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Characteristics of pregnant Jordanian women dissatisfied with life: A comparison between satisfied and dissatisfied women’s demographics

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ABSTRACT
Dissatisfied pregnant women who are at higher risk of negative outcomes perinatally have not been identified in Jordan. The purposes of the researchers were to identify and compare sociodemographic characteristics of satisfied pregnant women with dissatisfied pregnant women. A non-experimental, descriptive, comparative design was employed. Jordanian pregnant women (n = 203) were consecutively selected. We found that younger, better educated pregnant women with a high economic status and a small number of children were more satisfied with their lives. Practitioners can identify dissatisfied women and develop an educational and interventional package that focuses on improving satisfaction with life for pregnant mothers.

Dissatisfied pregnant women who are at higher risk of negative outcomes in pregnancy and childbirth have not been identified in Jordan. Knowing demographic characteristics of dissatisfied pregnant women may give opportunities for care providers to identify them and enhance their life satisfaction and subsequently prevent negative outcomes in pregnancy and childbirth. In the current study, the researchers identified and compared sociodemographic characteristics of satisfied pregnant women with dissatisfied pregnant women. We found that younger, better educated pregnant women with high economic status and small number of children were more satisfied with their life. Our findings contributed to better perception of the international audience about the life satisfaction of pregnant women in developing countries and its demographical dimensions. Furthermore, by this study, we would enhance the international understanding of pregnant women situations in third-world nations. Our findings are useful in providing guidance for maternal nurses and midwives, who can identify dissatisfied women by reviewing their demographics and develop an educational and interventional package that...

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focuses on improving satisfaction with life for pregnant mothers to use them in antenatal clinics, Maternal and Child Health Care centers, and antenatal wards of hospitals.

Satisfaction is the fulfillment of one’s desires, expectations or needs, or the happiness derived from this (Oxford Living Dictionaries, 2012). Satisfaction with one’s life involves enjoyment of one’s life situations, or the accomplishment of one’s goals of one’s life as a whole. Furthermore, life satisfaction is a subjective assessment of the quality of one’s life, and it has a large cognitive component (Sousa & Lyubomirsky, 2001).

Different factors have been found to positively affect life satisfaction, such as absence of pain, acceptance of illness, happiness-enhancing strategies, regular exercise and having fun, and good health awareness. Researchers found that patients with musculoskeletal pain were less satisfied with their lives when compared with the general population (Boonstra, Reneman, Stewart, Post, & Schiphorst Preuper, 2012). People who accepted their diseases, received happiness-enhancing strategies (optimism and gratitude conditions), exercised regularly, and who have fun over time showed more satisfaction with life (Boehm, Lyubomirsky, & Sheldon, 2011; Martin-Albo, Nunez, Dominguez, Leon, & Tomas, 2012; Van Damme-Ostapowicz, Krajewska-Kulak, Rozwadowska, Nahorski, & Olszanski, 2012). Moreover, perception of a good health (Melin, Fugl-Meyer, & Fugl-Meyer, 2003) has been affecting satisfaction with life positively.

Life satisfaction has many effects on non-pregnant women life. Less satisfied older women gained weight and had lesser levels of natural killer cells (i.e. healthy aging) than satisfied women (Korkeila, Kaprio, Rissanen, Koshenvuo, & Sorensen, 1998; Tsuboi et al., 2005). Furthermore, women who were less satisfied with life experienced more feeling of loneliness (Fernandez-Alonso, Trabalon-Pastor, Vara, Chedraui, & Perez-Lopez, 2012) and low psychological adaptation to the illness (multiple sclerosis) (Patten et al., 2012).

Researchers found that there was a significant positive correlation between life satisfaction and quality of life (Van Damme-Ostapowicz et al., 2012; Yildirim, Kilic, & Akyol, 2013), and the quality of life directly influenced stress during pregnancy (Shishehgar et al., 2014). Furthermore, they reported a negative association between depression and satisfaction with life (Koivumaa-Honkanen, Kaprio, Honkanen, Viinamaki, & Koskenvuo, 2004; Lue, Chen, & Wu, 2010; Page et al., 2010; Samaranayake & Fernando, 2011; Simpson, Schumaker, Dorahy, & Shrestha, 1996; Webster et al., 2001; Zawawi & Hamaideh, 2009).

Jordanian women live in a collectivist culture (tend to value family, belonging, and the needs of the group). Such culture reported less life satisfaction than individualist culture (tend to value individuality and independence). Jordan is considered to be from the poor countries. Poor countries reported lower life satisfaction than wealthy, industrialized countries (Sousa & Lyubomirsky, 2001). Moreover, Jordanian women are living in a patriarchal society and culture. The traditional family is structured by gender where men are strong and independent, while
women are weak and dependent. Men are, culturally, empowered, while women are, culturally, subordinates. The husband is the leader of the house, and the wife has to obey him. All these situations in Jordan are supported by law and social structure (Al-Badayneh, 2012), affected women’s psychological status and increased their stress, and consequently, lowered their life satisfaction (Darling, Coccia, & Senatore, 2012).

During pregnancy, life satisfaction is affected by age and social support. Aasheim, Waldenstrom, Rasmussen, Espehaug, and Schytt (2014) reported that first-time mothers of advanced and very advanced age reported a slightly lower degree of satisfaction with life compared with the reference group of younger women. This was not the case in non-pregnant women, as researchers found that life satisfaction was not affected by age (Sousa & Lyubomirsky, 2001). Furthermore, researchers found that there was a significant correlation between life satisfaction in the third trimester of pregnancy and social support. Researchers recommended assessing satisfaction with life during pregnancy in order to plan and implement the maternity care appropriate to the needs of women (Gebuza, Kazmierczak, Mieczkowska, Gierszewska, & Kotzbach, 2014).

Sociodemographic characteristics—age, education, income, and parity—correlate and predict many physical and psychological health problems, giving health professionals greater opportunities to help women who are suffering from such problems (Leigh & Milgrom, 2008). Researchers found that there was an association between some sociodemographics—age, education, income, marital status, smoking, parity—and satisfaction with life. For example, having a better income and being employed were very important predictors of higher life satisfaction (Baumann, Lurbe, Leandro, & Chau, 2012; Frijters, Haisken-Denew, & Shields, 2004; Ketchum et al., 2012; Melin et al., 2003). Additionally, people who have a better education (Baumann et al., 2012; Melin et al., 2003), a steady relationship (Melin et al., 2003), a healthy weight (Forste & Moore, 2012), and a greater fertility rate (Klemm, Magann, Morrison, & Chauhan, 2012) were particularly likely to be more satisfied with their lives. Unfortunately, none of these sociodemographics studies were done for pregnant women.

In developing countries like Jordan, care providers need to understand the role of life satisfaction in shaping the psychological status of pregnant women, which in turn affect women’s and their babies’ physiological status. As the researchers found satisfaction with life correlates with depression (Lue et al., 2010), while depression during pregnancy negatively impacts maternal and infant outcomes (Hammond & Crozier, 2007; Lusskin, Pundiak, & Habib, 2007; Pakenham, Smith, & Rattan, 2007; Zayas, Jankowski, & McKee, 2003). Knowing demographic characteristics of dissatisfied pregnant women may give opportunities for care providers to identify them and enhance their life satisfaction, and subsequently prevent negative outcomes in pregnancy and childbirth. Unfortunately to date, dissatisfied pregnant women who are at higher risk of negative outcomes in pregnancy and childbirth have not been identified in Jordan. Hence, our purposes were to identify
and compare sociodemographic characteristics of satisfied pregnant women with dissatisfied pregnant women.

A thorough literature review showed that satisfaction with life was measured among a variety of patients such as patients with chronic musculoskeletal pain (Boonstra et al., 2012), multiple sclerosis’s patients (Patten et al., 2012), malaria patients (Van Damme-Ostapowicz et al., 2012), post-traumatic brain injury (Ketchum et al., 2012), and post-stroke survivors (Baumann et al., 2012). Furthermore, it was measured among different age groups, for example, adolescents (Forste & Moore, 2012), young adult college students (Mahmoud, Staten, Hall, & Lennie, 2012), female midlife (Fernandez-Alonso et al., 2012), and military service people (Britton, Ouimette, & Bossarte, 2012). Moreover, few studies examined the association between satisfaction and psychological effects during pregnancy. In fact, none of these studies were about satisfaction with life. For example, some studies were about the effect of sexual satisfaction on emotional stress (Witting et al., 2008), as good partner relationship could have a protective effect against some stress (Rosand, Slinning, Eberhard-Gran, Roysamb, & Tambs, 2011). Other studies were about the relationship between body image satisfaction with depressive symptoms (Downs, DiNallo, & Kirner, 2008; Rauff & Downs, 2011) and practicing exercise (Boscaglia, Skouteris, & Wertheim, 2003). It is worthy to note here that pregnant women were more satisfied with their bodies than non-pregnant women (Loth, Bauer, Wall, Berge, & Neumark-Sztainer, 2011).

Most of the previous studies about satisfaction during pregnancy focused on the satisfaction with services and the care provided for specific conditions, for instance, satisfaction with care in a socially and economically at-risk population (Humbert et al., 2011), satisfaction with pregnancy and birth services (Goberna-Tricas, Banus-Gimenez, Palacio-Tauste, & Linares-Sancho, 2011), sexual satisfaction in relation to trimesters (Chang, Chen, Lin, & Yu, 2011), satisfaction with pregnancy loss aftercare (Geller, Psaros, & Kornfield, 2010), satisfaction with treatment of gestational diabetes patients (Trutnovsky et al., 2012), satisfaction with pregnancy follow-up in relation to health-care levels (Maderuelo et al., 2006), and satisfaction with medical information for pregnant women with hypertensive disorders (Lee-ners, Rath, Kuse, Neises, & Neumaier-Wagner, 2006). Unfortunately, none of the above-mentioned studies were about satisfaction with life and its correlation with demographics or pregnancy/birth outcomes.

In this study, we answered this question: What are the characteristics of Jordanian pregnant women dissatisfied with life?

**Methods**

**Design**

A non-experimental, descriptive comparative design was employed for our study. This design was used because we included a non-manipulative independent variable.
Pregnant women were screened for their satisfaction with life during pregnancy by using an Arabic version of satisfaction with life scale (SWLS) (Diener, Emmons, Larsen, & Griffin, 1985). Women were then, divided into two groups according to their SWLS score. Women were divided at the middle neutral point of the scale, which is 20. Twenty or below is dissatisfied, 21 or above is satisfied. This classification was recommended by Diener (personal communication, April 21, 2014). Subsequently, sociodemographic characteristics were compared between women who were dissatisfied with their lives and women who were satisfied with their lives.

**Setting**

Data were collected from three governorates which cover the north and middle parts of Jordan. These areas were selected because they contain the highest population rates in Jordan (Department of Statistics, 2008). Data were collected from Governmental Maternal and Child Health Care (MCHC) centers plus two University hospitals’ clinics. Such centers were selected because the majority of pregnant Jordanian women receive their antenatal care in these centers. Antenatal care in Jordan is free for all pregnant women at Ministry of Health’s (MOH) MCHC centers, and MOH is the accountable for all health-care dealings (in public and private sectors) according to Health Law no. 47 for 2008 (Department of Statistics (Jordan) & ICF-Macro, 2010).

**Sample and sampling**

The target population was all Jordanian pregnant women, while the accessible population was all the Jordanian pregnant women who were visiting the three Governorates’ and the two Universities’ MCHC centers. We consecutively selected 203 Jordanian pregnant women in their third trimester. This sampling technique (consecutive) was selected because information management and a computerized system have not been available in Jordan at all levels of the health-care system, which made it difficult to list all Jordanian pregnant women for randomization. This clearly affected the internal and external validity of our study, but it was the only solution for the situation in Jordan, and consecutive sampling would improve the representativeness of the non-probability samples to the whole population. Sample size was determined based on Thorndike’s rule (Thorndike, 1982), which requires 20 participants for each variable to ensure the statistical conclusion validity. All literate, married, aged 17 years old or above, either nulliparous or multiparous women were invited to participate and were selected in our study, while women with a previous history of mental illness were excluded. Such inclusion and exclusion criteria would control the effect of extraneous factors. The response rate was more than 80%.
**Instruments**

Our questionnaire consisted of two parts:

1. *Women’s information sheet*: This sheet was developed by the researchers, and its content validity was assessed by three academic members. This sheet was used to measure the women’s demographics and health information. The sheet included questions about sociodemographic characteristics—age, education, income, marital status, smoking, weight increase during pregnancy, drinking coffee, the number of children and parity—as the major dependent variables in our study. Another 12 items asking about other women’s demographics and health status (work status, height, weight, health status, previous pregnancies, problems during the current pregnancy, pregnancy plans, breastfeeding plans, social support, health-care provider, antenatal care visits, and fetus gender) were included in the questionnaire. Such variables were used to help in understanding and explaining the findings.

2. *Satisfaction with Life Scale (SWLS)*: SWLS was used to measure life satisfaction (Diener et al., 1985) among Jordanian pregnant women. This valid and reliable (Athay, 2012) scale consists of five items scored on a 7-point Likert scale ranging from one (strongly disagree) to seven (strongly agree). A total score was calculated by adding together the individual responses of the five items. Possible SWLS scores ranged from 5 to 35, with a score of 20 or below indicated that a woman was dissatisfied with her life and 21 or above was satisfied. This cut-off point was recommended by E. Diener (personal communication, April 21, 2014). Aasheim et al. (2014) reported that SWLS was a reliable measure of life satisfaction among pregnant women (Cronbach’s alpha was 0.89). Furthermore, SWLS was a valid and reliable measure for life satisfaction for Jordanians, as Zawawi & Hamaideh (2009) reported that the Cronbach’s alpha for SWLS among undergraduate students in Jordan was 0.79, and Guttman split-half alpha was 0.77. In addition, the average 3-week test-retest reliability coefficient for SWLS was 0.78.

   It is very important to note here that, for our purpose, we used a cut-off point of 20 to help us in identifying the characteristics of dissatisfied women. Using a comparison group would enhance the internal validity of our study (Polit & Beck, 2011). All previous studies used the whole range of the score, and reported that the higher the score, the more satisfied the individual was with his/her life (Ketchum et al., 2012; Van Damme-Ostapowicz et al., 2012).

**Data collection procedure**

The primary investigator trained three research assistants about how to select and invite the women, and how to collect the data. Then, the research assistants visited the settings and invited the women who met the inclusion and exclusion criteria to participate in our study. Each woman was given time to read the information sheet about our study. After that, if the woman agreed to
participate, she was asked to sign the consent form, without mentioning her name to ensure anonymity. The questionnaire was self-administered by each woman independently; unless she wanted clarification for any question (the research assistant was available while the woman was filling in the questionnaire to answer her questions). The response rate was more than 80%. The women completed the questionnaires at their convenience, which was while they were waiting for their appointments with the doctor. Then, women were asked to seal the completed questionnaires in an envelope to ensure confidentiality. The questionnaire took about 20 minutes to be completed. The data were collected between February 2009 and June 2010.

**Data analysis plan**

Data were analyzed using SPSS (version 17, SPSS Inc., Chicago, IL, USA) to obtain descriptive and inferential statistics. The sample was described by descriptive statistics. The differences in demographics between women who were dissatisfied with life and those who were satisfied were tested by independent t-test for the continuous variables and chi-square for categorical variables. The significance level was set to be $P < 0.05$.

**Ethical considerations**

Our protocols were approved by the Hashemite University’s Institutional Review Board (IRB), University hospitals’ IRB, and MOH’s IRB. Each participant was given enough time to fully understand the research protocols and to sign the consent form. Each participant was assured that her participation was voluntary and she could withdraw from the study at any time without any violation to her care. Furthermore, each participant could refuse to answer any question or to complete the questionnaire. Women assured that their participation would not put them at any physical, psychological, economical, or social risk, and in the case that they suffered from any problem as a result of their participation, they would be referred to the appropriate care. By participating in our study, women were satisfied that the other women would benefit from the findings of our study. Participants’ religions, cultures, norms, and values were respected by the researchers of this study, and there was not any discrimination among participants if they were belonging to other religions, cultures, norms and values. All collected data remained confidential. All information was anonymous after coding and was deleted upon finalizing the research study.

Our study was a part of a larger study about antenatal depression. It was reported separately because of the importance of understanding of the specific demographics of dissatisfied women, in order to identify them and help them before birth to prevent the negative impacts.
Results

Two hundred three women participated in our study. Women’s age ranged from 17 to 47 years (mean = 27.7, SD = 6.1). All women were in their third trimester, and the majority of them (n = 154, 67.2%) were educated to high school or above. All women were married, except two, one separated and one divorced. The household income of the women ranged between $171 and $2,571 (mean = $557, SD = $331). Most of the women’s (n = 154, 88.6%) monthly household income ranged between $171 and $857, which was considered below the national poverty level ($970) (Department of Statistics, 2010). Nine women (4.5%) were smokers (smoked between 2 and 40 cigarettes each day) and around 35% (n = 70) of them were drinking coffee during their pregnancy (between 1 and 8 cups of coffee per day). One fourth of the women (n = 52) had used contraceptives before pregnancy. Most of the women (85%) described their health as good to excellent during pregnancy, while the rest described it as acceptable to bad. Women’s weight increased for most of them during pregnancy (95%), and the increment ranged between 1 and 36 kg. Only 5% of the women lost weight during pregnancy (range between −1 and −10 kg). The average sleeping hours for the participants was 7.9 hours (SD = 2.1 hours). The majority of the women were multiparous (n = 144, 71%), with 1.9 (SD = 2) previous pregnancies on average.

The mean score for SWLS (Diener et al., 1985) was 22.3 (SD = 6.7), ranged between 5 and 35. For our purpose, women were divided at the middle neutral point of the scale, which is 20 (cut-off point) in order to identify the proportion of women who were dissatisfied. Women with a score of 20 or below were considered dissatisfied, while women with a score of 21 or above were considered satisfied. Around 38% (n = 78) of the women were dissatisfied with their lives. The internal consistency of the Arabic version of SWLS was evaluated, and the Cronbach’s alpha was 0.79 (n = 203), which was considered reliable with our sample.

Independent sample t-tests were conducted to compare age, income, number of children, and increase in weight during pregnancy for women who were satisfied with life (SWLS scores ≥21) and women who were dissatisfied (SWLS scores <21). There was a significant difference in the age [t (200) = 2.1, p = .04] between dissatisfied (mean = 28.9, SD = 6.2) and satisfied (mean = 27, SD = 6). Furthermore, there was a significant difference in the income [t (191) = −2.2, p = .03] between dissatisfied (mean = 345, SD = 191) and satisfied (mean = 419, SD = 251). Moreover, there was a significant difference in number of children [t (164) = 2.4, p = .02] between dissatisfied women (mean = 2.3, SD = 2.3) and satisfied women (mean = 1.5, SD = 1.8). However, there were no significant differences in weight increment during pregnancy (p = .2) and sleeping hours (p = .58) between the dissatisfied and satisfied women.

Chi-square tests were conducted to identify the differences in proportions of education level, smoking status, and drinking coffee between dissatisfied and satisfied pregnant women. The analysis showed that the proportion of satisfied
women who were educated to secondary or lower (53.1%) was significantly different ($p = .01$) from the proportion of satisfied women who were educated to diploma education or more (71.9%). Yet, the proportion of dissatisfied women who were smoking and drinking coffee was not significantly different from the proportion of satisfied women that were smoking ($p = .09$) and drinking coffee ($p = .2$).

**Discussion**

Our sample mean score for satisfaction with life was 22.3, which was lower than the only reported study scores of Norwegian mothers (Aasheim et al., 2014), where their scores mean was around 29.5 for the same age group and same gestational age of our sample. This could be explained by looking at the economic status of our sample, where around 90% of them were below the poverty line which was different from the Norwegian mothers who came from a well-developed country.

Biological changes after childbirth would be the same to some degree for all women; however, sociodemographic characteristics were unique for each. Our aim of this study was to compare sociodemographic characteristics of pregnant women who were satisfied with their lives with pregnant women who were dissatisfied with their lives. The main sociodemographic factors that we examined and have significant differences were: age, income, number of children, and education level.

The age of the woman was the first demographic variable that was different between satisfied and dissatisfied pregnant women; we analyzed data and thus believed that the younger pregnant women were more satisfied with their lives than older pregnant women. This result has been supported by recent researchers of Aasheim et al. (2014), which found that satisfaction with life among pregnant women decreased more or less continuously with the advanced age of the pregnant mothers. The aging process and the physiological changes that are associated with advanced age of the pregnant mothers might make it difficult for the pregnant mothers to adapt to the physiological and psychological changes of pregnancy, and this could lead to decrease in satisfaction with life for older pregnant mothers (Aasheim et al., 2014).

The income was the second demographic variable that was significantly different between satisfied and non-satisfied pregnant women. We found that pregnant women who had a high level of income were more satisfied with life than pregnant women who had low level of income. Our result was consistent with the findings of Frijters et al. (2004) who suggested that around 35–40% of the increase in life satisfaction was attributable to the large increase in household incomes. Life satisfaction during pregnancy increased as the level of income increased because those who were in lower income classes might have lower quality of life as they might be less able to afford additional financial requirements of their children (Asadian et al., 2014), and this might affect their satisfaction with life (Sousa & Lyubomirsky, 2001).
The number of children the pregnant woman was responsible for was another sociodemographic factor that was significantly different between satisfied and dissatisfied pregnant women. Pregnant women who had a higher number of children were dissatisfied with their lives more than the pregnant women who had smaller number of children (i.e. satisfaction decreases as number of children increases). On one hand, our results contradicted the findings of the Klemm et al. (2012) study, as they found that life satisfaction was positively correlated with fertility rate. On the other hand, our findings corresponded with the findings of Krause (2014), who found that the level of happiness of parents over their life time decreased as the number of children increased. Furthermore, Krause (2014) explained that women were much more likely than men to experience a drop in happiness with the birth of their second child. For women, the short-term impact of the second child was harder than the short-term impact of the first. This finding was supported by our findings if we considered life satisfaction is similar to the happiness of mothers (Oxford Living Dictionaries, 2012).

When we compared satisfied women with dissatisfied in relation to their educational level, we found that the higher the education level of the woman, the more satisfied she would be with her life. These findings were similar to Baumann et al. (2012) who found that life satisfaction was lower among post-stroke survivors with low level of education. One possible explanation of this result is that women with a higher level of education might have more knowledge about how to cope with stress factors, which would improve their happiness and satisfaction with their lives. Life satisfaction during pregnancy increased as the level of education increased because those who have lower education might have lower quality of life (Abbaszadeh, Bagheri, & Mehran, 2010) and subsequently lower life satisfaction (Sousa & Lyubomirsky, 2001).

**Recommendations**

Although satisfaction with life has a major role in pregnant women’s health, minimal research has examined it during pregnancy. Thus, further studies are needed to examine the impact of reduced level of satisfaction with life on pregnancy/birth outcomes. Furthermore, it is recommended to conduct training programs for maternal nurses and midwives in order to raise their ability to detect dissatisfied pregnant mothers, assess the factors of being dissatisfied, and help those mothers to overcome these factors and increase the level of satisfaction with their life.

**Limitations**

Our study has some limitations. First, information collected in our study was of a self-reported nature, which may be prone to some inaccuracy as a result of less than accurate understanding, lack of information, or discomfort with self-disclosure. Secondly, selection of participants was not randomized. This resulted in a less representative sample of the general population of pregnant Jordanian women,
and restricts the general conclusions that can be drawn from it to pregnant women in the selected areas of our study. However, consecutive sampling might reduce this problem.

**Implications**

Clinically, based on the researchers’ results, maternal nurses and midwives can identify dissatisfied women by reviewing their demographics and develop an educational and interventional package that focuses on improving satisfaction with life for pregnant mothers to use them in antenatal clinics, MCHC centers, and antenatal wards of hospitals. At the nursing research level, qualitative research can be conducted to understand in depth the experience of pregnant women who are dissatisfied with their lives. Educationally, clinical nursing teachers can include an assessment tool for the satisfaction level of pregnant mothers in the students’ requirement in their clinical training. Furthermore, nursing educators can incorporate evidence-based topics about the effect of satisfaction with life on the pregnancy/birth outcomes in the maternal and child health nursing modules and courses. Internationally, our findings contributed to better insight of an international audience about the demographical dimensions of life satisfaction of pregnant women in developing countries. Furthermore, by this study, we could enhance the international understanding of pregnant women situations in third-world nations.

**Conclusion**

The researchers found that there were significant differences between pregnant women in relation to their level of satisfaction with their lives. The age of the pregnant women, income level, education, and number of children were different between satisfied and dissatisfied mothers. Younger, better educated pregnant women with high economic status and small number of children were more satisfied with their life.

Although satisfaction with life plays a role in pregnant women’s health, minimal research has been examined it during pregnancy. Thus, further studies are needed to examine the impact of reduced satisfaction with life on pregnancy/birth outcomes.

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