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Original Research Article

Childbirth experience of mothers attending selected secondary hospital

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ABSTRACT

Background: Childbirth experience is an important event in every woman's life but there is lack of current research in this area in Bangladesh. For improving quality of care for pregnant women during childbirth, clinical care modalities should be designed to improve the experience of care by the mothers. The aim of the study was to assess the childbirth experience in regards to respectful maternity care, effective communication, companionship during childbirth and continuity of care.
Methods: A cross-sectional study was conducted between January to December 2020 among 98 mothers during facility-based childbirth in one model district hospital and one existing district hospital situated in northern part of the country.
Results: Mean age of the respondents was 23.2 years (+SD 5.0). Majority completed secondary education (53.1%), and their average monthly family income was 12081.63 taka (+SD 5469.08). Childbirth experience was not associated with socio-demographic status and educational background (P>0.05). This study presents data on physical abuse prevalence and consent refusal rates among respondents, stratified by age groups, educational levels, and monthly family income. Despite variations observed across demographics, statistical analysis, including chi-square tests with continuity correction, revealed no significant differences (P<0.05) in these outcomes based on demographic factors.
Conclusions: More than half of the mothers experienced non consented care and around one fourth of mothers being physically abused during childbirth.

Keywords: Birth companionship, Childbirth, Quality improvement, Respectful care, Rural health services, Women's experiences

INTRODUCTION

Pregnancy and childbirth is one of the most important moment and memorable events in every woman lives. This time is also a stressful situation when they require psychological and emotional support.[1] At this time the mother expressed their need to be understood, encouraged, and reassured by health workers, family members, and their local community. So they should be supported by their caregivers and their companion of choice. Women should receive respectful and dignified care during this crucial time.[2] Approximately 140 million women give birth every year in the world. The majority of these women and their babies are healthy and are regarded to be at low risk of accelerating complications during labour.[3] At the same time, for the minority of women and babies who experience complications, serious morbidity or even death can happen.[4] Most maternity care policies mark that women and their babies should have evidencebased, equitable, compassionate, and respectful care throughout labour and childbirth; however, the reality experienced by women and babies in a multitude of settings- rich or poor-is less than positive, and access to important interventions is not worldwide same.[5] Woman's childbirth experience and childbirth satisfactions both are interconnected. A woman's positive experience of childbirth in health facilities may have immediate and long term effects of a woman's satisfactions with her childbirth experience on her health and her relationship with her infant.[6] The childbirth experience with satisfaction has contributed to a woman's sense of accomplishment and self-esteem and has led to expectation for future positive childbirth experience. On the contrary, women who experienced unsatisfactory births remember the birth of their child only with pain, anger, fear, and sadness, or they remember nothing which is suggestive of "traumatic amnesia".[7] A traumatic and unsatisfactory birth might lead to postpartum depression or post-traumatic stress disorder in which women relive their labour in dreams and flashbacks that, in turn, trigger extreme distress. The negative childbirth experience in health facilities may discourage the use of health facilities and may also result in future abortions, a lack of ability to resume sexual intercourse or preference for a caesarean for subsequent births.[8] Over the last 20 years, women have been encouraged to give birth in health care facilities to ensure access to skilled health care professionals and timely referral should the need for extra care arise.[9,10] However, to access labour and childbirth care in health care facilities has a doubt to guarantee good quality care.[11,12] Disrespectful and undignified care is prevalent in many facilities settings in the world, especially for poverty stricken population, and this not only disturbs their human rights but is also an important barrier to accessing intrapartum care services.[13]

In addition, the prevailing model of intrapartum care globally, which enables the health care provider to control the birthing process, may expose obviously healthy pregnant women to unnecessary medical interventions that interfere with the physiological process to childbirth.[14,15] According to the highlight of World Health Organization (WHO) framework for improving quality of care for pregnant women during childbirth, experience of care is as important as clinical care provisions in achieving the desired person centered outcomes.[16]

This study was aimed to assess the childbirth experience of mothers attending selected secondary hospitals. Also, to assess respectful maternity care related to childbirth experience of mothers attending selected secondary hospitals. Additionally, to assess effective communication regarding childbirth experience of mothers attending selected secondary hospitals. Moreover, to assess companionship during labour and childbirth regarding childbirth experience of mothers attending selected secondary hospitals.

METHODS

A cross-sectional study was conducted between January to December 2020 among 98 mothers during facility-based childbirth in one model district hospital and one existing district hospital situated in northern part of the country. After developing the questionnaire by the month of June, pre-test was performed in the month of July 2020. After necessary modification and correction, data collection was started from 1st August to September 2020. Data analysis and report writing were completed by November and then finished with final report submission. This study was conducted at two district hospitals in Bangladesh, One was Kurigram District Hospital and another was Lalmonirhat District Hospital. Both district hospitals are situated in the Division of Rangpur. Kurigram district hospital is 250 bed hospital and Lalmonirhat district hospital is 100 bed hospital.

Inclusion criteria

Mothers who have met labour childbirth in institution and participants who will provide informed consent were included.

Exclusion criteria

Mothers who are not physically or mentally sound or critically ill. Mother who delivers a dead baby were excluded.

Data collection

The study population included mothers who had met labour and childbirth in Kurigram district hospital and Lalmonirhat district hospital and data were collected just before discharge from those facilities. Data were collected by face to face interview of the respondents. Privacy was maintained during the interview as far as possible. The interview time per respondent took about 20-25 minutes. The questions were adapted from

published literature and also emphasized on EMEN checklist. A pretested semi structured questionnaire was used for data collection. According to the study objectives, all variables were listed. In the study for maximum output, semi structured questionnaire was developed and applied for data collection.

Data analysis

SPSS (Statistical Package for Social Science) Version 26 and Microsoft Excel was used for data analysis. Test of significance was performed according to objectives as needed. The test statistics used to analyze the data were descriptive statistics and Chi square according to the demand of the study with 95% CI (confidence interval). Level of significance was set at 5% (0.05).

Ethical consideration

For conducting the study, formal ethical approval was obtained from the ethical Institutional Review Board (IRB) of the National Institute of Preventive and Social Medicine (NIPSOM). Before data collection, informed written consent was taken from the authorities of two district hospitals. An informed written consent in Bengali was used to take consent from the respondents. An English version of informed written consent was drafted and then translated into Bengali. Data was collected by face to face interview using semi structured questionnaire. Before starting the interview, the respondents were informed about the objectives and purpose of the study. Respondents were assured about the confidentiality of the data. Risk and benefits were also explained clearly to the respondents. They were informed about the full rights to participate or to refuse in this study at any time.

RESULTS

The Table 1 shows that majority of the respondents (61.2%) were from the age group 15-24 years followed by 33.7% from 25-34 years age group and 5.1% from 35-44 years old. Here the minimum and maximum age of the respondents was 17 and 40 years respectively. The mean age of the respondent was 23.2±5.0 years.

Table 1: Frequency distribution of the respondents according to their age (n=98).

Age (years)	Frequency	Percentage (%)
15-24	60	61.2
25-34	33	33.7
35-44	5	5.1
Total	98	100
Mean±SD	23.2±5.0	

Figure 1 shows that majority of the respondents have completed secondary education (53.1%), followed by 29.6% studied up to primary level, 9.2% of the respondents were illiterate and rest of the respondents (8.2%) have completed higher secondary and above.

Table 2 showing the distribution of the respondents according to their number of children the majority of the respondents (55.1%) have only one child, followed by 27.6% have two children, 11.2% have three, 3.1% have four, 2.0% have five and 1.0% have six children.

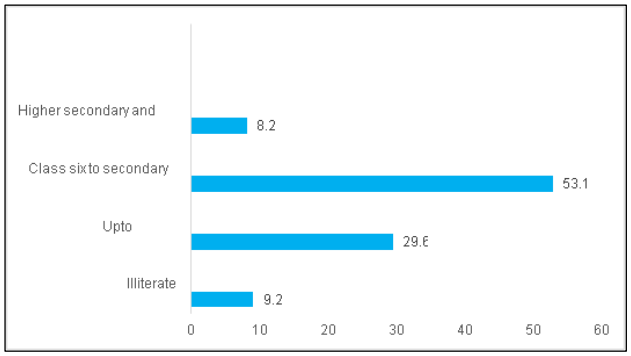

Figure 1: Frequency distribution of the respondents according to their level of education (n=98).

Table 2: Distribution of the respondents according to their number of children (n=98).

Number of children	Frequency	Percentage (%)
1	54	55.1
2	27	27.6
3	11	11.2
4	3	3.1
5	2	2.0
6	1	1.0
Total	98	100.0

Table 3: Distribution of the respondents according to their monthly family income (n=98).

Income (in taka)	Frequency	Percentage (%)
1000-10000	53	54.1
11000-20000	43	43.9
More than 20000	2	2.0
Total	98	100.0

Table 3 showing the distribution of the respondents according to their monthly family income, 54.1% respondent‘s monthly family income was 1000 to 10000 taka, 43.9% respondents earned within 11000 to 20000 taka and rest of the respondents 2.0% earned more than 20000 taka.

These Figure 2 shows that majority of the respondents (67.3%) experienced spontaneous vaginal delivery and rest of the respondents (32.70%) experienced assisted vaginal delivery.

The table 4 shows that majority of the respondents (74.5%) had not experience any kind of physical abuse, on the contrary 25.5% respondents experienced with physical abuse during their childbirth.

According to table 5, the frequency distribution of the respondents according to the types of birth companion presence during their labour and childbirth shows that 48.0% respondents had birth companion from parental side, 40.8% had birth companion from in law side and rest 11.2% of the respondents had birth companion from both side.

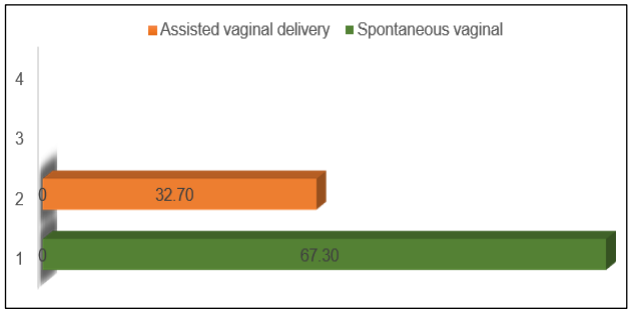

Figure 2: Distribution of the respondents according to their mode of delivery (n=98).

The table 6 shows that the respondents in the age group of 15 to 20 years, 29.5% experienced physical abuse while 22.2% respondents in the >20 years age group had the experience of physical abuse. Again, 38.6% in the 15 to 20 years and 37.0% in the >20 years age group were not approached for the consent before abdominal palpation. In majority of the respondents (37.0%) among >20 years age group, consent was not obtained for vaginal examination and consent was not also obtained for the same event in 36.4% among 15 to 20 years age group.

Table 4: Distribution of the respondents according to experience of physical abuse at the time of their childbirth (n=98).

Physical abuse	Frequency	Percentage (%)
Yes	25	25.5
No	73	74.5
Total	98	100

Table 5: Distribution of the respondents according to the types of birth companion presence during their labour and childbirth (n=98).

Types of birth companion present at the time of childbirth	Frequency	%
Relatives from parental side	47	48.0
Relative from in law side	40	40.8
Presence of family members from both side	11	11.2
Total	98	100.0

However, chi square test for independence (with continuity correction) revealed no statistical significance for these differences ($p<0.05$).

Table 6: Relation of age with childbirth experience at the time of delivery (n=98).

Age (years)	Physical abuse (%)		χ^2, df	P value
	Yes	No		
15 to 20	13 (29.5)	31 (70.5)	χ^2=0.353, df=1	0.552
>20	12 (22.2)	42 (77.8)		
Taking consent for abdominal palpation				
	Yes	No		
15 to 20	27 (61.4)	17 (38.6)	χ^2=0.026 df=1	0.871
> 20	34 (63.0)	20 (37.0)		
Taking consentbfor vaginal examination				
	Yes	No		
15 to 20	28 (63.6)	16 (36.4)	χ^2=0.005 df=1	0.945
> 20	34 (63.0)	20 (37.0)		

The table 7 shows that the respondents educational level above primary experienced more (28.3%) physical abuse than up to primary level (21.1%). Again, 44.7% up to primary level of education and 33.3% above primary level of education were not approached for the consent before abdominal palpation. Majority (44.7%) of the respondents up to primary level and 31.7% were above primary level education were not approached for the consent before vaginal examination. To see the statistical significance of this difference we did chi square test for independence (with Continuity Correction). It indicated that none of these differences were statistically significant ($P<0.05$).

The table 8 shows that the respondents monthly family income 1000 to 10000 taka, 28.3% experienced physical abuse while 22.2% respondents monthly family income >10000 taka. Again, 39.6% monthly family income 1000

to 10000 taka and 35.6% respondents had >10000 taka were not approached for the consent before abdominal palpation. In majority (37.7%) of the respondents monthly family income 1000 to 10000 taka consent was not obtained for vaginal examination and consent was not also obtained for the same event in 35.6% among the respondents monthly family income >10000 taka. However, chi square test for independence (with Continuity Correction) revealed no statistical significance for these differences (P<0.05).

Table 7: Relation of educational status with childbirth experience at the time of delivery (n=98).

Educational status	Physical abuse (%)		χ^2, df	P value
	Yes	No		
Up to primary	8 (21.1)	13 (78.9)	χ^2=0.322, df=1	0.570
Above primary	17 (28.3)	43 (71.7)		
	Taking consent for abdominal palpation			
Up to primary	21 (55.3)	17 (44.7)	χ^2=0.848 df=1	0.357
Above primary	40 (66.7)	20 (33.3)		
	Taking consent for vaginal examination			
Up to primary	21 (55.3)	17 (44.7)	χ^2=1.194 df=1	0.275
Above primary	41 (68.3)	19 (31.7)		

Table 8: Relation of monthly family income with childbirth experience at the time of delivery (n=98).

Monthly income	Physical abuse (%)		χ^2, df	P value
	Yes	No		
1000 to 10000	15 (28.3)	38 (71.7)	χ^2=0.207 df=1	0.649
> 10000	10 (22.2)	35 (77.8)		
	Taking consent for abdominal palpation			
1000 to 10000	32 (60.4)	21 (39.6)	χ^2=0.042 df=1	0.838
> 10000	29 (64.4)	16 (35.6)		
	Taking consent for vaginal examination			
1000 to 10000	33 (62.3)	20 (37.7)	χ^2=0.050 df=1	0.823
>10000	29 (64.4)	16 (35.6)		

DISCUSSION

This cross-sectional study was conducted to find out the status of childbirth experience of mothers those who were delivered their baby in a health facility. We also focused on to explore the difference of childbirth experience between two district hospital, where one was model district hospital and another was non model hospital. The study was carried out among mothers those who were delivered a healthy baby in Kurigram district hospital which was a model district hospital and Lalmonirhat district hospital which was a non-model hospital. To capture the real picture of the quality of care difference between the two health facilities, the model district hospital, where UNICEF's EMEN quality of care program was actively running, and the non-model district hospital were selected purposively.

The mean age of the respondents in current study was 23.2 years with (+SD 5.0), minimum age was 17 years while maximum age was 40 years and 53.1% completed secondary education. In most of the respondents the mean of their monthly family income was 12,081 taka.

Sudhinaraset et al conducted a study named "women's status and experiences of mistreatment during childbirth in Uttar Pradesh India" it was a mixed method study.[17] The quantitative sample included 392 women and the qualitative sample included 26 women. To be eligible, women had to be between 18 and 30 years of age, had at least one child currently under the age of five, and lived in the slum area. The quantitative analysis was restricted to 392 women who reported that their most recent birth took place in a health facility. The result found that the mean age of the respondents was 25.3 years SD=3.1 years with greatest proportion of women aged 25 to 30 years. A majority of the respondents (36.5%) had no formal education and 25.8% of women attended at least some secondary or post- secondary education. 22.5% women were in lower middle wealth quartile.[17]

In an another study conducted in Urban Tanzania, it was a direct observational study and data were collected during facility-based childbirth in one large referral hospital I Dar es Salaam, Tanzania. The total number of respondents were (1914) interviewed in postpartum period immediate before discharge and 197 deliveries were direct observed during labour and childbirth. In this study we found that the socio demographic characteristics finding were the average age of the respondents was 25 years, majority of the respondents had completed primary education and two-thirds were Muslim. Approximately 90% of the respondents were housewife and contained three or fewer children less than five years old.[18]

In the current study to assess the respectful maternity care and effective communication between service providers and respondents the findings presented that 25.5% of the respondents experienced physical abuse at the time of their childbirth whereas 24% respondents shared their experience that they needed episiotomy but the service providers conducted their delivery without anesthesia. It was praiseworthy that this study found total 98 respondents had 100% birth companion during their childbirth where 48.0% present from their parental side, 40.8% from in law side and rest 11.2% from both side. The respondents were reported that they have got spiritual and emotional support from their birth companion and they were very much satisfied about this. In a qualitative study in Nigeria where most of the women agreed that they would like to have a labour companion. Among them 80.8% women preferred their husband as their labor companion, 10.8% prefer their mother, 4.7% prefer their sister 2.8% their mother in law and 0.9% their friends.[19]

In this current study found that there was no association between childbirth experience (physical abuse, taking consent during abdominal palpation and vaginal examination) and monthly family income of the respondents (P=0.649, P=0.838, P=0.823 respectively). In a mixed method study in India, author found that richer women compared to poorer women were significantly more likely to verbal abuse, not being allowed a companion of their choice and had a higher mean disrespect score.[17] Childbirth experience (physical abuse, taking consent during abdominal palpation and vaginal examination) was not associated with educational status of the respondents (P=0.570, P=0.357, P=0.275 respectively). In an another study also found that, there were no significant difference in mistreatment by educational status of mothers.[17]

This study has few limitations**.** Desired sample size could not be achieved due to Pandemic situation of COVID19. Samples were collected purposively. However, if simple random sampling were done, the results could have been generalized. Study has been carried out at two district hospital in Rangpur division. So the results of this study may not represent overall picture of the country.

CONCLUSION

The study provided information that about one fourth of the mother experienced physical abuse at the time of their childbirth, more than half of the women experienced non consented care before abdominal palpation, vaginal examination, and episiotomy. But majority of the mothers experienced dignified care and did not need to pay any kind of bribe for good service. Health care providers maintained proper privacy and confidentiality during childbirth. But majority of the health care providers did not introduce themselves to the respondents. About half of the respondents reported that they were not monitored and informed about their delivery progress at the time of their delivery. It was praiseworthy that each and every respondent had birth companion during their childbirth and they got emotional and spiritual support from their companion and they were very much satisfied with the availability of birth companion. According to WHO guidelines 2013 in recommendation number 9, it was emphasizes that counseling should give to the mothers just before discharge from recovery after birth.

Recommendations

Continuous supervision and monitoring should be maintained to ensure quality of care service during labor and childbirth. More human resource should be recruited at district hospital for better compliance of clients. Ensure and enhance adequate supply of essential equipment which is required for the pregnant mothers and also during delivery. Partograph should maintain during labour. More research should be conducted to capture the field level data in a more comprehensive way.

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Ethical approval: The study was approved by the Institutional Ethics Committee

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