Taylor & Francis
Taylor & Francis Group

Reproductive Health Matters

An international journal on sexual and reproductive health and rights

ISSN: 0968-8080 (Print) 1460-9576 (Online) Journal homepage: www.tandfonline.com/journals/zrhm20

Women's satisfaction and perception of control in childbirth in three Arab countries

Tamar Kabakian-Khasholian, Hyam Bashour, Amina El-Nemer, Mayada Kharouf, Salah Sheikha, Nasser El Lakany, Rafik Barakat, Ohoud Elsheikh, Nadia Nameh, Rabih Chahine & Anayda Portela

To cite this article: Tamar Kabakian-Khasholian, Hyam Bashour, Amina El-Nemer, Mayada Kharouf, Salah Sheikha, Nasser El Lakany, Rafik Barakat, Ohoud Elsheikh, Nadia Nameh, Rabih Chahine & Anayda Portela (2017) Women's satisfaction and perception of control in childbirth in three Arab countries, Reproductive Health Matters, 25:sup1, 16-26, DOI: 10.1080/09688080.2017.1381533

To link to this article: https://doi.org/10.1080/09688080.2017.1381533

© 2017 The Author(s). Published by Informa UK Limited, trading as Taylor & Francis Group

Published online: 09 Nov 2017.

Submit your article to this journal

Article views: 5178

View related articles

View Crossmark data

Citing articles: 11 View citing articles

Full Terms & Conditions of access and use can be found at
https://www.tandfonline.com/action/journalInformation?journalCode=zrhm21

RESEARCH ARTICLE

Women's satisfaction and perception of control in childbirth in three Arab countries

Tamar Kabakian-Khasholian,[a] Hyam Bashour,[b] Amina El-Nemer,[c] Mayada Kharouf,[d] Salah Sheikha,[e] Nasser El Lakany,[f] Rafik Barakat,[f] Ohoud Elsheikh,[g] Nadia Nameh,[h] Rabih Chahine,[i] Anayda Portela[j]

a Associate Professor, Health Promotion and Community Health Department, Faculty of Health Sciences, American University of Beirut, P.O. Box 11-0236, Riad El-Solh/Beirut 1107 2020, Lebanon. *Correspondence*: tk00@aub.edu.lb

b Professor, Department of Family and Community Medicine, Faculty of Medicine, Damascus University, Damascus, Syria

c Professor, Faculty of Nursing, Mansoura University, El Gomhouria St, Mit Khamis WA Kafr Al Mougi, Mansoura, Dakahlia Governorate 35516, Egypt

d Lecturer, Department of Family and Community Medicine, Faculty of Medicine, Damascus University, Damascus, Syria

e Professor and Dean, Department of Family and Community Medicine, Faculty of Medicine, Damascus University, Damascus, Syria

f Obstetrician & Gynecologist, Professor, Department of Obstetrics and Gynecology, Faculty of Medicine, Mansoura University, El Gomhouria St, Mansoura Qism 2, Mansoura, Dakahlia Governorate, Egypt

g Assistant Professor, Faculty of Nursing, Mansoura University, El Gomhouria St, Mit Khamis WA Kafr Al Mougi, Mansoura, Dakahlia Governorate 35516, Egypt

h Research Assistant, Health Promotion and Community Health Department, Faculty of Health Sciences, American University of Beirut, P.O. Box 11-0236, Riad El-Solh/Beirut 1107 2020, Lebanon

i Obstetrician & Gynecologist, Obstetrics and Gynecology Department, Rafik Hariri University Hospital, Beirut, Lebanon

j Technical Officer, Department of Maternal, Newborn, Child and Adolescent Health, The World Health Organization, Avenue Appia 20, 1202 Geneva, Switzerland

Abstract: *Women's satisfaction and perceived control in childbirth are important attributes of the childbirth experience and quality of care indicators. This article presents findings from the pre-intervention phase of a multi-centre implementation study in Egypt, Lebanon and Syria, to introduce a labour companionship model in these countries. A sample of 2620 women giving birth in three public teaching hospitals from November 2014 to July 2015 in Beirut and Mansoura, and from November 2014 to April 2015 in Damascus were interviewed by trained field workers. Additional information was abstracted from medical charts. An adapted version of the Mackey Childbirth Satisfaction Rating Scale was used to measure women's satisfaction and the shortened version of the Labor Agentry Scale was used to assess perception of control. The total satisfaction score was high in all sites with the lowest being in Egypt. Perceived control was directly related to satisfaction. Women with low education levels had higher levels of childbirth satisfaction. Women who had fewer children from Egypt and Lebanon, and those who received care by a team including both male and female physicians in the Syrian hospital were more likely to be dissatisfied than their counterparts. Variations in the management and provision of care between the three countries may explain the differences in satisfaction levels observed. Further qualitative research is needed to deepen our understanding of the concepts of control and satisfaction in the Arab culture as well as to establish the factors associated with women's positive childbirth experiences to inform the provision of quality maternity care.* DOI: 10.1080/09688080.2017.1381533

Keywords: childbirth satisfaction, perception of labour control, Egypt, Lebanon, Syria

Introduction

Childbirth is an important life-changing event and women's birth experiences have been reported to have long and short-term influences on women's well-being.[1–3] Reviews indicate that women's sense of control during labour is an important

 © 2017 The Author(s). Published by Informa UK Limited, trading as Taylor & Francis Group
This is an Open Access article distributed under the terms of the Creative Commons Attribution License (http://creativecommons.org/licenses/by/4.0/), which permits unrestricted use, distribution, and reproduction in any medium, provided the original work is properly cited.

determinant of their satisfaction with the childbirth experience,[4,5] which is considered an important indicator of the quality of maternity care services.[6]

A woman's satisfaction with the birth experience has been shown to influence her relationship with her infant, to affect her self-esteem and self-image, and influence her future childbirth expectations.[1,3,7] Perceptions of being in control during childbirth have been recognised as the strongest component of women's birth experiences,[8–11] of their own behaviour during labour and their interaction with care providers,[10] contributing largely to women's feelings of fulfilment and postpartum well-being.[10,12] Satisfaction is also related to the caregiver's attitude, good communication with care providers, and the responsiveness of staff to women's needs.[5,13] One report indicates that dissatisfaction with care and perceptions of diminished control over the process of childbirth have led to a preference for caesarean sections for future births.[14]

A number of individual-level and system-level factors pertaining to the policies, organisation and management of health care have been reported in the literature to be associated with positive childbirth experiences, such as women's involvement in the decision-making process, access to information, familiarity with the care provider, support during labour and type of birth.[5,11,15–17] Demographic factors like education, age, socio-economic status, marital status have been found to have little relationship with childbirth satisfaction in a systematic review, except for higher levels of satisfaction with multi-parity[5] and high education levels.[9]

Despite the increased recognition of the importance of women's positive experiences with birth as an essential attribute of quality of care and women-centred care,[18–20] research on quality of maternity care has focused mainly on avoidance of adverse events and minimal attention has been given to women's childbirth experiences.[21] In 2016, the World Health Organization (WHO) put forward a framework of quality of care for pregnant women and newborns, highlighting the importance of women's experiences including the provision of companionship during labour and birth and ensuring respectful maternity care.[22] Also recently, social movements such as the humanisation of childbirth and the promotion of women-centred approaches aim to prevent disrespect and abuse and improve women's experiences with care.[23] The provision of emotional support through a birth companion is a component in models advocating respectful maternity care.[24,25]

The objective of this article is to describe the levels of satisfaction with the childbirth experience and perceptions of control of women giving birth in public hospitals in three middle-income Arab countries, Egypt, Lebanon and Syria, and to determine the service delivery factors associated with their satisfaction. The data analysed here is from the findings of a pre-intervention phase of a multi-centre implementation research study to develop and introduce a labour companionship model in public hospitals. Baseline levels of satisfaction and perceptions of control were established during this phase in order to inform the implementation of the intervention and measure their changes during implementation.

Maternity care services in the three settings

The structure of health systems in the three Arab countries (Egypt, Lebanon and Syria) involved in this project is different. In this regard, Egypt and Syria have both active private and public sectors for service delivery. In Lebanon, the private sector is dominant. Fragmented care is characteristic to each of these settings with lack of continuity from prenatal to postpartum care. Out of pocket money spent on health is high in the three countries, although a health insurance system is better established in Lebanon. In addition, the ongoing political instability in the region continuously influences the provision and access to health care services in these three countries. We note that the situation in Syria has changed since the beginning of the conflict in 2011, with around half of the public health care facilities reported being closed or non-functional with consequent disruption in access to health care.[26]

Egypt and Syria are characterised by total fertility rates of around 3, whereas Lebanon has a total fertility rate of 1.5.[27] The Arab region, including these three countries, has witnessed a decrease in maternal mortality levels during the last decades[28] coupled with high levels of skilled birth attendants.[29] The most recent estimates point to seven out of ten births happening in health facilities in Syria[30] and Egypt,[31] 98% of births occur in hospitals in Lebanon.[32] Childbirth is highly

medicalised in hospital settings in these three countries where a substantial discrepancy between routinely followed practices and best practices in maternity care exist with a number of unnecessary or even harmful practices, such as non-indicated labour induction, and enemas and episiotomies for primiparas being routinely applied.[33] Reported Caesarean section rate in these countries have also followed the worldwide increasing trends with 41% in Lebanon[34] based on hospital-based studies, 52% in Egypt[35] and around 27% in Syria[30] based on population-based studies. Earlier studies from the region indicate that there are no national or hospital policies supporting labour companionship in these countries and women's choices for having a labour companion is not always considered in Lebanon, and almost never considered in Egypt and Syria.[33] This comes in contrast to women's needs for support and experiences of isolation and fear as documented previously in these countries.[36]

Study setting

One public teaching hospital was chosen in each of Mansoura, Egypt; Beirut, Lebanon; and Damascus, Syria as the sites to conduct the project. All three are university teaching hospitals that provide services to a population of low to middle socio-economic level, and have large number of births compared to other hospitals in their geographic areas. The hospitals in Beirut and in Damascus also serve a large number of Syrian refugee or internally displaced women. The hospitals in Mansoura and Damascus have both a public and a private section, while the hospital in Beirut is only public. However, this study only included participants using the public section of the hospitals in Mansoura and Damascus. Labour care, in all three sites, is provided mainly by midwives, nurses and residents with slight variations between settings. Birth is attended by senior residents in Syria and Egypt, and by residents and obstetricians in Lebanon. Both hospitals in Damascus and Mansoura have shared labour rooms accommodating four to twelve women in each room, while in the selected hospital in Beirut, the labour and birthing rooms are designed to house only one woman. The policies at the Damascus and Mansoura hospitals do not allow labour companionship and continuous labour support is not offered by the staff. In the Beirut hospital, labour companions are allowed, however, this practice is not institutionalised and is usually left to the discretion of the care provider.

Methods

A total sample of 2620 women (709 in Mansoura, 705 in Beirut and 1206 in Damascus) giving birth in the three selected hospitals participated in the pre-intervention phase of the study. The sample size was calculated based on an estimated reduction of 4% on the average C-section rates in the three countries (35%), the primary outcome of interest in the intervention study, considering a power of 85% and a significance level of 5%. Women who gave birth and consented to participate in the study during the period November 2014 to July 2015 in Beirut and Mansoura, and November 2014 to April 2015 in Damascus, were approached and recruited in the study. Recruitment was continuous throughout different time periods on all days of the week. Women who were classified as high-risk by health care providers upon arrival to the hospital, those who suffered from intrauterine foetal death and those below 18 years of age were excluded from the study. The age restriction was applied to include women who could provide informed consent without the need to seek the consent of a guardian considering that a legal guardian for women below the age of 18 might not be present at the time of recruitment. The overall refusal rate was 1.4% in the three sites.

Trained female field workers checked the labour and birth registry daily and approached women eligible for the study in the postpartum ward before their discharge from the hospital which ranged from 6 hours to a maximum of 48 hours after giving birth, to obtain informed consent and conduct an interview using structured questionnaires. Socio-demographic data, women's satisfaction with the childbirth experience and perception of control during labour were assessed through women's interviews using the questionnaire. In addition, a member of the staff abstracted information from medical charts on a daily basis using a form prepared by the study team. Information about type of birth, Apgar score and length of labour was obtained from the medical charts.

To measure women's satisfaction, we used the Mackey Childbirth Satisfaction Rating Scale, a 34-item scale of established reliability and validity, consisting of six sub-dimensions capturing aspects related to self, partner, baby, nurse/midwife,

physician and general rating scale.[9] Women indicate their degree of satisfaction with each item using a 5-point Likert scale. This scale was adapted to a 31-item scale, translated and used in Arabic in a previous study.[37] Additional adaptations, pertaining to the wording in Arabic, were made for this study. The items removed pertained to women's expectations, which were not relevant for women in these contexts. The scale was pilot tested in the three sites for comprehension of the wordings used in Arabic. Internal consistency reliability coefficients for this adapted scale was calculated from data used in a previous study conducted in Lebanon[37] (total scale 0.95; self 0.93; husband/family 0.97; baby 0.83; nurse 0.95; physician 0.95) and were found to be comparable to the reported ones for the English version of the original scale.[9]

The Labor Agentry Scale (LAS) was used to assess women's perception of control. The LAS is a 29-item scale with a shortened 10-item version that measures personal control during childbirth with established robust psychometric properties of validity and reliability.[38] Women's degree of agreement or disagreement with each item is measured on a 7-point Likert scale. We used the shortened 10-item version, which was translated into Arabic and back-translated into English to check for accuracy of translation and was pilot tested in the three sites. Coding was reversed for the negatively worded items so that a higher score on the scale reflects a higher personal control.

The independent variables were identified from the literature (education, parity, type of birth) and from the formative research conducted by the study team prior to the intervention where women's preferences for female providers were noted.[37]

Ethical approval was obtained from the Institutional Review Board at the American University of Beirut, the University of Damascus, the University of Mansoura, the hospital in Beirut and the World Health Organization Ethics Review Committee. The approval and the collaboration of the management of the three selected hospitals were ensured. Written informed consent was obtained from women prior to interviews.

Descriptive analysis was conducted initially for the variables of interest to this study. Chi-squared statistics and one-way analysis of variance (ANOVA) test were used to compare socio-demographic and birth-related characteristics among the three country sites. Sub-scores were created for the sub-dimensions of the satisfaction scale in addition to the total satisfaction score. Multiple regression analysis was performed to identify the determinants of the total satisfaction in this sample. For this purpose, the variables of education and gender of the obstetrician were grouped into dichotomous variables. Low level of education included the categories of illiterate and primary education and high level of education included those of elementary education and above. The variable for the obstetrician's gender was grouped as having both genders in the team versus having only one gender.

Results

The average age of women giving birth in these hospitals was 26 years and the vast majority reported not working outside the home. There was a variation in the education level of women between the country sites with more women in the Syrian and Lebanese hospitals having low levels of education and more women in the hospital in Egypt with higher levels of secondary education. The average number of children was found to be higher in Syria (3.53) than in Lebanon (2.68) and Egypt (2.19) (Table 1).

Thirty-three percent of women in Lebanon reported having both male and female obstetricians within the team providing labour and childbirth care, whereas the majority of obstetricians were males in the Egyptian site (72.5%) and females in the Syrian site (60.6%). C-section rate was the highest in the hospital in Egypt (32.4%) and lowest in the Syrian hospital (16.3%). Only 14% of women from Egypt reported having less than four antenatal visits, whereas 23.7% of women in Lebanon and 32.5% of women from the Syrian site reported it (Table 1).

The mean childbirth satisfaction score as measured with the Mackey Childbirth Satisfaction Rating Scale in the total sample was high (X = 113.3; range 45–155). It was highest in Lebanon (X = 127.4; SD = 22) and below the mean score in Egypt (X = 99.5; SD = 20.5) and in Syria (X = 104.2; SD = 16.2). The satisfaction scores for the sub-dimensions differed also with the highest scores obtained in the sample from Lebanon and the lowest scores from Egypt except for the sub-dimensions of baby and nurse/midwife where the levels were lowest in Syria. The perception of labour control as measured by the Labour Agentry

Table 1. Socio-demographic and birth characteristics of women by country sites ($N = 2620$)

Characteristics	Egypt $N = 709$		Lebanon $N = 705$		Syria $N = 1206$		p-Value
	N	%	*N*	%	*N*	%	
Age (mean (SD))	709	26.3 (5.18)	690	26.07 (5.56)	1205	26.08 (6.07)	0.663
Education of woman							0.000
Illiterate	81	11.4	208	29.5	422	35.0	
Primary	146	20.6	239	33.9	404	33.5	
Elementary	232	32.7	159	22.6	179	14.8	
Secondary	202	28.5	26	3.7	102	8.5	
University	48	6.8	72	10.2	99	8.2	
Employed							0.000
No	629	88.7	672	95.3	1130	94.2	
Yes	80	11.3	33	4.7	70	5.8	
Number of children (mean (SD))	709	2.19 (1.19)	676	2.68 (1.78)	1206	3.53 (2.02)	0.000
Gender of physician							0.000
Female	192	27.1	255	36.2	721	60.6	
Male	514	72.5	216	30.6	331	27.8	
Both genders in team	3	0.4	234	33.2	137	11.5	
Type of birth							0.000
Normal	479	67.6	569	80.7	1010	83.7	
C-section	230	32.4	136	19.3	196	16.3	
Apgar score (mean (SD))	709	8.84 (1.78)	695	8.84 (0.7)	1195	8.52 (1.52)	0.000
Antenatal visits							0.000
Less than 4 visits	102	14.4	167	23.7	390	32.5	
4 or more visits	607	85.6	538	76.3	810	67.5	

Note: Totals might not add up because of missing values.

Scale (LAS) was around the average score ($X = 44.9$; range 10–70) and lowest in Egypt (Table 2).

The associations between the variables and with sub-dimensions of the satisfaction scale as well as the total childbirth satisfaction level were calculated. Women's education, number of children, the country site, gender of the physician and perception of control were found to be significantly associated with childbirth satisfaction ($p = .000$) whereas type of birth was not shown to be statistically associated with satisfaction ($p = .220$). Women's education, gender of the physician, perception of control and number of children were entered into a multiple regression model to identify the determinants of overall satisfaction separately for each country site whereas the gender of the physician was removed from the model combining the sample from all three sites. Table 3 shows that in the sample from Egypt, women's satisfaction increases with an increase in their number of children ($p < .01$) and their perception of control during labour ($p < .000$). Similar predictors are identified for the sample in Lebanon ($p < .000$). As for the sample from the Syrian site, an increase in the level of perceived control during labour predicts an increase in satisfaction level ($p < .000$) and having physicians from both genders in the team decreases women's satisfaction levels with childbirth ($p < .05$). When the sample from all three sites is combined, perceived control during labour ($p < .000$) and number of children ($p < .01$) remain significant predictors of increased levels of

Table 2. Women's childbirth satisfaction levels and perception of labor control (LAS) by country site (*N* = 2620)

	Egypt *N = 709*		Lebanon *N = 705*		Syria *N = 1206*		Total	
	N	Mean (SD)	N	Mean (SD)	N	Mean (SD)	N	Mean (SD)
Satisfaction *Range (49–155)*	503	99.5 (20.5)	689	127.4 (22.0)	300	104.2 (16.2)	1492	113.3 (24.3)
General *Range (4–20)*	596	14.3 (3.1)	704	15.8 (3.9)	1056	14.4 (2.6)	2356	14.8 (3.2)
Self *Range (9–45)*	576	26.5 (7.5)	704	33.8 (7.6)	1042	31.5 (5.4)	2322	31.0 (7.2)
Baby *Range (2–10)*	595	7.1 (1.7)	690	8.9 (1.8)	1163	5.2 (2.0)	2448	6.7 (2.4)
Nurse/midwife *Range (7–35)*	627	23.3 (5.0)	703	28.9 (6.8)	389	22.6 (3.8)	1719	25.4 (6.3)
Physician *Range (7–35)*	647	24.0 (5.3)	704	31.1 (5.6)	1119	26.8 (3.8)	2470	27.3 (5.5)
Husband/family *Range (2–10)*	599	6.3 (1.8)	704	8.7 (1.9)	1057	7.7 (1.2)	2360	7.7 (1.8)
LAS	490	40.0 (6.6)	696	46.5 (11.5)	1078	46.2 (12.9)	2264	44.9 (11.7)

satisfaction, in addition to women's education level. The satisfaction level decreased by 4.89 points for women with higher level of education compared to those with low level of education ($p < .000$).

Discussion

This study assessed satisfaction and perceived control in childbirth among a large sample of women giving birth in three public hospitals in Egypt, Lebanon and Syria. Our findings revealed a high level of satisfaction and an average level of perceived control in labour in each country and in the overall sample of women giving birth in the three public hospitals. Perceived control during labour was a significant predictor of improved satisfaction levels among women in the three sites of the study. In addition, having few children in the sample from Egypt and Lebanon and receiving care by a team including both male and female physicians in the Syrian hospital decreased satisfaction.

The lack of choice given to women in the care received during labour and birth and lack of awareness about alternative options are known to result in women's low expectations during childbirth[39] and might partly explain the high level of satisfaction found in this study when considering the type of care provided in these hospitals. The fact that women's interviews were conducted in the early postpartum period at the hospital can also play a factor in the reported high satisfaction levels. The initial relief and the feelings of physical and emotional vulnerability have been previously reported to mask any negative feelings that women might have.[20] Similar high levels of satisfaction were reported in a sample of women with hospital birth in Belgium and Netherlands using the same scale.[40] Contrary to our findings, a study in Jordan found high levels of dissatisfaction with maternity care when women were interviewed during their seven-week postnatal visit to public clinics.[41] Hodnett[5] argues that there is no optimum time to measure satisfaction in childbirth and that it is highly dependent on the purpose of the study. As mentioned earlier, our purpose in this study was to observe differences in satisfaction due to the planned intervention, and the data reported here was used as the baseline. Although the mean satisfaction score was high, there were slight variations in the levels between the three sites, something that might be attributed to the variations in the process of care between the hospital in Lebanon, where women are offered individual labour and birthing rooms, and the hospital in Egypt where crowding and lack of privacy were found to be major complaints expressed by women.[36] These differences might also be explained by the context of conflict and displacement that affect Syria and Lebanon.

The hospitals from these two countries included in the study provide services to refugees and to internally displaced populations, therefore it is expected that these women will be reluctant to express criticism about the care they received while feeling "grateful" for accessing a hospital and giving birth to a healthy infant.

Perceived control during labour was found to be at an average level in the overall sample with slightly higher scores in Lebanon and Syria than in Egypt. It is known that personal control can be achieved by providing professional or lay support with the aim of empowering the woman to endure pain and feel a sense of accomplishment and self-efficacy.[2,5,8,12,40] In this regard, the lack of opportunities to participate in the decision-making process in these settings[33,41–43] as well as the absence of continuous professional or lay support during labour and birth might have played a role in reducing women's feelings of control. In fact, higher scores observed in Lebanon compared to the other sites may be explained by the availability of lay support during labour.

The finding that women with high perceived control reported more childbirth satisfaction in this study is similar to what has been reported in the literature where personal control is identified as the most important predictor of childbirth satisfaction in different settings.[1,2,8–10,12,40] Women's satisfaction with childbirth improved with an increased number of children, specifically in the samples from Egypt and Lebanon. These women would have prior experience with the system of care and therefore have already shaped their expectations according to the routines followed at these facilities. The lack of this relationship in the sample from Syria could be attributed to the lack of previous experience with birthing in a hospital for women displaced from rural to urban areas due to the prevailing conflict.

Satisfaction scores in this study tended to be lower with increased education levels. Women with a low level of education were more satisfied than their counterparts with a higher level of education. This trend, although not statistically significant, was mainly observed in the sample from the Lebanese site. As mentioned earlier, low expectations from the system of care among this group of women can explain this finding, as well as their reluctance to express dissatisfaction particularly when being interviewed in the hospital setting. We had previously documented women's low expectations through a qualitative study conducted at these sites[36] revealing that women arrive at these hospitals aware of the little that is being offered in the public system and accept the policies and procedures without challenging them. Similarly, women's low expectations and their reluctance in reporting dissatisfaction have been documented in a previous study in Lebanon, where women related satisfaction to the outcome of the birth.[44] Women will report negative birth experiences when their expectations and their actual experiences do not match.[5] We believe that this mismatch was not experienced by women in this study due to their initial low expectations. There might be some variation in expectations by educational level in this group of women that warrants further research. The lack of association of satisfaction with the type of birth in this study is similar to some other settings.[45,46] The rising caesarean sections in the three countries might have shaped women's expectations by normalising this practice and increasing its acceptance, therefore lowering expectations of having a vaginal birth.

The gender of obstetricians present during birth was another variable that was found to be associated with women's satisfaction with their childbirth experience. It is to be noted that women in the hospitals in this study are not entitled to choose their health care providers. The hospitals in Lebanon and Syria were found to have teams of both male and female obstetricians, residents, medical and nursing students attending the birth. This was a factor inducing dissatisfaction among women in the Syrian hospital compared to being offered care by either a male or a female physician. This finding needs to be considered together with the fact that the majority of the women in our sample from the Syrian site received care from a female physician. Women in Arab cultures prefer female obstetricians as they feel more at ease communicating about personal issues and undergoing vaginal exams.[44,46] The presence of a male provider in the team together with female providers is considered disrespectful in this context and influences their satisfaction with care.

There are a number of limitations identified in this study. The fact that this study is reporting from data gathered for an intervention project did not allow us to explore all potential elements related to women's satisfaction. Moreover, interviewing women at the hospital in the very early postpartum hours or days has most probably shifted satisfaction levels towards more favourable ones. It is recommended that future research in

Table 3. Simple regression analysis for the variables predicting total childbirth satisfaction by country and for the total sample

Variable	Egypt *N = 709*			Lebanon *N = 705*			Syria *N = 1206*			Total		
	B	SEB	β	B	SEB	β	B	SEB	β	B	SEB	β
Low education	−0.04	2.08	−0.001	−2.58	1.42	−0.57	−2.00	1.47	−0.58	−4.89	1.07	−0.101***
Physicians from both genders in the team[a]	–	–	–	0.24	0.72	0.10	−1.79	0.79	−0.96*	–	–	–
Number of children	2.30	0.78	0.137**	1.38	0.38	0.11***	−0.12	0.39	−0.02	0.94	0.31	0.067**
LAS	1.09	0.16	0.322***	1.08	0.06	0.58***	1.16	0.08	0.71***	1.33	0.05	0.567***
R^2[b]		0.12			0.37			0.50			0.37	
F[c]		19.185			95.76			69.61			197.05*	

***$p < .001$; **$p < .01$; *$p < .05$.

[a]The variable on gender of the physician was removed from the analysis for the sample of Egypt as only three women reported receiving care from physicians from both genders.

[b]The coefficient of determination of how well the model fits the data.

[c]F statistics measuring the precision with which the regression coefficient is measured.

this area accommodate the expected changes in women's childbirth experiences over time. Qualitative studies, offering in-depth understandings of the concepts of control and satisfaction in Arab culture would make important contributions to the efforts on humanisation of childbirth conducted in other regions[23] as well as to the global discourse on disrespect and abuse in childbirth.[47]

This comparative multi-country study provides an insight into women's experiences of childbirth and their satisfaction in Arab countries. The study provides contextualised information on the importance of women's feelings of control in shaping their experience with labour care and may have important implications on policy, practice and research. More research is needed to understand the different dimensions of women's experiences of childbirth in different health care systems and different regions of the world.

Acknowledgements

The authors would like to thank the management and the staff of the three participating hospitals as well as all women who participated in the study. The authors acknowledge the technical support received from the World Health Organization Department of Maternal, Newborn, Child and Adolescent Health. The authors thank Ms Laura Wick for revising earlier versions of this article.

Funding

The study was funded by the Alliance for Health Policy and Systems Research, WHO (Geneva) with support from the Norwegian Agency for Development Cooperation (Norad), the Swedish International Development Cooperation Agency (Sida) and the UK Department for International Development (DFID).

References

1. Simkin P. Just Another day in a woman's life? Women's long-term perceptions of their first birth experience. Part I. Birth. 1991;18(4):203–210.
2. Nilsson L, Thorsell T, Wahn E, et al. Factors influencing positive birth experiences of first-time mothers. Nurs Res Pract. 2013;2013:349124.
3. Reisz S, Jacobvitz D, George C. Birth and motherhood: childbirth experience and mothers' perceptions of themselves and their babies. Infant Ment Health J. 2015;36(2):167–178.
4. Meyer S. Control in childbirth: a concept analysis and synthesis. J Adv Nurs. 2013;69(1): 218–228.
5. Hodnett ED. Pain and women's satisfaction with the experience of childbirth: a systematic review. Am J Obstet Gynecol. 2002;186(5):S160–S172.
6. Tuncalp O, Were WM, MacLennan C, et al. Quality of care for pregnant women and newborn- the WHO vision. BJOG. 2015;122(8):1045–1049.
7. Waldenström U, Borg I, Olsson B, et al. The childbirth experience: a study of 295 new mothers. Birth. 1996;23 (3):144–153.
8. McCrea B, Wright M. Satisfaction in childbirth and perceptions of personal control in pain relief during labour. J Adv Nurs. 1999;29(4): 877–884.
9. Goodman P, Mackey M, Tavakoli A. Factors related to childbirth satisfaction. J Adv Nurs. 2004;46(2):212–219.
10. Green J, Baston H. Feeling in control during labor: concepts, correlates, and consequences. Birth. 2003;30(4):235–247.
11. Lobel M, DeLuca RS. Psychosocial sequelae of cesarean delivery: review and analysis of their causes and implications. Soc Sci Med. 2007;64(11):2272–2284.
12. Gibbins J, Thomson, AM. Women's expectations and experiences of childbirth. Midwifery. 2001;17:302–313.
13. Ahmad I, Nawaz A, Khan S, et al. Predictors of patient satisfaction. Gomal J Med Sci. 2011;9(2):183–188.
14. Ryding EL. Investigation of 33 women who demanded a cesarean section for personal reasons. Acta Obstet Gynecol Scand. 1993;72:280–285.
15. Fair C, Morrison T. The relationship between prenatal control, expectations, experienced control, and birth satisfaction among primiparous women. Midwifery. 2012;28(1):39–44.
16. Leap N, Sandal J, Buckland S, et al. Journey to confidence: women's experiences of pain in labour and relational continuity of care. J Midwifery Womens Health. 2010;55 (3):234–242.
17. Bryanton J, Gagnon AJ, Johnston C, et al. Predictors of women's perceptions of the childbirth experience. J Obstet Gynecol Neonatal Nurs. 2008;37(1):24–34.
18. Siassakos D, Clark J, Sibanda T, et al. A simple tool to measure patient perceptions of operative birth. BJOG. 2009;116:1755–1761.
19. Arulkumaran S, Wells B, Boddington R. Lessons learnt from the reorganization of maternity services. Br J Hosp Med (Lond). 2008;69(2):74–77.

20. Larkin P, Begley C, Devane D. Women's experiences of labour and birth: an evolutionary concept analysis. Midwifery. 2009;25:e49–e59.
21. Attanasio L, Mcpherson M, Kozhimannil K. Positive childbirth experiences in US hospitals: a mixed methods analysis. Matern Child Health J. 2013;18 (5):1280–1290.
22. Tuncalp Ö, Were WM, MacLennan C, et al. Quality of care for pregnant women and newborns – the WHO vision. BJOG 2015;122:1045–1049.
23. Diniz SG, Bick D, Bastos MH, et al. Empowering women in Brazil. Lancet. 2007;370(9599):1596–1598.
24. White Ribbon Alliance. Respectful maternity care: the universal rights of childbearing women. Washington (DC): White Ribbon Alliance; 2011.
25. World Health Organization. The prevention and elimination of disrespect and abuse during facility-based childbirth: WHO statement. Geneva: World Health Organization; 2014.
26. Humanitarian Health Action [Internet]. Geneva: World Health Organization; c2017. Five facts on the Syrian crisis and its impact on health; 2016 Jan 12. Available from: http://www.who.int/hac/crises/syr/releases/28january2016/en/
27. The World Bank [Internet]. Washington (DC): World Bank Group; c2016. Available from: http://data.worldbank.org/indicator/SP.DYN.CBRT.IN/countries
28. Alkema L, Chou D, Hogan D, et al. Global, regional, and national levels and trends in maternal mortality between 1190 and 2015, with scenario-based projections to 2030: a systematic analysis by the UN Maternal Mortality Estimation Inter-Agency Group. Lancet. 2016;387:462–474.
29. The World Bank [Internet]. Washington (DC):: World Bank Group; c2016. Available from: http://data.worldbank.org/indicator/SH.STA.BRTC.ZS?view = chart
30. Pan Arab Project for Family Health (PAPFAM) Survey. Damascus: Syrian Bureau of Statistics; 2009.
31. El Zanaty F, Way A. Egypt demographic and health survey 2008. Cairo: Ministry of Health, El-Zanaty and Associates, and Macro International; 2009. Available from: http://dhsprogram.com/pubs/pdf/fr220/fr220.pdf
32. Ministry of Social Affairs. Lebanon family health survey 2004. Beirut: Ministry of Social Affairs & the Arab League; 2006.
33. Choices and Challenges in Changing Childbirth Research Network (CCCC). Routines in facility-based maternity care: evidence from the Arab World. BJOG. 2005;112:1270–1276.
34. DeJong J, Akik C, El Kak F, et al. The safety and quality of childbirth in the context of health systems: mapping maternal health provision in Lebanon. Midwifery. 2010;26:549–557.
35. Ministry of Health and Population [Egypt], El-Zanaty and Associates [Egypt], and ICF International. Egyptian demographic and health survey. Cairo and Rockville. Maryland: Ministry of Health and Population and ICF International; 2015. Available from: http://dhsprogram.com/pubs/pdf/fr302/fr302.pdf
36. Kabakian-Khasholian T, El-Nemer A, Bashour H. Perceptions about labor companionship at public teaching hospitals in three Arab countries. Int J Gynaecol Obstet. 2015;129:223–226.
37. Kabakian-Khasholian T, Shayboub R, Kanaan M, et al. Promoting women's participation in maternity care in Lebanon. Int J Childbirth. 2015;5(3):166–176.
38. Hodnett ED, Simmons-Tropea DA. The Labour Agentry Scale: psychometric properties of an instrument measuring control during childbirth. Res Nurs Health. 1987;10(5):301–310.
39. van Teijlingen ER, Hundley V, Rennie A, et al. Maternity satisfaction studies and their limitations: "What Is, Must Still Be Best". Birth. 2003;30(2):75–82.
40. Christiaens W, Bracke P. Assessment of social psychological determinants of satisfaction with childbirth in a cross-national perspective. BMC Pregnancy Childbirth. 2007;7 (26). Available from: http://www.biomedcentral.com/1471-2393/7/26.
41. Mohammad KI, Alafi KK. Mohammad AI, et al. Jordanian women's dissatisfaction with childbirth care. Int Nurs Rev. 2014;61:278–284.
42. Bashour H, Abdulsalam A, Al-Faisal W, et al. The patterns and determinants of maternity care in Damascus. East Mediterr Health J. 2008;14(3):595–604.
43. Bashour HN, Kanaan M, Kharouf MH, et al. The effect of training doctors in communication skills on women's satisfaction with doctor–woman relationship during labour and delivery: a stepped wedge cluster randomised trial in Damascus. BMJ. 2013;3:e002674.
44. Kabakian-Khasholian T, Campbell O, Shediac-Rizkallah M, et al. Women's experiences of maternity care: satisfaction or passivity? Soc Sci Med. 2000;51:103–113.
45. Sadler LC, Davison T, McCowan LME. Maternal satisfaction with active management of labor: a randomized controlled trial. Birth. 2001;28(4):225–235.
46. Bashour H, Abdulsalam A. Syrian women's preferences for birth attendant and birth place. Birth. 2005;32(1):20–26.
47. Bohren MA, Vogel JP, Hunter EC, et al. The mistreatment of women during childbirth in health facilities globally: a mixed-methods systematic review. PLOS Medicine. 2015;12 (6):e1001847.

Résumé

La satisfaction des femmes et le contrôle perçu dans l'accouchement sont des attributs importants de l'expérience de l'accouchement et de la qualité des indicateurs de soins. Cet article présente les résultats de la phase de pré-intervention d'une étude de mise en œuvre multicentrique en Égypte, au Liban et en Syrie, afin d'introduire un modèle de compagnonnage dans ces pays. Un échantillon de 2 620 femmes qui ont accouché dans trois hôpitaux d'enseignement public de novembre 2014 à juillet 2015 à Beyrouth et Mansoura et de novembre 2014 à avril 2015 à Damas ont été interviewés par des agent qualifiés sur le terrain. Des informations supplémentaires ont été extraites des tableaux médicaux. Une version adaptée de l'échelle d'évaluation de la satisfaction de l'accouchement de Mackey a été utilisée pour mesurer la satisfaction des femmes alors que la version abrégée de l'échelle Labor Agentry a été utilisée pour évaluer la perception du contrôle. Le score de satisfaction totale était élevé dans tous les sites dont le plus bas était en Egypte. Le contrôle perçu était directement lié à la satisfaction. Les femmes ayant un faible niveau d'éducation avaient des niveaux plus élevés de satisfaction de l'accouchement. Les femmes qui avaient moins d'enfants d'Égypte et du Liban, et celles qui avaient été soignées par une équipe comprenant des médecins hommes et femmes dans l'hôpital syrien étaient plus susceptibles d'être insatisfaites que leurs homologues. Les variations dans la gestion et la fourniture de soins entre les trois pays peuvent expliquer les différences dans les niveaux de satisfaction observés. Une recherche qualitative supplémentaire est nécessaire pour approfondir notre compréhension des concepts de contrôle et de satisfaction dans la culture arabe ainsi que pour établir les facteurs associés aux expériences positives d'accouchement des femmes pour communiquer la fourniture de soins de maternité de qualité.

موجز االمقال

يعتبر رضى المرأة والتحكم المتصور خلال الولادة من السمات الهامة في تجربة الولادة وفي نوعية مؤشرات الرعاية. ويتطرق هذا المقال إلى نتائج مرحلة ما قبل التدخل لدراسة تنفيذ في مراكز متعددة في مصر ولبنان وسوريا من أجل إدخال نموذج مرافقة للمرأة الحامل أثناء المخاض في هذه البلدان. وقد أجرى موظفون ميدانيون مؤهلون مقابلات مع عينة من 2620 امرأة ولدن في ثلاثة مستشفيات تعليمية عامة من تشرين الثاني / نوفمبر 2014 إلى تموز/ يوليو 2015 في بيروت والمنصورة، ومن تشرين الثاني / نوفمبر 2014 إلى نيسان / أبريل 2015 في دمشق. هذا وتم استخراج معلومات إضافية من الجداول الطبية. استخدمت نسخة معدلة من مقياس ماكي لتقييم رضى المرأة المولدة. كما تمّ استخدام نسخة مختصرة من مقياس عامل المخاض (Labor Agentry Scale) لتقييم تصور درجة التحكم. وكانت النتيجة الإجمالية للرضى مرتفعة في جميع البلدان مع تسجيل أدنى مستوى للرضى في مصر. ويرتبط التحكم المتصور خلال الولادة ارتباطًا مباشرًا بالرضى. وتجدر الإشارة هنا إلى أنّ النساء اللواتي أدركن مستويات تعليم منخفضة شعرن بمستويات أعلى من الرضى لدى الولادة. أما النساء اللواتي لديهن عدد أقل من الأطفال في مصر ولبنان وأولئك اللواتي خضعن لعلاج من قبل فريق من الأطباء الذكور والإناث في المستشفى السوري فكنّ أكثر استياء من نظرائهن. وقد تفسر الاختلافات في إدارة الرعاية وتوفيرها بين البلدان الثلاثة الفروق في مستويات الرضى الملحوظة. وثمة حاجة إلى مزيد من البحث النوعي لتعميق فهمنا لمفاهيم التحكم و الرضى في الثقافة العربية، وكذلك لتحديد العوامل المرتبطة بتجارب الولادة الإيجابية للمرأة وذلك لإعلام تقديم رعاية للأمومة عالية الجودة.