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Women's expectations of health care providers in the labor and delivery room in the Kurdistan Region of Iraq

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Abstract

Background and objective: The World Health Organization recognizes the importance of positive childbirth experience. In Iraq, patient satisfaction during maternity care visits is not routinely collected. This study was aimed to find out the women's expectation during labor from physicians and midwives and associated factors such as socio-demographic and obstetrical characteristics.

Methods: This cross-sectional study was conducted in Erbil city, located in the Kurdistan region of Iraq. A total of 1,500 women were targeted while they were accompanying another person, including children, to receive health services in Erbil and eventually 1,196 participated in the study. Data were collected through direct interviews after receiving informed oral consent. Participants were asked to describe their expectations for childbirth using an open-ended question. Responses were then grouped and categorized into 20 expectation items based on overlapping themes. Chi-square tests were used to identify associations with key socio-demographic and obstetric characteristics.

Results: Level of expectation was significantly associated with education (illiterate and high education, P = 0.028),residency (suburban, P = 0.003), parity (grand multipara, P = 0.001), satisfaction with care (those satisfied, P <0.001), and satisfaction with provider communication (those satisfied, P <0.001). This study found that positive and calming verbal and non-verbal expressions, environmental control, encouragement of different positions and mobilization, hygiene, promotion of urinary elimination, and instruction on breathing and relaxation are highly expected by parturient women.

Conclusion: Understanding women's expectations in the delivery room is critical to health care providers in order to make appropriate care plan and support women to have a positive birth experience and to meet expectations.

Keywords: MCH; Childbirth; Expectation; Behavior; Communication; Health care provider.

Introduction

Patient experience of health care delivery and support is an important part of health care in every context. It is increasingly considered standard practice to collect patient satisfaction and other evaluations directly from consumers, the patients.

Further, the field of public health acknowledges that there is a need to capture patients' views as means to interpret patient feedback.[1]

Data on patient's experience is particularly critical for maternity care patients. Each year, approximately 140 million births occur globally.[2] A positive childbirth experience, defined as one that fulfills or exceeds a woman's prior personal and socio-cultural beliefs and expectations, including giving birth to a healthy baby in a clinically and psychologically safe environment with continuity of practical and emotional support from a birth companion (s) and kind, technically competent clinical staff, is a significant

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endpoint for all women undergoing labor.[1] Understanding experience-of-care is a critical aspect of ensuring high-quality labor and childbirth care and improving woman-centered outcomes.[3]

The World Health Organization (WHO) supports the need for data collection surrounding maternal patient experiences of care to complement research about clinical care quality as means to achieve person-centered outcomes[4]. In spite of this, collection of patient experience data is not common practice in many parts of the world, including Iraq.

The literature is beginning to demonstrate the necessity of capturing patient experiences in labor and delivery for quality improvement purposes. Women experience a wide range of pain in labor and have an equally wide range of responses to their vocalization about that pain by their health care providers and support staff. Women's reactions to labor pain may be influenced by the circumstances of her labor, including the environment that it takes place and the support-level that she receives.[5] Mistreatment of women in labor and delivery, sometimes labeled obstetric violence, has been shown to occur in high, middle, and low-income countries.[6-8]

Research shows that quality issues occur during labor and delivery. A 2013 study following over 3,000 health care providers in the United States demonstrated that 92% of physicians, 93% of midwives, and 98% of nurses observed at least one concern during a one-year period of work.[9] Whereas, just 9% of physicians, 13% of nurses, and 13% of midwives communicated their concerns with the person involved in the infraction.[9]

The use of patient-reported assessments of experience while receiving care varies by location. Patient-reported assessments are routinely used in higher income countries to capture experience for all patients, including maternity patients.[10]

These assessments allow hospitals and clinics to collect responses from a large number of patients, but they are cost prohibitive for some sites[11] and suffer from low response rates.[12,13] These types of assessments are not standard practice in middle- and low-income countries and, therefore, less is known about quality of patient experience in these settings. Research published in 2018 following over 63,000 maternal and child health care visits in Ethiopia, Haiti, Kenya, Malawi, Namibia, Nepal, Rwanda, Senegal, Tanzania, and Uganda suggests that primary care quality is low and that patient experience was particularly low.[14]

Awareness of patients' expectations for their care and understanding the formation of these expectations are potentially important aspects for policy development and service provision. Exploring how women prefer their health care providers to communicate and interact with them during labor and delivery is a critical first step to identifying strategies to best support women during this formative period of care. Through identifying these expectations for communication and behavior, health care providers can better create an environment that leads to a positive experience and increases satisfaction with care by midwives and physicians.

In Iraq, collection of patient satisfaction surveys is not a standard practice. This study aims to describe maternity care patients' expectations in the labor and delivery room in the Kurdistan region of Iraq. Specifically, this study explores expectations of three domains: a) emotional support, b) physical support and comfort measures, and c) providing information, advice, and advocacy. Another aim of this study was to explore association between overall level of expectation with the women's socio-demographic and obstetrical characteristics, general satisfaction with birth care, and overall satisfaction with communication of health care providers in the labor and delivery room.

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Methods

A cross-sectional study was conducted from January through March 2019 in Erbil city, located in the Kurdistan region of Iraq. A total of 1,500 women were targeted while they were accompanying another person, including children, to receive health services in Erbil. Of these candidates, 1,234 met the inclusion criteria of having at least one vaginal-birth experience within the past year at the Maternity Teaching Hospital, Rezgary Hospital, or Malafandy Primary Health Center in Erbil city and did not have a psychological disorder. Of those who met the inclusion criteria, 1,196 agreed to participate. The response rate was 96.9%.

The Maternity Teaching Hospital is the biggest specialized public hospital for women's health care in Erbil with 300 hundred beds and 30 delivery beds. Rezgary Hospital has a unit for women's health care services with a capacity of six beds. Malafandy Primary Health Center has a unit for women with low-risk and normal health conditions and has a capacity of five beds for labor and delivery care. Each of these institutions is a public health setting.

Data were collected through direct interviews after receiving informed oral consent. The purpose of the study was explained to the women and they were assured that their personal information would remain confidential. Three midwifery students supported data collection after completing training on interviewing and data collection techniques. A questionnaire was developed based on review of the literature and consisted of socio-demographic and obstetrical characteristics as well as questions about the behavior of health care providers. Two questions were asked regarding general satisfaction with birth care and general satisfaction with communications of health care providers.

The socio-demographic characteristics included age (less than 20 years old, 20 to 29 years, 30 to 39 years, and 40 or more years); educational level ("primary" defined as finishing 9 years of education, "secondary" defined as completing 12 years of education, and "tertiary" defined as having finished 2 or more years at a university); occupation ("housewife," "employed," and "student"); residency ("urban," defined as Erbil city, "suburban" defined as towns within 30-60 minute drive from Erbil city), and "rural" defined as towns and villages which are far from cities more than 60 minutes).

Obstetrical characteristics included parity ("primipara" (1 delivery), "multipara" (2 to 4 deliveries), and "grand multipara" (5 or more deliveries), history of abortion, sex of the baby at last delivery, admission of the most recent infant delivered to the intensive care unit (ICU), and history of episiotomy at most recent delivery. Further, satisfaction with care at last delivery (satisfied, partially satisfied, not satisfied) and satisfaction with communication with health care providers at last delivery (satisfied, not satisfied) were captured.

Participants were asked to describe their expectations for birth using an open-ended question. Responses were then grouped and categorized into 20 expectation items based on overlapping themes. Content validity of these expectation items was examined through consultations with health care experts from the field. These items were developed based on a comprehensive literature review about expectations of birthing persons from health care providers during labor and delivery. These items fit into three dimensions: emotional support, physical support and comfort measures, and giving information and advice and advocacy. Emotional support expectations included: physical presence (continuously present during the labor and delivery experience); demonstrating an effective caring attitude; positive and calming verbal expressions; nonverbal expressions (using positive non-verbal expression like smiling, and warm eye contact); providing distraction; and use of humor. Physical support and comfort measures expectations included

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environmental control (listening to women's requests in the delivery room); encouragement to use different positions; touch, massage; application of hot and cold packs; hygiene (using hygienic practices to maintain patient comfort and hygiene); promotion of urinary elimination (encouraging regular voiding of the bladder, which promotes delivery); and nourishment (nutritional intake of the patients for energy to push during delivery). The third category of expectations, giving information and advice, and advocacy, included listening to the patient's views; instruction on breathing and relaxation; information about procedures and progress; protecting the patient (ensuring the rights of the patient to have a safe delivery); assisting the patient to make informed choices; being the patient's voice when required; and conflict resolution.

Responses to expectation items were categorized as "mentioned" (score=2) or "not mentioned" (score=1). Then, the sum of each of the items in each dimension of emotional support, physical support and comfort measures, and giving information and advice and advocacy, was calculated and categorized according to "numerous expectations" (total score= 34-40), "some expectations" (total score=27-33), or "few expectations" (total score= 20-26).

Statistical analysis

Univariate and bivariate statistical analyses were performed using the IBM statistical package for the social sciences (SPSS, version 21) program. Socio-demographic and obstetric data and expectation items were summarized by frequency and percentage. Chi-square tests and Fisher exact tests (when more than 20% of cell, the expected counts was less than 5) were used to identify associations between overall birth expectations and socio-demographic and obstetric variables, general satisfaction with birth care, and communication with health care providers. A *P* value of ≤ 0.05 is considered as statistically significant.

Ethical consideration

The study was approved by the Scientific Committee of the College of Nursing/ Hawler Medical University. (NO.6, 23/1/2019)

Results

The socio-demographic characteristics of participants are presented in Table 1. Half were between 20 to 29 years old, nearly half (40.8%) had completed primary school, and more than half (54.4%) were living in an urban area. The majority (92.8%) of participants were housewives. Most (62.5%) were multigravida and 34.2% reported a history of abortion. Of the participants, 91.2% had no history of a deceased baby and 63.6% had experienced episiotomy or laceration during delivery. Only 13.1% of their babies had been admitted to the NICU (Table 1).

The majority of participants expected the following from their health care providers in the delivery room: presence (78.6%), positive and calming verbal expressions (76.3%), positive nonverbal expressions (72.3%), environmental control (74.6%), encouragement of different positions and mobilization (75.9%), hygiene (77.5%), promotion of urinary elimination (75.8%), and instruction on breathing and relaxation (71.9%).

Responses regarding expectations for communication and behavior of the nurses, midwives, and physicians in the delivery room are provided in Table 2. Focusing on emotional support, the majority of participants reported that they expected their health care provider to be physically present (79%), to express positive and calming expressions (76%), and to have nonverbal expressions. Just over half (66%) reported that they expected a caring attitude and half (51%) reported wanting distraction. Only 38% reported expecting humor during the delivery process.

Focusing on physical support, most mentioned expecting environmental control (75%), encouragement to use different birthing positions (76%), practicing good

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hygiene (78%), and promoting their urinary elimination (76%). Half expected massage (50%), and nourishment (55%).

Table 1 Socio-demographic and obstetric characteristics of participants

Variables	No.	%
Age		
less than 20 years	93	7.8
20-29 years	597	49.9
30-39 years	445	37.2
≥ 40 years	61	5.1
Education level		
Illiterate	268	22.4
Read and write	168	14.0
Primary	488	40.8
Secondary	139	11.6
Tertiary	133	11.1
Residency		
Urban	651	54.4
Suburban	340	28.4
Rural	205	17.1
Occupation		
Housewife	1110	92.8
Employed outside the home	59	4.9
Student	27	2.3
Parity		
Primipara	238	19.9
Multipara	748	62.5
Grand multipara	210	17.6
Having abortion		
No abortion	787	65.8
1-2	356	29.8
3 and more	53	4.4
Dead baby ever		
0	1091	91.2
1	88	7.4
2-3	17	1.4
Episiotomy or laceration at last delivery		
Yes	761	63.6
No	435	36.4
Sex of baby		
Male	581	48.6
Female	600	50.2
Missing	15	1.3
Admission to NICU at last delivery		
Yes	157	13.1
No	1039	86.9
Total	1196	100.0

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With regards to providing information, advice, and advocacy, most expected instruction on breathing and relaxation (72%), information about procedures and progress (62%), and listening to women's needs (67%). Nearly half expected the health care provider to protect them (42%), to assist them with making informed choices (49%), to serve as their voice to advocate for them (47%), and to resolve conflicts (45%) (Table 2).

Table 2 Women's expectations regarding the communication and behavior of nurses, midwives, and physicians in the delivery room

Expectations	Mentioned No. (%)	Not mentioned No. (%)
Emotional support		
Physical presence	940 (78.6%)	256 (21.4%)
Demonstrating an effective caring attitude	790 (66.1%)	406 (33.9%)
Positive and calming verbal expressions	912 (76.3%)	284 (23.7%)
Nonverbal expressions	865 (72.3%)	331 (27.7%)
Distraction	614 (51.3%)	582 (48.7%)
Use of humor	459 (38.4%)	737 (61.6%)
Physical support and comfort measures		
Environmental control	892 (74.6%)	304 (25.4%)
Encouragement to use different positions	908 (75.9%)	288 (24.1%)
Touch, massage	595 (49.7%)	601 (50.3%)
Application of hot and cold packs	769 (64.3%)	427 (35.7%)
Hygiene	927 (77.5%)	269 (22.5%)
Promotion of urinary elimination	906 (75.8%)	290 (24.2%)
Nourishment	653 (54.6%)	543 (45.4%)
Giving Information, advice, and advocacy		
Listening to women's views	796 (66.6%)	400 (33.4%)
Instruction on breathing and relaxation	860 (71.9%)	336 (28.1%)
Information about procedures and progress	746 (62.4%)	450 (37.6%)
Protecting the client	497 (41.6%)	699 (58.4%)
Assisting the client to make informed choices	584 (48.8%)	612 (51.2%)
Being the client's voice when required	556 (46.5%)	640 (53.5%)
Conflict resolution	538 (45.0%)	658 (55.0%)

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Table 3 presents the levels of expectations for each of the overall domains, from numerous expectations, some expectations, and few expectations. Most women (69%)had high expectations for emotional support and physical comfort measures (75%). Half of participants (48%) had high expectations for their health care providers to provide information, advice, and to advocate for them, (Table 3).

Associations with women's expectations for communication and behaviors with health care providers

Table 4 presents associations with women's expectations for health care providers during delivery. Level of expectation was significantly associated with level of education (illiterate and high education, *P* = 0.028), residency (suburban, *P* = 0.003), parity (grand multipara, *P* = 0.001), satisfaction with care (those satisfied, *P* <0.001), and satisfaction with provider communication (those satisfied, *P* <0.001). No significant association was identified with age, abortion, delivery type, experiencing episiotomy, death of baby, or NICU.

Table 3 The overall expectation domains of the study sample

Domains	Numerous expectations No. (%)	Some expectations No. (%)	Low expectations No. (%)
Emotional support	823 (68.8%)	257 (21.5%)	116 (9.7%)
Physical support and comfort measures	887 (74.2%)	265 (22.2%)	44 (3.7%)
Giving information and advice, and advocacy	578 (48.3%)	484 (40.5%)	134 (11.2%)
Overall expectations (all domains)	821 (68.6%)	358 (29.9%)	17 (1.4%)

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Table 4 Selected associations with women's expectations for communication and behaviors with health care providers

Variables	Level of expectation			*P*-value
	Numerous expectations N (%)	Some expectation N (%)	Few expectations N (%)	
Level of education				
Illiterate	194 (72.4%)	71 (26.5%)	3 (1.1%)	
Read and write	113 (67.3%)	52 (31.0%)	3 (1.8%)	0.028
Primary	344 (70.5%)	138 (28.3%)	6 (1.2%)	
Secondary	92 (66.2%)	42 (30.2%)	5 (3.6%)	
Institute and above	58.6 (78.0%)	55 (41.4%)	0 (0%)	
Occupation				
Husewife	773 (69.6%)	321 (28.9%)	16(1.4%)	
Employed	35 (59.3%)	23 (39.0%)	1 (1.7%)	0.053*
Student	13 (48.1%)	14 (51.9%)	0 (0%)	
Residency				
Urban	446 (68.5%)	199 (30.6%)	6 (0.9%)	
Suburban	252 (74.1%)	81 (23.8%)	7 (2.1%)	0.003*
Rural area	123 (60.0%)	78 (38.0%)	4 (2.0%)	
Parity				
Primipara	143 (60.1%)	95 (39.9%)	0 (0%)	
Multipara	526 (70.3%)	208 (27.8%)	14 (1.9%)	0.001*
Grand multi para	152 (72.4%)	55 (26.2%)	3 (1.4%)	
Satisfied with care				
Yes	746 (79.9%)	185 (19.8%)	3 (0.3%)	<0.001*
No	49 (25.9%)	126 (66.7%)	14 (7.4%)	
Partially	26 (35.6%)	47 (64.4%)	0 (0)	
Satisfied with communication				
Satisfied	642 (91.8%)	57 (8.2%)	0 (0%)	<0.001
Not satisfied	179 (36.0%)	301 (60.6%)	17 (3.4%)	
Duration of last delivery				
1-5 hours	473 (66.9%)	228 (32.2%)	6 (0.8%)	0.010
6-10 hours	238 (71.3%)	90 (26.9%)	6 (1.8%)	
11-15 hours	78 (74.3%)	22 (21.0%)	5 (4.8%)	
16-72 hours	32 (64.0%)	18 (36.0%)	0 (0%)	

*Fisher exact test was used.

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Discussion

This study presents women's expectations for health care provider communication and behavior in the labor and delivery room. Two-thirds of the women interviewed had numerous expectations, particularly for emotional and physical support and comfort measures. Women who had numerous expectations were generally satisfied with the care that they received during their most recent delivery and were generally satisfied with the communication of health care providers during their most recent delivery. Having numerous expectations was associated with having a higher level of education, not working outside of the home, living in a suburban area, and having multiple children.

This study's findings align with previous research. For example, in a phenomenological qualitative study in Turkey, researchers analyzed women's expectations of nurses during vaginal birth and found that women wanted physiological support needs in the forms of fulfillment of personal care needs, provision of support to cope with pain, and provision of freedom of mobility; as well as psychological support needs including not being left alone, receiving support from family and friends, having a positive relationship with the birth team, and protection of privacy; and meeting knowledge needs about the process of delivery.[15]

An analytical-cross sectional study in Egypt showed that the highest-ranked needs for parturient women during labor were maintaining privacy throughout all procedures, accessibility of nurses, demonstration of empathy, ability to vent and express fear and anxiety, quick response to requests, frequent monitoring, accessibility of caring medical staff, and short delivery.[16] In another cross-sectional study in the same country, mothers were asked about their satisfaction with birth care services. Although most participants were satisfied by the delivery service provided to them, a small group of mothers were dissatisfied due to lack of communication, perceived lack of privacy during the hospital stay, and obligatory blood donation.[17] In India, research shows that women prioritize the availability of doctors at the facility, availability of medicine, quality of ambulance services, maintenance of cleanliness and hygiene, privacy, patient-provider interaction, and financial cost of care.[18] In Mozambique, a population-based cross-sectional study concluded that satisfaction with childbirth was driven by respect and dignity and emotional support.[19] Finally, research following first-time mothers in Sweden demonstrated that participants felt empowered by trustworthy relationships with professional and their partners. When women felt empowered, they also felt in control, felt the strength of their bodies, and also felt more satisfaction and reassurance, along with experiencing better pain management.[20]

This study found that having numerous expectations for birth and delivery were associated with having a higher level of education, not working outside of the home, living in a suburban area, and having multiple children. Additional analysis identified a significant association between level of education with work status, residency location, and number of children. This suggests that higher educated women are more likely to, not work outside of the home, live in suburban areas, and have multiple children. Considering that education status is associated with women's empowerment and awareness of one's rights in the sustainable development realm, we suggest that education should be considered a critical factor for improving patient's awareness of their rights.[21]

Because women's satisfaction with verbal and nonverbal communication in the delivery room is associated with their satisfaction with birth care, it is critical to improve the communication skills of health care providers.[22]

In this culture and others, patients expect social niceties like greetings, social smiles,

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offering a seat, avoiding jargon, adequate time, paraphrasing and empathy. There is also some evidence that patients are increasingly requesting instructions as well as explanations about procedures, and also desire opportunity to express their opinions and fully act in the decision-making process.[23] Additional training for health care providers about these expectations would be beneficial to ensure that providers are meeting patient's needs and expectations.

Post-consultation expectation, perceived health status, and perceived control of health were factors identified as increasing patient satisfaction. In addition, the presence of any disappointments or worries, previous bad experiences with the health care system, and a perceived lack of influence on the consultation had a negative influence on satisfaction.[24]

Strengths and limitations

This study captures important information that is informative for the development of patient-centered programs and policies. It is worth mentioning that none of the women interviewed had taken an antenatal birth class as these types of classes are not provided in Iraq. As a result, they would not have been educated about standard practices during labor and delivery in an antenatal birth class setting. While the research captured a large sample size, findings from this study are limited by the fact that we used a convenience sample. Further, this study examined women's expectations from midwives, nurses, and physicians as a single unit, rather than examining separate expectations for each type of provider separately, which may be a weakness of the present study.

The decision to ask about expectations for all health care providers as a single unit was made because of the intent to capture a diversity of expectations knowing that, in Iraq, most medical decisions are made by physicians. Given that in Iraq, physicians are the dominant clinical decision makers for patients. One of other limitations of this study is that it focused on public sector, but did not investigate women's expectations at private sector hospitals and delivery rooms.

Conclusion

This study found that presence, positive and calming verbal and nonverbal expressions, environmental control, encouragement of different positions and mobilization, hygiene, promotion of urinary elimination, and instruction on breathing and relaxation are highly expected by parturient women, followed by demonstrating an effective caring attitude, listening to women's views, application of hot and cold packs, information about routines and procedures, and progress updates. Knowing women's expectations in the delivery room and being able to effectuate them may be one of the best approaches tocare planning, and it may also help to increase expecting mothers' satisfaction levels and help them to have a positive birth experience.

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Competing interests

The authors declare that they have no competing interests.

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