table 3).

Chi-square analysis revealed that maternal satisfaction was significantly influenced by variables such as age of the mother and occupation at $p<0.05$. this may be interpreted that, women's who were being mother in the reproductive age group of 25-35 years and were homemakers were more satisfied than others (Table 4). Additionally, quality of life also significantly associated with age and occupation at $p<0.05$, indicating that women who conceived in the reproductive age and were homemaker, have good Qol, as they can rest more and can have more planned parenthood (Table 5).

Table 1: Description of Socio-demographic Characteristics, Obstetric Parameters and HDP outcomes in Frequency and Percentage (N=100)

Variables	f (%)
Age	
< 25 years	19 (19)
25 to 35 years	70 (70)
> 35 years	11 (11)
Education	
No Formal Education	2 (2)
Primary education	10 (10)
Secondary	40 (40)
Graduation and above	48 (48)
Occupation	
Home maker	61 (61)
Working	39 (39)
Religion	
Hindu	94 (94)
Muslim and others	6 (6)
Hemoglobin	
<11 g/dl	31 (31)
11-12 g/dl	46 (46)
12.1-14 g/dl	21 (21)
>14 g/dl	01 (01)
Obstetric Parameters	

Gravida *n(%)*	
≤ 2	85 (85)
3-4	11 (11)
> 4	4 (4)
Para *n(%)*	
Primi	68 (68)
Multi	32 (32)
Livebirth *n(%)*	
None	52 (52)
One or more	48 (48)
Abortion *n(%)*	
None	79 (79)
One	14 (14)
Two	02 (2)
Three	04 (4)
Four	01 (01)
Gestational Age *n(%)*	
<34 weeks	13 (13)
34-37 weeks	49 (49)
38-40 weeks	36 (36)
>40 weeks	02 (02)
Outcomes of HDP	
History of LSCS *n(%)*	
Present	17 (17)
Absent	83 (83)
Mode of delivery *n(%)*	
Vaginal delivery	19 (19)
Assisted vaginal delivery	02 (02)
Planned LSCS	18 (18)
Emergency LSCS	61 (61)
Presence of Complication *n(%)*	
Absent	35 (35)
Present	65 (65)
Type of complication	
No complication	37 (37)
Endocrine	24 (24)
Hypertension related complication	15 (15)
Other reasons	24 (24)

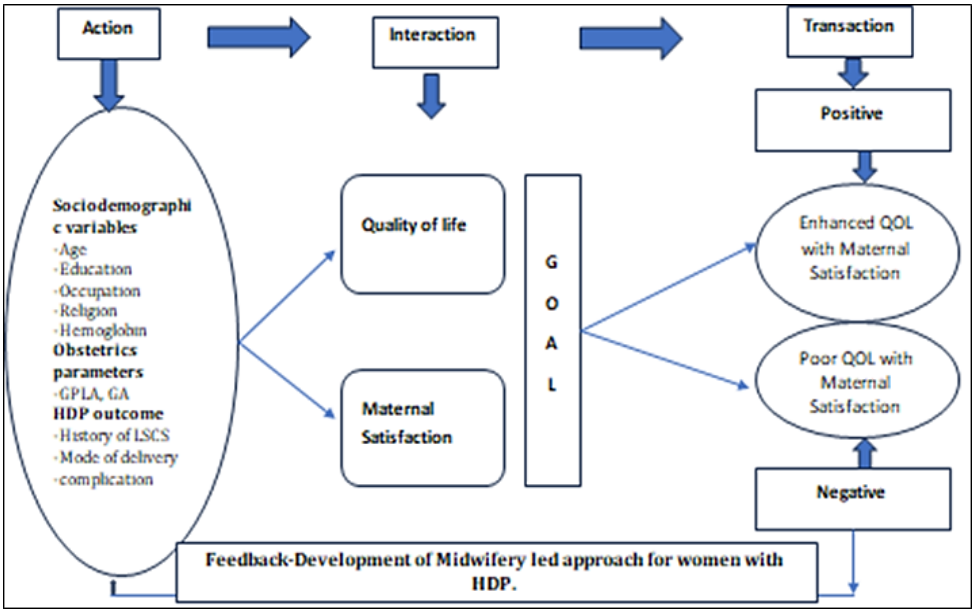

Figure 1: Conceptual Framework of the Study

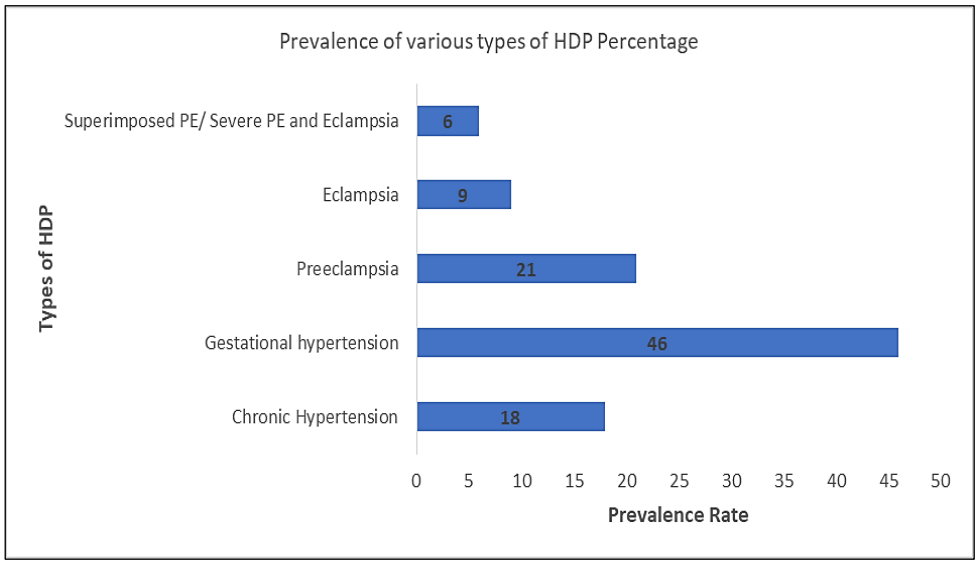

Figure 2: The Prevalence Rate of Various types of HDP

Table 2: Frequency and Percentage Distribution of level of Maternal Satisfaction and Quality of Life

Variables	f (%)
Level of Maternal Satisfaction	
Low level of maternal satisfaction	42 (42)
Moderate level of maternal satisfaction	34 (34)
High level of maternal satisfaction	24 (24)
Level of Quality of life	
Low level of Quality of life	35 (35)
Moderate level of Quality of life	42 (42)
High level of Quality of life	23 (23)

Table 3: Correlational Analysis between Maternal Satisfaction and Quality of Life by using Karl Pearson's Correlation coefficient among Women with HDP

Variables	r Value	p Value
Maternal satisfaction		
Quality of life	0.66	0.001*

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

Table 4: Association between Maternal Satisfactions (MS) of Women with HDP with Selected Sociodemographic Variables by Chi Square Test

Variables	MS					
Age	Dissatisfied	Satisfied	Highly satisfied	Chi square value	df	p value
<25 yr	1	6	11			
25-35 Yr	0	40	30			
>35 Yr	0	3	9	10.47	4	0.033*
Education						
No formal education	0	2	1			
Primary education	0	5	6			
Secondary Education	0	22	24			
Graduation & above	1	20	19	2.04	6	0.91
Occupation						
Homemaker	0	30	34			
Working	1	19	16	2.28	2	0.031*
Religion						
Hindu	1	45	48			
Muslim & others	0	4	2	0.82	2	0.66

Table 5: Association between Quality of Life (Qol) of Women with HDP with Selected Sociodemographic Variables by Chi Square Test

Variables	Qol					
Age	Low Qol	Moderate Qol	High Qol	Chi square value	df	p value
<25 yr	1	3	14			
25-35 Yr	5	28	37			
>35 Yr	0	2	10	6.91	4	0.014*
Education						
No formal education	1	0	2			
Primary education	1	4	6			
Secondary Education	4	20	23			
Graduation & above	1	9	30	10.931	6	0.09
Occupation						
Homemaker	1	21	42			
Working	5	12	19	6.46	2	0.041*
Religion						
Hindu	6	31	57			
Muslim & others	0	2	4	0.41	2	0.81

Discussion

The present study offers important insights into how hypertensive disorders of pregnancy shape maternal satisfaction and quality of life, while also highlighting contextual factors that influence these outcomes. Most women were aged 25–35 years (70%), nearly half had education up to graduation or higher (48%), and the majority were primigravida (68%). Educational status appeared to enhance quality of life by enabling access to information, proactive health-seeking and better communication with providers, while parity influenced satisfaction through prior birth experiences and coping abilities. Religion, though not a direct medical determinant, may have shaped cultural expectations and social support, thereby influencing satisfaction. The study further reports gestational hypertension (46%) and preeclampsia (21%) were being most common, with emergency cesarean section accounting for 61% of deliveries and 24% of women developing endocrine complications. These complications and advanced gestational age were linked to lower satisfaction due to greater medical interventions, psychological stress, and disruption of birth expectations. Overall, the findings underscore that maternal satisfaction and quality of life in HDP are influenced not only by disease severity but also by educational, cultural, and experiential contexts.

These findings align with prior Indian epidemiological data where the mean age of women affected by preeclampsia was approximately 29 years, with a near-equal distribution between primigravida and multigravida groups, emphasizing the influence of demographic and clinical factors such as blood pressure variability and proteinuria on HDP outcomes (14). A systematic review noted HDP prevalence ranges between 5.2% and 8.2%, gestational hypertension from 1.8% to 4.4%, and preeclampsia between 0.2% and 9.2%, echoing our prevalence rates. Modifiable risk factors identified included maternal age, parity, and pre-existing hypertension or diabetes (15). Another meta-analysis in India reported a pooled HDP prevalence of 11%, urging policymakers to prioritize early hypertension screening to prevent adverse outcomes (16).

Further literature reviews highlight HDP prevalence in India at around 7.8%, with pre-eclampsia at 5.4%, significantly contributing to maternal morbidity and mortality. Recommended management strategies emphasize emergency obstetric care, fetal surveillance, timely medical interventions, and respectful maternity care (17). Studies from Kashmir and Malaysia reported HDP prevalences of 6.5%, associating advanced maternal age, high BMI, and ethnicity as key risk factors, supporting the role of demographic and lifestyle influences (18, 19). In a large cohort study involving 807 women, advanced maternal age, family history of HDP, obesity, gestational diabetes, IVF pregnancies, and PCOS were significant risk factors for HDP development (20).

Our study revealed that 42% of women reported low satisfaction with healthcare services, while a similar proportion (42%) experienced a moderate level of quality of life. A significant positive correlation between maternal satisfaction and quality of life suggests that improved satisfaction may enhance overall well-being in women with HDP. This is critical, as while hypertension presents with overt physical symptoms, psychological distress often remains under-recognized and unaddressed. Systematic reviews corroborate our findings, showing that women with gestational hypertension commonly experience low health-related quality of life (HRQoL), affected physically and psychologically (21). Interventional studies, such as self-care counseling implemented in Iran, demonstrated significant improvements in quality of life among women with HDP, underscoring the potential of targeted interventions (22). Similarly, Ethiopian research reported significantly lower QOL scores in preeclampsia women compared to normotensive counterparts, especially in physical health domains (23).

Further Systematic reviews indicate that stressors such as concerns over fetal wellbeing, pregnancy complications, and limited familial or community support contribute substantially to reduced quality of life (24). However, in some contexts, the gap in QOL between hypertensive and normotensive women is less pronounced. For instance, research comparing women with HDP to normotensive women found no statistical difference, a finding attributed to early hospitalization, structured clinical pathways, and multidisciplinary care approaches that mitigate the impact of HDP on maternal well-being (25). Interestingly, an Indonesian study reported a high

quality of life among preeclampsia women, suggesting that cultural norms, family support structures, and access to high-quality, woman-centered healthcare strongly influence maternal outcomes (26). Maternal satisfaction is similarly shaped by systemic and cultural dimensions of care. Reports indicate that up to 68.6% of women with preeclampsia express dissatisfaction often linked to adverse fetal outcomes and perceived gaps in care (27). Qualitative research from Ghana underscores how respectful, culturally sensitive, and empathetic care enhances maternal satisfaction, whereas poor communication, indifferent staff behavior, and experiences of verbal or physical mistreatment diminish it (28). Our findings reflect this complex interplay, emphasizing that both systemic healthcare provision and culturally informed, respectful maternity care are critical determinants of maternal satisfaction and Qol.

Conclusion

This study reveals that both quality of life and maternal satisfaction among women with hypertensive disorders of pregnancy are areas requiring greater attention in the Indian context. Although the findings provide valuable insights, they are based on purposive sampling from a single tertiary care center, which may limit the representativeness and generalizability of results to the wider population. Nonetheless, the study highlights important psychosocial dimensions such as satisfaction with care and quality of life, which remain underexplored in women with HDP. Future multi-centre studies with larger and more diverse samples are recommended to validate these findings and to guide context-specific, midwifery-led interventions aimed at improving maternal well-being and health outcomes.

Strengths of the Study

This observational study adds valuable evidence from Bhubaneswar, Odisha, on HDP-related maternal outcomes, offering a foundation for designing midwifery interventions tailored to this population. The study's methodological rigor is enhanced by stringent validity and reliability measures, clear objectives, and adherence to ethical standards, making its findings robust and relevant for tertiary care settings.

Limitations

The study was conducted in a single tertiary care hospital using purposive sampling with a sample size of 100, which limits the representativeness of participants and thereby reduces the generalizability of the findings. In addition, the relatively short data collection period may have influenced the comprehensiveness of the results. These limitations have been acknowledged, and future multicentric studies with larger and more diverse samples are recommended to enhance the strength, validity, and applicability of the evidence.

Abbreviations

GA: Gestational age, GHTN: Gestational Hypertension, GPLA: Gravida, para, living and abortion, HDP: Hypertensive disorders of pregnancy, HELLP: Hemolysis, Elevated Liver enzymes and Low Platelet, PIH: Pregnancy Induced hypertension, QOL: quality of life.

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Author Contributions

Madhusmita Nayak: conceptualization, conducted the study, collected the data, analysis, interpreted the data, drafted the manuscript, Pravati Tripathy: conceptualization, Prasanta Kumar Nayak: conceptualization, analysis, interpreted the data. All three authors critically reviewed the final manuscript.

Conflict of Interest

The author declares no conflict during the study.

Declaration of Artificial Intelligence (AI) Assistance

This manuscript was written by the authors without the use of generative AI or AI-assisted technologies. All content is original and has been created by the authors themselves.

Ethics Approval

Obtained from Institutional Ethics Committee. Letter no- Ref.no/IEC/IMS.SH/SOA/2021/234

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