

## **Jordanian women's dissatisfaction with childbirth care**

### **Abstract**

**Background:** Dissatisfaction with childbirth care can have a negative impact on a woman's health and wellbeing, as well as her relationships with her infant.

**Aim:** To investigate the prevalence and associated factors of dissatisfaction with intrapartum care by Jordanian women.

**Method:** A descriptive cross-sectional study was used. Participants (n = 320) who were seven weeks postpartum were recruited from five maternal and child health centres in Irbid city in northern Jordan. Participants provided personal and obstetric information, and completed the Satisfaction with Childbirth Care Scale.

**Results:** The majority of women (75.6%) were dissatisfied with their intrapartum care. Dissatisfaction was associated with being attended by staff that a woman did not want present, experiencing labour as more painful than expected, and perceptions of inadequate help from health care providers to manage pain during labour.

**Limitations:** Findings are limited to Jordanian women accessing public sector perinatal health services.

**Conclusion:** The high percentage of women reporting dissatisfaction with intrapartum care in this study is of concern. Women's perception of pain and expectations of staff during labour and birth need to be addressed through education and improved communication by staff.

**Implications for Nursing and Health Policy:** Development of national evidence-based policies and quality assurance systems would help reduce the rate of obstetric interventions, and give greater emphasis to respect for women's preferences during labour and birth.

**Key words:** childbirth, dissatisfaction, postpartum women, pain, pain management,  
Jordan

## **Introduction**

Childbearing is an important event in women's lives. Parturition marks the transition to motherhood and has significant social, emotional and physical effects. Investigations of women's satisfaction with intrapartum care is important to improve health care services and has implications for the health and wellbeing of the mother, newborn, and mother-infant relationship (Bertucci et al., 2012; Ford & Ayers, 2009; Kuo et al., 2010). Dissatisfaction with childbirth care increases the risk of developing postpartum depression and anxiety (Bertucci et al., 2012; Mohammad et al., 2011) and may contribute to posttraumatic stress symptoms (Beck, 2004). It may also lead to fear of a subsequent birth (Waldenstrom et al., 2006) and problems with maternal/infant attachment (Bertucci et al., 2012).

Measuring women's satisfaction with health care has been recognised as an important outcome in the evaluation of health care delivery systems (Bazant & Koenig, 2009; Bertucci et al, 2012). In the context of childbirth, satisfaction is a broad, multi-faceted concept that includes women's satisfaction with the experience of labour and birth as well as satisfaction with the care provided and whether the birth was perceived as a positive or negative experience (Bertucci et al., 2012; Rudman et al., 2007). Satisfaction with childbirth is often about giving birth in a manner and style that suits the woman given her individual circumstances and needs (Bertucci et al., 2012).

In many studies, satisfaction with childbirth has been linked to the availability of support, the relationship between labouring women and health care providers, explanation of procedures, avoiding obstetric intervention, and involvement in decision-making (Bazant & Koenig, 2009; Khresheh & Barclay, 2010; Rudman et al., 2007). Women's satisfaction with childbirth care has also been associated with aspects of quality of care, including availability of staff, confidence in providers,

adequate pain relief, being treated with respect, receiving information and physical comfort (Abdel Ghani & Berggren, 2011; Harriott et al., 2005).

Factors associated with dissatisfaction with intrapartum care are often associated with labour processes and birth outcomes, such as lack of support and involvement in decision-making, a longer and more painful labour than expected, inadequate pain management, frequent vaginal examinations, lack of privacy, an increased number of obstetric interventions, episiotomy, and limited mobility during childbirth (Hassan-Bitar & Wick, 2007; Hatamleh et al., 2012; Rudman et al., 2007).

### **Maternity care in Jordan**

In 1995 the Jordanian Ministry of Health initiated a national maternal and child health program (Mohammad et al., 2011). Primary health care (PHC) for childbearing women in Jordan is provided through a network of public health care centers (Ministry of Health, 2010). Outcomes for women and children have improved. Infant mortality rates decreased from 40 per 1000 live births in 1985 to 23 per 1000 live births in 2010, and maternal mortality rates decreased from 41 deaths per 100,000 live births in 2002 to 19.1 deaths per 100,000 live births in 2010 (Department of Statistics and Macro International Inc (DOS & MI) 2010).

Almost all women (99%) receive antenatal care from trained personnel, with 93% of women receiving care from a doctor, and around 5% of women accessing a midwife or nurse (DOS & MI, 2010). Most births (97%) occur in hospitals attended mostly by doctors (Oweis, 2009). The percentage of women receiving postnatal care however remains low at 25% (DOS & MI, 2010).

Despite improvements, significant deficits in the provision of basic maternity services remain. There continues to be a limited understanding and application of research evidence in practice, and a lack of health education for women and their families (Abushaikha, 2007; Khalf et al., 2007). Jordan also lacks maternity services policies that encourage evidence based practice, respect the rights of women, and require adequate quality assurance systems including auditing the use of obstetric procedures. Furthermore, empirical data about women's satisfaction with health care services during childbirth are limited. To date, much of the research on maternal satisfaction has been undertaken in developed countries. The current study investigated the prevalence and associated factors of dissatisfaction with intrapartum care.

## **Method**

### *Design*

A descriptive cross-sectional design was used.

### *Sample*

The sample consisted of women receiving postnatal care in one of five public health centers in Irbid city in northern Jordan. Women who were 7 weeks or more postpartum and had a live term baby were recruited into the study. Women who gave birth to a preterm baby or had a stillbirth were not recruited. Privately insured women do not attend public clinics and could not be recruited. The rationale for the timing of the interview was based on the desire to obtain information as soon as possible after birth yet close enough to the event for accurate recall. The seven week time period provided an opportunity for women to assimilate and reflect on their experiences (Rudman et al., 2007).

### *Data Collection Tool*

The survey included a demographic data form (15 items) to collect data about selected demographic variables including age, level of education, parity and occupation. Items concerning the current childbirth experience (such as mode of birth, length of labour and birth, effectiveness of pain relief techniques, obstetric procedures, and opportunities to talk to a health professional about their feelings in relation to the birth) were also included.

The Satisfaction with Childbirth Care Scale (SCCS) is a brief, 8-item questionnaire developed from an extensive review of the literature and items used in previous studies of mothers' experiences of maternity care conducted in Australia, Sweden, and Canada (Biro et al., 2003; Janssen et al., 2006; Rudman et al., 2007; Waldenstrom et al., 2006). There are 4 items about interpersonal care by the midwife/doctor who provided most of the care during labour, and 4 items about women's satisfaction with the information they received and involvement in decision-making (4 items). Participants rated their satisfaction on a five-point Likert scale of 1 = strongly disagree to 5 = strongly agree. Four items "Overall poor quality of care", "Decisions made without taking wishes into account", "Felt pressured to have the baby quickly" and "Felt labour was taken over by strangers and machines" were reverse scored. The total possible score for the scale was 40, and scores of  $\geq 26$  indicated satisfaction with intrapartum care. This cut-off score was calculated using the total mean score (22.40) plus one standard deviation ( $SD \pm 4.06$ ). The Cronbach's alpha value for the Satisfaction with Childbirth Care Scale was 0.81.

The SCCQ was translated into Arabic and back-translated to ensure content validity and semantic validity by four bi-lingual scholars who lived in Jordan but had

completed postgraduate degrees in English speaking countries. Face and content validity were also assessed by a panel of experts in midwifery and nursing who reviewed the items for clarity, relevance, comprehensiveness, understandability, and ease of administration. The SCCQ was then piloted with a group of 20 childbearing Jordanian women for face validity. Results of the pilot study showed that the questionnaire was easy to administer, clear to read and required 10 minutes (on average) to be completed. Based on the feedback, some questions in the SCCQ were reworded to improve clarity. The data for the 20 women used for the face validity pilot were not used in the study itself.

#### *Data Collection Procedures*

Midwives in each clinic initially identified women meeting the inclusion criteria and invited them to speak with a researcher. Participants received information verbally and in writing about the nature and purposes of the study and were notified of their right not to participate, ability to withdraw at any time without explanation, and to not answer any questions as they wish. Opportunities were provided for participants to ask questions at any stage. Participants were required to sign a consent form. Subsequently, the researcher, who was not employed by the health center, interviewed participants to complete the survey. Interviews were conducted at a location convenient to the woman and away from the maternal and child clinic in order to provide privacy. No health care providers were present. Data was collected in June to October, 2012.

#### *Ethical considerations*

Approval for the study was obtained from the Ministry of Health and Human Research Ethics Committee at The World Islamic Sciences & Education University in

Jordan. Permission was gained from each health center for research staff to be present and recruit women.

### *Statistical analysis*

Data were analyzed using the Statistical Package for the Social Sciences (SPSS) version 17, personal computer version. Frequencies, mean, and standard deviations were calculated on demographic and obstetric variables, and the SCCS. Cronbach's alpha was used to assess internal reliability. Relationships between dependent and independent variables were examined using Chi-square and Pearson's correlation analyses. To determine the relationship between obstetric variables and dissatisfaction with intrapartum care, stepwise multiple regression analyses were undertaken. An alpha level of 0.05 was used for all statistical tests.

## **Results**

### *Characteristics of participants*

A sample of 320 women agreed to participate in the study and completed the questionnaire (response rate = 83.2%). Characteristics of the study population are presented in Table 1.

### *Satisfaction with intrapartum care*

Findings indicated that the majority of women were not satisfied with intrapartum care. The total mean score of the SCCS was 22.40 (SD  $\pm$  4.06, range 12 - 31). Only 24.4% (n = 78) of participants scored  $\geq$  26 indicating satisfaction (as outlined in Table 2).

### *Factors associated with dissatisfaction with intrapartum care*

Analysis revealed that a number of obstetric variables were associated with dissatisfaction with intrapartum care (as outlined in Table 3). Long labour (> 11

hours), labour more painful than expected, poor pain relief during labour, increased number of vaginal examinations ( $> 8$ ), being in lithotomy position during birth, experiencing an episiotomy, attendance of anyone they did not want to be there, and not asked about how they felt about labour and/or birth were associated with dissatisfaction with intrapartum care.

A multiple regression analysis of the eight variables associated with dissatisfaction with intrapartum care, resulted in five variables being excluded (long labour ( $> 11$  hours), number of vaginal examination ( $> 8$ ), being in lithotomy position during birth, had an episiotomy, and not asked about how they felt). Three variables (attendance of anyone they did not want to be there, labour more painful than expected, and poor pain relief during labour) were retained as predictive of dissatisfaction with intrapartum care. The regression model accounted for approximately 43% ( $r^2 = 0.428$ ) of variance in dissatisfaction with intrapartum care. The results of this analysis are shown in Table 4.

## **Discussion**

The majority of participants (75.6%) were dissatisfied with intrapartum care. This rate of dissatisfaction is much higher than that reported in the developed countries (Britton, 2006; Rudman et al., 2007) but similar to rates reported in some developing countries (Senarath et al., 2006). Similarities in the rate of dissatisfaction with intrapartum care in developing countries may be related to cultural norms that manifest in the medical model of maternity care and the low status of women.

In the present study eight variables were associated with dissatisfaction with intrapartum care. Long and more painful labour than expected, receiving inadequate

support in managing pain, high rate of obstetric procedures during labour and birth (such as excessive vaginal examinations and episiotomy), birth in lithotomy position, attendance of unwanted persons, and not being afforded the opportunity to talk to health professional about the birth experience are, unsurprisingly, associated with dissatisfaction with intrapartum care. The findings of the present study are consistent with previous studies (Bryanton et al., 2008; Rudman et al., 2007).

Variables with the lowest mean scores on the SCCS were mainly concerned with women's perceptions of care they received during labour and birth such as help from doctors, midwives or nurses, provision of information, and involvement in decision-making regarding their care. This is consistent with findings of previous studies which reported that women were more likely to be satisfied with their care if they had access to unbiased information, involved in making decisions concerning interventions, felt respected, and confident that the right treatment and care would be provided (Kongnyuy et al., 2009; Waldenstrom et al., 2006).

Support and continuity of care have been found to be effective in decreasing women's need for analgesia, reducing the length of labour, accelerating the mothers' recovery, improving maternal-infant bonding, and increasing maternal satisfaction (Abdel et al., 2011; Hodnett et al., 2009). In Jordan, health care providers only provide physical care to labour women, not emotional support, and most hospitals do not allow social support during labour and birth from family members or friends (Khresheh, 2010; Sweidan et al., 2008).

Feeling informed is also central to a positive birth experience. Women want information that is accurate and sensitively communicated (Rudman et al., 2007). Information provision is an essential prerequisite for feeling involved in decisions and feeling in control. These factors appear to be vital contributors to levels of satisfaction. In the birthing units in Jordan and other Arab countries, health care providers (doctors and midwives) usually make decisions without taking the women's wishes into account (Hatamleh et al., 2012; Kempe et al., 2011). This approach to care may lead to high levels of dissatisfaction and subsequent distress.

Providing women with education about non-pharmacological methods of pain management during labour and birth may improve satisfaction with care. There is strong evidence that women who have continuity of caregiver, midwife-led care, a good relationship with their caregiver, and continuous support during labour, are more likely to require no pain relief, have an intervention-free labour and birth and be more satisfied with intrapartum care (Hodnett et al., 2009; Leap et al., 2010). Childbirth education may empower Jordanian women by providing culturally sensitive information about labour pain and different methods of pain management. This would enable women to participate in choosing effective pain management options and using culturally acceptable methods of coping with labour pain (Abdel Ghani & Berggren, 2011; Abushaikha, 2007; Callister et al., 2003).

In Jordan and other Arab countries, women are exposed to harmful, non-evidence based procedures during labour and birth such as routine episiotomy and excessive vaginal exams (Hassan-Bitar & Wick, 2007; Hassan et al., 2012; Mohammad et al., 2011). In addition, women are restricted in their movement during labour and the

lithotomy position is usually adopted for birth (Hassan-Bitar & Wick, 2007; Hassan et al., 2012; Shaban et al., 2011). These practices contributed to women's discomfort during labour and birth and dissatisfaction.

In the present study, exposure to unknown and unwanted persons during childbirth was associated with dissatisfaction with intrapartum care. In Jordan, most public hospitals are teaching hospitals and labour suites are usually crowded by medical, nursing, and midwifery students. Currently, medical and midwifery students are allowed to attend labour and birth as well perform procedures on labouring women without agreement from the woman. Labouring women cannot refuse the attendance of students at their labour and birth if they have been admitted as a public patient. The contribution of exposure to strangers, painful labour, and increased medical intervention to negative birth experiences has been reported by Jordanian women in a previous study (Safadi, 2005). Measures are needed to encourage evidence-based practice, adherence to human rights and the right to high quality health care and rigorous evaluation of services in Jordan (UN committee on Economic, Social and Cultural Rights, 2000).

Findings of the present study indicate that lack of attention to women's emotional care by asking about their birth experience was associated with dissatisfaction with care. Previous studies have reported a similar low priority given to women's postpartum emotional response to labour and birth (Mohammad et al., 2011; Waldenstrom et al., 2006). After childbirth, women reported that they wanted to talk about their labour and birth experiences with a knowledgeable person such as a midwife and/or obstetrician. Some women may have a sense of loss if they are not

able to remember the whole experience coherently and may require explanation or support to gain an accurate understanding of events (Gamble & Creedy, 2009). Health professionals (midwives and obstetricians) are able to affirm women's perceptions by discussing their birthing experiences, providing explanations about the course of events, and giving support if the birth had not proceeded as originally planned.

Midwives in Jordan are required to attend to many labouring women simultaneously and this makes it difficult to provide individualized quality care to all women (Oweis, 2009). This organization of health services and the inadequate educational preparation of midwives have adverse implications for the care offered and contributes to adverse emotional and physical consequences for childbearing women.

### **Implications for Nursing and Health Policy**

The high level of dissatisfaction by Jordanian women in the current study is of concern and requires immediate action by health care professionals, hospital administrators and policy-makers. At a national level, maternity services policy may be used to encourage evidence based practice, enshrine the rights of women, and require adequate quality assurance systems including auditing the use of obstetric procedures. At a health provider and institutional level a focus on improving the quality of information giving and emotional care provided to labouring women will improve satisfaction levels. Providing continuing professional development to inform practitioners of women's rights, and teach empathetic communication coupled with inclusion of women in decision making, will facilitate respectful care. Informing women about labour and birth procedures may enable them to better understand and participate in the decision-making process.

## **Strengths and Limitation**

The current study was conducted with a large representative sample of postpartum women to assess prevalence and associated factors of dissatisfaction with childbirth care. The findings can be generalised to postpartum women in developing countries who share similar cultural and traditional values.

There are limitations associated with this survey study. Privately insured women were not recruited in this study. The inclusion of privately insured women may have affected results as they experience much higher rates of obstetric intervention during labour and birth (Safadi, 2005). Conversely, privately insured women may receive more respectful care from their care providers (Oweis, 2009). The experience of these women needs to be investigated in the future.

Even though the refusal rate for participation was low (16.8%), privacy was assured, and assistance was offered to women to complete the questionnaire. However, women most in need of assistance may not have participated. Therefore, repeated studies with large samples of Jordanian women need to be conducted.

While piloting the data collection tool with Jordanian women addresses face validity for use with this population, there are limitations of using a tool that reflects concepts of satisfaction with maternity care in western, developed countries. However, the tool seemed to capture concepts that reflect universally accepted rights of women such as respect and privacy (UN Committee on Economic, Social and Cultural Rights, 2000). For researchers, using a tool that enables international comparisons is important, in

part because it can highlight the quality of care experienced by many women in the developing world and give a measure of change in the quality of services over time.

## **Conclusion**

The findings of this study contribute to our understanding of the birthing experiences and needs of women from different cultural backgrounds. The percentage of women reporting dissatisfaction with intrapartum care in this study is of concern. It was found that Jordanian women were dissatisfied with their labour and birth and the quality of care provided. There was a lack of attention to emotional aspects of care.

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**Author contributions**

The contribution of authors is as follows: Study Design (KM, KA, AM, JG, DKC); Data Collection (KM, KA, AM); Data Analysis (KM, KA), Manuscript Writing and Intellectual Content (KM, KA, AM, JG, DKC)