

6-2017

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Recommended Citation

Okumus, F. Birth experiences of primiparous Turkish women: public and private hospitals. *Journal of Asian Midwives*. 2017;4(1):35–50.

Birth experiences of primiparous Turkish women: public and private hospitals

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Abstract

Introduction: We wished to better understand primiparous women's childbirth experiences in private and public hospitals. Within the context of high caesarean section rates, in both private and public hospitals in Turkey, the experiences of women who delivered vaginally needs to be considered if we aim to decrease the number of caesarean births. We, therefore, conducted a descriptive study of women's vaginal birth experiences in two hospitals in Istanbul.

Methods: Two hundred and forty primiparous women, from two hospitals (one public, one private), who had vaginal births, were included in this descriptive study. Information was obtained from medical records and through personal interviews with women in the early postpartum period. Birth perceptions, interventions, and supportive practices were investigated.

Results: Women in both the private and public hospitals had high rates of obstetric interventions. Interventions, such as enemas, amniotomies, fundal pressure and episiotomies commonly occurred in both hospitals. Oxytocin induction was twice as common in the private hospital. The most common supportive practice was position and mobility during the first stage. Women seldom received oral nourishment or had skin-to-skin contact with the baby. The women in the private hospital, significantly, more often reported that protection of privacy and encouragement from the midwife and from the gynecologist were greater than expected. Conversely, these women, significantly, more often indicated that their levels of fear and anxiety were greater than expected.

Conclusions: Primiparous women in both hospitals, who delivered vaginally, experienced multiple interventions during the course of labour and birth. The overall context of high caesarean section rates and high interventions in labour in women at full term illustrate the over-medicalisation of birth. These findings point to the need for greater understanding by women, maternity care providers and policy makers about the potential harm of such practices. Midwives are an essential part of the healthcare system, who can improve the quality of care

for mothers and babies by providing education, counseling, and support to women and families and through implementing known best practices that promote normal childbearing.

Keywords: *obstetric interventions, childbirth, birth experience, primiparous women*

Background

Childbirth is a very significant event that is affected by different social, environmental, and organizational processes. Various physiological and psychological elements are also involved and are interrelated.¹ A woman's experience of labour and birth may have long-lasting and profound effects on her wellbeing and that of her baby and husband.² Further, the childbirth experiences of primiparous women are especially important because of their impact on future births, most especially if the first birth is a caesarean section. There is also an impact on the nature of the birth stories that are told to subsequent generations.³

Turkish maternity services are hospital-based and highly medicalised. It is, therefore, important that Maternity services provided by hospitals should meet women's needs for supportive care. There is a direct relationship between large-scale use of interventions and women's negative experiences of birth. Routinely used interventions in hospitals, without valid indications, can transform childbirth into a medical and surgical procedure.⁴ The Royal College of Obstetricians and Gynecologists in the United Kingdom recommends that the second stage of labour should be personally directed and interventions should not be applied routinely.⁵ Rowe-Murray and Fisher⁶ state that instrumental and surgical births have negative effects on the first contact between the mother and infant in the early postpartum period. Previous studies have indicated that operative vaginal births can result in long term symptoms related to acute trauma.⁷⁻⁸

Negative childbirth experiences often lead women to prefer caesarean sections to a vaginal birth.⁹ In Turkey, the caesarean rate has increased by 2.5 times in the last ten years. According to the 2014 Health Statistics Yearbook of the Republic of Turkey Ministry of Health the rate increased from 21% in 2002 to 51% in 2014.¹⁰ This rapid rise may be related to the increased tendency of Turkish women to give birth in private hospitals, where both women and physicians appear to prefer caesarean births. During this period, private hospitals claimed to provide higher quality health care services. Health data show that 18% of caesarean births are done at the mother's request, 50% are performed because of a medical indication, and the remaining 32% are physician preference.¹⁰

Government policies in Turkey have been developed to reduce caesarean rates but policies implemented to reduce rates failed to improve the vaginal delivery experience of women and led to an increase rather than a reduction in caesarean rates. We, therefore, wanted to better understand primiparous women's childbirth experiences in private and public hospitals to shed light on the reasons for women's preference of caesarean sections.

Methodology

This descriptive study was conducted in May and June 2016, in two different hospitals located in the Istanbul province.

Setting and Sample Selection

The study sites were one public hospital and one private hospital both located in the Europe side of urban Istanbul. In each hospital, there are approximately 1200 births annually.

The population of the present study consisted of 240 primiparous women admitted for postpartum care. A convenience sample of women were enrolled, using the following inclusion criteria: between the ages of 18 and 35, married, primiparous, delivered a singleton infant between gestational weeks 38–40, had no pregnancy or birth-related complications, and spoke and understood Turkish. All women who volunteered to participate met the aforementioned criteria.

Data collection

The data were collected by using a descriptive information form, a birth follow-up form, and an expectation evaluation form. The forms were adopted from previously published studies.¹¹⁻¹² The descriptive information form sought the women's identification information. The birth follow-up form was used to record interventions and supportive practices performed during the births. Medical records were reviewed and women were asked about six aspects of the birth process in a face to face interview: (a) the experience overall, (b) the amount of support received from the midwife and the gynecologist, (c) the degree of privacy provided, and her recall of (d) fear, (e) anxiety, and (f) pain. Each aspect was rated as "less than expected", "as expected" or "more than expected". The data were collected by midwives working in the selected hospitals, who were unknown to the women.

Data analysis

The SPSS 22.0 statistical programme was used to analyze the data. Percentage, mean, and Chi-square tests were used to evaluate the data. Results were considered statistically significant when the *p* value was less than 0.05.

Ethical Approval

Ethics committee's approval was obtained from the Istanbul Medipol University Non-Invasive Clinical Research Ethics Board (protocol number: 10840098-604.01.01-E.6579).

Findings

We enrolled 240 primiparous women, half of whom had given birth in the public hospital and half in the private hospital. The women's mean gestational age at the time of birth was 39.0 ± 1.2 weeks (min: 38-max: 40). About 13.8% had undergone an abortion in the past. The women who gave birth in the private hospital differed significantly from those cared for in the public hospital ($p > 0.05$). They were older (mean 29.5 vs 24.1 years), had more education (85.1% vs 14.9% with university education), were more likely to be employed (79.4% vs 20.6%), and to have a "good" income (85.4% vs 14.6%) (see Table 1).

Table 1. Demographic characteristics of the women

	Private Hospital	Public Hospital	TOTAL	Test value	p value
Years (Mean±SD)	29.5±3.9	24.1±5.2	26.8±5.3	2.911	0.000
Gestational age (week) (Mean±SD)	38.9±1.0	39.0±1.4	39.0±1.2	1.237	0.370
Education	n (%)	n (%)	n (%)	121.937	0.000
Elementary	2/120 (3.1)	63/120 (96.9)	65/240 (27.1)		
Secondary	3/120 (12.5)	21/120 (87.5)	24/240 (10.0)		
High school	29/120 (58.0)	21/120 (42.0)	50/240 (20.8)		
University	86/120 (85.1)	15/120 (14.9)	101/240 (42.1)		
Work status				61.381	0.000
Employed	81/120 (79.4)	21/120 (20.6)	102/240 (42.5)		
Housewife	39/120 (28.3)	99/120 (71.7)	138/240 (57.5)		
Type of family				18.586	0.000
Nuclear	115/120 (55.6)	92/120 (44.4)	207/240 (86.3)		
Extended	5/120 (15.2)	28/120 (84.8)	33/240 (13.8)		
Income status				51.368	0.000
Good	41/120 (85.4)	7/120 (14.6)	48/240 (20.0)		
Moderate	78/120 (48.4)	83/120 (51.6)	161/240 (67.1)		
Bad	1/120 (3.2)	30/120 (96.8)	31/240 (12.9)		
Abortion				0.035	1.000
Yes	16/120 (48.5)	17/120 (51.5)	33/240 (13.8)		
No	104/120 (50.2)	103/120 (49.8)	207/240 (86.3)		

Upon admission to the hospital nearly 45% of the women were in the latent phase of labour, as defined by cervical dilation. Significantly more women at the private hospital were admitted when they were in the latent phase of labour (57.5%) compared to women admitted in

the latent phase (31.7%) to the public hospital ($p < 0.05$). There was no significant difference between groups in overall length of hospital stay for childbirth ($p > 0.05$) (Table 2).

Table 2. Phase of labour at the time of admission to hospital and duration of total hospital stay

	Private Hospital n (%)	Public Hospital n (%)	TOTAL n (%)	Test value	p value
Duration in days of hospitalization (Mean±SD)	5.9± 3.3	6.1±5.1	6.0±4.3	26.652	.708
Cervical dilatation at admission					
Latent phase (0-3 cm)	69/120 (57.5)	38/120 (31.7)	107/240 (44.6)	19.835	.000
Active Phase (4-7 cm)	40/120 (33.3)	51/120 (42.5)	91/240 (37.9)		
Transition phase (8-10 cm)	11/120 (9.2)	31/120 (25.8)	42/240 (17.5)		

Thirty percent of all the participants had augmentation of labour with oxytocin (Table 3). There was a significant relationship between oxytocin use and hospital type, with augmentation of labour occurring nearly twice as often in the private hospital (39% vs 20%).

Other intervention rates were also high: 50.8% had an amniotomy; 57.1% an enema, 89.6% an episiotomy, and 57.5% fundal pressure. There was no significant relationship between the groups in the hospital type and the frequency of these obstetric interventions (Table 3).

Table 3. Medical interventions during labour and birth according to the site of birth

	Private Hospital n (%)	Public Hospital n (%)	TOTAL n (%)	Test value	p value
Oxytocin induction				10.581	.001
Yes	47/120 (39.2)	24/120 (20.0)	71/240 (29.6)		
No	73/120 (60.8)	96/120 (80.0)	169/240 (70.4)		
Episiotomy				.045	.833
Yes	107/120 (89.2)	108/120 (90.0)	215/240 (89.6)		
No	13/120 (10.8)	12/120 (10.0)	25/240 (10.4)		
Amniotomy				.267	.349
Yes	63/120 (52.5)	59/120 (49.2)	122/240 (50.8)		
No	57/120 (47.5)	61/120 (50.8)	118/240 (49.2)		
Fundal Pressure				.068	.794
Yes	68/120 (56.7)	70/120 (58.3)	138/240 (57.5)		
No	52/120 (43.3)	50/120 (41.7)	102/240 (42.5)		
Enema				2.874	.090
Yes	62/120 (51.7)	75/120 (62.5)	137/240 (57.1)		
No	58/120 (48.3)	45/120 (37.5)	103/240 (42.9)		

We found from our inquiry about supportive practices that 65.8% of the women were supported to position and to be mobile during the first stage; 12.9% of them had oral intake during first stage; and 12.9% of them had immediate skin-to-skin contact with their babies. However, these practices were provided significantly more often in the private hospital

(mobility 82.5%; skin-to-skin contact 21.7%) vs the public hospital (mobility 49.2%; skin-to-skin 4.2%) (Table 4).

Overall, slightly more than half (53%) of the women rated the support from a midwife as greater than expected. There was, however, a very large difference between the groups: far more women in the private hospital reported 'more than expected' support from midwives than women in the public hospital (78.3% vs 27.5%). Similar differences were seen about receiving 'more than expected' support from gynecologists (79.2% private vs 29.2% public) and for protection of personal privacy (75.8% private vs. 18.3% public). Differences between the groups were all statistically significant (Table 4).

Table 4. Supportive practices provided to women during labour and birth according to the site of birth.

	Private Hospital n (%)	Public Hospital n (%)	TOTAL n (%)	Test value	<i>p</i> value
Position & mobility				29.639	.000
Yes	99/120 (82.5)	59/120 (49.2)	158/240 (65.8)		
No	21/120 (17.5)	61/120 (50.8)	82/240 (34.2)		
Maintaining the oral intake				3.000	.083
Yes	11/120 (9.2)	20/120 (16.7)	31/240 (12.9)		
No	109/120 (90.8)	100/120 (83.3)	209/240 (87.1)		
Skin to skin contact				16.336	.000
Yes	26/120 (21.7)	5/120 (4.2)	31/240 (12.9)		
No	94/120 (78.3)	115/120 (95.8)	209/240 (87.1)		
Midwife support				65.840	.000
Less than expected	3/120 (2.5)	30/120 (25.0)	33/240 (13.8)		
As expected	23/120 (19.2)	57/120 (47.5)	80/240 (33.3)		
More than expected	94/120 (78.3)	33/120 (27.5)	127/240 (52.9)		
Gynecologist support				63.360	.000
Less than expected	3/120 (2.5)	28/120 (23.3)	31/240 (12.9)		
As expected	22/120 (18.3)	57/120 (47.5)	79/240 (32.9)		
More than expected	95/120 (79.2)	35/120 (29.2)	130/240 (54.2)		
Protection of the privacy				80.347	.000
Less than expected	4/120 (3.3)	22/120 (18.3)	26/240 (10.8)		
As expected	25/120 (20.8)	76/120 (63.3)	101/240 (42.1)		
More than expected	91/120 (75.8)	22/120 (18.3)	113/240 (47.1)		

Women's perceptions about of their pain during labour did not significantly differ between the two hospitals ($p > 0.05$). Overall, 78% perceived their pain to be less than expected and only 3.3% thought the pain was greater than expected. In contrast, there were marked

differences in perceived levels of anxiety and fear: 76.7% of women in the public hospital perceived their anxiety to be less than expected vs 27.5% of women in the private facility; whereas, only 10% of the public hospital group perceived more anxiety than expected vs 32.5% of the private group ($p=0.000$). Similar differences were found for perceived fear (Table 5).

Table 5. Women's perceptions of pain, anxiety and fear during labour and birth according to the site of birth

	Private Hospital n (%)	Public Hospital n (%)	TOTAL n (%)	Test value	p value
Pain				3.350	.187
Less than expected	99/120 (82.5)	89/120 (74.2)	188/240 (78.3)		
As expected	19/120 (15.8)	25/120 (20.8)	44/240 (18.3)		
More than expected	2/120 (1.7)	6/120 (5.0)	8/240 (3.3)		
Anxiety				58.142	.000
Less than expected	33/120 (27.5)	92/120 (76.7)	125/240 (52.1)		
As expected	48/120 (40.0)	16/120 (13.3)	64/240 (26.7)		
More than expected	39/120 (32.5)	12/120 (10.0)	51/240 (21.3)		
Fear				44.562	.000
Less than expected	37/120 (30.8)	88/120 (73.3)	125/240 (52.1)		
As expected	47/120 (39.2)	22/120 (18.3)	69/240 (28.7)		
More than expected	36/120 (30.0)	10/120 (8.3)	46/240 (19.2)		

Discussion

In an environment of high rates of caesarean section, driven in part by women's requests for a surgical birth, it is important to understand the experiences of those who have vaginal births if policies to reduce caesarean section rates are to be effective. The experiences of women in this study who delivered vaginally show that obstetric interventions were commonly used. Turkey is not alone in this regard, since high rates of obstetric interventions continue to be found in many countries.¹³⁻¹⁴ While some studies have found higher rates of intervention in private hospitals,¹⁵⁻¹⁷ our study did not demonstrate this difference.

A large percentage of the primiparous women in our study, who were all at full term and had a vaginal birth, had experienced one or more of enema administration, amniotomy, episiotomy and fundal pressure. These practices are associated with pain and discomfort for women in labour; their routine usage is not supported by current evidence.¹⁸⁻¹⁹ Our data showed that fundal pressure was used in more than half (58%) the women, yet, there is insufficient evidence to support its routine usage, by any method, in the second stage of labour.¹⁹ The belief that routine episiotomy reduces perineal trauma is not proven by the evidence. Maternal pain, bleeding, painful intercourse and urinary incontinence are potential complications of the procedure¹⁸, yet nearly all the women (90%) experienced this intervention. This is consistent

with other studies in the Turkish population²⁰⁻²² where episiotomy rates far exceed those recommended by the World Health Organization.²³ Similarly, routine amniotomy has not been shown to confer benefit and is associated also with adverse outcomes.^{4,24} The use of oxytocin for augmenting labour was significantly higher in the private hospital and may be related to the greater number of women who were admitted to that facility in the latent phase of labour. Studies have shown that early admittance resulted in more frequent use of obstetric interventions, as compared to admittance in the active phase of labour.²⁵⁻³⁰

We were interested in the findings concerning aspects of supportive care. A majority of the women were able to alter position and be mobile but very few were provided oral nourishment or immediate skin-to-skin contact with their babies. Women in the private hospital group were much more likely to report that support from the midwife and gynecologist and protection of privacy was more than expected. This is, perhaps, not surprising since private hospitals are likely to provide personal supportive care to a patient population that is directly paying for services. However, the greater than expected level of support did not appear to have a direct relationship with a reduction in fear and anxiety in women in the private group. Compared with women in the public hospital group, they more often expressed that their levels of fear and anxiety were greater than expected.

There were many differences between the groups in terms of education, employment and income, all of which may have contributed to varying expectations about the care that would be available to them and their response to that care. Our study was not designed to probe those relationships, but research that examines differences in expectations across groups of women could elucidate the variation in expectations, the impact of current information about birth practices, and the kinds of supportive care practices that reduce women's fears of the birth experience.

Conclusions and Implications

Medicalised birth is widespread and caesarean births in 2014 were just above 50% in Turkey. In our study of primiparous women who delivered vaginally, obstetric interventions were prevalent. Supportive care practices were limited, especially in the public hospital group. The women in the private hospital more often reported greater than expected support from midwives and physicians, but they also more often perceived their fear and anxiety to be greater than expected. These findings suggest a need for health professionals to engage more in communicating information about best care practices and providing supportive care based on individual needs. Midwives are an ideal professional group to advocate for women, provide up

to date information that can empower women to ask questions and become active participants in their care. To accomplish this, midwives themselves must be well informed about best practices and actively implement forms of care that can promote normal birth and avoid ineffective and potentially harmful interventions.^{27, 31-32} They can enable women to have birth experiences and birth stories that they will want to tell the subsequent generations.

Acknowledgements

The author thanks the delightful mothers and babies who so graciously participated in this study, as well as the hardworking and dedicated midwives. The author would like to thank Midwives Umran Erciyes and Semsî Aslan for their support in data collection.

Conflict of Interest

Author confirms no conflict of interest.

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