

## Women's Perception of Support and Control During Childbirth



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### ABSTRACT

**Background:** Good delivery experience is mostly dependent on support and control during the process. **Aim:** The current study aimed to assess women's perception of support and control during childbirth. **Method:** The study design used was a cross-sectional descriptive study. The current study was conducted at Mansoura University Hospital's labor unit in Egypt. A purposive sample of 163 parturient women was included. A structured interviewing questionnaire and the Support and Control in Birth (SCIB) scale were the two tools utilized to gather data. **Results:** More than one-third of the parturient women experienced too strong pain, they were tired during labor and birth, and they couldn't control themselves. More than one-third of the studied women didn't have control over when procedures happened, whether procedures were carried out or not and even for the decisions that were made for them. Also, the same proportion of the studied women were completely disagreed that the staff treated them and their husband with warmth and respect, listened to them more during labor and helped them to try different positions. **Conclusion:** More than one-third of the studied parturient women had low perception support and control during childbirth. **Recommendation:** In order to give parturient women the highest level of supportive nursing care and give them more control over their entire childbirth experience, effective supervision, guidance, and monitoring should be provided.

**Keywords:** Childbirth, Support, Control, Women's Perception

### Introduction

Worldwide childbirth is a stressful life experience for women throughout their pregnancy, childbirth, and postpartum period as women experience physical, psychological, and social changes. The baby's health and wellness as well as their own may be impacted (Hildingsson & Rubertsson, 2020). Therefore, it is important for caregivers to encourage and foster a culture that gives women control over the birthing process so that they can have a happy, unforgettable birth experience (Ilska et al., 2021; Jha et al., 2018).

World Health Organization defines "a positive childbirth experience as one that fulfils or exceeds a woman's prior personal and sociocultural beliefs and expectations, including giving birth to a healthy baby in a clinically and psychologically safe environment with continuity of practical and emotional support from a birth companion and kind, technically competent clinical staff" (WHO, 2018).

The level of control that women feel during childbirth is an essential component of the quality of maternity care services, which improves women's satisfaction with their childbirth experience (Baranowska et al., 2020; Navas Arrebola et al., 2021). Positive birthing experiences have been linked to a variety of individual and systemic characteristics,

including involvement in the decision-making process, participation in information access, familiarity with the care provider, and support during childbirth (Hosseini Tabaghdehi et al., 2020; Lalonde et al., 2019).

The experience of the woman giving birth impacted by ongoing support. It enhances the outcomes for mothers and newborns. In addition to improving neonatal outcomes, women's satisfaction, and their bonding with their children, continuous labor assistance decreased the need for epidurals, aided deliveries, caesarean section births, postpartum depression, and other related issues (Ghanbari-Homaie et al., 2021; Lunda, Minnie, & Benadé, 2018).

Despite all of these advantages, continuous childbirth support is not always used because hospital settings frequently employ medical interventions like epidural anaesthesia. The last three decades have seen significant advancements in medical technology, which has led to a rise in the usage of invasive birthing techniques. As a result, midwives may devote more of their time to routine tasks and technology rather than providing continuous support during delivery (Ivry, Takaki-Einy, & Murotsuki, 2019; Kiti, Prata, & Afulani, 2022).

Without consistent assistance, women may experience feelings of abandonment, dissatisfaction, and fear. Thus, midwives should be aware of the various requirements that women have during labor, such as emotional, physical, and informational demands, since positive interpersonal interactions can lessen the fear that comes with giving birth and ultimately lead to a positive birth experience (Seefeld et al., 2021; Preis, Lobel, & Benyamini, 2019; Kabakian-Khasholian et al., 2018).

### 3. Significance of the study

In compliance with Egypt's Vision 2030 and its sustainable development plan, which aims to enhance maternal health by facilitating access to high-quality care delivered by qualified medical professionals before to, during, and following childbirth. One of the most important factors in improving maternal health is providing women with support and control during childbirth; this influences both the woman's experiences and delivery outcomes (Chabbert, Panagiotou, & Wendland, 2021).

Support for women during childbirth improves outcomes for mothers and newborns, and lowers the need for medical interventions like medicated births. Midwifery nurses' supportive care also helps women achieve the level of control they want, enhances their dignity during childbirth, empowers them to take part in decisions about their care, reduces the need for obstetric interventions during delivery, and promotes prudent use of maternity health services in future pregnancies (Colley et al., 2018; ElShora et al., 2023).

Mistreatment of women during childbirth can take many forms, including loss of control and inadequate support, which might impact future decisions about using intrapartum care services (Hameed, Uddin, & Avan, 2021). Even while constant support throughout labour has been shown to have benefits, not all maternity facilities consistently implement this approach, and women's opinions and experiences may not be taken into account. Thus, the purpose of this study was to assess women's perception of support and control during childbirth.

### 4. Aim of the study

The current study aimed to assess women's perception of support and control during childbirth.

### 5. Research question

Q1: What is the women's perception of support and control during childbirth?

## 6. Method

### 6.1 Study Design

A descriptive cross sectional study design was adopted. This design measure specific condition and potentially related characteristics at a certain moment in time for a defined population (Sharma, 2018).

### 6.2 Study setting

The labor unit of Mansoura University Hospital was used as the study's site. It is located on the first floor of the hospital's main structure. This particular environment was chosen since it is an educational hospital where research may be implemented without any obstacles and with adequate staff collaboration. The unit consists of the following four areas: admissions, examination, delivery operation, and post-delivery. It offers emergency obstetric care services 24 hours per day, three days a week, with a flow rate of 280 cases annually.

### 3.3 Sampling

The research involved a purposive sample of 163 parturient women who were admitted to the previously mentioned study setting between November 2022 and April 2023. The women were allowed to be involved in the study when they met these criteria:

#### Inclusion criteria:

- Women aged from 18–35 years old.
- Have a single, full term, viable fetus.
- Free from any medical or obstetrical complications that could affect the progress of labor.

#### Exclusion criteria

- Women who delivered before coming to the hospital.

#### Sample size calculation

Based on data from literature (Colley et al., 2018), considering level of significance of 5%, and power of study of 80%, a 5% level of significance. Sample size was calculated by substitution of the following formula: 
$$n = \frac{(Z_{1-\alpha/2})^2 \cdot SD^2}{d^2}$$

Where,  $Z_{1-\alpha/2}$  = is the standard normal variate, at 5% type 1 error it is 1.96, SD = standard deviation of variable and d = absolute error or precision. So, 
$$n = \frac{(1.96)^2 \cdot (0.65)^2}{(0.10)^2} = 162.3$$

The formula above resulted in 163, which was the necessary sample size for the study.

### 3.4 Tools of Data Collection

Two tools were used for data collection as follows:

**Tool I: A Structured Interviewing Questionnaire:** The researcher prepared it after checking over the appropriate content, and it was divided into two sections:

**Part I.** The parturient women under study were characterized by age, place of residence, educational level, occupation, and income.

**Part II.** the parturient women under study's obstetric history, including their gravidity, parity, abortion, previous mode of delivery, number of prenatal visits during the present pregnancy, and gestational age at delivery.

**Tool II: Perception of Support and Control in Birth (SCIB) Scale**

This tool was adapted from (Ford, Ayers, & Wright, 2009) and is used to determine how women felt about their level of control and support throughout childbirth. The tool had 33 items when it was initially developed, but after one item was added to the internal control subscale, two items were removed from the external control subscale, and three items were added to the support subscale, the tool had 35 items with three subscales:

**Part I.** The internal control subscale (11 items) assessed the capacity of women to exert self-control over all aspects of childbirth, including behaviors, thoughts, pain, emotions, and bodily functions.

**Part II.** The external control subscale (9 items) assessed women's ability to influence events that are governed by outside factors like knowledge, setting, choices, and actions.

**Part III.** The support subscale (15 items) assessed coaching, coping mechanisms, employee behavior, support, listening to women's needs, informative assistance, and involved pain reduction.

**Scoring System**

The 5-point SCIB scale was used as completely agree (score 5), agree (score 4), neutral (score 3), disagree (score 2), and completely disagree (score 1) were the possible outcomes on the Likert scale. For items (1, 2, 6, 7, and 9) in the internal subscale, (8 and 9) in the external control subscale, and (14 and 15) in the support subscale, the scoring system was reversed.

The SCIB total score ranged from 35 to 175; high scores indicated greater perception of control or support, and low scores indicated less. For example, a score of 35–81 indicated low perception of control or support, a score of 82–128 indicated

average perception of control or support, and a score of 129–175 indicated high perception of support or control during childbirth.

**3.5 Tools Validity and reliability:**

A panel of five experts in women's health and midwifery confirmed the validity of the study tools, ensuring that the questionnaire consistently conveyed the intended meaning. They made suggestions, such as rephrasing some statements to make them easier to understand and adding more statements to the SCIB to make it more comprehensive.

Using Cronbach's alpha test in the statistical package for social science (SPSS) version 20, the instruments were evaluated for reliability; the SCIB scale's internal consistency (Cronbach's alpha value) was 0.894, indicating high reliability.

**Pilot Study**

In order to assess the ease of use, practicality, comprehensibility, and relevance of these instruments as well as the time needed for data collection, a pilot study was carried out on 10% (17) parturient women prior to the actual data collection. In light of the pilot study's findings, the study sample did not include the pilot research, and a few topics were added and some were removed to make the material easier for women to understand. The results of the pilot research confirmed the adequate reliability of the data collection tool.

**Ethical Considerations**

The study's implementation was authorized ethically by the Mansoura University Faculty of Nursing Research Ethics Committee. Prior to the investigation, all parturient women were given the option to give written, formal consent and were informed about the purpose and scope of the study. Parturient women were able to leave the research at any time. Confidentiality, privacy, safety, and anonymity were all assured throughout the entire study. The results would be used for upcoming publications and instructional materials, as well as for the research needed to get a master's degree.

**Field Work**

This process was divided into two phases: preparatory phase and data collection phase.

**Preparatory Phase**

In this stage, the director of Mansoura University Hospitals, the head of the department of obstetrics and gynecology, and the Faculty of Nursing Research Ethics Committee formally authorized the researcher to carry out the current study. Data collection tools were developed and

their validity and reliability assessed after a review of literature. Then, 10% of the study sample was used for a pilot study before the real sample was gathered.

### **Data Collection Phase**

The actual fieldwork of the study started from the beginning of November 2022 to the end of April 2023. Three days a week, the researcher was present in the previous setting till the purposive sample was collected. The researcher first gave each woman an introduction and asked for written consent after outlining the purpose of the study. The researcher then obtained each woman's age, place of residence, degree of education, employment, and income, as well as information about her obstetric history, including the number of pregnancies, parities, and abortions, previous mode of delivery, number of antenatal visits in the current pregnancy and gestational age at the time of delivery using tool I.

Then the researcher assessed women's perceptions of support and control during childbirth after they gave birth using tool II. Before recording the woman's answers, the researcher read each question on the questionnaire to her and explained its meaning during the interview. With each woman, the researchers took 20 to 30 minutes to complete the assessment. Until the researcher finished the predetermined sample, this process was repeated.

### **Statistical Analysis**

Version 20.0 of SPSS for Windows was used for all statistical analyses (SPSS, Chicago, IL). The continuous data were presented as mean  $\pm$  standard deviation (SD) and had a normal distribution. Numbers and percentages were used to express categorical data. Variables were compared using the chi-square test (or, if appropriate, the Fisher's exact test) using categorical data. With continuous data, correlations between two variables were examined using the correlation coefficient test. Calculations were made about the reliability (internal consistency) test of the study's questionnaires. At  $p < 0.05$ , statistical significance was established.

## **7. Results**

**Table 1** reveals that 45.4% of the studied women aged  $24 < 29$  with mean age ( $27.3 \pm 4.2$ ), more than half (54%) of them were from rural areas. 44.2% & 51.5%, respectively of the studied women had secondary education and were working. 56.4% of them did not have enough income.

**Table 2** shows that more than half of the studied women were multigravida and multipara (57.7% & 50.3%, respectively). Most of them (92.6%) had no previous abortion. Among the women in the study, 54.6% had more than four prenatal visits during this pregnancy. At the time of delivery, the mean gestational age was  $38.9 \pm 0.8$ .

**Figure 1** illustrates that 51.2% of the studied women had normal vaginal delivery without episiotomy, 42.7% of them had normal vaginal delivery with episiotomy. Only 6.1% of them had a previous cesarean section.

**Table 3** shows that more than one-third of the studied women experienced too strong pain, they were tired during labor and birth, and they couldn't control themselves (41.1%, 43.6% & 36.8%, respectively). More than one-third of them did not have control over their reactions to the pain, their emotions, and the screaming they were making (36.2%, 34.4% & 35.6% respectively)

**Table 4** clarifies that 38.6% & 45.4%, respectively, of the studied women hadn't control over when procedures happened and whether procedures were carried out or not. Also, 36.9%, 52.1% & 46.6%, respectively, of them didn't control over the decisions that were made for them, chose whether they were given information or not and when they received information. However, 52.8% and 32.5% of the women in the study, respectively, were free to move as much as they pleased and choose the mode of delivery.

**Table 5** clarifies that 37.4%, 50.3%, 38.7% & 48.5%, respectively of the studied women completely disagreed that the staff treated them and their husband with warmth and respect, seemed to know what they wanted or needed, conveyed an atmosphere of calm and went out of their way to keep them comfortable. 46% & 43.6%, respectively, disagreed that the staff listened to them more during labor and helped them to try different positions. While 33.1%, 45.4%, 36.8% & 38%, respectively of the studied women agreed that the staff helped them find energy to continue, encouraged them to explore new coping mechanisms (such as breathing techniques), acknowledge their suffering, and encourage them to stop resisting their bodies' natural processes.

**Figure 2** clarifies that more than one-third of the studied parturient women (35%) had low perception of control and support when giving delivery. However, during birthing, less than one-third of them (31.9%) experienced high levels of perception in control and support.

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**Table 7** donate that the level of education, occupation, and income of the women in the study had a high significant association with their support and control over childbirth  $P(<0.001)$  as women who read and write, housewives and had not enough income had low perception of support and control during childbirth (59.6 %, 73.7% & 82.5%, respectively).

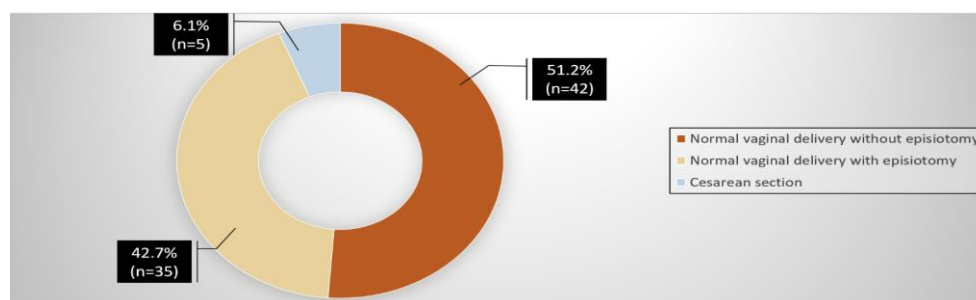
**Table 8** reveals that a statistically significant association existed between the women's perception of control and support during childbirth and their obstetric history  $P (<0.05)$  as women who were primigravida, primipara and had normal vaginal delivery with episiotomy had low perception of support and control in birth (50.9%, 68.4% & 77.8 %, respectively).

**Table 1.** Demographic Characteristics of The Studied Parturient Women (n=163)

Items	n (163)	%
<b>Age (Years)</b>		
18 < 24	64	39.3
24 < 29	74	45.4
29 ≤35	25	15.3
Mean ±SD	27.3 ±4.2	
<b>Residence</b>		
Urban	75	46.0
Rural	88	54.0
<b>Level of education</b>		
Illiterate	12	7.3
Read and write	49	30.1
Secondary education	72	44.2
Higher education	30	18.4
<b>Occupation</b>		
House wife	79	48.5
Working	84	51.5
<b>Income (L.E)</b>		
< 4000	92	56.4
4000 – 6000	66	40.5
>6000	5	3.1

**Table 2.** Obstetric History of The Studied Parturient Women (n=163)

Items	n (163)	%
<b>Number of gravidity</b>		
Primigravida	69	42.3
2 – 3 times	71	43.6
More than 3 times	23	14.1
<b>Number of parity</b>		
Primipara	81	49.7
2 – 3 times	68	41.7
More than 3 times	14	8.6
<b>Number of abortion</b>		
Non	151	92.6
1 – 2 times	12	7.4
<b>Number of antenatal visits in the current pregnancy</b>		
≤4 Visits	74	45.4
>4Visits	89	54.6
<b>Gestational age at the time of delivery (Weeks) (Mean ±SD)</b>	38.9 ±0.8	



**Figure 1.** Previous Mode of Delivery of the Studied Parturient Women

**Table 3.** Internal Control Scale of the Studied Parturient Women (n = 163)

Items	Completely disagree		Disagree		Neutral		Agree		Completely agree	
	n	%	n	%	n	%	n	%	n	%
The pain was too strong for me to gain control over it	7	4.3	13	8.0	22	13.5	67	41.1	54	33.1
I was tired during labor and birth	3	1.8	16	9.8	31	19.0	71	43.6	42	25.8
I was mentally calm	29	17.8	57	35.0	34	20.9	24	14.7	19	11.6
I was able to control my reactions to the pain	59	36.2	52	31.9	29	17.8	12	7.4	11	6.7
I was in control of my emotions	56	34.4	42	25.8	21	12.8	27	16.6	17	10.4
I felt my self was on a mission that I could not control	23	14.1	19	11.7	17	10.4	60	36.8	44	27.0
Negative feelings overwhelmed me	65	39.9	54	33.1	21	12.9	15	9.2	8	4.9
I gained control by working with my body	37	22.7	54	33.1	27	16.6	26	16.0	19	11.6
I behaved in a way not like myself	42	25.8	39	23.9	41	25.2	25	15.3	16	9.8
I could control the screaming I was making	58	35.6	53	32.5	22	13.5	16	9.8	14	8.6
Labor and birth went as I had expected	56	34.4	48	29.4	32	19.6	15	9.2	12	7.4

**Table 4.** External Control Scale of the Studied Parturient Women (n=163)

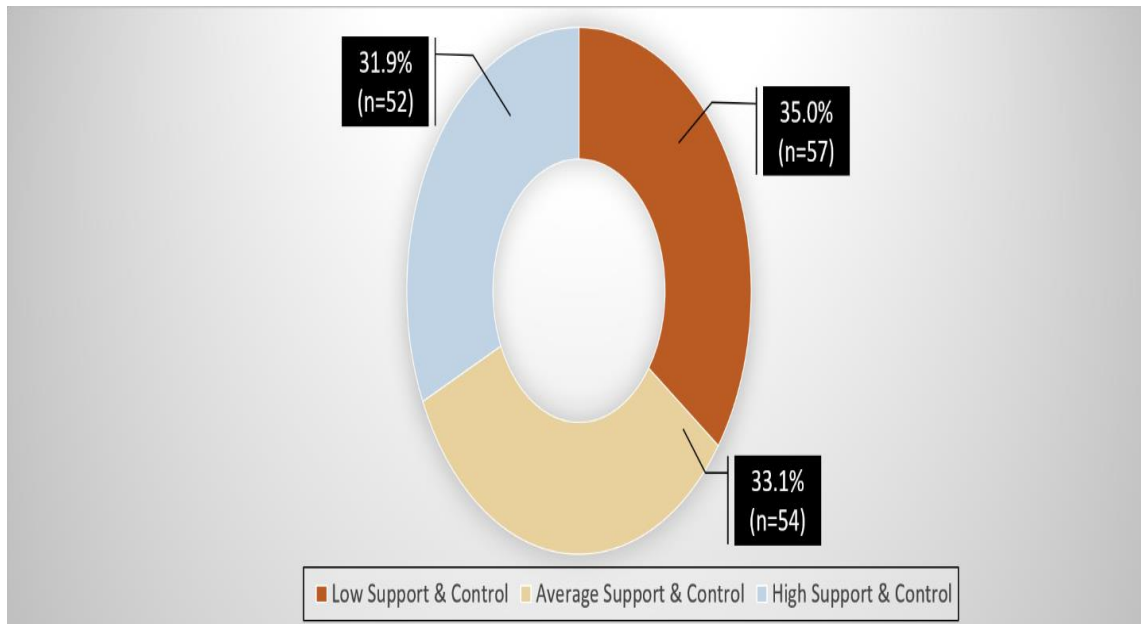
Items	Completely disagree		Disagree		Neutral		Agree		Completely agree	
	n	%	n	%	n	%	n	%	N	%
I had control over when procedures happened	63	38.6	58	35.6	16	9.8	14	8.6	12	7.4
I decided whether procedures were carried out or not	74	45.4	58	35.6	15	9.2	10	6.1	6	3.7
I had control over the decisions that were made	54	33.1	60	36.9	23	14.1	15	9.2	11	6.7
I could get up and move around as much as I wanted	4	2.5	8	4.8	14	8.6	86	52.8	51	31.3
I chose whether I was given information or not	56	34.4	85	52.1	15	9.2	5	3.1	2	1.2
I could decide when I received information	61	37.4	76	46.6	16	9.8	6	3.7	4	2.5
I had control on the type of delivery	12	7.4	15	9.2	37	22.7	53	32.5	46	28.2
People in the room took control	9	5.5	6	3.7	17	10.4	66	40.5	65	39.9

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People coming in and out of the room was beyond my control	13	8.0	10	6.1	16	9.8	83	50.9	41	25.2
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**Table 5.** Support Scale of the Studied Parturient Women (n=163)

Items	Completely disagree		Disagree		Neutral		Agree		Completely agree	
	n	%	n	%	n	%	n	%	N	%
The staff treated me and my husband with warmth and respect	61	37.4	54	33.1	21	12.9	15	9.2	12	7.4
The staff helped me find energy to continue when I wanted to give up	16	9.9	22	13.5	23	14.1	54	33.1	48	29.4
The staff seemed to know instinctively what I wanted or needed	82	50.3	49	30.1	23	14.1	7	4.3	2	1.2
The staff conveyed an atmosphere of calm	63	38.7	58	35.6	27	16.5	9	5.5	6	3.7
The staff went out of their way to keep me comfortable	79	48.5	47	28.8	24	14.7	7	4.3	6	3.7
The staff encouraged me to try new ways of coping (such as breathing)	8	4.9	11	6.8	22	13.5	74	45.4	48	29.4
The staff listened to me more during labor and birth	59	36.2	75	46.0	20	12.2	5	3.1	4	2.5
The staff accepted the pain I was in	19	11.7	10	6.1	21	12.9	60	36.8	53	32.5
The staff encouraged me not to fight against what my body was doing	9	5.5	8	4.9	25	15.3	62	38.0	59	36.2
The staff give me time to ask questions	33	20.2	16	9.8	12	7.4	58	35.6	44	27.0
The staff helped me to try different positions	59	36.2	71	43.6	14	8.6	10	6.1	9	5.5
The staff stopped doing something if I asked them to stop	16	9.9	24	14.7	39	23.9	46	28.2	38	23.3
The staff dismissed things I said to them	9	5.5	11	6.8	17	10.4	65	39.9	61	37.4
I felt the staff had their own agenda	52	31.9	61	37.4	21	12.9	19	11.7	10	6.1
I felt the staff tried to move things along their own convenience	56	34.3	60	36.8	21	12.9	14	8.6	12	7.4



**Figure 2.** Total Score of Women's Perception of Support and Control During Childbirth

**Table 7.** Association Between the Studied Women's Demographic Characteristics and Their Total Score of Support and Control Perception During Childbirth (n=163)

Items	Low perception of Support and control (n=57)		Average perception of Support and control (n=54)		High perception of Support and control (n=52)		Significance test	
	n	%	n	%	n	%	X <sup>2</sup>	P
<b>Age (Years)</b>								
18 – 23	21	36.8	19	35.2	24	46.1		
24 – 29	28	49.1	29	53.7	17	32.7		
29 – 35	8	14.1	6	11.1	11	21.2	5.625	0.229
<b>Residence</b>								
Urban	25	43.9	23	42.6	27	51.9		
Rural	32	56.1	31	57.4	25	48.1	1.092	0.579
<b>Level of education</b>								
Illiterate	10	17.5	1	1.8	1	1.9		
Read and write	34	59.6	10	18.4	5	9.7		
Secondary education	12	21.1	42	77.8	18	34.6		
High education	1	1.8	1	1.9	28	53.8	112.460	<0.001**
<b>Occupation</b>								
House wife	42	73.7	29	53.7	8	15.4		
Working	15	26.3	25	46.3	44	84.6	37.891	<0.001**
<b>Income</b>								
Not Enough	47	82.5	33	61.1	12	23.1		
Enough	9	15.8	19	35.2	38	73.1		
Enough and save	1	1.7	2	3.7	2	3.8	40.395	<0.001**

**Table 8.** Association Between the Studied Women's Obstetric History and Their Total Score of Support and Control Perception During Childbirth (n=163)

Items	Low perception of Support and control (n=57)		Average perception of Support and control (n=54)		Good perception of Support and control (n=52)		Significance test	
	n	%	n	%	n	%	X <sup>2</sup>	P
<b>Number of gravidity</b>								
Primigravida	29	50.9	24	44.4	16	30.8		
2 – 3 times	26	45.6	28	51.9	17	32.7		
More than 3 times	2	3.5	2	3.7	19	36.5	32.222	<0.001**
<b>Number of parity</b>								
Primipara	39	68.4	26	48.1	16	30.8		
2 – 3 times	17	29.8	25	46.3	26	50.0		
More than 3 times	1	1.8	3	5.6	10	19.2	21.390	<0.001**
<b>Number of abortions</b>								
Non	53	93.0	51	94.4	47	90.4		
1 – 2 times	4	7.0	3	5.6	5	9.6	0.655	0.721
<b>Mode of previous deliveries (n=82)</b>	(n=18)		(n=28)		(n=36)			
Normal vaginal delivery without episiotomy	3	16.7	16	57.1	23	63.9		
Normal vaginal delivery with episiotomy	14	77.8	11	39.3	10	27.8		
Caesarian section	1	5.5	1	3.6	3	8.3	13.256	0.010*
<b>Number of antenatal visits in current pregnancy</b>								
≤ 4 Visits	25	43.9	26	48.1	23	44.2		



> 4Visits	32	56.1	28	51.9	29	55.8	0.248	0.883
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## 5. Discussion

The present study aimed to assess women's perception of support and control during childbirth. The current study's findings, which revealed that during childbirth, over one-third of the women undergoing the study experienced inadequate support and control. The study found a statistically significant association between the women's control and support during childbirth and their obstetric history and demographic information.

The study findings revealed that more than one-third of the parturient women experienced too strong pain, and they were tired during labor and birth. These findings may be attributed to the severity of uterine contraction during labor and inadequate reassurance and explanations to the parturient women. These results in line with **Rodríguez-Almagr et al. (2019)** who studied "Women's Perceptions of Living a Traumatic Childbirth Experience and Factors Related to a Birth Experience in Spain" and concluded that women described differing degrees of pain during labor making their experience more traumatic.

In addition, **Baljon et al. (2022)** studied the effectiveness of Breathing Exercises, Foot Reflexology and Massage (BRM) on maternal and newborn outcomes among primigravida women in Saudi Arabia and reported that it was believed that labor pain contributed to the lack of support and control during delivery. Similarly, **Safitri, Lubis, and Laili (2023)** who studied "The effect of hypnobirthing relaxation method on pain intensity among laboring women at Pratama Hadijah Clinic, Medan Perjuangan District Medan City". They concluded that nearly half of respondents experienced severe pain during the childbirth process. In contrast to the current study findings Mathur, Morris, and McNamara (2020) who studied cultural conceptions of women's labor pain and pain management in America and Turkey. They reported that women experience less pain during labor, and women do not have the right to labor pain management.

The current study findings revealed that more than one-third of the studied women didn't control their reactions to the pain, their emotions, and the screaming they were making. These findings may be attributed to the severity of labor pain and inadequate explanations and reassurance to the women during the childbirth process.

In agreement with the current study findings **Karaduman and Akköz Çevik (2020)** conducted a study to assess the effect of sacral massage on labor pain and anxiety in Bağcılar Hospital. They reported that labor pains, unlike other pains, do not have a stable intensity and are gradually intensified as a result of the uterine contraction, so the women are not able to control their emotions or reactions to labor pain. Additionally, **Aynaci (2020)** studied "Maternal Perspective for Support and Control in Birth" in Trakya and women reported that "I am not myself in pain responses, the pain I had was much more than I could control." These items point to a lack of control during childbirth.

In contrast to the current study findings **Siyoun and Mekonnen (2019)** study entitled "Labor pain control and associated factors among women who gave birth at Leku primary hospital, southern Ethiopia". They concluded that physical, psychological, and cultural factors all have an impact on labor pain tolerance as well as how intensely and emotionally pain manifests. For example, women should keep calm and quiet during childbirth to avoid embarrassing their family. The disagreement between the study's findings could be caused by the different culture of the studied women in the expression of their emotions and their reactions to pain. Also, continuous support from the health care provider helps women feel calm and quiet

The results of the current study presented more than one-third of the women under studying did not experience the labor and delivery as they had expected. This result might be explained by the fact that women's expectations about the childbirth process were negatively shaped by services that did not match their requirements, expectations, or maternity nurses' lack of sharing in decision making, support, or explanations.

This Finding is matched with **Gaudernack et al. (2020)** who conducted a study to assess whether prolonged labor has an impact on first-time mother delivery experiences and future desire for a caesarean section in a Norwegian university hospital. They clarified that the main themes from women's written comments were "unexpected events"; Some women had stressful operative deliveries, their labor took longer than expected, and they had both more and less pain relief than they expected. Women also reported that labor is unexpected and unsupportive. Furthermore, this

result is supported by **Collins et al. (2021)** study entitled "Nature and characteristics of Black women's interactions with medical providers during childbirth when accompanied by a perinatal support professional in the United States in Cleveland". They concluded that birth not went as they expected as more women are experiencing medical professionals' fear, intimidation, and rushing them into interventions.

The recent study's findings demonstrated that more than one-third of the studied women hadn't control over when procedures happened and whether procedures were carried out or not. The absence of knowledge, consent for any procedures performed on women, which would provide a detailed explanation of what would be done and an opportunity for her to decide whether or not to accept could cause these results.

This results in a line with **Baranowsk et al. (2019)** who studied "Is there respectful maternity care in Poland? Women's views about care during labor and birth." They revealed that nearly half of the women in the research experienced hostility or mistreatment from the midwife nurse, which upset them. Receiving medical treatment without the patient's previous consent was the most common kind of abuse. Moreover, parallel with the present study findings **Mastylak et al. (2023)** study entitled "The Blessing" of pregnancy? Barriers to getting good maternity care in Poland. They revealed that medical treatments are routinely performed on women without their consent by maternal care providers.

The current results revealed that nearly half of the studied women hadn't control over the decisions that were made for them, chose whether they were given information or not, and when they received information. These findings may be attributed to the work workload of staff nurses and the shortage of staff, which leads to inadequate interaction and decision-making sharing between women and nurses. These findings agreed with those by **Hildingsson et al. (2019)** who studied "A known midwife can make a difference for women with fear of childbirth- birth outcomes and women's experiences of intrapartum care in Sweden". They documented that the majority of the women felt that the intrapartum care was inadequate overall, and the areas that need significant improvement were centred around feelings of control, knowledge and communication, and participation in decision-making and the actual care.

Similarly, **Mangindin et al. (2023)** who concluded that women who gave birth in a mixed-risk hospital setting were more likely to report feeling less in control when it came to making decisions regarding their maternity care, compared to women who gave birth at home or in a midwife-led unit. Moreover, **Christe & Padmanaban (2022)** who studied "Respectful maternity care initiative" in India and concluded that nearly half of the studied Women were unsatisfied with the hospital's policies on their freedom of choice, possession of knowledge, and preferences.

Parallel with the present study findings **Mastylak et al. (2023)** who concluded that maternal care providers fails to provide comprehensive information about progress of labor and medical procedures to parturient women. While, these findings in contrast with **Mazúchová et al. (2020)** who studied "Women's control and participation in decision making during childbirth in relation to satisfaction" in Martin and found that almost two-thirds of the women in the study were satisfied with this aspect of their control and involvement.

The study findings revealed nearly half of studied women were completely disagreed that the staff treated them and their husband with warmth and respect, seemed to know what they wanted or needed. These findings may be attributed tasks overloads of nurses, severe workloads, lack of motivation, and inadequate facility resources.

These findings align with a qualitative study that assessed the mistreatment and abuse women experienced during childbirth in Midwife-Led Obstetric Units in Tshwane District, South Africa. They concluded that the maltreatment of women are frequent during labor, and women got undignified care from the midwives throughout the birthing process. The women characterized the midwives' communication style with them as "forever shouting" during childbirth. Similarly, **Silveira et al. (2019)** who studied "The association between disrespect and abuse of women during childbirth" in Brazil and concluded that being mistreated and abused is common during childbirth. Additionally, discrimination was used during maternity care depending on particular patient characteristics, the conditions of the health system, and the constraints it faced.

The study findings revealed that nearly half of studied women were completely disagreed that the staff conveyed an atmosphere of calm and went out of their way to keep them comfortable. These

findings may be attributed to infrastructure of main hospital building as no private room for providing care during childbirth for each woman, overcrowding from relatives and internship medical and nursing students in the labor unit.

These findings are in agreement with **Khalil, Carasso, and Kabakian-Khasholian (2022)** who studied "Exposing obstetric violence in the eastern Mediterranean region (EMR) a review of women's narratives of disrespect and abuse in childbirth". They reported that women experiencing an obstetric violence during childbirth as a result of the health facility's infrastructure, women were unable to get care in single rooms and were unable to give birth in a peaceful setting that supported a comfortable and natural vaginal delivery.

Contrary to the present study findings **Oluoch-Aridi et al. (2021)** study about exploring women's childbirth experiences and perceptions of delivery care in periurban settings in Nairobi, Kenya, and concluded that maintaining a calm, quiet environment is an important factor for the proper delivery of maternity care.

The current results revealed that almost half of the studied women disagreed that the staff listened to them more during labor and birth. This finding may be attributed to improper communication skills between maternity nurses and women and secondary to a shortage of staff members. This finding is supported by **Oluoch-Aridi et al. (2021)** who reported that nurses and other medical professionals ignored parturient women's concerns and refused to answer them. Similarly, **Christe et al. (2022)** who concluded that women did not respond rapidly when they called in case of need.

The findings revealed that nearly half of the studied women had completely disagreed that staff helped them to try different positions. This finding may be attributed to inadequate knowledge of maternity nurses about the importance of changing position during birth stages on maternal and fetal outcomes. Also, may be due to work load of staff nurse and not having time to change position of the parturient women. This finding is matched with a qualitative study conducted by **Colley et al. (2018)** entitled "Women's perception of support and control during childbirth" in Gambia and reported that women not being assisted in trying alternative positions during childbirth was one of the characteristics with the lowest feeling of support.

In addition **Mselle, Kohi, and Dol (2019)** who studied "Humanizing birth in Tanzania: a

qualitative study on the mistreatment of women during childbirth from the perspective of mothers and fathers. The women stated that nurses denied the ability to move around and follow safe customs when giving birth, as well as the ability to select the delivery positions they desired. In contrast with the current study findings **Akinwale and George (2020)** study entitled "Linking the work environment to missed nursing care in labor and delivery" in Nigeria, and concluded that midwives' nurses teach, counsel parturient women about repositioning, and explain the benefits of different positions during childbirth.

The study findings revealed that more than one-third of studied women agreed that the staff helped them find energy to continue and encouraged them to try new ways of coping (such as breathing exercises). These findings may be attributed to the importance of alternative methods such as breathing exercises on pain reliefs during childbirth. parallel with the current study results **Akinwale et al. (2020)** who clarified that maternity nurses teach, counsel women about breathing exercises, relaxation techniques during childbirth process.

In addition, **Prata et al. (2021)** study entitled "Non-invasive care technologies used by obstetric nurses: therapeutics contributions in Municipal Health Department of Rio de Janeiro (MHD/RJ)". They reported that maternity nurses use different methods with women during parturition to promote comfort and relaxation as breathing exercises and massage techniques. While the current study findings disagreed with **Collins et al. (2021)** who concluded that women have nobody to empower them, speak up for them, encourage them to try new coping techniques, and calm them during the process of childbirth.

The current study findings revealed that more than one-third of parturient women had a low level of perception in support and control during childbirth. These results may be attributed to a lack of counselling, explanations, and sharing in decision making and support between maternity nurse and women. Also, lack of hospital resources and unnecessary medicalization of care contribute to poor support and control during birth.

These findings are in agreement with **Alavi, Zaheri and Shahoei (2023)** who studied support and control during childbirth and attachment after birth in mothers referring to comprehensive health centers in Bijar. They reported that the women had low perception level of support and control during childbirth. Also, **Mazúchová et al. (2020)** study entitled "Woman's control and participation in

decision making during childbirth in relation to satisfaction". They reported that a low level of control perception was demonstrated during childbirth. Similarly, **Abdulghani, Edvardsson, and Amir (2018)** who studied "Worldwide prevalence of mother-infant skin-to-skin contact after vaginal birth" and concluded that lower levels of support and control were found in more than one-third of parturient women in Brazil.

Contradict with the present study findings, **Kabakian- Khasholian, El-Nemer, and Bashour (2015)** study entitled "Perceptions about labor companionship at public teaching hospitals in three Arab countries". They reported that almost half of the participating women in the study reported that they received positive support from the doctors and one of them stated that "the doctor was very kind and human; I will never forget his encouragement". The disagreement observed in the study results could perhaps be attributed to the provision of highly nursing care, ongoing assistance from healthcare providers, consideration of the diverse requirements and preferences of women, and the accessibility of resources and facilities within healthcare environments.

The results of the current study showed that there was a highly statistically significant correlation between the studied women's level of education, occupation, and income and their perception of support and control during childbirth. Specifically, women who were housewives, read and write, and had not enough income been found to have less perception of support and control during childbirth. This could be explained by underutilizing prenatal care services during the pregnancy, which led to a lack of knowledge about and application of coping mechanisms for various stages of labor, finally resulting in a lack of control during birthing. Additionally, unemployment and financial problems are frequently linked to a fear of childbirth, which exacerbates the lack of control perception during labor.

Similarly, **Dencker et al. (2019)** study entitled "Causes and outcomes in studies of fear of childbirth" and concluded that unemployment, economic problems and lower educational level were associated with fear of childbirth, which led to low control during childbirth and negative childbirth experience. Additionally, **Aşci and Bal (2023)** study about the prevalence of obstetric violence among women receiving treatment during childbirth and factors that trigger it in Turkey. They documented that Low-income women are more likely to have unpleasant birth experiences due to

obstetric violence, inadequate support, and lack of autonomy during childbirth.

Also, **Hamal et al. (2020)** study entitled "Social determinants of maternal health: a scoping review of factors influencing maternal mortality and maternal health service use in India". They concluded that poverty is associated with less use of maternal health services, which led to poor support and control perception during childbirth. Moreover, in agreement with the present study findings **Pimentel et al. (2020)** who studied "Factors associated with short birth interval in low- and middle-income countries: a systematic review". The study found that women with greater levels of education feel more in charge and autonomous during childbirth, as well as making better informed decisions.

The present investigation indicated a statistically significant relationship between the women's obstetric history and their perception level of support and control during childbirth. Specifically, women who were primigravida, primipara, and had a vaginal delivery with an episiotomy demonstrated lower levels of support and control perception during childbirth. This could be because women who are primipara and primigravida have higher expectations and less expertise with the childbirth process, which made them less supportive and in control. Additionally, women who have had an episiotomy may have experienced more pain, which also contributed to their lack of control during labor.

In the same line **Franchi et al. (2020)** who studied "Selective use of episiotomy: what is the impact on perianal trauma? In Italy and reported that the fewer use of episiotomy in unassisted vaginal births may be a good indicator of the quality of obstetric treatment as women feel more supported with reduction rate of episiotomy.

Additionally, **Nakamura et al. (2020)** who studied "Perinatal depression and anxiety of primipara is higher than that of multipara in Japanese women. They declared that primipara women had higher rates of anxiety, which led to poor support and control perception during childbirth than multipara women. While the current findings in contrast with **Fenaroli et al. (2019)** who studied "Satisfaction of women with childbirth" in Martin and reported that women undergoing vaginal deliveries with episiotomy had more support from medical staff, which lead to positive childbirth experience and satisfaction.

Finally, Evaluation of women's perception of control and support during childbirth is crucial since women with high support and control during childbirth feel embowered by childbirth, report a higher level of self-esteem and improve maternal newborn bonding, as well as improved their satisfaction with overall experience.

## 9. Conclusion

**The present study handled women's perception of support and control during childbirth based on the study findings;** more than one-third of the studied parturient women had low perception of support and control during childbirth. More than one-third of the studied women experienced too strong pain, they were tired during labor and birth, and they couldn't control themselves. Also, the same proportion of them didn't control over when procedures happened, whether procedures were carried out or not and even for the decisions that were made for them. More than one-third of the women in the study disagreed that the staff showed them and their husband kindness and respect, seemed to understand their needs and wants, and went above and beyond to make them feel comfortable. The study found a strong statistical association between the women's perception level of control and support during childbirth and their obstetric history and demographic information.

## 10. Recommendations

**In the light of the present study findings, the following can be recommended:**

- Parturient women should receive high-supportive nursing care with effective supervision, coaching, and monitoring to offer them more control over their entire delivery experience.
- Encouraging maternity nurses to implement care initiatives that are appropriate to the women's needs.
- Encouraging maternity nurses to apply non pharmacological pain relieve measures to alleviate women pain during childbirth.
- Maternity nurses should obtain an informed consent from women before any procedure doing.
- Encouraging maternity nurses to increase the involvement of women in decision-making during childbirth, encouraging them to communicate their emotions and giving enough explanations.
- Encouraging maternity nurses to increase time they spend with women during delivery.

- Encouraging position change to minimize obstetric complications and interventions during childbirth.
- Further research is needed to implement health education programs for training maternity nurses and obstetricians about effective intrapartum care including women's support to develop the best care& best childbirth experience.
- Develop hospital policies based on evidence-based practice regarding use of supportive care during childbirth.

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