

## DEDICATION

TO MY DAD- DOMINIC MUSONDA CHISEMBELE. LITTLE DID I KNOW THAT I  
WOULD REALISE YOUR DREAM. YES!

“BUT THOSE WHO HOPE IN GOD RENEW THEIR  
STRENGTH,  
THEY PUT OUT WINGS LIKE EAGLES.  
THEY RUN AND DO NOT GROW WEARY  
WALK AND NEVER TIRE.”


ISAIAH 40:31.

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6. The departmental secretaries:- Ms Rose Willombe, Emma Mutale and Betty Ndulo.
7. The women who consented to take part in the study.
8. And above all, to the Alpha and the Omega, who holds all things for good to all who place their trust in Him.

## STATEMENT


I HEREBY STATE THAT THIS DISSERTATION IS ENTIRELY THE RESULT OF MY OWN PERSONAL EFFORT. THE VARIOUS SOURCES TO WHICH I AM INDEBTED HAVE BEEN CLEARLY INDICATED IN THE BIBLIOGRAPHY AND ACKNOWLEDGEMENTS.

SIGNED :  \_\_\_\_\_

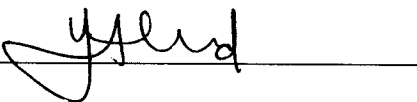
DR MAUREEN C CHISEMBELE

## DECLARATION

I HEREBY DECLARE THAT THIS DISSERTATION HEREIN PRESENTED FOR THE DEGREE OF MASTERS OF MEDICINE IN OBSTETRICS AND GYNAECOLOGY HAS NOT BEEN PREVIOUSLY SUBMITTED EITHER WHOLLY OR IN PART FOR ANY OTHER DEGREES AT THIS OR ANY OTHER UNIVERSITY. NOR IS IT BEING CURRENTLY SUBMITTED FOR ANY OTHER DEGREE.

SIGNED:- 

DR MAUREEN C CHISEMBELE

APPROVED BY:- 

DR Y AHMED (SUPERVISOR)

## APPROVAL

This dissertation of **Dr. Maureen Chileshe Chisembele** is approved as fulfilling the requirements for the award of the degree of Master of Medicine in Obstetrics and Gynaecology by the University of Zambia.

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## ABSTRACT

The birth experience is something that affects a woman's perception of her labour. A positive birth experience may correlate with a positive perception of labour and vice versa. As caregivers we are interested in whether a mother perceives her birth experience positively or not, because in some ways we feel responsible and it reflects on the care that we are providing.

In trying to find answers to what factors affect the birth experience, 282 women who had a vaginal delivery at the UTH over a period of eight weeks were surveyed. Also studied was whether there were any differences between the primiparas and multiparas.

The findings were that, of the factors that affect the birth experience, pain relief, length of labour, whether labour is thought to be straightforward or difficult, whether the staff attitude was perceived positively or negatively, significantly affected the birth experience. Primiparas tended to perceive their labours as longer than multiparas and they tended to rate their birth experience less positively.

A fulfilling and positive birth experience is as important as a good outcome. Some of the factors noted above like pain relief and helpful staff attitude can be improved upon to contribute positively to women's overall birth experience.

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## ABBREVIATIONS

ANC	Antenatal clinic.
ANT	Antenatal.
ANT. ED	Antenatal Education
ANTE. EXP.	Antenatal Exposure
ATTEND	Attendance
AUG	Augmentation.
B/FEED	Breastfeed
DOC	Doctor.
ED	Education.
EXP	Experience.
FIG	Figure.
IND	Induction.
N/A	Not applicable
NO	Number.
OR	Odds ratio.
p	'p' value.
SIDA	Swedish International Development Agency.
SAREC	Swedish Agency for Research and Cooperation.
UTH	University Teaching Hospital.
$x^2$	Chi-square.
+ve	Positive
-ve	Negative

## INTRODUCTION

The experience of childbirth is something that is difficult to describe and quantify as it is multidimensional. A lot has gone into providing good antenatal care services - the objective being to produce a healthy contented mother and baby by preventing and treating the complications of pregnancy and infancy and thereby reducing the maternal and perinatal morbidity and mortality in the community.

Inherent in the provision of care during delivery are the same objectives of having produced a contented mother and healthy baby at the end of the delivery. Efforts have been made to improve the clinical care during delivery : advanced technology such as electronic fetal monitoring has been developed; ways have been found to make the patient more comfortable; new positions have been encouraged for giving birth, for example squatting, sitting, and new places like birthing pools; women have been allowed greater freedom in terms of movement while in labour; partners have also been allowed in the labour ward. There is often more emphasis on clinical care at the expense of social and psychological care.

The outcome of the experience of birth is to some extent determined by the care received while pregnant, the personal expectations of the pregnant woman, the care and support that she receives during labour and the outcome of the baby whether alive or not - the birth experience is therefore multidimensional!

## LITERATURE REVIEW

The British Birth Survey data suggest that less than 1 percent of pregnant women receive no formal antenatal care (O'Brien and Smith, 1981; Simms and Smith, 1986). Some studies have asked women their reasons for first attending late in pregnancy or missing their antenatal care. The largest category was that of frightened young women, some of whom did not admit, even to themselves, that they were pregnant (Parsons and Perkins, 1980; Perfrement, 1982; Simms and Smith, 1986).

Women expect personalised care during pregnancy, an expectation that often remains unfulfilled by institutionalized antenatal care. Research has shown that women feel undervalued as individuals in hospitals. Research from many parts of the world has reported women's need for information, and the difficulties they face in asking questions and receiving satisfactory answers. Women want to know more than they are often told about the procedures carried out during pregnancy (Cartwright, 1979; Oakley, 1979; Reid and McIwaine, 1980; Macintyre, 1982; Dickinson, 1985). While the official ideology has been of free exchange of information, with the caregivers providing the answers to consumers' questions, the reality is often different (Kirke, 1980). As Riley (1977) has pointed out, different women want different kinds of experiences and different kinds of information about their pregnancies and birth. It can be difficult for caregivers to provide information in a way that fits with a woman's individual wishes as well as with her particular knowledge of medical terms (Perfrement, 1982).

There are a number of methodological difficulties in conducting research on the place of birth, style of care and the question of choice, and especially in determining women's immediate experiences of labour and delivery at the time that they occur. Women's views of the experience change over time (Erb et al, 1983; Bennet, 1985). In addition, the type of answers received depend on the place of asking and on the form of the questions (Lumley,1985; Oakley,1985; Shaw, 1985). Another important dilemma for researchers concerns the interpretation of reported satisfaction with care (Lumley, 1985). Expectations and priorities also influence women's reactions to care (McIntosh, 1989).

Research about the place of delivery involves either asking women about their present choice of place of delivery (for example, home, hospital or birth centre), or asking their preference for future birth. In the North American context the main alternatives to conventional hospital birth are home birth or birth in some kind of birthing room, either within or outside an obstetric hospital. These alternatives reflect a growing interest in a less technological and more flexible approach to birth and also reflect the high cost of hospital care to the individual.

Harmon (1994), Waldenstrom (1994) and Propst and Schenk (1994) have published on preference of place of birth. Birth centre care deliveries have been compared with standard maternity care deliveries. Randomized studies have shown that women who deliver at birth centres where there was restricted use of medical technology and pharmacological pain relief, but whose environment was more like home, had a slightly more positive birth

experience than women who delivered at a standard maternity care centre. Women who delivered at birth centres were more satisfied with their own achievements and felt more involved in the birth process than their counterparts at standard care centres.

A picture of polarization between the medical model and the women's view of childbirth has been presented by several authors, including Nash and Nash (1979) and Graham and Oakely (1981). Their argument is that while members of the medical profession see pregnancy as a kind of illness, and labour and delivery as a process that should be controlled by professionals, women themselves wish to see pregnancy as a natural condition and birth as a natural process in which little interference from professionals should occur. Other researchers, however, have suggested that the professional/client split is more complex. Nelson (1983), for example, looked in detail at social class and women's preferences about aspects of labour care. Working class women were more likely to have the kind of labour they wished for, that is, with considerable monitoring, including electronic fetal monitoring. Middle class women suffered a greater discrepancy between what they wished for (little intervention) and what they subsequently received, markedly affecting their experience negatively.

In a Scottish study, working class, first time mothers were interviewed once in late pregnancy and on several occasions after the birth (McIntosh, 1987). Their attitudes do not conform to a model of childbirth as natural and fulfilling. More than three-quarters had negative expectations of childbirth. Fear of pain was a major component of this

expectation. Sixty-percent wanted pain relief and some of those who did not were afraid of the pain relief itself or of its consequences for the baby.

Bramadt and Dreidger (1993) have shown the difficulty in evaluating satisfaction with childbirth. In trying to analyze why some women are satisfied with their labour while others are not they found support for a discrepancy theory of satisfaction.

Support during childbirth can be provided by the professionals who are also responsible for the clinical care of the woman in labour, by professionals specifically designated to provide support rather than clinical care, or by the woman's partner, family or friends. Experimental studies thus far have only examined the contribution of the second group i.e. a 'doula' as a person specifically designated to provide social but not clinical support in labour. In a study by Sosa et al (1980) support was defined as 'physical contact, (for example, rubbing the mother's back and holding her hands), conversation, and the presence of a friendly companion whom the mother has not met before'. In another study it was made clear that support had both emotional and physical components, with the provision of explanation and encouragement an explicit factor (Klause et al, 1986). A central feature of support in Sosa's and Klause's studies is the promise that the labouring woman will not, at anytime, be left alone. Other descriptions of the support role mention advocacy as well as explanation, physical comfort and encouragement. Advocacy, which is particularly associated with plans and expectation before labour, is a common component of partners' and labour 'coaches' support activities.

Hofmeyr et al (1991) in Johannesburg had shown that companionship during labour aimed at promoting self-esteem improved a woman's perception of labour and feeling of competence.

Husbands have entered the labour ward for two reasons. The first is that in reclaiming birth by women as a positive experience, it has meant that the exclusion of a woman's sexual partner and father of the newborn, while another man is allowed to preside over the event, is widely seen as incongruous. The second reason for the partner's presence in the labour ward has been to fill the gaps. Recognizing that labouring women require psychological support, and realizing that nurses have little time to give it, hospitals have increasingly permitted and encouraged husbands to assume active roles in the care of their wives during labour (Hodnett, 1983). Some doubts have been expressed about handing-over the supportive role to fathers. One concern relates to whether they are equipped for tasks that were formerly the responsibility of an experienced and professionally trained person. One researcher has suggested that some support people, the woman's partner being no exception, can interfere with the normal progress of labour by their effects on the woman (Odent, 1984). In addition, Odent goes on to suggest that, when there are major tensions in the couple's relationship, practical and emotional support in labour may be difficult to provide or to accept.

Deliveries by midwife-led units and those by routine medical care with doctors have been compared by a number of researchers (Callister, 1995; Rowley et al, 1995; Hundley et al, 1995; Walther et al, 1995). Mothers with certified midwives as caregivers participated more

actively in childbirth care decisions and expressed a better quality of the birth experience.

There is little published data on childbirth experience in Africa or in Zambia. However studies like that done by Hofmeyr (1991) from South Africa have been taken note of. It would be interesting to find out whether the birth experience is different from that published in the western studies and whether there are any peculiar features that can be attributed to the social-cultural environment of Africa and Zambia in particular.

## AIMS AND OBJECTIVES

To determine the experiences of childbirth in women delivering at the University Teaching Hospital, Lusaka, Zambia.

### **Broad objective**

To establish what factors contribute to a positive birth experience and what factors lead to a negative experience with a view to improving upon them.

### **Specific objectives**

1. To determine whether primiparas have a more positive birth experience than multiparas. The hypothesis being that primiparas have a more negative experience.
2. To determine whether natural spontaneous, vaginal deliveries are associated with a positive birth experience than induced or augmented labours. The hypothesis being that a natural spontaneous labour is more positively perceived.
3. To determine whether spontaneous vaginal deliveries are associated with a more positive birth experience than instrumental deliveries. The hypothesis being that vaginal deliveries have a more positive experience.
4. To determine whether pain relief is associated with a more positive birth experience than no pain relief at all. The hypothesis being that pain relief results in a better birth experience.
5. To determine whether deliveries conducted by midwives are associated with a more positive experience than those conducted by a doctor. The hypothesis being that deliveries by midwives are more positively perceived.

## **METHODOLOGY**

The study was an institutional based descriptive study. A structured questionnaire was administered a day after delivery by trained research assistants and the author. An informed consent was obtained (Appendix I). The questionnaire included socio-demographic characteristics, reproductive history and questions relating to the experience of the labour (see Appendix II).

Approval was obtained from the University of Zambia Research and Ethics Committee for conducting this study.

### **Patient selection**

Patient interviews were conducted in the postnatal wards at University Teaching Hospital between 5.1.97 and 14.3.97. Every morning those postnatal mothers in the lying in wards who had a vaginal delivery but not a caesarean section were interviewed. 282 women were available at the time to be interviewed. No subject refused to participate when approached.

### **Standardisation / piloting**

All research assistants were trained to administer the questionnaire so that similar answers were obtained. The questionnaire was pilot tested. Interviews were carried out in a room in the ward where privacy was ensured. An informed consent was signed before the interview. The local languages as well as English, the official language were used. The answers were

entered on an answer sheet which did not in anyway identify the patient. Most of the clients were not comfortable with filling-in the questionnaire themselves as it was in English, therefore it was translated verbally into the local language that the client spoke. Those who could fill out the questionnaire were given the option to do so. It took approximately twenty to forty minutes to be administered.

The data was analysed using Epi Info software. Selected variables were analysed against question 82 of the questionnaire, which queried the overall birth experience (Appendix II). The stems of the question 82 was divided into two parts : a positive birth experience (stem a) and a negative birth experience (stems b,c,d). Stem b (satisfactory) was noted by all interviewers as being a negative response. If subjects had a good experience they would answer stem a, otherwise b,c,d. Primiparas and multiparas were compared against each other using selected variables.

Some responses were missing. Accordingly not all totals presented in the Results section would add up to 282 (total number of subjects).

Analysis was mainly by Chi square. The odds ratios and 95% confidence intervals were calculated. Where necessary descriptive statistics (mean, standard deviation) were calculated.

## RESULTS

### DESCRIPTION OF DEMOGRAPHICS OF ALL SUBJECTS ASSESSED (n=282).

There were a total of 282 women interviewed.

**Age:** The highest number of subjects was between the ages of 21 and 25 years. The mean age for all subjects was 25 years with a standard deviation of 6.3 (Table 1a, Figure 1). The mean age for multiparas (28 years) was significantly higher than primiparas (21 years) (Student t Test,  $p < 0.0001$ ).

**Parity:** There were more primiparas than any other parity when analysed separately (Table 2, Figure 2). However overall there were more multiparas (159 vs 123).

**Marital Status:** Overall, there were more married than single women (244 vs 38) and of these the majority were multiparas (Table 3, Figure 3).

**Socio-economic status:** The majority of the patients tended to be housewives and of these there were more multiparas (Table 4, Figure 4).

**Education:** Primary school education seemed to be the highest level of education that most of the patients had attained and of these multiparas were more (Table 5, Figure 5).

**Table 1a Mean Ages of Subjects by Parity**

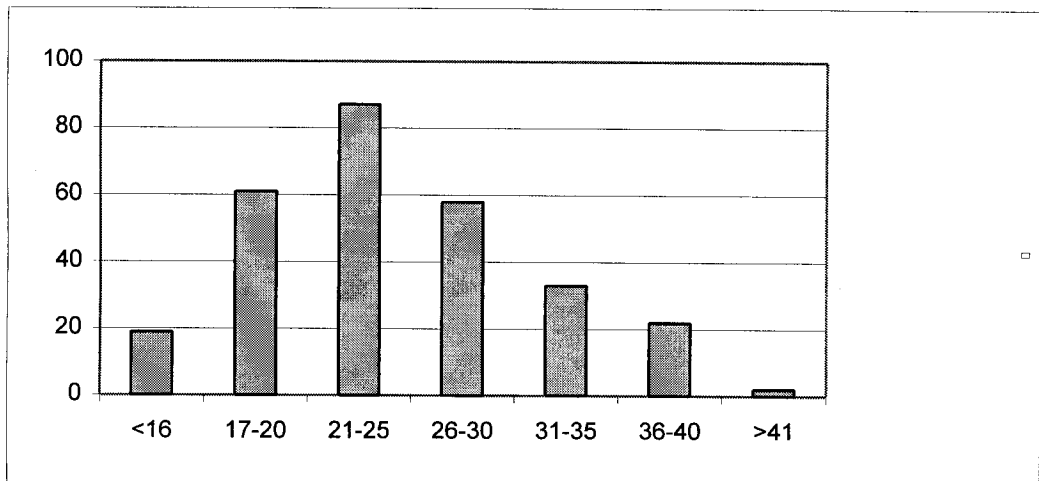
	n	%	Range	Mean	SD
Primiparas	123	40	15-34	21*	4.2
Multiparas	159	60	15-42	28*	6
All	282	100	15-42	25	6.3

\* significantly different ( $p < 0.0001$ )

**Table 1b Age distribution of all subjects**

ages (yrs)	n	%
<16	19	6.7
17-20	61	21.6
21-25	87	30.9
26-30	58	20.5
31-35	33	11.7
36-40	22	7.8
>41	2	0.7
all	282	100

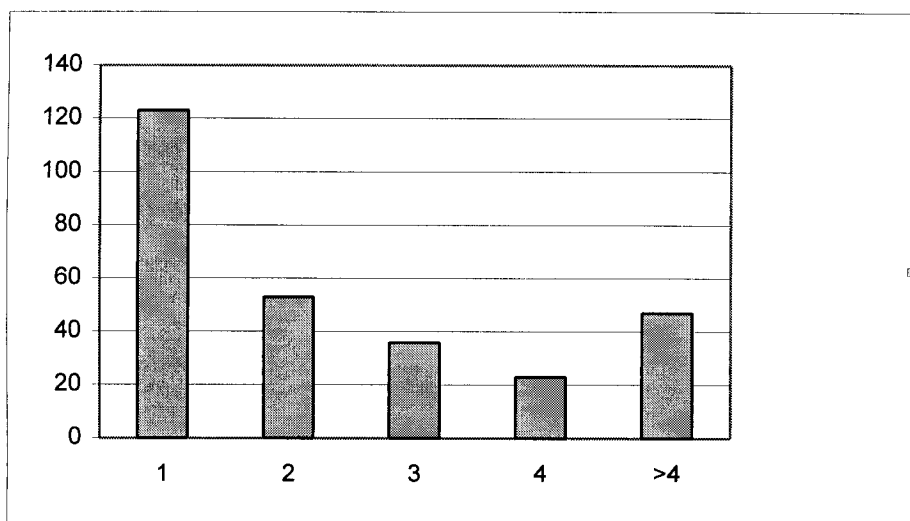
**Figure 1 Histogram of Age Distribution - all subjects**



**Table 2 Parity Distribution of Subjects**

<b>Parity</b>	<b>n</b>	<b>%</b>
<b>Primiparas</b>	123	43.6
<b>Multiparas</b>	159	56.4
<b>All</b>	282	100
<b>Para</b>	<b>n</b>	<b>%</b>
<b>1</b>	123	43.6
<b>2</b>	53	18.8
<b>3</b>	36	12.8
<b>4</b>	23	8.2
<b>&gt;4</b>	47	16.7
<b>All</b>	282	100

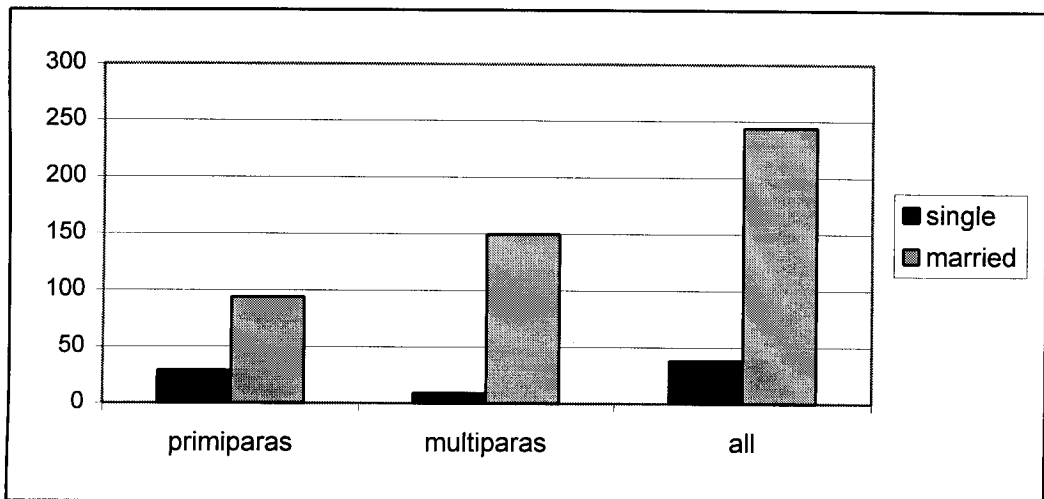
**Figure 2 Parity Distribution of all subjects**



**Table 3 Marital Status of Subjects**

<b>marital status</b>	<b>single</b>	<b>married</b>	<b>all</b>
<b>primiparas</b>	29	94	123
<b>multiparas</b>	9	150	159
<b>all</b>	38	244	282

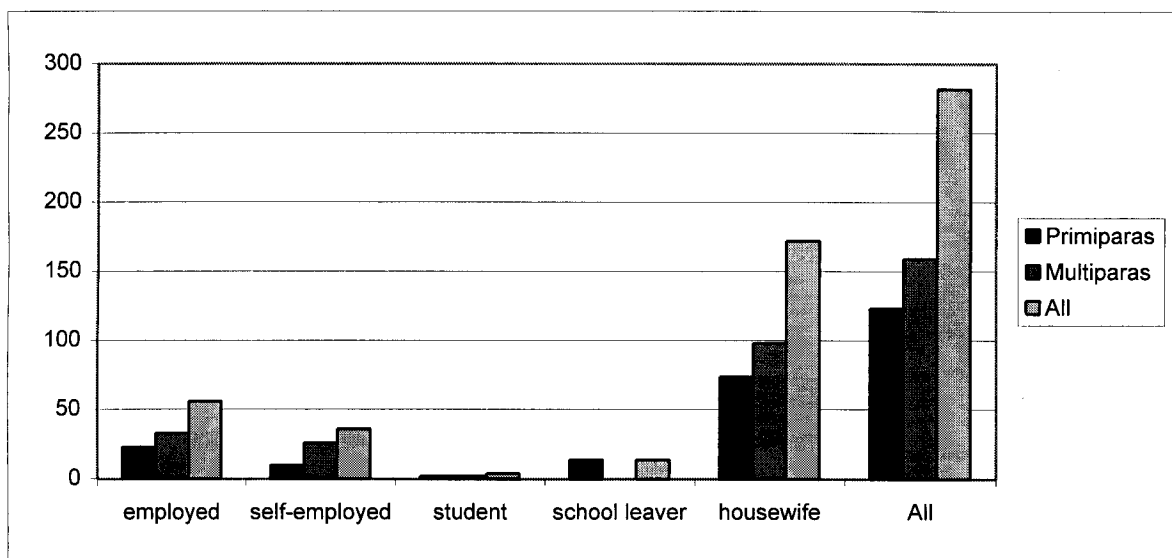
**Figure 3 Marital status of Primiparas and Multiparas**



**Table 4 Socioeconomic Distribution of all Subjects**

<b>Socio-economic status</b>	<b>Primiparas</b>	<b>Multiparas</b>	<b>All</b>
employed	23	33	56
self-employed	10	26	36
student	2	2	4
school leaver	14	0	14
housewife	74	98	172
<b>All</b>	<b>123</b>	<b>159</b>	<b>282</b>

**Figure 4 Histogram of Socioeconomic Status of all Subjects**

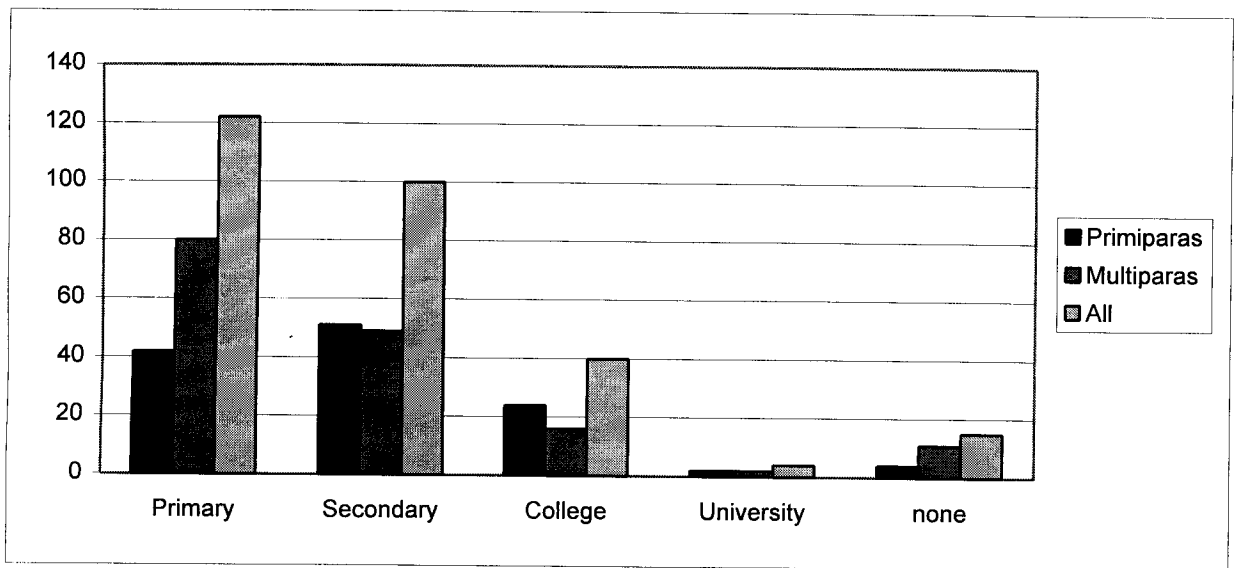


**Table 5 Educational Status of All Subjects**

Education	Primiparas	Multiparas	All
Primary	42	80	122
Secondary	51	49	100
College	24	16	40
University	2	2	4
none	4	11	15
<b>all</b>	<b>123</b>	<b>158</b>	<b>281*</b>

\* no response for one subject

**Figure 5 Histogram of Educational Status of All Subjects**



## ANTENATAL EDUCATION

Of those who received antenatal education on specific topics (as outlined in the results in Table 6) , most found the topics helpful. Note that not all patients had received various aspects of health education. Most of the 282 had received education on what to bring in labour (238 of the 282 – 84% and most found it useful – 232 of the 238 – 97.5%)

(Table 6).

**TABLE 6: ANTENATAL EDUCATION RECEIVED, WHETHER HELPFUL.**

<b>ANTENATAL EDUCATION</b>	<b>RECEIVED (n=282)</b>	<b>% RECEIVED</b>	<b>FOUND HELPFUL</b>	<b>% WHO FOUND A/N EDUCATION HELPFUL</b>
Breast-feeding	137	48	131	95.6
Preparation for labour	194	68	189	97
Baby	170	60	167	98.2
Process of labour	170	60	166	97.5
What to bring for labour	238	84	232	97.5

## **OVERALL BIRTH EXPERIENCE OF ALL SUBJECTS (n=282) (see Table 7)**

Twenty two variables were noted to be relevant (see Table 7). They were all related to the overall birth experience (Q82, Appendix II – ‘How would you rate the delivery process as a whole?’)

The results are summarised and are illustrated in the Table 7 following the narrative. Odds ratios (OR) are presented together with the 95% confidence intervals. The ‘p’ value of the chi-square is also presented.

Antenatal attendance of more than three times tended to confer a positive birth experience (OR 1.6; 95%C.I. 0.83<OR<3.08, p=0.13). However, the antenatal education received in clinic was actually associated with a less positive response, although not statistically significant.

Those in whom labour started spontaneously tended to have a positive experience as compared to those in whom labour was induced (OR 1.2;95%C.I. 0.53<OR<2.72, p=0.64).Those who felt the induction or the augmentation of their labour to be an interference tended to have a negative birth experience (OR 0.35; 95%C.I 0.09<OR<1.28, p=0.07). Those who rated their labour as short tended to have a positive experience (OR 2.12; 95%C.I. 1.27<OR<3.55) and this was statistically significant (for chi square, p=0.002) and conversely those who rated their labour as long, tended to have a negative experience

(OR 0.48; 95%C.I. 0.29<OR<0.81) statistically significant (for chi square,  $p=0.003$ ).

Only pethidine injectable was available for pain relief. Pain relief did make one view labour more positively (OR 1.24; 95%C.I. 0.66<OR<2.34,  $p=0.48$ ) though not statistically significant. Most women who rated their pain as easier than expected tended to have a positive experience (OR 2.14; 95%C.I. 1.07<OR<4.34) this was statistically significant with a 'p' value of 0.02.

Women who preferred to have someone by the bedside tended to have a negative experience (OR 0.78; 95%C.I. 0.44<OR<1.38,  $p=0.37$ ). Women who preferred to be delivered by midwives did not necessarily have a positive birth experience (OR 0.78; 95%C.I. 0.44<OR<1.37,  $p=0.36$ ). This was not statistically significant. Instrumental deliveries were associated with a negative experience (OR 0.48; 95%C.I. 0.11<OR<1.99,  $p=0.26$ ), though not statistically significant. Caesarean section patients were not included in this study.

Labours that were rated as straightforward tended to have a positive experience (OR 1.98; 95%C.I. 1.06<OR<3.68) than those that were rated as difficult. This was statistically significant (for chi square,  $p=0.02$ ). A live baby outcome was associated with a positive experience (OR 2.74; 95%C.I. 0.42<OR<21.93,  $p=0.23$ ). Those with antenatal problems during pregnancy tended to have a positive experience (OR 1.51; 95%C.I. 0.91<OR<2.51).

Planned pregnancies were associated with a positive experience (OR 1.07; 95%C.I. 0.64<OR<1.8,  $p=0.78$ ) as compared to unplanned pregnancies. Those who rated

their care as very good tended to have a positive experience (OR 1.41; 95% C.I. 0.81 < OR < 2.45, p=0.91) compared to those who did not. Those who had a positive expectation before the delivery did not necessarily have a positive experience (OR 0.98; 95% C.I. 0.59 < OR < 1.62, p=0.91) statistically not significant. However, the attitude of the staff to the patient was significant statistically (p=0.0008) - women who rated the attitude as good were associated with a positive outcome (OR 2.4; 95% C.I. 1.38 < OR < 4.17) than those who did not.

For each subject various questions were asked, (these variables which were to do with demographics, related to the pregnancy, labour etc see Appendix II). Each variable was divided into two stems (usually yes or no; primiparity or multiparity; attended clinic or not attended clinic etc). All subjects were asked to give an impression of the overall birth experience (see Q2, Appendix II) which was either positive or negative as previously described in the Methods section.

A 2x2 contingency table was then made for responses of each variable against birth experience. Analysis was by Chi square and Odds ratios were calculated. For example, Parity (Q2 in Appendix II). The total number of responses was 281. Of these 122 were primiparas and 159 were multiparas. The 2x2 contingency table is as follows:

	Positive experience (+ve)	Negative experience (-ve)
1 (primiparas)	67	55
>1 (multiparas)	94	65

Chi-square was 0.5 (p value 0.48 - no significance); odds ratios 0.84 (95% confidence interval  $0.51 < OR < 1.4$ ). The odds ratio implies that primiparas do not have a positive experience, although the 95% confidence interval and the chi square's 'p' value does not show any significance. The analysis for each variable's contingency table is shown in the tables following narration of results.

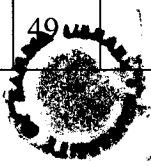
**TABLE 7 : RESULTS OF SELECTED VARIABLES OF ALL SUBJECTS  
AGAINST OVERALL BIRTH EXPERIENCE (Question 82)**

Variable	Stems	No.	+ve Exp	-ve Exp	Total	OR	95%C.I	X <sup>2</sup>	'p'																																																																																																																								
Parity (Q 2)	1	122	67	55	281	0.84	0.51<OR<1.4	0.5	0.48																																																																																																																								
	>1	159	94	65						Marital Status(Q4)	M	242	134	108	281	0.55	0.25<OR<1.2	2.63	0.1	S	39	37	12	Education (Q6)	b, c, d	144	79	65	280	0.8	0.48<OR<1.32	0.84	0.36	a, e	136	82	54	Clinic Attend.(Q10)	c	230	137	93	280	1.6	0.83<OR<3.08	2.24	0.13	a, b, d	50	24	26	Ant Ed. on labour (Q13)	Yes	193	107	86	281	0.78	0.45<OR<1.35	0.86	0.35	No	88	54	34	Ant. Exp. of labour (Q17)	Told	169	95	74	281	0.89	0.54<OR<1.49	0.2	0.65	Not told	112	66	46	Spontaneous labour? (Q21)	Yes	251	145	106	281	1.20	0.53<OR<2.72	0.21	0.64	No	30	16	14	Ind/Aug of labour? (Q28)	a,b,d	17	7	10	59	0.35	0.09<OR<1.28	3.20	0.07	c	42	28	14	Labour short? (Q30)	Yes	159	104	55	280	2.12	1.27<OR<3.55	9.38	0.002	No	121	57	64	Labour long? (Q31)	Yes	113	53	60	280	0.48	0.29<OR<0.81
Marital Status(Q4)	M	242	134	108	281	0.55	0.25<OR<1.2	2.63	0.1																																																																																																																								
	S	39	37	12						Education (Q6)	b, c, d	144	79	65	280	0.8	0.48<OR<1.32	0.84	0.36	a, e	136	82	54	Clinic Attend.(Q10)	c	230	137	93	280	1.6	0.83<OR<3.08	2.24	0.13	a, b, d	50	24	26	Ant Ed. on labour (Q13)	Yes	193	107	86	281	0.78	0.45<OR<1.35	0.86	0.35	No	88	54	34	Ant. Exp. of labour (Q17)	Told	169	95	74	281	0.89	0.54<OR<1.49	0.2	0.65	Not told	112	66	46	Spontaneous labour? (Q21)	Yes	251	145	106	281	1.20	0.53<OR<2.72	0.21	0.64	No	30	16	14	Ind/Aug of labour? (Q28)	a,b,d	17	7	10	59	0.35	0.09<OR<1.28	3.20	0.07	c	42	28	14	Labour short? (Q30)	Yes	159	104	55	280	2.12	1.27<OR<3.55	9.38	0.002	No	121	57	64	Labour long? (Q31)	Yes	113	53	60	280	0.48	0.29<OR<0.81	8.68	0.003	No	167	108	59								
Education (Q6)	b, c, d	144	79	65	280	0.8	0.48<OR<1.32	0.84	0.36																																																																																																																								
	a, e	136	82	54						Clinic Attend.(Q10)	c	230	137	93	280	1.6	0.83<OR<3.08	2.24	0.13	a, b, d	50	24	26	Ant Ed. on labour (Q13)	Yes	193	107	86	281	0.78	0.45<OR<1.35	0.86	0.35	No	88	54	34	Ant. Exp. of labour (Q17)	Told	169	95	74	281	0.89	0.54<OR<1.49	0.2	0.65	Not told	112	66	46	Spontaneous labour? (Q21)	Yes	251	145	106	281	1.20	0.53<OR<2.72	0.21	0.64	No	30	16	14	Ind/Aug of labour? (Q28)	a,b,d	17	7	10	59	0.35	0.09<OR<1.28	3.20	0.07	c	42	28	14	Labour short? (Q30)	Yes	159	104	55	280	2.12	1.27<OR<3.55	9.38	0.002	No	121	57	64	Labour long? (Q31)	Yes	113	53	60	280	0.48	0.29<OR<0.81	8.68	0.003	No	167	108	59																						
Clinic Attend.(Q10)	c	230	137	93	280	1.6	0.83<OR<3.08	2.24	0.13																																																																																																																								
	a, b, d	50	24	26						Ant Ed. on labour (Q13)	Yes	193	107	86	281	0.78	0.45<OR<1.35	0.86	0.35	No	88	54	34	Ant. Exp. of labour (Q17)	Told	169	95	74	281	0.89	0.54<OR<1.49	0.2	0.65	Not told	112	66	46	Spontaneous labour? (Q21)	Yes	251	145	106	281	1.20	0.53<OR<2.72	0.21	0.64	No	30	16	14	Ind/Aug of labour? (Q28)	a,b,d	17	7	10	59	0.35	0.09<OR<1.28	3.20	0.07	c	42	28	14	Labour short? (Q30)	Yes	159	104	55	280	2.12	1.27<OR<3.55	9.38	0.002	No	121	57	64	Labour long? (Q31)	Yes	113	53	60	280	0.48	0.29<OR<0.81	8.68	0.003	No	167	108	59																																				
Ant Ed. on labour (Q13)	Yes	193	107	86	281	0.78	0.45<OR<1.35	0.86	0.35																																																																																																																								
	No	88	54	34						Ant. Exp. of labour (Q17)	Told	169	95	74	281	0.89	0.54<OR<1.49	0.2	0.65	Not told	112	66	46	Spontaneous labour? (Q21)	Yes	251	145	106	281	1.20	0.53<OR<2.72	0.21	0.64	No	30	16	14	Ind/Aug of labour? (Q28)	a,b,d	17	7	10	59	0.35	0.09<OR<1.28	3.20	0.07	c	42	28	14	Labour short? (Q30)	Yes	159	104	55	280	2.12	1.27<OR<3.55	9.38	0.002	No	121	57	64	Labour long? (Q31)	Yes	113	53	60	280	0.48	0.29<OR<0.81	8.68	0.003	No	167	108	59																																																		
Ant. Exp. of labour (Q17)	Told	169	95	74	281	0.89	0.54<OR<1.49	0.2	0.65																																																																																																																								
	Not told	112	66	46						Spontaneous labour? (Q21)	Yes	251	145	106	281	1.20	0.53<OR<2.72	0.21	0.64	No	30	16	14	Ind/Aug of labour? (Q28)	a,b,d	17	7	10	59	0.35	0.09<OR<1.28	3.20	0.07	c	42	28	14	Labour short? (Q30)	Yes	159	104	55	280	2.12	1.27<OR<3.55	9.38	0.002	No	121	57	64	Labour long? (Q31)	Yes	113	53	60	280	0.48	0.29<OR<0.81	8.68	0.003	No	167	108	59																																																																
Spontaneous labour? (Q21)	Yes	251	145	106	281	1.20	0.53<OR<2.72	0.21	0.64																																																																																																																								
	No	30	16	14						Ind/Aug of labour? (Q28)	a,b,d	17	7	10	59	0.35	0.09<OR<1.28	3.20	0.07	c	42	28	14	Labour short? (Q30)	Yes	159	104	55	280	2.12	1.27<OR<3.55	9.38	0.002	No	121	57	64	Labour long? (Q31)	Yes	113	53	60	280	0.48	0.29<OR<0.81	8.68	0.003	No	167	108	59																																																																														
Ind/Aug of labour? (Q28)	a,b,d	17	7	10	59	0.35	0.09<OR<1.28	3.20	0.07																																																																																																																								
	c	42	28	14						Labour short? (Q30)	Yes	159	104	55	280	2.12	1.27<OR<3.55	9.38	0.002	No	121	57	64	Labour long? (Q31)	Yes	113	53	60	280	0.48	0.29<OR<0.81	8.68	0.003	No	167	108	59																																																																																												
Labour short? (Q30)	Yes	159	104	55	280	2.12	1.27<OR<3.55	9.38	0.002																																																																																																																								
	No	121	57	64						Labour long? (Q31)	Yes	113	53	60	280	0.48	0.29<OR<0.81	8.68	0.003	No	167	108	59																																																																																																										
Labour long? (Q31)	Yes	113	53	60	280	0.48	0.29<OR<0.81	8.68	0.003																																																																																																																								
	No	167	108	59																																																																																																																													

Table 7 continued overleaf

**TABLE 7 (continued) : RESULTS OF SELECTED VARIABLES OF ALL SUBJECTS AGAINST OVERALL BIRTH EXPERIENCE (Question 82).**

		No.	+ve Exp	-ve Exp	Total	OR	95%C.I	X <sup>2</sup>	'p'
Pain relief? (Q33)	Yes No	57 224	35 126	22 98	281	1.24	0.66<OR<2.34	0.49	0.48
Pain (Q37)	Easy Hard	53 227	38 123	15 104	280	2.14	1.07<OR<4.34	5.37	0.02
Social support (Q40)	Yes No	203 78	113 48	90 30	281	0.78	0.44<OR<1.38	0.79	0.37
Doc/Midwife? (Q50)	A B	158 87	83 51	75 36	245	0.78	0.44<OR<1.37	0.84	0.36
Instrumental Delivery? (Q53)	Yes No	10 271	4 157	6 114	281	0.48	0.11<OR<1.99	1.26	0.26
Opinion of Labour (Q56)	okay difficult	198 61	130 30	68 31	259	1.98	1.06<OR<3.68	5.34	0.02
Baby (Q61)	live dead	275 6	159 2	116 4	281	2.74	0.42<OR<21.9	1.43	0.23
Problems? ANC (Q71)	Yes No	136 145	85 76	51 69	281	1.51	0.91<OR<2.51	2.91	0.09
Pregnancy (Q76)	Planned unplanned	108 173	63 98	45 75	281	1.07	0.64<OR<1.80	0.08	0.78
ANC (Q78)	a,b c,d,e	201 80	120 41	81 39	281	1.41	0.81<OR<2.45	1.66	0.19
Expectations (Q79)	Okay anxious	159 121	91 70	68 51	280	0.98	0.59<OR<1.62	0.01	0.91
Staff attitude (Q80)	good bad	196 85	125 36	71 49	281	2.4	1.38<OR<4.17	11.1	0.001



## COMPARISON OF PREGNANCY AND CHILDBIRTH EXPERIENCE BETWEEN PRIMIPARAS AND MULTIPARAS

The results are presented in Table 8, after the narration of the results. The mean age for the primiparas was significantly less than that for the multiparas (21.0 years vs 28.0 years,  $p=0.0001$ ) Multiparas tended to have shorter labours than primiparas do and they tended to view their labours more positively. This was statistically significant : OR 0.59 ; 95% CI  $0.35 < OR < 0.95$ , for chi square,  $p=0.02$ .

Overall primiparas compared to multiparas tended to have a negative birth experience with an OR of less than 1 though this was not significant (OR 0.84; 95% C.I.  $0.51 < OR < 1.4$ ). The OR for married women for a positive birth experience was less than 1 (OR 0.55; 95% C.I.  $0.25 < OR < 1.2$ ). However this is not statistically significant. Those who are educated tended to have a less positive experience, but again this was not statistically significant (OR 0.8; 95% C.I.  $0.48 < OR < 1.32$ ).

Fewer primiparas rated their labour as easier than expected and accordingly they tended to view their experiences negatively (OR 0.5; 95% C.I.  $0.26 < OR < 0.99$ ,  $p=0.03$ ). Although less primiparas than multiparas wanted someone with them while in labour, they tended to view their experiences more positively than the multiparas do (OR 1.81; 95% C.I.  $1.02 < OR < 3.25$ ,  $p=.03$ ). More primiparas had instrumental deliveries and they tended to view their

experience more positively (7 vs 3 : OR 3.14 ; 95% CI .71<OR<15.67; chi-square 2.98, p=.087). This was not statistically significant probably due to the small numbers.

Fewer primiparas compared to multiparas rated their deliveries as straightforward when asked whether the delivery was straightforward (i.e. without difficulties) or was difficult. Furthermore they tended to rate their experiences more negatively (OR 0.58; 95%C.I. 0.33<OR<1.01, p=.04). Primiparas who had problems antenatally during their pregnancy rated their experience more negatively than the multiparas (OR 0.78; 95%C.I. 0.47<OR<1.28, p=.03).

Fewer primiparas than multiparas had a planned pregnancy, however they tended to rate their experiences more positively – though not significant (OR 1.12; 95%C.I. 0.67<OR<1.87, p=0.64). Although fewer primiparas rated their antenatal care as good, they tended to have a more positive experience than the multiparas (OR 1.17; 95%C.I. 0.67<OR<2.02, p=0.55), though not statistically significant. Fewer primiparas compared to multiparas tended to have positive expectations on arrival to labour ward, and their birth experience was rated negatively (OR 0.61; 95%C.I. 0.37<OR<1.02, p=0.4). Primiparas tended to rate their staff as less friendly compared to multiparas and their experience was viewed more negatively than the multiparas (OR 0.71; 95%C.I. 0.42<OR<1.23, p=0.19).

**TABLE 8 : RESULTS OF THE PERCEPTION OF VARIOUS EXPERIENCES IN PREGNANCY AND LABOUR BETWEEN PRIMIPARAS (1) AND MULTIPARAS (>1)**

Variable	No.	Yes	No	Total	OR	95%C.I	X <sup>2</sup>	P	
Labour short? (Q30)	1 >1	122 159	60 99	62 60	281	0.59	0.35<OR<0.95	4.79	0.02
Labour long? (Q31)	1 >1	122 159	57 57	65 102	281	1.57	0.94<OR<2.61	3.37	0.06 6
Pain felt? (Q37)	1 >1	123 138	18 35	105 103	261	0.5	0.26<OR<0.99	4.61	0.03
Social support? (Q40)	1 >1	123 159	97 107	26 52	282	1.81	1.02<OR<3.25	4.62	0.03
Instrumental delivery? (Q53)	1 >1	123 159	7 3	116 156	282	3.14	0.71<OR<15.67	2.98	0.08 7
Delivery okay?(Q56)	1 >1	122 158	79 120	43 38	280	0.58	0.33<OR<1.01	4.18	0.04
Problems ANC? (Q70)	1 >1	123 159	55 81	68 78	282	0.78	0.47<OR<1.28	1.07	0.3
Pregnancy Planned? (Q76)	1 >1	123 159	49 59	74 100	282	1.12	0.67<OR<1.87	0.22	0.64
ANC Good?(Q78)	1 >1	123 159	38 44	85 115	282	1.17	0.67<OR<2.02	0.35	0.55
Expectations okay? (Q79)	1 >1	122 158	61 98	61 60	280	0.61	0.37<OR<1.02	4.04	0.04
Staff Friendly?(Q80)	1 >1	123 159	81 116	42 43	282	0.71	0.42<OR<1.23	1.66	0.19

## DISCUSSION

The results illustrate that various factors affect the outcome of the birth. In this study primiparas have rated their labours as being longer compared to multiparas and comparatively more primiparas have rated their labours as difficult – this has correlated with a negative birth experience. McIntosh (1987) also showed this where first time mothers did not conform to a model of childbirth as natural and fulfilling – three quarters of them had negative expectations of childbirth.

Spontaneous labour correlated with a positive birth experience and those whose labours were induced tended to rate their labours more negatively. Furthermore, women who had a negative perception of their induction or augmentation tended to rate their labours negatively. These women tended to think that induction or augmentation was either an interference or made their labour more painful and they attributed any complication that arose to the induction or augmentation. This probably reflects a misunderstanding of the concept of either induction or augmentation of labour. It may also reflect a traditional belief that “forced” labour, as induction is commonly referred to, is bad and causes difficult and painful labours, therefore perhaps making patients expect such an outcome. Cartright’s study (1979) amongst others have shown that women want to know more than they are often told about procedures carried out in labour and the difficulties they sometimes have in asking questions to their satisfaction. In our study, as shown, if procedures are not well

explained wrong perceptions will be allowed to continue and these may consequently affect the perception of the birth outcome.

Instrumental deliveries, though few (only 10), were correlated with a negative birth experience. Interestingly though, primiparas with instrumental deliveries tended to rate their birth experience more positively compared to multiparas.

Pain was found to be negatively correlated to birth experience and did influence the outcome significantly in this study. Women who rated their pain in labour as easier than expected rated their experiences as positive as did those who thought their labours to be straightforward. Pain relief had a significant impact on the birth experience, with those given pain relief (pethidine intramuscular injection) tending to view their birth experience more positively than those who were not. Less painful labours, are correlated with a positive birth experience. However note is made of the fact that women will have different thresholds for pain and this may affect the outcome of the birth experience. In McIntosh's study of 1987 fear of pain was a major contributory factor to the negative expectation of childbirth.

Interesting data though not statistically significant, was that married women and educated women tended to have a less positive birth experience. Perhaps one expects educated women to have higher expectations and to be more demanding. Riley (1977) pointed out that different women want different types of childbirth experiences. In Britain, Nelson (1983) found that middle class women's expectations were not met thus markedly

affecting their experience of childbirth negatively.

In this study, antenatal attendance was correlated with a positive experience, although the antenatal education did not help in giving a positive outcome. A study by Parsons and Perkins (1980) showed that not all women would attend antenatal clinic, particularly young mothers-to-be who are already frightened with the prospect of pregnancy. The current study did not determine which type of patients attended or did not attend clinic. Nevertheless women who received antenatal education on specific topics found them helpful. This was regardless of what topic was discussed. This perhaps implied that the actual health education was not focused on the pregnant woman's needs although they found it helpful. The health talk on 'what to bring in labour' was received by the most number of patients. Interestingly again was the finding that those with antenatal problems tended to have a positive outcome perhaps because their problems were identified and treated. Those who rated their antenatal care as good tended to have positive birth experiences.

Social support in labour did not necessarily correlate with a positive experience. This is different from other studies e.g. that of Sosa et al (1980). This may be perhaps because women who needed to have someone by the bedside may have been more anxious about their labour or that the person providing the social support did not meet the needs of the labouring woman. There were more women who preferred to have someone by the bedside than those who did not and they were less satisfied with their labours. This perhaps implies a need for women in labour to have their psychological needs met. Social support has

both physical and emotional components (Klaus et al , 1986) which may not have been met in the current study. At UTH, it is not standard practice to allow relatives or friends to be by the bedside, although in selected cases this is allowed. Odent (1984) has suggested that some support people can interfere with normal progress of labour by their effects on the women and this may lead to a negative experience.

Planned pregnancies were associated with a positive experience as compared to unplanned pregnancies. Although fewer primiparas than multiparas had planned pregnancies, they tended to rate their birth experience more positively. It is difficult to find an explanation for this as one would expect those who have planned their pregnancies to be better prepared and to have good expectations.

High expectations did not necessarily correlate with a positive experience showing that other factors do affect the birth experience such as were found in this study (pain relief, staff support, difficult labour and perceived length of labour). Fewer primiparas had higher expectations on arrival on labour ward compared to multiparas and they had less positive birth outcomes. This is expected as one would expect first time mothers to be more apprehensive about their labour and delivery even if they have been adequately prepared, as labour is an altogether new and much talked about experience.

A live baby outcome does affect the overall perception of the birth experience. Only two out of the six who had stillbirths rated their experience as being positive. A live baby

can make a mother forget a long and difficult labour, while a dead baby can take away the significance of an easy, painless and straightforward labour and make it appear worthless.

Deliveries by midwife-led units have shown mothers to express a better quality of birth experience (Callister et al, 1995). In our study, though more women preferred midwives to deliver them, the birth experience was not necessarily a positive one. Interestingly, although more women, preferred to be delivered by midwives as compared to doctors, deliveries by midwives were less positively correlated with birth experience than those attended by doctors. Most women at UTH found the staff to be friendly and therefore were expected to be free in expressing themselves. It is surprising that the experience in the study was actually negative. Perhaps it was not fair to ask women about safety with regards to whether a doctor or midwife was delivering them, but it was one way of gauging with whom women were most comfortable.

Factors that came out as (statistically) significantly influencing the birth experience in this study were: pain relief - associated with a positive experience; perceived length of labour - with short labours being correlated to a positive experience; whether labour was thought to be straightforward or difficult - with straightforward labours being more positively perceived than difficult labours; and the overall attitude of the staff - perceived as good and giving a positive experience.

## **STUDY LIMITATIONS**

There can be up to forty deliveries per day at the UTH with five postnatal wards. In spite of five researchers including the author, due to the high numbers of deliveries, it was not possible to see every woman who had a delivery everyday, but effort was made to see as many patients as possible in a day. As in Waldenstrom et al's study (1996), it would have been preferable to interview each and every patient delivered over a given time period of say a few weeks. In this study a time frame of mornings for interviewing was utilised.

Multivariate analysis and developing a model based on the data will be considered as an extension of this study and would have enhanced the data analysis.

## CONCLUSION

Factors that affect the outcome of the delivery are not new and have been well documented in literature. Whether the labouring woman is in a well-developed country with all the high technology or whether she is in a less well-developed country like Zambia, the factors remain more or less the same. They can all be improved upon. All that is needed is a little more effort by the caregivers - that does not require much technology.

## RECOMMENDATIONS

Continued research in clinical care that brings about improved care should be encouraged. From this study factors that have been found to significantly affect the birth experience should be encouraged. Pain relief should be given more freely, as shown by the study, few women actually get it. Efforts should be made to shorten labour where indicated and prolonged labours should be treated more judiciously. Caregivers should be seen to be dealing caringly in difficult labours and above all good attitude from staff should be encouraged and insisted upon. Perhaps more effort should be made to encourage social support more widely than is being done currently at UTH.

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**APPENDIX I**

**SAMPLE CONSENT FORM**

**THE ASSESSMENT OF THE EXPERIENCE OF BIRTH IN WOMEN  
DELIVERING AT THE UNIVERSITY TEACHING HOSPITAL, LUSAKA.**

I willingly give consent to participate in this study. It has been explained to me that I will be asked questions of what I thought of my labour.

I will not be identified by the answers as they will not bear my name nor any number that can identify me.

If I do not wish to enter the research study, there will be no penalty and full treatment will continue. If I agree to join the research study I am free to leave the study at any time I wish, without penalty and without any change in treatment.

The purpose of this research study have been explained to me, and I agree to join the study under the terms.

Signed: .....

Date:.....

Witnessed by:.....

(Researcher)

**APPENDIX II**  
**QUESTIONNAIRE**

**Demographics**

1. Age.....
2. Parity.....Gravidity.....
3. Residential Address (Area).....
4. Marital status:       a) Single  
                              b) Married  
                              c) Divorced
5. Socio-economic status:
  - a) Employed
  - b) Self employed
  - c) Student
  - d) School leaver
  - e) Housewife
6. **Education level:**
  - a) Primary school
  - b) Secondary school
  - c) College
  - d) University
  - e) Never been to school

**Antenatal Care:**

7. Which antenatal clinic were you attending?
- a) Chelstone
  - b) Chilenje
  - c) Chawama
  - d) Chipata
  - e) Kanyama
  - f) Kabwata
  - g) Kamwala
  - h) George
  - i) Matero
  - j) Mtendere
  - k) Chainama
  - l) Civic Centre
  - m) Private
  - n) None
  - o) Other
8. Were you referred to UTH Antenatally?
- a) Yes
  - b) No
9. How many months pregnant were you when you started attending antenatal for this pregnancy?
- a) Less than 6 months
  - b) More than 6 months
  - c) Not sure
10. How many times did you attend clinic?
- a) Once
  - b) At least 3 times
  - c) More than 3 times
  - d) None

11. Did you get any antenatal education on breast-feeding?
- a) Yes
  - b) No
12. Did this make you prepared for breast-feeding?
- a) Yes                      c) N/A
  - b) No
13. Did you get any antenatal education on the preparation for labour?
- a) Yes
  - b) No
14. Did this make you better prepared for labour?
- a) Yes                      c) N/A
  - b) No
15. Did you get any antenatal education on the baby?
- a) Yes
  - b) No
16. Did this make you better prepared for the baby?
- a) Yes                      c) N/A
  - b) No
17. Were you told what to expect when in labour ( the actual process of labour)?
- a) Yes
  - b) No

18. Did it make you better prepared for the labour?
- a) Yes                      c) N/A
  - b) No
19. Were you told what to bring in preparation for the labour ?
- a) Yes
  - b) No
20. Did it make you better prepared for the labour?
- a) Yes                      c) N/A
  - b) No

**Labour**

21. Did your labour start on its own?
- a) Yes
  - b) No
22. Did you take some herbal / African medicine to make it start?
- a) Yes
  - b) No
23. Or did you take any medicine after your labour had started to make you deliver quickly?
- a) Yes
  - b) No
24. Was your labour induced ("forced") at the hospital?
- a) Yes
  - b) No

25. Did anyone explain to your satisfaction why they were doing this?
- a) Yes                      c) N/A
  - b) No
26. Was your labour augmented (that is, was a drip put up and some medicine put in to help your labour)?
- a) Yes
  - b) No
27. Did anyone explain to your satisfaction why they were doing this?
- a) Yes                      c) N/A
  - b) No
28. If your labour was induced augmented, how did you feel about it? (Perception)?
- a) Felt it was interference
  - b) Made labour more painful
  - c) Made labour progress quickly
  - d) Caused a complication, elaborate.....
29. How long was your labour?
- a) A few hours
  - b) 1/2 a day
  - c) A whole day
  - d) A couple of days
- (from the case notes..... hrs)

30. Was your labour unexpectedly short?

a) Yes

b) No

31. Was your labour unexpectedly long?

a) Yes

b) No

### **Analgesia**

32. Were you aware that you could obtain pain relief in labour?

a) Yes

b) No

33. Were you given anything to relieve your pain?

a) Yes

b) No

34. Was the pain adequately relieved?

a) Yes                      c) N/A

b) No

35. OR was the pain just made bearable (but you still felt it)?

a) Yes                      c) N/A

b) No

36. OR was there no pain relief at all?

a) Yes

b) No

37. How would you rate the pain you experienced during your labour?
- a) Easier than expected
  - b) As expected
  - c) Unexpected but bearable
  - d) Unbearable

**Staff support**

38. During labour did you have a midwife by your bedside all the time?
- a) Yes
  - b) No
39. If NO, were you able to get one on demand?
- a) Yes
  - b) No
  - c) N/A
40. Would you have wanted someone with you throughout labour?
- a) Yes
  - b) No
41. If YES, who?
- a) Midwife
  - b) Doctor
  - c) Mother/Female relative
  - d) N/A

Answer more than one (1)

42. Did you feel free enough to let the Midwife know what you were feeling?
- a) Yes
  - b) No
43. Did the Midwife allow you to express yourself (e.g. shout, walk-about, sit up, groan etc)?
- a) Yes
  - b) No
44. If not, (to Q 43) were you in anyway intimidated?
- a) Yes
  - b) No
  - c) N/A
- If yes (to Q 44) state why.....
45. Were you delivered by a doctor?
- a) Yes
  - b) No
46. Have you ever been delivered by a doctor before?
- a) Yes
  - b) No
47. Was there a difference in the delivery by a doctor and that by the nurse?
- a) Yes
  - b) No
  - c) N/A
48. Was there a difference in the feeling of safety (competence)?
- a) Yes
  - b) No
  - c) N/A

49. Was there a difference in the freedom to express yourself with Doctor/Midwife?
- a) Yes
  - b) No
  - c) N/A
50. If you had a choice, whom would you choose to be delivered by?
- a) A doctor
  - b) A midwife

**The delivery**

51. Did you deliver vaginally on your own (you were able to push the baby out)?
- a) Yes
  - b) No
52. If YES, did that add to your sense of achievement?
- a) Yes
  - b) No
53. Did you have an instrumental delivery?
- a) Yes
  - b) No

If yes what did you think of the delivery.....

54. Did that take away your sense of achievement?
- a) Yes
  - b) No
  - c) N/A
55. If YES (to Q 53) state what kind of delivery?
- a) Forceps
  - b) Vacuum
  - c) N/A

56. Overall, what did you think of the delivery?
- a) Straightforward
  - b) Difficult
- If (b) state why.....
57. Did you have to have caesarean?
- a) Yes
  - b) No
58. When were you told about this caesarean?
- a) Antenatally
  - b) At the beginning of labour
  - c) Sometime during the labour
  - c) N/A
59. Were you told of the indication for the caesarean?
- a) Yes
  - b) No
  - c) Cannot remember
  - c) N/A
60. How do you feel about having had a caesarean?
- a) It's okay, the reasons were well explained
  - b) It was not under my control, it was the doctor's decision.
  - c) I felt can if woman as I did not deliver by myself
  - d) N/A

### **Outcome of the delivery**

61. Did you deliver a live baby?
- a) Yes
  - b) No
62. Did your baby cry at birth?
- a) Yes
  - b) No
63. When did it cry?
- a) Immediately
  - b) After a few minutes
  - c) After some time
  - d) Not at all
64. When were you shown your baby?
- a) Immediately
  - b) After a few minutes
  - c) After some time
  - d) Not at all
65. Were there any problems with your baby?
- a) Yes
  - b) No





### **Overall experience of the antenatal care**

78. How would you rate the care received?

- a) Excellent
- b) Very good
- c) Satisfactory
- d) Fair
- e) Not good

### **Arrival at the delivery ward**

79. How would you rate the way you were feeling?

- a) Full of expectation
- b) Fine, this was nothing unusual
- c) Very anxious

80. How would you rate the attitude of the staff towards you on admission?

- a) Very friendly
- b) Busy, but acknowledged me
- c) Busy, but ignored me
- d) Just ignored me

81. How would you rate your midwife?

- a) Very supportive and was there when I needed her.
- b) Was there sometimes
- c) Left me alone

82. How would you rate the delivery process as a whole?
- a) Very positive/good
  - b) Satisfactory
  - c) Fair
  - d) Very negative/bad
83. How would you rate the medical care that you received from the doctors throughout your stay?
- a) Excellent
  - b) Good
  - c) Satisfactory
  - d) Bad
84. If you had a choice would you come back to deliver at this Institution (UTH) again?
- a) Yes
  - b) No

**Thank you.**