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The American University in Cairo
School of Humanities and Social Sciences

**WOMEN'S EXPECTATIONS AND EXPERIENCES OF CHILDBIRTH IN AN
EGYPTIAN PUBLIC HOSPITAL**

A Thesis Submitted to

The Department of Sociology, Anthropology, Psychology and Egyptology

In partial fulfillment of the requirements for

The Degree of Master of Arts

In Sociology- Anthropology

by

Zeinab Ahmed Mohamed Farahat

Under the supervision of

Dr. Nazek Nosseir

September 2010

ABSTRACT

The American University in Cairo

WOMEN'S EXPECTATIONS AND EXPERIENCES OF CHILDBIRTH IN AN EGYPTIAN PUBLIC HOSPITAL

Zeinab Ahmed Mohamed Farahat

Under the Supervision of Dr. Nazek Nosseir

This thesis seeks to understand women's reasons for giving birth at a busy teaching hospital in Greater Cairo, and what their experiences of it have been. It asks whether women's parity and the money paid upon admission to the hospital had an impact on their expectations and experiences. The thesis uses secondary data from interviews conducted in 2001 with mothers who had normal births, before they left the hospital. It is part of a larger project that investigated practices surrounding normal childbirth. The results are analyzed using the perspectives of critical medical anthropology, biomedicine and public health.

Fear of the home setting with its lack of qualified personnel and equipment was the leading cause for not giving birth there, and mothers of lower parities were most likely to give this response. Comments concerning the delivering physician did not clearly show that women in the paying section would be more satisfied than those in the free section. Also, more women in the free section reported that they felt discomfort regarding the lack of pain relief. Negative feedback about the availability of pediatricians did not clearly show whether women were more satisfied in the paying section or not.

The third hypothesis stated that women who had a higher parity reported a more positive birthing experience than first-time mothers. Comments regarding the nature of communication with the delivering physician support this hypothesis, and the same is true but to a lesser extent concerning the pediatrician. The same hypothesis is not clearly supported when we find that a minority of women across hospital sections and parity groups were given information about their own health or that of their babies and this has a negative impact on their health. Recommendations for improvement were focused on the delivering physician, the pediatrician, the nurses, and the general service level at the hospital.

This project could be repeated every five years and include an in-depth ethnographic dimension, to measure improvements in health care provision and women's perceptions throughout their pregnancy and after childbirth. Comparisons could be made between different socioeconomic classes and regions of Egypt.

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I. Chapter 1: Introduction

Childbirth is not simply a biological function, it is a social event linking women with their community and supporters, and over the past decades there have been changes in the various cultures' norms and practices surrounding it. Two of the main shifts in the practice of birthing are the location and companionship. In terms of the location, childbirth in Egypt has moved from being mainly a home-based event to one that occurs more often in institutions such as hospitals. With these changes comes a new dynamic in the relationships between delivering mothers and the midwife or physician. Soheir Morsy (1982) saw that women who gave birth in the rural area with a midwife at home and surrounded by their female family members, felt a sense of community and emotional support.

A. Research Objective and Questions

The objective of this research is to understand why women decide to give birth at a hospital and what their experiences of childbirth have been. To this end, in this thesis, I ask three main questions which relate women's expectations and experiences with their income level and their previous knowledge of motherhood. A woman's knowledge of motherhood is measured by her parity, that is, the number of children she had previously given birth to, regardless of whether they have survived or not.

The first research question is how does a woman's previous knowledge of motherhood (measured by her parity) affect her own experience of giving birth in the hospital? The second attempts to find out whether a woman's experience has been overall positive or negative, depending on whether she paid admission fees or not upon entering the hospital. The third question asks whether a woman's parity has an effect on her expectations of hospital birth.

Due to the increasing numbers of women giving birth in facilities, and with skilled providers such as obstetricians-gynecologists, there is a need to evaluate the quality of service, in terms of medical care and also the overall levels of comfort related to interpersonal relations with the medical and non-medical staff and the overall well-being of women. An observational study was conducted in 2001 at Al Omouma Hospital, a large teaching maternity hospital in the Greater Cairo area to understand hospital practices regarding normal labor. The name of the hospital has been changed to protect the identities of its clients and staff members; the pseudonym means “The Motherhood” in Arabic. Three journal articles have been published which detail the results from a medical perspective. I will use data from interviews with mothers which were conducted before they were discharged from the hospital, thereby providing a complete picture of what typically occurred at Al Omouma Hospital for normal births.

In the current state of Egypt’s health care sector, it is safer to give birth in a hospital compared to the home setting, but this does not necessarily provide a positive experience for the mother. The National Maternal Mortality Study (NMMS), which tracked the maternal mortality rates in Egypt between 1992/1993 and 2000 show that they have decreased as more women gave birth in facilities that were well-equipped and had well-trained providers and in the case of any danger, have sought care promptly (Campbell et al. 2005).

The mothers’ opinions of their hospital birthing experience could affect their future health seeking behavior if they decide to have more children, and for this reason it is important to understand what women ask for as components of their care. From a biomedical perspective, it would assist hospital managers in providing better services based on women’s needs beyond equipment and supplies, such as the system

of visits from family members, or the ability to move freely during labor. From a social science perspective, we need to understand what they perceive to be their rights as a delivering mother, what kind of communication do they expect to get such as information on the progress of their labor or reassurance and motivation. I am also interested in knowing how they perceive their bodies during birth and how others around them reinforce or ignore these perceptions. These may reflect the differences between giving birth with an obstetrician, compared to a traditional midwife, or a trained nurse-midwife.

B. Variables, Hypotheses and Data Analysis

1. Variables

This research investigates the effect of women's economic status and previous knowledge of motherhood on their expectations and experiences of childbirth. It uses two independent variables, the first one is the hospital section, which is an indication for the cost of childbirth and women's financial ability. A mother's income level was measured by whether she chose to get admitted to the free or paying section of the hospital. No other questions were asked about her exact income level, although her husband's and her own occupation were recorded, in addition to her education level. However, no real conclusions could be reached about how much money the family has saved from before or earns per month to categorize them into reliable groups. The second independent variable is the woman's parity, which is defined as the "number of pregnancies a woman has had that have each resulted in the birth of an infant capable of survival" (Concise Medical Dictionary, accessed 4 February 2010). Within the sample of 172 respondents, the parities have ranged from zero to five. For the

purposes of tabulation, parities of three to five will be combined as one group due to their lower frequencies.

Women's expectations and experiences are two concepts from which I will derive the dependent variables. Firstly, in terms of mothers' expectations of hospital births, the variable that will be used to measure it is "the reason for not giving birth at home". This was an open ended question and the answers have been grouped into a few categories to facilitate quantitative analysis. The categories used are "No one can save the mother at home/ I'm scared of home birth / the hospital is better equipped", "No one gives birth at the home these days" and "given advice to give birth at the hospital by her doctor / midwife / family member / through the mass media".

The tables of results present the percentages of women who have given each of these reasons and they will be reviewed in greater detail in the results chapter. The experiences of mothers is a wider concept with more variables used to measure her opinions of the general service level at the hospital, her opinion of the delivering physician, the nurses, the hospital staff members such as workers and security personnel, the information exchange regarding her health and her baby's health. In addition, some of their views may not have been captured by the earlier interview questions, and therefore a final question asking about their recommendations for improvement may highlight different problems or ones that they previously mentioned in a different way.

Women were asked about their delivering physician in terms of positive and negative aspects and the variable used which is "feedback on delivering physician" has yielded answers which were grouped into eight categories, one pair of positive and negative responses for each aspect reported. For example, "The physician was good" and "The physician was not good" are two general categories reported, in

addition to “Did not cause pain or discomfort” as opposed to “Made me feel pain and discomfort during procedures”. The other four categories are “positive communication”, “negative communication”, “constant follow-up/no neglect” and “Physician neglected me/there was lack of follow-up”. These categories are not mutually exclusive, as each mother could have had more than one positive or negative comment.

During the interview, women were also asked to give their opinion on the quality of service at the hospital, again this gave a range of answers and categories which were not mutually exclusive. In addition to a miscellaneous category, I have divided their responses into 8 categories, half for positive comments and the other half for negative feedback regarding the same issues which were “The Birth and/or the medical team”, “Communication”, “General level of service” and “Hospital Facilities”.

Information exchange regarding the mother’s own health and that of her infant were asked about in two questions. Regarding the baby’s health I created five major categories based on the answers given, they are “no information given to the mother / no information given but she knew from television or nursing school”, “she was informed about the immunizations”, “she was told the baby had a health risk”, “she was given information about illnesses and how to care for the baby” and “she was told the baby was in good health”. These categories are mutually exclusive, as are the ones for the question regarding the mother’s health described below.

For the mother’s health status I have made four categories as follows: “no information given to the mother (although she may have known from television or family, or she was feeling well in any case)”, “she was told she was in good health”, “she was given instructions to care for herself” and “she was told she had a health risk

/ She was told she needed to stay in the hospital". A final category is given for miscellaneous answers which did not fit these answers, and their proportions were low compared to the total sample.

At the end of the interview, the mothers were asked to suggest any improvements or recommend changes that could be seen at the hospital to improve the level of service and their comfort. Their answers were varied and open ended, and they have been grouped into five major categories concerning the delivering physician, the pediatrician, the nurses, the general service level at the hospital, and other miscellaneous recommendations. Chapter 5 provides detailed examples of mothers' quotes and a discussion of the results. Even though the interview mostly consisted of open-ended questions, I have taken the replies and grouped them into categories which are used for quantitative analysis. The interview was part of a larger observational study which also looked at the detailed procedures and medical examinations that took place for each woman who agreed to participate in the study, in addition to observations of ward activities and interactions of the staff members with the mothers. The observers also recorded the occupancy of the beds to determine if there was overcrowding in the wards or not, as well as taking notes of the discharge procedures and what kind of medications or information is given to mothers before they leave the hospital.

2. Hypotheses

This thesis sets out to test three main hypotheses which were derived from the research questions, they are as follows:

1. Women who had higher parities, had higher expectations of the hospital birth than mothers with lower parities.

2. Women who were admitted to the paying section report an overall more positive experience than women in the free section.
3. Women who have a higher parity report a more positive birthing experience than first-time mothers.

A woman who has had at least one child before may have higher knowledge of childbirth and how it may progress compared to a new mother. This knowledge may help to lessen any fears she has and give her knowledge of when to rest or push, and might allow her to have more communication with her delivering physician. These reasons are personal opinions, or assumptions for which I don't have a stronger basis, therefore I felt it would be beneficial to test them as hypotheses, and compare women's expectations and experiences based on their parities. Having to pay more in return of a service or product, usually gives a person the impression that it is of higher quality, the same is true for medical care even if within the same setting. The paying section gives the women in this study more advantages, such as greater privacy in the postpartum ward, having a higher ranked physician on duty, compared to the free section. There was a need to test this hypothesis, to see if the experiences of women were indeed better in the paying section, compared to the free one.

3. Data Analysis

In order to simplify the analysis of qualitative data from the interviews, during my working period in the Population Council, I had converted the answers into a quantitative format and entered them on a spreadsheet file. This data was exported to Statistical Package for the Social Sciences (SPSS) in order to generate frequency tables. The results were analyzed in light of the critical medical anthropology theory.

The interview answers were translated and typed into English in one step. They were sorted by the respondent's serial number, according to the checklist used during observation, that is, not according to the hospital's numbering system. Answers for each open-ended question were reviewed and categorized into broad categories of answers, and frequency tables were based on the differentiation between free and paying section. In March 2010, I started to analyze the data in greater detail, going beyond the "good" and "bad" comments which were recorded earlier, to look at specific phrases and key words. This was done especially for the questions asking about the physician and the service level at the hospital, and for each one, more than 30 distinct answers were recorded. The data was entered on a spreadsheet, and each mother's answer was read again and for each keyword there was a column on the worksheet, when this word is found, it is recorded as a "1" on the sheet, so it could be analyzed using SPSS.

The following step was to cross-tabulate women's answers with the hospital section and parity. This was done by exporting the data from the spreadsheet file to SPSS in order to generate tables automatically. Due to the large number of answers for some questions, and the low frequencies of many of them, general themes were developed to combine these answers into more substantial categories. In these combined categories, the total number of women who gave answers to any of the constituent sub-categories was counted. Since some women could have given more than one answer in the same category, they were counted once. Thus, the unit of analysis is the woman, not the number of answers.

The questions whose answers were mutually exclusive, and therefore the percentages adding up to 100 were the ones asking about reasons for not giving birth at home, and the information given to them about their baby's and their own health.

The questions generated more than one possible reply for each woman, were those asking about her delivering physician, her opinion about the service level at the hospital and her recommendations for any improvements. Mothers came to the hospital for various reasons, one of the questions they were asked was to understand the reason(s) they did not give birth at home and what they perceived were the disadvantages of home births. On the other hand, talking about their experiences brought up rich insights as to what women needed from their delivering physician, the nurses and workers at the hospital, as well as the setting of the hospital itself and to what extent it was equipped to meet their needs, within or beyond their expectations. Information about the progress of birth and interaction with the health providers are also highlighted to evaluate their level of satisfaction. Finally mothers were requested to express any possible improvements required at the hospital. Also, information exchange while waiting in the postpartum ward to be discharged will be noted. This will help in knowing how many women have heard the messages and advice about how to care for their own baby and themselves, and to know when to come in cases of emergency. This information is significant as it relates to Chapter 2 where I will discuss maternal and child health in more detail. It is important to understand to what extent the hospital setting is contributing to the reduction of maternal and infant mortality rates by providing women with information which could lead to life-saving behavior, if needed.

C. The Study at Al Omouma Hospital

There is an increased trend in Egypt towards women giving births in hospitals with skilled practitioners, and away from the home setting with traditional birth attendants (El-Zanaty and Way: 2009). However, it was not known for sure whether giving birth at a hospital would guarantee a high degree of safety through compliance

with the guidelines set by the World Health Organization that are also concerned with a woman's comfort and well-being during childbirth, and satisfaction of the overall experience from the mother's point of view.¹ As briefly mentioned before, a study carried out by the Population Council, set out to investigate birthing practices in Al Omouma Hospital, a busy maternity hospital in Greater Cairo. This section provides an overview of the study's methodology and main findings in addition to explaining how this thesis would fill the gap of analyzing women's opinions of the service they received.

1. Study Objectives

The study at Al Omouma Hospital set out to record the routine practices which take place during normal delivery in order to compare them with practices for which there is evidence concerning their effectiveness or harmful consequences, based on a report by the World Health Organization. It also sought to explain why healthcare providers in the facility carried out such practices and to understand women's perceptions of their childbirth experience (Sholkamy et al. 2003:2).

In further detail, the research team sought to know how labor is augmented, or sped up, in its early stages, and active management of the third stage. Active management of the third stage of labor, when done correctly, could help to minimize cases of severe bleeding after birth, which are a leading cause of maternal deaths in Egypt (Cherine et al. 2004). Overall, in terms of medical procedures, there was a need to understand when and how health care providers conducted a large number of procedures that could contribute to improving mothers' health and avoiding life-threatening situations (Cherine et al. 2004; Khalil et al. 2004).

¹ In November 2001, I joined the Population Council's regional office of the Middle East and North Africa in Cairo as a research assistant in the Reproductive Health program. In this capacity, I had good access to the interview responses of the mothers, and this has become the main source of data for the thesis.

The hospital was chosen due to its relatively high caseload, approximately 55 deliveries per day. It is also a specialized obstetric facility in Egypt, which trains about 200 young physicians each year. What the junior physicians acquire, in terms of knowledge and practices will be transferred to other facilities and this will impact the quality of birthing services nationwide and the study authors believe that this could have “direct policy relevance to the hospital itself as well as to obstetricians, researchers and policy-makers in Egypt and elsewhere” (Sholkamy et al. 2003:2).

The following information about the hospital setting was provided during a telephone conversation with Dr. Mohamed Cherine, a member of the original research team who conducted the study in 2001. At the time of the study, the free section did not charge any money at admission. Recently, a fee of LE 50 is being added just to be able to enter the hospital to give birth but it is still referred to as the “free” section. For the paying section, if a woman is entering the hospital, and planning to have a normal delivery, she would expect to pay between LE 400 to LE 500, depending on whether her room has one or two beds, and her relatives are expected to be able to visit her after she has given birth. The women in the free section stay in wards, the prelabor ward is different from the postpartum ward, and she is not allowed to have visitors. There are two separate buildings in the hospital, one for the free section and another for the paying section, each with its separate delivery and operating rooms, therefore there is no ambiguity among the health care providers about the section to which she chose to be admitted.

The births in the paying section are usually supervised by the specialist, while those in the free section are usually performed by the resident or assistant specialist, and in any case that the specialist’s expertise is required, he or she would be called on to provide guidance. As for the heads of units, on certain days they could be

supervising both the free and paying sections (Dr. Mohamed Cherine, personal communication 2010).

2. Data set and collection

The main method of data collection was observation using a detailed checklist of 537 items that were recorded by 12 female obstetricians who were not affiliated with the hospital. In total there were 176 births for which practices were documented through all of its stages in the emergency room, prelabor ward, delivery room and postpartum ward (Sholkamy et al. 2003:2). The criteria used for judging were based on practices documented by the World Health Organization technical group, which classified forty-four practices, ranging from useful, effective, harmful, or not having enough evidence to support its use (Khalil et al. 2005). A pilot study was conducted after training the observers, and afterwards, the main period of data collection took place between 10 October and 6 November 2001, in continuous 8-hour shifts for 28 consecutive days (Khalil et al. 2005:284). The study focused on recording “undocumented frequencies of practices rather than their clinical outcomes. Documenting processes identifies service delivery deficiencies ... and helps to assess quality of care” (Khalil et al. 2005:286).

The selection of women to be included in the sample was according to several criteria, such as the mother giving birth to a single full-term fetus whose head would descend first and to be “in active labor with 3 to 6 cm cervical dilatation²” in addition to giving informed consent for participation (Khalil et al. 2005: 284). The sample generated was not a random one therefore it cannot be generalized to all settings of urban teaching hospitals in Egypt. One of the main conditions was to study

² Dilatation is the opening of the cervix which allows the baby to pass through the birth canal. The limits of 3 to 6 cm guarantee that the birth is not at a very early stage or too advanced that it would progress too soon after admission (Khalil et al 2005).

procedures that took place for normal births, therefore no women who appeared to have high risk conditions were included, and if any complications arose during labor and delivery, the mother would be excluded from the study. Out of the 176 mothers whose labor was documented in full, four declined or were unable to answer the interview questions, which gave 172 interviews. Two-thirds of them (N=113) have given birth in the free section while the remaining third (N=59) gave birth in the paying section. As for the parity (or number of children previously born), 32% of the sample were first time mothers (with zero parity), another 31% had a parity of one. One quarter of mothers had 2 children before the study began, and a remaining 13% had 3 or more children before. Table 1 summarizes the distribution of the study participants by parity and hospital section. It shows that for mothers in the free and paying section, one third of each group has a parity of zero. In addition, mothers who had a parity of 4 or 5 were only found in the free section.

In terms of women's backgrounds and education levels, Table 2 shows that one fifth of the mothers in the free section were illiterate, and nearly one third were literate or had a primary or preparatory school certificate, while two-fifths had reached secondary school, or equivalent, or a higher level of education. In the paying section, almost two-thirds of women have received a secondary school diploma or certificate, and a further 12% had a university degree. As for employment status of the mothers, 86% to 89% in each of the sections have reported that they were housewives and did not work for cash.

The interview consisted of fourteen questions, asking about their occupation, education level, number of babies she already had, if any, use of contraceptives in addition to open-ended questions about their expectations and experiences of the hospital birth regarding their own and their baby's health. In addition they were also

asked about the communication with their delivering physician and any recommendations on how the level of service could be improved. This makes their responses closely tied to the research questions and hypotheses. The checklist and interview were published by the Population Council within a monograph. The following are all the questions asked of the mothers; the translation is copied as it was originally written in the checklist (Sholkamy et al. 2003: 48-51)³:

- Congratulations, can I ask you a few questions about the services offered by the hospital before you leave? If no, please explain why?
- Question 1: Are you feeling comfortable now or is anything bothering you?
- Question 2: Is this your first baby? How many children do you have? What are their ages? What are their names?
- Question 3: Have you ever had any miscarriages? (Instruction to interviewer: please take complete reproductive history including full term pregnancies, miscarriages, neo-natal deaths and other significant problems such as infertility).
- Question 4: What type of work do you do?
- Question 5: What level of education did you reach?
- Question 6: What is your husband's work?
- Question 7: Why did you come to deliver at this hospital?
 - Options: Close to home, delivered here before, she had antenatal care here, someone told her about it, or other reason to be filled out.

³ Since I do not have a copyright for this publication, I am unable to copy the pages as images in the appendix, rather the bullet points of the questions are considered as direct quotes with the page number of their source provided.

- Question 8: Who delivered your baby, i.e. do you know his/her name? Was he/she good? How did he or she make you feel comfortable? How did he or she make you feel uncomfortable?
- Question 9: What made you not deliver at home? What are the problems of delivering at home? Did you deliver at home before?
- Question 10: Is the service here good? (As much details as possible about the health services & the treatment). What was good? What was bad?
- Question 11: Did they tell you anything about the baby's health? What did they tell you? Did they tell you about danger signs? Who gave this information?
- Question 12: Did they tell you anything about your health? What did they tell you? Did they tell you about danger signs? Who gave this information?
- Question 13: Did you use any family planning method before? What type of method did you use? (tell me about it)
- Question 14: Finally, I want to ask you, in your opinion, how can services in this hospital be improved?

The interview questions that I will use in answering my research questions are those which asked why the mother did not give birth at home, what she thought of her delivering physician and the hospital's services, whether information was provided to her about her own health or that of her infant, and what she felt were improvements that needed to take place.

3. Main Findings

There were positive and negative aspects of the hospital as a whole. On the positive side, it was observed that the facility preparedness for normal birth was

acceptable (Khalil et al. 2005). However, when women were admitted to the hospital, their condition was not routinely monitored closely during labor and delivery. If no follow-up of labor progress was conducted, then this could lead to what the team has found: routine augmentation of labor conducted for about 91% of the women while it was inappropriate in 93% of this subset of cases. Labor is augmented, or made faster, using a solution containing Oxytocin that makes uterine contractions more powerful. One of the conditions for safe augmentation of labor is prior rupture of the membranes⁴ in order to avoid certain complications. However, it was found that “augmentation was done in the presence of intact membranes for over one-third (36%) of the inappropriately augmented labors. Both spontaneous and artificial rupture of membranes ... stimulate endogenous Oxytocin and may accelerate labor without further intervention” (Khalil et al. 2004: 77). Interviews with providers from the same hospital gave reasons to such high use of Oxytocin, and most of them cited the high caseload (8 women per physician) and shortage of beds as reasons for this practice. Oxytocin is safe when used appropriately and with constant monitoring, however when these conditions are absent, it may lead to complications for mother and baby. It was recommended by the study team that protocols be followed closely, and high caseloads to be reduced (Khalil et al. 2004).

Among the other shortcomings of medical procedures, was the infrequent use of beneficial practices and high prevalence of harmful procedures. In addition to these observations, there has been an inadequate assessment of each woman’s condition during routine labor augmentation and childbirth. It was observed that “all women ... were subjected to approximately one-half (6 of 13) of practices categorized by WHO’s Technical Working Group as harmful” (Khalil et al. 2005: 286).

⁴ This is commonly known as the breaking of the “water”, or the expulsion of amniotic fluid, which surrounded the baby during pregnancy, from the uterus.

This thesis looks at the study's data from a different perspective as it highlights the women's opinions of their childbirth experience. In addition to comparing the experiences of mothers in the free and paying sections, I will also look at how a mother's parity may influence her opinions. The application of medical procedures did not differ much between the free and paying sections (Khalil et al. 2005), so among other aspects, I would like to see if women's opinions matched this observation or not.

In the Demographic and Health Survey of Egypt (DHS Egypt) for the year 2003, data showed that approximately 59% of births in Egypt took place in a facility, and just over two-thirds of the total births in Egypt were medically assisted (El-Zanaty and Way 2004:60). In addition, the Maternal Mortality Ratio (MMR) remains at 84 maternal deaths per 100,000 live births. When examining the importance of studying hospital care, we will find that substandard care by the obstetric team is the leading cause of death for 43% of maternal mortality cases. Therefore monitoring the quality of care in a hospital continuously, is essential to maintain high levels of safety (Khalil et al. 2005). Maternal mortality does not just affect women who have had a complicated delivery from the beginning, since according to Akins, "of all maternal deaths that are due to bleeding after delivery (up to half of all maternal deaths), most of these happen to women who experienced a normal labor" (Sholkamy et al. 2003:1).

The management of the third stage of labor (after the baby is born, while waiting for the placenta to be delivered), if it was active and performed in accordance to protocols, could contribute to lowering the incidence and intensity of bleeding and thereby contributing to decreasing the cases of maternal mortality which arise from this cause. The mothers for whom active management was performed, accounted for 15% of cases, for the remaining 85% the advantages of active management to reduce

postpartum hemorrhage were missed (Cherine et al. 2004).

D. Organization of the Thesis

This introductory chapter presented the research questions and methodology of the thesis and went on to give a background of the study at Al Omouma Hospital from which this research derives its secondary data, and fills the gap regarding mothers' feedback on their experience of the hospital. In Chapter 2, I will discuss maternal and child health in the global context and present statistics from this perspective and Egypt's progress in reducing maternal and child health problems and mortality. It also gives a brief explanation of the process of childbirth. Chapter 3 discusses the status of the health care sector in Egypt by giving a brief history of the introduction of Western scientific medical practice (also referred to as biomedicine). It also provides an overview of the governmental and non-governmental agencies and individuals who provide health care services in Egypt. The chapter concludes by describing the traditional and contemporary childbirth practices in Egypt and gives a social background on Egyptian women, particularly those who live in Cairo. Chapter 4 describes the various theoretical approaches which concerned themselves with maternal health, and in particular childbirth, and I will discuss this significant life event from the points of view of public health professionals, professionals in biomedicine, and anthropologists who adopted the ideas of critical medical anthropology. I also provide a review of the literature on previous studies that have discussed childbirth from social perspectives. In Chapter 5, I present the results of this research, namely the women's answers to the interview in relation to their parity and economic ability. Chapter 6 is the conclusion and is followed by the tables of results.

II. Chapter 2: Maternal and Child Health

A. Maternal and Child Health in Global Context

The developing world is home to millions who die every year from preventable conditions, among them maternal and child health causes. In 2008, nearly 340,000 women around the world died due to reasons related to pregnancy and childbirth and more than half of these deaths took place in six countries all located in Africa and South Asia (Hogan et al. 2010).

Maternal death is defined as “the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes” (WHO 2007:4). One of the indicators to measure it is the Maternal Mortality Ratio (MMR), which is defined as the “number of maternal deaths during a given time period per 100,000 live births during the same time-period” (WHO 2007:5). Maternal deaths are not distributed equally along the time frame of pregnancy and the six weeks after birth (the postpartum period), rather the majority of them occur at the time of labor, delivery and the immediate postpartum period. The main medical cause of maternal death is obstetric bleeding (Ronsmans et al. 2006:1189).

In order to reduce complications of pregnancy and childbirth, it is recommended that expectant mothers schedule at least 4 visits for antenatal care (ANC) with a health care provider (El-Zanaty and Way 2009:125). The main purpose of antenatal care is the “early detection and skilled and timely interventions for factors having proven impacts on maternal and infant outcomes” (MOHP et al. 2005:109). Delivery care also has the same objective and this is achieved through the “use of

skilled and trained delivery care providers ... to ensure that all women have access to lifesaving emergency interventions at the time of labor and delivery”, however this does not mean that the only qualified health care providers to perform deliveries are obstetricians. According to Koblinsky, qualified personnel are those who possess “midwifery skills [and] been trained to proficiency in the skills necessary to manage normal deliveries and diagnose and manage or refer complicated cases” (MOHP et al. 2005:109). The period of time extending for 6 weeks after birth, known as the postpartum period, is of great importance when it comes to monitoring a mother’s health status, and any pregnancy or childbirth-related death that occurs during this period would count as an incidence of maternal mortality. Another importance of postnatal care involves family planning counseling, the encouragement of breastfeeding and the detection of any health risks for the baby (MOHP et al. 2005).

In addition to having skilled providers at the birthing location, there is a need to provide medical equipment and facilities in case complications arise. Adolescent mothers (aged 15 to 19) face an increased risk of dying while giving birth, and in cases where they do survive, they are at risk of adverse affects on their own health and those of their infants (UNDESA 2008: 27).

The risk of maternal death also increases when there are obstetric complications such as “post-partum hemorrhage, infections, eclampsia⁵, and prolonged or obstructed labor” and other complications from unsafe abortion. Anemia could also increase the risk of death from bleeding (UNDESA 2009: 27). Post-partum hemorrhage is excessive bleeding from the uterus that occurs after birth, and in severe cases it could be life-threatening if emergency blood transfusion is not available. A number of socio-economic factors also have an impact on high maternal mortality

⁵ Eclampsia is the onset of high blood pressure accompanied by seizures (Webmd: Accessed 6 April 2010).

rates, these are most common in low-income countries “where there is a strong association between reproductive risk and high fertility, low literacy, poverty, lack of access to services and poor quality medical care” (Gipson et al. 2005:71). A good way to foresee problems in a pregnancy and subsequent childbirth is by having at least four antenatal visits (UNDESA 2009:27).

Eight Millennium Development Goals (MDGs) were agreed-upon in 2000 by world leaders from developing and developed countries, with the aim to relieve millions of humans from “extreme poverty, hunger, illiteracy and disease” and to achieve “gender equality and the empowerment of women, environmental sustainability and a global partnership for development” (UNDESA 2009:3). The goals and their constituent indicators take 1990 as a benchmark year, and set certain targets for each indicator to be reached by 2015.

The fifth Millennium Development Goal aims to improve the health conditions of mothers, using a number of indicators and targets to measure progress towards achieving them. One of the targets is to reduce, for each country, the Maternal Mortality Ratio (MMR) by three quarters (UNDESA 2008: 24). The efforts to reach the fifth goal are constrained by low levels of funding to projects that provide family planning services to women in disadvantaged areas since the 1990s (UNDESA 2009:4). Insufficient funding has been reflected in numbers which show little progress in the developing world where the MMR has only decreased to 450 deaths per 100,000 live births in 2005, compared to 480 in 1990 (UNDESA 2009: 27).

In relation to child mortality, the fourth MDG aims to cut the under-five mortality rate, from the baseline level of 1990 by two thirds (UNDESA 2009). One important indicator is neonatal mortality, which measures the probability of dying

within the first month of life, and it is of higher concern for this thesis due to its relevance to mothers who have just given birth (El-Zanaty and Way 2009:115).

Intervention programs which sought to reduce childhood mortality rates in sub-Saharan Africa, worked on a number of preventive measures to improve nutrition, prevention of malaria, the encouragement of mothers to breastfeed their children exclusively and to have all children immunized. In addition to this, programs to combat the spread of HIV and AIDS were expanded, involving more access to anti-retroviral drugs to HIV-positive pregnant women (UNDESA 2009:25).

The burden of childhood death is highest in sub-Saharan Africa and Southern Asia where little progress has been achieved to reduce the under-five mortality rate (UNDESA 2009:25). On a larger scale, the developing regions have achieved a reduction of under-five mortality, as the number of deaths per 1000 live births has decreased from 103 in 1990 to 74 in 2007. However, due to high levels of fertility in developing regions, the absolute number of children who died under the age of five, has risen from 4.2 million in 1990 to 4.6 million in 2007, with sub-Saharan Africa being the home of half of the children (UNDESA 2009:25).

B. The Case of Egypt

Egypt has seen good progress on a national level and in most governorates towards reaching and even surpassing the fourth MDG targets nationwide. On the country-level, the statistics from the first National Maternal Mortality Survey (NMMS) in 1992-1993 show that the baseline Maternal Mortality Ratio (MMR) level of 1990 in Egypt was 174 per 100,000 live births (Campbell et al. 2005:462). Therefore the target level for 2015 would be 43.5. Due to accelerated progress, the expected level in 2015 has been revised to be almost half that of the target, that is, 21.3 maternal deaths per 100,000 live births (UNDP and INP 2008: 43-44). Different

agencies report varying MMR levels according to their measurement methods. For example, a report by the World Health Organization reports Egypt's MMR for the year 2005 to be 130 per 100,000 live births (WHO 2007:24), whereas the Human Development Report of Egypt states that the rate in 2006 was 52.9 deaths per 100,000 live births (UNDP and INP 2008:15).

On the governorate level, there are still challenges facing Cairo, Alexandria, Port Said and Dakahliya as each of them had a "high baseline level, which makes incremental improvements more difficult to achieve" (UNDP and INP 2008: 43). On the governorate level, MMR rates reported in the National Maternal Mortality Study varied considerably. In the southern regions, for instance it was 217 per 100,000 live births compared to 132 deaths per 100,000 live births in the northern regions of Lower Egypt (Gipson et al. 2005:71).

There is also good progress in reducing the national infant mortality rate, as the projected figure is 9.9 deaths per 1000 live births for 2015, and this is lower than the initial target of 14.7 deaths per 1000 live births, which was based on the 1990 data (UNDP and INP 2008: 43). In the group of children who die before reaching the age of five, almost 87 percent of them die before their first birthday, and nearly 58 percent die within the first month of their lives (El-Zanaty and Way 2009: 116).

A number of factors have been identified which contributed to achieving the national MMR target, namely, the increased use of antenatal care services, improved health care facilities coupled with their staffing by more skilled providers, overall higher rates of education among females and the increased use of contraceptives, as a preventive measure. A focus on the most vulnerable regions, such as Upper Egypt, has shown high success rates when the issue of maternal mortality was tackled with several interventions at the same time (Gipson et al. 2005). In terms of prevalence of

medically assisted births in Egypt, between 1992 and 2008, the percentage rose from 40.7% to 78.9% (El-Zanaty and Way 2009:137). In addition, births, which took place in a health facility, accounted for almost 72% of all births in Egypt in the five-year period prior to the 2008 Demographic and Health Survey of Egypt (El-Zanaty and Way 2009:132).

Two projects were implemented in Upper Egypt by the Ministry of Health and Population to reduce the maternal mortality rates, namely the Mother Care and Healthy Mother/Healthy Child projects. The factors that contributed to the substantial reduction of MMR were

improved access to, and quality of maternal and reproductive health services, reduced fertility rates, antenatal care utilization and skilled attendance at delivery. This integrated approach with special emphasis on the population with highest risk is a successful strategy, and may account for the major reduction in MMR that has occurred in Egypt over a 7-year period [Gipson et al. 2005: 81].

On the other hand and in order to increase the proportion of women seeking delivery care from a skilled practitioner, including midwives, or *dayas* (traditional birth attendants), a project was implemented by the United Nations Children's Fund (UNICEF) and the Ministry of Health and Population (MOHP) to train and license midwives nationwide (Gipson et al. 2005: 72-73). However, these efforts would not have been completely successful, if awareness on the community level had not increased, and this was a dimension tackled by the Mother Care Egypt project to raise the media profile of messages relating to prompt seeking of care when emergencies arise during pregnancy, delivery and the postpartum period (Gipson et al. 2005).

Within the framework of the MDGs, Indicator number seventeen follows-up on the "proportion of births attended by skilled health personnel" (UNDP and INP 2008:38). Between 1992-1993 and 2000, the two years when the National Maternal Mortality studies were conducted, there has been a noticeable decrease in the number

of maternal deaths caused by delays in seeking emergency care. Deaths caused by substandard care from a healthcare provider have also decreased, these births were attended by general practitioners, obstetricians or *dayas* (Gipson et al. 2005).

According to the Egypt Human Development Report, there has been an increase in seeking delivery care by a skilled provider, from just over a half of births in 2001 and reaching 80% in 2006 (UNDP and INP 2008).

C. Childbirth Explained

Cheng and Caughey (2009) explain that childbirth is a “physiologic process during which the products of conception (i.e., the fetus, membranes, umbilical cord, and placenta) are expelled outside of the uterus”. These painful contractions gradually increase in frequency and intensity and along with this, the cervix expands to allow the passage of the newborn(s). In addition, labor is considered a “clinical diagnosis” (Cheng and Caughey 2009) for the changes happening to a woman’s body, so they are not considered an illness or disease, and in most cases it progresses normally without need of lifesaving interventions. There must be however, facilities near the location of giving birth to provide emergency care, because complications can arise suddenly without previous indicators. Nearly 4 in every 5 cases of maternal morbidity and mortality occurs in women who had a high risk pregnancy, therefore for the remaining one-fifth, the medical team should be on high alert to notice risk symptoms and act accordingly (Cheng and Caughey 2009).

Labor is divided into three main stages. The first stage starts with uterine contractions and is completed when the cervix has dilated to 10cm, thereby allowing the infant’s head to pass without obstruction. The rate of dilatation is usually slower for first time mothers and they normally go through labor for longer hours than ones

who have given birth before, thereby having a parity of 1 or more. The second stage “begins with complete cervical dilatation and ends with the delivery of the fetus” whereas the third stage of labor involves the delivery of the “placenta and fetal membranes” which contained the amniotic fluid during pregnancy, and provided a cushion and safe environment for the fetus to grow (Cheng and Caughey 2009).

There are a couple of approaches to manage childbirth, especially in biomedical settings such as hospitals or birthing centers, one of them is active management of the third stage of labor, and the other is expectant management. In expectant management, the placenta is allowed to be delivered by itself, without intervention from a birthing attendant, whereas active management “often involves prophylactic administration of oxytocin or other uterotonics ... early cord clamping/cutting, and controlled cord traction of the umbilical cord” (Cheng and Caughey 2009). There have been extensive reviews of clinical studies comparing the outcomes of expectant management and active management, and the data showed that

active management was associated with lowered risks of maternal blood loss, postpartum hemorrhage, and prolongation of the third stage, but it increased maternal nausea, vomiting, and blood pressure ... However, given the reduced risk of complications, this review recommends that active management is superior to expectant management and should be the routine management of choice [Cheng and Caughey 2009]

In addition to notions of risk, one needs to see in which cases the medical team considers a birth to be taking much longer than normal as an assessment for the need of Cesarean section should not be based only on the time factor, although this may alert the medical team to complications which might arise. Through extensive research and observation of the times taken for thousands of women to give birth without complications, physicians have been able to give a range in terms of number of minutes or hours for each stage of labor to take place, and anything beyond these

guidelines would alert them that labor is starting to become abnormal “which suggests an increased risk of an unfavorable outcome. Thus, abnormal labor alerts the obstetrician to consider alternative methods for a successful delivery that minimize risks to both the mother and the infant” (Joy et al. 2009). Physicians have identified 3 main categories of problems for abnormal labor which could be due to the “passenger”, in reference to the infant’s size and position, the mother’s pelvis, and the power of uterine contractions (Joy et al. 2009).

One of the methods used to minimize the risks stated above, is to perform a caesarean section. Caesarean sections could be planned or performed as a result of a condition that arises during childbirth such as fetal distress or complications with the umbilical cord. Other reasons include “difficult, slow labor”, or one that has stopped, as well as the size of the infant’s head being too large in proportion to the mother’s pelvis (WebMD 2008).

This chapter presented a review on the progress achieved in reducing maternal and child illnesses and mortality rates, both globally and in Egypt. It also briefly explained the process of childbirth and terms associated with it, which would be a reference for future chapters. In the following chapter (Chapter 3) I will discuss the health care sector in Egypt, how it was established and how it is currently managed and financed. I will also describe examples of how women in Cairo access health care within their financial constraints and provide a background on Egyptian women in general, and their status within their families, as determined by the law.

III. Chapter 3: Health Care in Egypt

A. History of Biomedicine in Egypt

Biomedicine is a system of therapy that is widespread in most urban and rural areas of Egypt through the local health centers (El-Mehairy 1984). It has also been given various names by social scientists, such as “regular medicine, allopathic medicine, scientific medicine, modern medicine and cosmopolitan medicine” and the term “biomedicine” which was coined by Comaroff and Hahn (Baer et al. 2003:11). Hahn argues that biomedicine’s approach in treating patients involves a focus on “diseased bodies” which may be due to its philosophy of depending on “physical reductionism that radically separates the body from the nonbody” as well as working to cure patients rather than preventing their illnesses in the first place. This system of healing has spread from Europe and North America to almost every other corner of the world (Baer et al. 2003:11-12).

Muhammad Ali is credited for founding the first medical school in Egypt-Qasr al-Aini, which taught western-style biomedicine; his other contributions and the desire to establish the Egyptian medical profession were hampered by the arrival of British colonial rule (Inhorn 1994:64). The changes they brought about helped to establish medicine as an elitist profession which was reserved for European residents and wealthy upper-class Egyptians who were able to afford the expenses of medical education (Inhorn 1994). This led to the profession gaining a reputation of excluding Egyptians and being turned into a for-profit endeavor as it applied most features of the British medical system which were prevalent at the time, including the advantages of applying scientific research in aid of reduction of diseases.

Amira Sonbol explained the role of the British colonial rule in Egypt and how it created a medical ethic, which is practiced until now, but by Egyptian physicians with their fellow citizens. She notes that the problems we witness in the Egyptian medical education system are due to the legacy of the British who sought to change the system already established by Muhammad Ali (Inhorn 1994:249). Lock and Gordon consider biomedicine as a cultural phenomenon, just like any other system of healing that is affected by social and cultural factors within each society, and Inhorn adds that we should therefore look at the adaptation of biomedicine in Egypt as a unique product of the country's culture (Inhorn 1994:251). In addition, Egypt shares several features of the British version of the western biomedical model that were "forcibly" introduced to other colonized countries. This powerful influence of biomedicine leads more and more women of lower classes to seek therapy for their conditions in the realm of biogynecology, which is based on western biomedical science (Inhorn 1994:244).

B. The Healthcare Sector in Egypt

The Egyptian law regulates medical practice by giving this right to registered physicians and reinforces their authority within society. After finishing medical school, getting registered with the Ministry of Health and Population, and becoming listed with the syndicate of physicians, a physician becomes licensed to practice medicine and may open his or her own clinic, or work in a hospital. There are special procedures for foreigners or Egyptians who studied in medical schools abroad, as they must pass certain examinations to become licensed (MOHP 1954). The law, which dates back to 1954 and regulates medical practice, gives rights and obligations to physicians which must be followed in order to maintain minimum levels of safety for the patients. Therefore any power in the doctors' hands cannot be abused for their

own personal gain, and to treat patients harshly. There are also regulations which only permit doctors and registered midwives to help a woman while giving birth (CEDAW 2000:14).

Brigitte Jordan argues that in order for physicians to maintain this monopoly within their society, their “authoritative knowledge” has to remain “legitimate, consequential, official, worthy of discussion, and appropriate for justifying particular actions by people engaged in accomplishing the tasks at hand” meaning that it has to be sanctioned by law, their actions have to bring about certain changes or the consequences, that are positive for people to believe in their efficacy and with that, the success of their profession would encourage more people to seek the type of care they practice (Jordan 1997:58). Another form of this power is the ability to make decisions and perform certain procedures that affect peoples’ lives and in the case of childbirth, being in possession of certain tools and “artifacts necessary to manage the labor” such as medications for pain relief, instruments for delivering the baby and fetal heart monitors (Jordan 1997:61).

Health services in Egypt are provided by several categories of providers, including the public sector under the government’s management, or financial support or both, and the private sector. The public sector has two main branches, one whose services are directly provided by the government, and receive funding from the ministry of finance, these include the ministries of health and population, the ministry of higher education, other ministries which provide health services to their employees and the ministry of scientific research. Al Omouma Hospital, the research site for this study, is a public hospital and indirectly receives part of its funding from the Ministry of Finance and another part from direct fees for the birthing services they offer which are still subsidized, since they are lower than fees at most private hospitals (MOHP et

al. 2005).

One of the government-owned organizations, which are under the management control of the Ministry of Health and Population (MOHP), is the Health Insurance Organization (HIO). This organization was founded in 1964 to provide health care benefits to “all employees working in the government sector; some public and private sector employees; pensioners; and widows” and in 1993, an additional 15 million school children were added as beneficiaries within its umbrella. Four years later, in 1997, newborns up to the age of one year also became included within the scheme, bringing the total number of beneficiaries to 30 million (MOHP et al. 2005: 14). The Health Insurance Organization receives funding from four main sources, including “The Social Insurance Organization and the Pensioners Insurance Organization ... school registration fees and ... government subsidy. HIO also receives some revenues in the form of copayments, primarily from government employees” (MOHP et al. 2005: 14-15).

The private sector includes profit and non-profit health care providers such as private clinics, hospitals and pharmacies and traditional midwives. The non-profit sector is mainly composed of clinics affiliated with charitable nongovernmental organizations (NGOs) and annexes of churches and mosques; they are supervised by the ministries of health and population and the ministry of social affairs. The private sector is generally considered to be a provider of high-quality services, but this comes at a high price which a minority of Egyptians could afford, and even then not all of them have a form of health insurance which would minimize these costs (MOHP et al. 2005).

The health care system in Egypt has a good network of “physicians, clinics and hospitals, availability of technology and pharmaceuticals, and excellent physical

access to care, with 95 percent of the population being within five kilometers of a medical facility” (MOHP et al. 2005: 13). However, despite the availability of the human capital, their skills and allocation in different regions nationwide is not appropriate with the population distribution (MOHP et al. 2005: 9). There is still no comprehensive system of health insurance which benefits every Egyptian and a large segment of the population has to depend on their personal funds to pay for health care in public and private-run establishments, the latter usually providing what is usually perceived as higher quality service. Nearly one half of Egypt's population has access to a health insurance program and benefits from it (MOHP et al. 2005: 9). In order for the Egyptian government to solve these issues and many others, it has started to implement certain measures in the "Health Sector Reform Program ... to provide services using a family health model, where maternal, child, reproductive tract, and infectious disease services are offered as a package of services in one facility” (MOHP et al. 2005:13). The first aim of this reform program is to achieve “universal coverage with basic health services. To meet this objective the MOHP aims to make a basic package of health care services accessible to all Egyptians through a system of universal health insurance (MOHP et al. 2005). The state faces a challenge of providing high standards of health services to all citizens, and as the population increases as a result of higher life expectancy and a relatively high birth rate, this places certain pressures on expanding its reach to even more children and older citizens each year. At the current rate of growth, the population of Egypt is expected to reach approximately 92 million by the year 2020 (MOHP et al. 2005:13).

This review will focus on obstetric (birthing) services and what facilities need to be available in order to provide timely care and show the difference between basic essential and emergency obstetric care services. Comprehensive essential obstetric

care combines the two approaches. Basic essential obstetric care should include the following:

preventive services as well as medical interventions and procedures that can be provided by well-trained primary care physicians and nonphysician providers. This includes [antenatal care], with preventive interventions, early detection and treatment of common problems of pregnancy, and the ability to manage simple problems of pregnancy, as well as first aid for complications of pregnancy and labor to minimize the need for emergency interventions. [MOHP et al. 2005: 109-110]

In addition to the above, Emergency Obstetric Care (EmOC) must provide facilities for surgery and blood transfusions that could save mothers' lives in the case of severe bleeding (MOHP et al. 2005). The modernization and provision of these obstetric care services in Egypt is supported by foreign funding from the United States Agency for International Aid (MOHP et al. 2005:110).

C. Traditional and Contemporary Birthing Practices

Traditionally in Egypt, and many other societies, childbirth was an experience shared mainly among women, with the assistance of midwives. In Egypt, by the early 1900s, the midwives' profession was replaced by the medical expertise of male physicians, and nurses who were trained in Europe and their ways of delivering a baby gradually became more dominant (Ali 2002:85-86).

Traditional birth attendants, or *dayas*, are often critical of how physicians manage childbirth and a laboring mother's experience. One *daya* who had forty years of experience once questioned an anthropologist about the relatively large number of providers in a delivery room of a hospital, or health care centre. She considered it a stressful situation where the woman has no chance to be relaxed. Midwives consider themselves caring providers who provide comfort to mothers through various procedures such as massages and soothing words, but in cases of complicated births

where an expectant mother needs immediate medical care, they promptly refer her to a specialist (Ali 2002: 86-87). In the early years of the 20th century, women were more likely to give birth with a midwife who was either a traditional birth attendant known as a *daya* or a trained public health specialist with knowledge in obstetrics and gynecology, known as a *hakima*. *Hakimas* were trained in schools that were founded during the rule of Mohammad Ali Pasha (1805-1848).

The United Nations published guidelines which recommended that no more than 5 percent of deliveries be done by caesarian section, however, due to the “danger of overuse, a maximum acceptable level is taken to be 15 percent. If the rate of caesarean deliveries in a health facility falls below (or above) these levels, it indicates that inadequate (or excessive) services are being provided” (Cook et al. 2001:64). In the five years preceding the 2008 Demographic and Health Survey of Egypt, nearly a quarter of all deliveries were by caesarean section. A woman was more likely to give birth this way if she lived in an urban area, worked for cash, belonged to a higher wealth quintile or attained a higher educational level (El-Zanaty and Way 2009:135).

D. The Lives of Egyptian Women

The lives of Egyptian women are often bound by rules of law, religion and a culture that values motherhood highly. In the institution of marriage, which is affected by these factors, Islamic Sharia law gives each partner certain rights but also responsibilities. In terms of the husband’s responsibilities, he is expected to provide a living for his own nuclear family and if he had aging parents and orphaned children of his brothers and “in return for these responsibilities, a husband is assumed to have the unilateral right to end his marriage without the consent of his wife” (Hoodfar 1999: 52-53). A Muslim man also has the right to marry up to four women as long as he is able to “provide adequately and equally for all of them and treat them equally”

(Hoodfar 1999:53). Women's mobility and employment opportunities may be hindered if their husbands exercise "the right to restrict his wife's mobility" (Hoodfar 1999:53).

In return to these restrictions, which do not occur in every household, a Muslim woman has the right to *mahr*, which is a gift from the groom given to her at the time of marriage. She also has the right to file for divorce if her sexual rights are not fulfilled, whether or not the husband agrees to the divorce (Hoodfar 1999: 53). Any money that a woman earns through inheritance or employment, or through the *mahr*, is for her to keep, and she is not required to spend it on household needs, although in the circumstances of high living costs, a large proportion of women from different socio-economic classes save money to ease the burdens of furnishing a home or maintaining a higher living standard than the one permitted by the husband's income alone (Ghannam 1997). Commenting further on the roles within households, Hoodfar notes that

both traditional and modern views of the sexual division of labor designate men as the breadwinners: hence their primary role and responsibilities are outside the home, in the labor market. A man who does not have a job and stays home is pitied and considered a failure. A woman's primary contribution is considered to be domestic work and childcare. Though this does not exclude her from labor market activity, her choices are governed by different criteria [Hoodfar 1999:81]

Fatma Khafagy also discussed some of the inequalities facing women and how they have been changed through updated laws since the 1980s when the fieldwork conducted by Homa Hoodfar was published. Khafagy gives examples of several laws which gave women more rights within and outside the family, one of these was the right to give her nationality to her children, if she was married to a non-Egyptian, thus providing her children with the same rights and privileges as those given to children born of Egyptian fathers. Another significant law was the application of *khule*, which

starting in the year 2000, to give women “the right to get a divorce from their husbands, without their permission, in the condition that they give up ‘some or all of their financial rights’ in addition to paying back to the husband the portion of the dower or bridal gift which he gave her upon marriage (Cuno 2008:196-197). Previous restrictions on married women to travel have been lifted as husbands could no longer prevent their wives from traveling. A law concerning rape has also been changed, and currently the rapist would not be able to marry his victim in order to escape punishment (Gaess and Soriano 2008:32).

Egyptian law, based on the constitution of 1971, places obligations on the state to protect women’s rights, and this involves articles that aim to “protect the mother and child and to guarantee the equality of men and women in the political, social, cultural and economic spheres” (CEDAW 2000:8). Efforts by the state to eliminate general illiteracy, especially among females, have not been entirely successful as it is still prevalent. The progress achieved so far has contributed to reducing the rates of population growth and fertility and thus helped in improving women’s health status, and in the case of mothers, reducing their mortality rates during and after childbirth (CEDAW 2000:8).

A divorced mother, even if she had given up her rights through *khule*, is not permitted to give up her children’s rights. The law, as it has been applied until 2000, allows mothers to increase the age of custody of her children, although there is a discrepancy based on the child’s gender. The boy’s custody could be extended from the age of 10 up to 15, and for a girl, from the age of 12 up to her marriage; however, during this time their father has the right to see them and is obliged to provide for them financially (CEDAW 2000:16-17).

Farha Ghannam tells the stories of women in a low-income neighborhood in Cairo, and shows how the relationships with their spouses and their financial positions could impact their health seeking patterns. Zahra is a young woman who got pregnant right after her wedding night and at the time of the interview, she was five months pregnant. She has a sister-in-law called Salwa. Zahra needed more money from her husband to get some lab tests done but she didn't get the money a few weeks after this visit. She told her husband that she suffered from a more serious condition than a "heavy discharge" which she actually had, but felt that she had to do this in order for her husband to give her the money to treat the serious condition. Her explanation was that "she prefers to go to the clinic in the local mosque because the cheaper government hospital that is designated for *al-ghalaba* (the poor) is very crowded and the doctors there do not pay any attention to the patients" (Ghannam 1997:1). Zahra's sister-in-law, Salwa, is more able to afford a visit to the doctor to treat the same condition, but she doesn't go because she "does not see the importance of her reproductive health except in terms of having children" (Ghannam 1997:12). In these two stories, we will find that a woman's fertility and the health of her unborn child are often seen to be of higher importance than her own health and therefore worthy of asking for more resources for medical treatment, or for deciding to go to the physician in the first place (Ghannam 1997:12).

Homa Hoodfar, an Iranian scholar who conducted research in Cairo mostly during the 1980s, started her account of women's lives by reliving her past experiences and what she learned in her childhood and adolescence. Her experiences are similar to what many Egyptian women would go through and therefore it seems appropriate to retell them here. One of Hoodfar's earlier memories when her mother gave her and her sister some advice, would be the differences between her and her

own brothers in terms of the responsibility to “uphold their own and their family’s honor and reputation” but beyond this the differences were not self-evident (Hoodfar 1999:2) which shows that they are cultural notions, not necessarily or directly related to biological differences between the siblings of different sexes.

As the story of Zahra above tells us, Hoodfar’s observations also relate to these situations and show how resilient and resourceful women could be in trying “to manipulate their circumstances from *within* a culture and a legal system, and why breaking all the cultural norms can be very painful and not necessarily advantageous” (Hoodfar 1999:5). The majority of households in Cairo, especially ones with low-incomes, are based on nuclear families (Hoodfar 1995) and even though the levels of educational attainment have improved, there still remain a proportion of the population who are either illiterate or have not completed preparatory education, and women are at a greater disadvantage than men. The Egypt Human Development Report for 2008 shows that the enrolment ratio⁶ of females in Egypt has been increasing in the advantage of younger generations, as more than 94% of girls are enrolled in primary education, as opposed to 88% in preparatory and 70% in secondary education, all for the year 2006 (UNDP and INP 2008:294).

Chapter 3 reviewed the health care sector in Egypt, from the creation of the first medical school during the reign of Muhammad Ali (r.1805-1848) to the organization of the health care system in Egypt in the present day, describing both the private and public sectors. The chapter also described traditional and more contemporary childbirth practices in Egypt, and the fourth section dealt with the lives of women, describing the situation from two ethnographies based on research

⁶ The gross enrolment ratio is calculated by dividing “the number of pupils (or students) enrolled in a given level of education regardless of age by the population of the age-group which officially corresponds to the given level of education, and multiply the result by 100” (UNESCO 2010).

conducted in the 1980s. Within this discussion was a review of women's rights, particularly those of Muslim women, within the context of the family, and how laws, which have been introduced or amended since 2000, have provided them with greater freedoms. The next chapter presents a theoretical framework of different perspectives of studying childbirth, using critical medical anthropology, public health and biomedicine. It also reviews a number of studies which discussed childbirth practices including women's perceptions of them.

IV. Chapter 4: Theoretical Framework and Literature Review

A. The Cultures of Birthing

During the nineteenth and twentieth centuries, a shift has occurred in the rituals of giving birth, especially with rules concerning the care provider (from midwives to obstetricians) and the location (from the home to the hospital). The personal interaction between the woman in labor and the person who delivers her baby has also changed, in addition to the number of people who provide support and their relationship to her. A shift occurred most clearly during the twentieth century, where the hospital became the site where the majority of childbirths took place, with the assistance of surgical experts specifically trained in obstetrics and gynecology and using more technologically advanced tools to monitor the unborn's condition, and drugs for pain relief, but also restricting the woman's mobility by restricting her to her bed.

Al Omouma Hospital, like other public hospitals in Egypt, could be seen as sites of power struggles between the working class clients and the middle and upper class, physicians who work within them and are the most influential providers, but one should not forget the nurses and support staff. Critical medical anthropology could be a starting point to analyze these relationships through women's feedback about how the health providers communicated with them. On the other hand, considering women's decision to come to the hospital in the first place, may be shaped by a culture of fear, imposing a sense of risk on pregnancy and childbirth to encourage births to take place in hospitals, where physicians have the final word. This was one side to the issue, the other shows us women who seek the hospital for its

comforts, and it would be useful to see if they feel any contradictions between what they need and what the hospital offers them.

B. The Public Health Perspective

One of the aims of the public health approach concerning childbirth practices, is to reduce maternal and child mortality. The correct identification of causes of maternal death is essential, in order to have accurate records and be able to reduce them based on the prevention method that is recommended (Pattinson 2008). For example, if one of the main causes of maternal death is severe bleeding, and there have been adequate supplies of blood at health centers, but mothers have been unable to reach them on time, then the time-frame and mode of transportation would need to be assessed and if they were the main obstacles to reaching emergency obstetric care, then they require different kinds of infrastructure, compared to providing equipment at the health facility in the first place.

C. The Biomedical Lens

Byron Good uses the cultural interpretive theory to explore the relationship between patients and physicians. He argues that disease is an “explanatory model”, meaning that it is a product of one’s culture which looks at the human body in one of many different ways (Baer et al. 2003:36). One of these is the lens of biomedicine, which tends to distinguish organs and systems from each other, each having its own function and allows medical students who later become physicians to perceive reality in this unique way (Baer et al. 2003:36). This view was reflected in an obstetrics and gynecology textbook first published in 1903, written by J. Whitridge Williams, a professor who taught at Johns Hopkins University from 1899 to 1931 (Hahn 1995).

Robert Hahn argues that Williams contributed to major changes in the study and subsequent practice of obstetrics since he “took as his mission the institutionalization of science in obstetrics and the maintenance of standards for obstetrical education and practice” (Hahn 1995:212). Williams’ view of the human body, and especially the female reproductive system, could be explained in four points. The first considers the “childbearing woman ... as ‘the generative tract’—the organ system ... abstracted from the person, so that the woman is no longer seen”, and the second feature of his vision places a high-risk factor on the childbirth process which would require high levels of medical intervention and constant supervision” (Hahn 1995: 215-216). The third point gives the laboring woman a “passive role” in the childbirth process, and thus shifts the focus and “central agency” to the delivering physician. This relates to the fourth point, in that, even if “childbearing women and their consociates are ascribed any agency, it is essentially as adversaries obstructing their own childbirths” (Hahn 1995:216). In Williams’ writing, the term *physiological* takes on two meanings in relation to the study of the human body. The first one is that we could equate medicine with physiology, or “the science of bodily function—the physical, chemical, and biological workings of the body”. In its second sense, physiological refers to two kinds of events in the body, one is not related to illness, referred to as “nonpathological” and the second type is an event that does not involve medical intervention, such as childbirth. Therefore he considers the “excessive obstetrical intervention” that takes place to be “pathological” (Hahn 1995:216).

D. Critical Medical Anthropology

The main theory, which I will use in the analysis of the research results, is critical medical anthropology (CMA), as developed and elaborated by Merrill Singer,

Hans Baer and in later publications in collaboration with Ida Susser. Many theories have emerged in the sub-discipline of medical anthropology to explain how patients perceive their illnesses or medical conditions and seek care. Critical medical anthropology “emphasizes the importance of political and economic forces ... in shaping health, disease, illness experience, and health care” (Singer and Baer 1995:5). Critical medical anthropology does not restrict itself to one level of analysis, rather it is concerned with issues of healthcare and illness perception from the macro-level of societies to the narrower level of a person while going through intermediate levels concerned with interactions between health care providers and patients (Singer and Baer 1995).

The theory is closely related to Marx’s ideas about the ideological hegemony of a dominant class within society over the less powerful ones (Singer and Baer 1995). The factor which encourages this form of hegemony to be perpetuated is the “diffusion of self-interested values, attitudes, ideas, and norms from the dominant group to the rest of society” (Singer and Baer 1995: 62) and I believe that this can occur when there is a discrepancy in the socio-economic conditions between one class and the other, so it is not just a gap between the rich and poor, but also between those who have higher educational achievements and those who do not. Despite this power, critical medical anthropology also “recognizes that ‘ideologies are not all-powerful in constraining those they potentially confine’” (Singer and Baer 1995:63) and although there are exceptions to every rule, we can see in the case of childbirth taking place in institutional settings, there is an upward trend.

Related to the above, I will discuss in more detail the concept of *medical hegemony* as it is understood by proponents of CMA and show how it could be used to analyze the results of the interview. This concept explains that within the wider

discipline of anthropology, there was a “[concern] with meaning in its social context, with the persuasive power of symbols to touch and motivate the individual and the group, with the complex process of socially situated signification” (Singer and Baer 1995: 81-82).

Biomedicine has benefited from being applied in capitalist societies as the economic system encouraged the development and marketing of medicines and equipment of high technological standards and the provision of health services in large “medical complexes” such as large hospitals (Baer et al. 2003:40). Baer, Singer and Susser also argue that the colonial history of developing countries and the “neocolonial situation” that is imposed on them in the present “impose health care modeled after that found in capitalist nations” (Baer et al. 2003). They also refer to the work of James A. Paul, who believes that capitalism and the search for new markets has encouraged the spread of medicine “in the service of imperialism” (Baer et al. 2003:40). However, according to Judith Justice, colonial powers do not work in a vacuum, as they are assisted by “ruling elites [who] collaborate with international agencies, foundations, and bilateral aid programs to determine health policies” (Baer et al. 2003: 40-41). The elites and the foreign agencies they deal with do not always practice what they call for, in terms of encouraging “nationalized and preventive medicine”, in reality, what they encourage and what benefits them is curative medicine which may impose more costs and hardship after illness have taken place, and thus provide greater market opportunities for pharmaceutical companies (Baer et al. 2003:40-41).

One of the goals of critical medical anthropology is to understand the ways in which certain groups in society, such as lawmakers and medical professionals, have control over biomedicine and its practice, and what the consequences for such control

are over the recipients of such kind of health care (Baer et al. 2003). In addition, it aims to uncover “the causes of sickness, the classist, racist, and sexist characteristics of biomedicine as a hegemonic system” (Singer and Baer 1995:6). Biomedicine is the predominant medical system that is endorsed and regulated by Egyptian law which gives it a higher status, and this is transferred to its practitioners, and even the establishments where they work, and this dominant status allows it to have a “monopoly over certain medical practices and limit or prohibit the practice of other types of healing” (Baer et al. 2003:41).

I will use critical medical anthropology in my analysis of the reasons that women gave for coming to the hospital, whether they were based on a conscious decision or due to circumstances out of their control. It will also be used to explain the mothers’ interactions with the health care providers, especially their delivering physician, and their opinion of the hospital as a whole. This could be seen in Al Omouma Hospital with the extensive use of drugs to augment labor and to provide pharmacological means of pain relief. This is in addition to the hospital itself being a large referral center, serving more than 20,000 women per year (Cherine et al. 2004:55). In the analysis of women's reasons for coming to the hospital, I will take into consideration the following questions concerning biomedicine within the framework of this theory. The first is "who has the power over the agencies of biomedicine?", secondly "how and in what forms is the power delegated?" and thirdly "how is the power expressed in the social relations of the various groups and actors that comprise the health care system?" (Baer et al. 2003:38). If women had reported that mass media messages encouraged them to give birth in a medical facility then this could be explained by the state encouraging the spread of biomedicine.

Through reviewing some results of the interview which will be presented in greater detail in the following chapter, I found that working class women, who were the main clients of this hospital, highly valued the use of technology and a medicalized birth overall, and they welcomed procedures such as being strapped to a fetal heart monitor, to have medications that make their labor go faster, the availability of a blood supply in case of emergency and medications for pain relief. They were made aware of these facilities in the hospital through the mass media, their own physicians if they had antenatal care, and through their acquaintances and family members. This was also encouraged by the notion that even if a birth was progressing normally, an emergency could arise suddenly that required immediate medical care, so it would be better for them to be prepared at the hospital in the first place to avoid any delays in caring for themselves or their infants.

Critical Medical Anthropology is also concerned with several issues in the provision of health care, the ones which are most relevant to this research project are the “exploration of the social relations among interacting medical traditions” in a national context as well as looking at how the biomedical system is related to the “political economic context” of the hospital within its community of health care providers and clients (Singer and Baer 1995: 61).

Abercrombie, Hill and Turner argue that the differences in socio-economic classes reveal disparities and dominant status of the more powerful group which is more able to influence other peoples’ actions and beliefs, in this case of hospital birthing practices, it is more likely that the more educated middle and upper classes who possess the medical knowledge are able to send their message across that their method of providing birthing services is the most appropriate (Singer and Baer 1995).

E. Literature Review

This section reviews relevant research, which has been conducted concerning maternal satisfaction of birthing experiences, starts with a summary of Egypt's economy from the 1950s and how the policies of President Gamal Abdel Nasser have influenced the current living standards and the quality of health services offered in the public sector. A program for nationalization started in 1956 under Nasser's rule, and at the time when the population was relatively small, the government was able to provide secure jobs for civil servants, and laws and structures were available which gave people access to "free, universal education, an impressive public health care system, subsidies for basic needs, an elaborate rent control system, and a liberal labor law that gave equal opportunity to women" (Hoodfar 1999: 43). The subsidies provided became a burden on the government's budget as food prices have increased due to inflation since the war with Israel in 1973 during the term of President Sadat which lasted until 1981. The job security of the government sector led many of its white-collar male employees to seek manual labor as second jobs to supplement their income and be able to support their families. They would stay in the government job because it provided pension schemes that were difficult to find elsewhere, and for its ability to give its holder a middle-class status (Hoodfar 1999). Manual labor, however, did not provide the same high status as professional jobs of engineers and physicians, as these were preferred for successful older sons in the family who did well in school (Hoodfar 1999:84).

However, the class distinctions were a feature of society that the Nasser regime aimed to minimize. It sought to create equal opportunities for all citizens in an economic system where "individuals' capabilities and talents would decide their gains and their position" (Hoodfar 1999:43). After nationalization, there was hardly room

for the private sector to grow, and “the state became ... Egypt’s largest national employer. More than half of the industrial labor force and more than 90 percent of industrial technicians, foremen, and administrators became employees of the public sector (Hoodfar 1999: 43). The private sector provided well-paying opportunities in fields such as banking, but they were available almost exclusively to “better-educated upper-class workers. The formal jobs accessible to people of the lower social groups ... are almost exclusively in the government and public sectors” (Hoodfar 1999: 81-82).

During the open-door policy, which officially started in 1974 during the rule of Mohamed Anwar El Sadat, Egypt has been under pressure from international organizations to reduce subsidies on basic food items. The policies which started a decade earlier were more sustainable when the population was much smaller, but with increased dependents on subsidies, and low levels of foreign direct investment, free services such as education and health care have suffered in quality, and private sector alternatives were emerging to fill the gap but their costs were and still are “expensive and beyond the reach of most” (Hoodfar 1999:47) and the quality of services and who had access to them are seen as an indication of a person’s economic status.

Even though at least half of the mothers interviewed in the Al Omouma Hospital study have reached secondary level education or even earned a university degree, there remains a stereotype that women who are only able to access public health care are uneducated as well as poor, although a higher income or wealth status does not always correspond or correlate with higher education levels. There are disparities which could be partly explained by the model of formally free education. Such stereotypes however, may be present in physicians’ minds as they come in touch with women in labor, and if they assume that a woman is illiterate, then it might be

less likely that they would communicate with her in more detail and give more information about the progress of her labor. I do not have data to support this notion.

Baer et al. (2003), commenting on the increased incidence of childbirth with medical professionals which is “sometimes called the medicalization of childbirth”, stated that it has taken women away from notions of “responsibility and autonomy previously associated with the process of childbirth” despite the measured improvements in survival rates (Baer et al. 2003:300).

Women all around the world give birth every day in different circumstances and within diverse cultures. Although childbirth is generally regarded as a natural process, women expect to receive a certain mode of care. This could be female companions, family members, or midwives. Increasingly in some areas, it takes the form of a full medical team within the well-sterilized and technologically advanced environment of hospitals. Women’s expectations and eventually their overall satisfaction are highly dependent on their conceptualization of what constitute normal birth and the multitude of socio-economic and behavioral factors associated with their birthing experience.

At the time that the study at Al Omouma hospital was conducted, there has not been enough data in the literature about hospital practices for normal labor, especially in Egypt, and therefore this study sought to fill this gap (Khalil et al. 2005:289).

Over the past century, childbirth has become increasingly influenced by medical technology, and now medical intervention is the norm in most Western countries. Richard Johanson and his colleagues argue that perhaps normal birth has become too “medicalized” and that higher rates of normal birth are in fact associated with beliefs about birth, implementation of evidence based practice, and team working (Johanson et al. 2002:892).

Childbirth and the use of biomedicine and intervention as opposed to natural way of doing birth with midwives, in uneventful births could be viewed as a cultural model. Women in public hospitals often welcomed the medical aspect of birth, compared to the home setting. This is due to the belief of mothers that biomedicine provides technological tools which allow the baby's and their own condition to be monitored continuously.

The decision-making process to access certain health facilities, the underlying modes and what constitutes a satisfying childbirth experience was the subject of many researchers' work, including Lazarus (1994), Bazant et al. (2009), Hodnett (2002), and Goodman (2004).

Ellen Lazarus' study (1994) set in the United States sought to understand the extent to which middle class and poor American women consider childbirth to be natural, and their acceptance of having a "medicalized birth". Her informants were lay middleclass women, middleclass health professionals and poor women. Her study revealed that most women desired "quality medical care. On the other hand, poor women neither expected nor desired control but were more concerned with continuity of care." (Lazarus 1994: 25).

In the developing countries, the increasing use of maternal health care through the private sector, particularly for the poor, has received increasing attention. In the Kenyan capital Nairobi, for instance, a study among 1926 women living in informal settlements found that "more women gave birth at private facilities located in the settlements than at government facilities, and one-third of the women gave birth at home or with the assistance of a traditional birth attendant." (Bazant et al. 2009:39). In contrast to what one may find in Egypt regarding the access for free medical

services “residents in the more disadvantaged settlement were more likely than those in the better-off settlement to give birth in private facilities” (Bazant et al. 2009:39).

Ellen D. Hodnett intensively investigated mothers’ expectations and their satisfaction of their childbirth experience. Her review of 137 reports showed that “the amount of support from caregivers, the quality of the caregiver-patient relationship, and the involvement in decision making appear to be so important” in predicting women’s satisfaction with their childbirth experience, to a greater extent than factors such as age and socioeconomic status or even “childbirth preparation, the physical birth environment, pain, immobility, medical interventions, and continuity of care” which are issues of concern when looking at hospital births in comparison with a home setting (Hodnett 2002:S160).

Petra Goodman and her colleagues examined the “multiple factors associated with childbirth satisfaction and total childbirth experience” using “a correlational descriptive study” also concluded that “helping women to increase their personal control during labour and birth may increase the women’s childbirth satisfaction” (Goodman 2004:212).

Overall childbirth experience and satisfaction are closely linked to the quality of care which varies considerably between private and public facilities. Many governments have targets to improve maternal health services and increasing access to institutional delivery care as reported by Hulton, Matthews and Stones (2007). The three scholars conducted a comprehensive study by objectively looking at the quality and preparedness of facilities and childbirth services in addition to the perceptions of mothers. Their data was gathered between January and December 1999 from public and private hospitals using “observation, exit interviews, provider interviews, review of hospital records, the mystery client approach and a household survey of 650

women in the immediate vicinity of the case study hospitals” (Hulton et al. 2007:2083). The study findings show “evidence that quality is far from optimal in both public and private facilities” and the shortcomings of the facilities “included a lack of essential drugs, women being left unsupported, evidence of physical and verbal abuse, and births occurring in hospitals without a health professional in attendance.” (Hulton et al. 2007:2083).

This chapter compared the study of childbirth practices from three perspectives, including critical medical anthropology. This was followed by a presentation of the results of previous studies that looked at the social and medical aspects of birthing experiences. In the next chapter, there is a detailed presentation and discussion of the results of the interview which was conducted with the mothers before leaving the hospital.

V. Chapter 5: Research Findings and Discussion

This chapter presents the results of the interviews with the mothers, using selected questions to test the hypotheses. It will be divided by themes, the first will present the reasons that women gave for not giving birth at home, illustrating the disparities in the settings and facilities. In the subsequent sections, I will review women's responses to questions related to their opinion of their delivering physician, the information provided to them about their baby's and their own health, their opinion of the hospital as a whole and any recommendations they might have given on how to improve the service at the hospital.

A. Expectations of Hospital Births

Mothers avoided the home setting for birth for several reasons, the leading one was fear of the home setting and the attraction of the hospital as it is better equipped. This feeling was stronger among the groups with lowest parities, for example, 82% of mothers who had a parity of zero cited this reason. Eighty-nine and ninety percent of women in parities 1 and 2 respectively have also given this reason, but only 61% of mothers who had a parity of 3 or more had given answers which were grouped in the same category.

The second most common reason given was getting advice from one's physician, family members or hearing about the advantages of hospital births in the mass media. Almost 4 in 10 women who had a parity of 3 or more gave this as their reason for coming to Al Omouma hospital. The second highest group were the new mothers at 15%. The lowest percentages however were at mothers with parity of 1 or 2, at 4% and 2% respectively. In between these two extremes, the belief that giving birth at home is an old habit and not common is mostly shared by women who came

in to have their first baby, at 4%. In the groups of mothers who had a parity of 1 or 2, only 2% of each group agreed with this idea, whereas none of the mothers who had a parity of 3 or more mentioned it. The results are summarized in Table 3.

The following are examples of some of the mothers' answers when asked why they came to the hospital. One mother from the free section talks about her sister's experience when she gave birth at home with the assistance of nurses who worked at a family planning clinic. She continues by saying, "they gave her eight injections to induce labor, after that she bled a lot and her color turned black and when we took her to the hospital they said her uterus was going to get ruptured". The interviewer asked her about other risk symptoms she may know, but she couldn't give any others. This mother had entered the free section of the hospital, she had 3 children before but never gave birth at home. Another first-time mother from the free section, says:

I was afraid to get sick. Here in the hospital, the medical care is better, the doctor knows more than the midwife and won't do anything wrong, like she might. Emergency care is available with supplies such as glucose. The midwife's hands could be unclean and lead to infection. The baby could be delivered wrongly or bleeding could occur.

As for other risks, a first-time mother in the free section was worried about a possible obstruction by the baby's head which she feared may threaten her life. She added that her home had no equipment as opposed to the hospital which was staffed by physicians who would give her different medications and glucose. One mother who gave birth at the free section was aware of her medical history, involving diabetes during pregnancy and therefore she felt she could not have her baby at home. She continues by saying "I don't know the problems exactly but there could be negligence. The equipment in hospital wouldn't be available at home. They put me on fetal heart sound monitor and made some scans. The hospital is cleaner than my home". Another example comes from a mother who gave birth three times before, and

was aware from the newspapers and television that giving birth at home is very dangerous due to the lack of pain relief and she was also worried about severe bleeding after birth.

There is also a concern that midwives are not competent enough to handle high-risk situations. One mother who went into the free section, and had three children before including two times at home with a midwife, stated that she used to bleed a lot and the midwife wouldn't give her anything to stop it. Also, since she is new in her neighborhood and does not know another midwife, decided to come to the hospital because it is cleaner and better. She recognized that two other problems of giving birth at home are the possibility of a complicated birth, or not having the fetus in the proper position. Other fears about giving birth with a midwife, included not being referred to a hospital soon enough, as a mother of four, also in the free section, was giving birth at her home, and after being told that her midwife would come back the following day, her husband felt more worried about her and decided to take her to the hospital because he was worried about the complications of bleeding or any other problem that might arise. The third account is from a new mother at the free section. At first her mother in law brought a midwife to their home, but her own mother was not satisfied with the midwife, so she insisted on bringing her daughter to the hospital. The baby needed an incubator as soon as he was born, so with hindsight she feels that her mother's decision was the right one.

A first-time mother in the free section said she received antenatal care at the same hospital and in another private clinic and was advised by her physicians to give birth at a hospital, due to the need for a Rhesus factor blood type injection. She cited the risks of giving birth at home such as bleeding, the inability of the midwife to deliver her or the possibility of harming the baby, as well as the risk of giving birth

before her due date. Three other mothers from the free section were worried about the home setting and had a greater feeling of trust towards the hospital. For example, a first time mother stated that the home birth “isn’t good, there is no medical care. In the hospital if there’s something wrong with the baby they will take care of him, and the same for me”. For a mother of two, the fear of complications and risk of dying while giving birth led her to give birth at hospital. As for the third mother, who also had two children before, she believes that “there is no care or cleanliness at home, there could be contamination. The hospital is sterilized. The birth could have a complication, such as the umbilical cord twisting around the baby’s neck. If I need a Cesarean section it won’t be available at home”.

As noted, a number of women said that giving birth at home is not a practice that is common these days due to peoples’ greater awareness, according to one of the respondents. Another mother, who came to the free section of Al Omouma to give birth to her first baby, said that her own mother was worried about her health “because in TV she saw a public announcement [which stated that] that hospital births are better because they had equipment. Problems of giving birth at home are high temperature, cramps or chest pain”. Another message which a mother heard from television was that her child would not be able to enter school if they were born at home.

Medical technology offers the chance, using medications such as Oxytocin, to increase the rate and strength of uterine contractions, thereby allowing the first and second stages of labor to progress faster. One mother who had another child before, mentioned that hospitals provide her with the opportunity to give birth faster than at home, but she did not mention any health risks of home birth. In contrast, a mother who knows she has anemia, feels there is a risk to giving birth at home, and therefore

it is much safer for her to be at a hospital as she cannot be sure what complications might arise, she already had another child before and had come to the paying section this time. The following is a case of a mother who had two children before, she came to the free section of the hospital and knew that her cousin who worked at the hospital would take care of her needs, she adds, “if I need emergency care they would help me. The facilities at home are limited and if the baby needs anything it wouldn’t be available there. The first birth was in another hospital and I needed 8 blood bags. For the second birth I gave birth at home because there was no time to go to a facility, but it was an easy birth”.

B. The Delivering Physician

Mothers were asked about their delivering physician, whether or not they knew his or her name and what their opinion of him or her was. The most common comments were simply a statement of “the doctor was good” and this was almost equally the answer given by women in both the free and paying sections (73% and 78% respectively), as well as the different parity groups (ranging from 71% to 79%). Four main themes were used to compare between women’s perceptions about the delivering physician, and each one has its equivalent in the positive or negative sense and these are presented in pairs in tables 4 and 5. The first pair is a simple statement given by most women, on whether the doctor was “good” or “bad”. The other points of comparison were the prevention of pain and discomfort, or lack of taking action, the level of communication – whether verbal or physical, and finally the level of care and attention.

Besides stating that the physician was “good”, there was an overall more positive response from mothers in the free section in certain aspects, but also certain responses showed more negative feedback from the free section, compared to the

paying section. In most other cases of positive feedback about physicians, the percentages are nearly the same. One cannot find clear evidence of the women in the paying section having a better experience. With almost three quarters of women stating they were satisfied by their delivering physician, the remaining ones reported low incidences of negative feedback and it showed slightly more dissatisfaction from women in the free section.

In terms of discomfort regarding lack of pain relief, use of cold instruments or when the physician makes sutures (stitching of a wound or surgical cut), twenty percent of women in the free section made complaints about it, compared to 10% in the paying section. One of the mothers in the free section, who came to give birth to her first child said that her female delivering physician made her feel comfortable during birth despite the pain while suturing her wounds. The physician had told her that she used anesthetic to relieve the pain. In addition, the mother did not know her name. It is surprising to see that when women mentioned that their physician did not cause any discomfort and provided them with pain relief, the opposite relations were reported, this time, it was women in the free section who felt more satisfied with 37% reporting this positive aspect about their physician, compared to only 29% in the paying section. The following is an example of a mother from the paying section who did not feel comfortable throughout her birthing experience, she said her doctor “wasn’t good, left me until I was exhausted and didn’t give me any anesthetic and I was in great pain”. Another mother from the paying section stated that her doctor “was good [but the] nurses weren’t good, they didn’t give me anesthetic until at the very end when I already felt everything. One of them jumped on my stomach. Last time I didn’t feel anything from the moment I entered”.

There were almost equal proportions of women bothered by the type of communication between them and the physician, four and five percent in the free and paying sections, respectively. This took several forms, such as not letting the mother talk freely, not giving her enough reassurance about the progress of labor, or even the physician not introducing him or herself by name. One positive example was experienced by a mother in the free section, she stated that her male delivering physician told her to hold her breath and push down when she feels a contraction coming, adding that “he did the right thing so I could give birth as soon as possible and get done with it”. She had two other children before. Another good experience was from a first-time mother in the paying section, who had two doctors, the second one was “better than another doctor who wasn’t talking to me properly. The doctor cared about me and we laughed together. The nurses were bad as they didn’t talk properly to us”. Another positive account was given by a mother in the free section, she said that her male physician “was always checking my status and telling me it’s almost over now. He didn’t shout at me because I heard other ones shouting at the doctors”.

Another form of unsatisfactory care, was the lack of follow-up, or letting the mother give birth on her own, were comments given by 9% of women in the free section, compared to 5% in the paying section. One example of this, was given by a mother in the free section, who came in to give birth to her fourth child. She said that as she was admitted, the physicians examined her and then attached solutions but told her she wouldn’t give birth just yet. There were 6 or 7 physicians following her case who later left her alone. She continues by saying “when I told them that something came out of me the doctors came and took the girl and moved me to delivery room for the placenta. No one caused discomfort, they’re all good”. Another bad experience

was recounted by a mother who was giving birth to her second child in the free section. She had this to say:

[she was] not very good. She was following me before birth. She was nervous and whenever I scream she shouts at me and says she doesn't want any noise and would hit me on my leg. She didn't give me chance to talk. I asked for anesthesia. Last time nothing bothered me during birth, it was my first birth and I didn't get exhausted like now. She left me in post labor ward and expressed boredom and annoyance from delivering babies. [I] apologized for screaming but the doctor didn't answer me. She was a bad doctor.

On the other hand, some women gave positive feedback about being followed up during the birth, 18% in the free section compared to 8% in the paying section. A number of mothers' comments gave a contradictory impression about their physician, such as one at the free section who said that the delivering physician was "good in everything. Shouted at me every time I screamed". Another mother from the same section was also happy about her delivering physician, she said:

they worked hard with me and they were worried about me and didn't want me to come here [the postpartum ward] until they made sure the bleeding was fine and an older doctor was with her. She came here after birth, she had put a piece of cotton for me and removed it and then a doctor came and saw me twice.

Certain comments by women have shown greater satisfaction in the free section. For example, the proportion of women who reported that their physician made them feel comfortable was 20% in the free section, compared to 10% in the paying section. Women who noted the physician's level of attention to her condition, and not leaving her alone, the proportions were 16% in the free section, and 5% in the paying. A third highlight is the incidence of a physician giving instructions to the mother on how to breathe and push during active labor, and giving encouragement in general, this was reported by 9% in the free section, but none of the women in the paying section experienced it. The comparison of women's opinions from the free and paying sections are summarized in Table 4.

Dissatisfaction with the level of comfort and pain relief were highest in the groups with zero and 1 parity, at 25% and 19% respectively, while it was slightly lower for women who had a parity of 2 and 3 or more, at 15% and 17%. These results support the hypothesis which associates greater satisfaction with higher parities. Communication problems were also reported by women of zero and one parity, but none for 2 or more. The main problem which women of parity of 3 and higher complained from was the lack of follow-up on a woman's condition, or when a senior physician's instructions are not followed by trainee physicians. Seventeen percent of women in this parity group had such complaints, compared to only 7 or 9 percent in the parities of zero and one, and this does not support the hypothesis which predicts a better experience for women of higher parity. These results are summarized in Table 5.

C. Information Provided about the Baby's Health

Nearly seven out of ten mothers had not been given any information about their baby's health, at the time of conducting the interview, nor given advice on how to care for them. Tables 6 and 7 give more details regarding this low level of sharing information. There were very little differences between women across the hospital section and parity groups regarding this lack of information exchange. In more detail, 73% of women in the free section were not given any information, compared to 71% in the paying section. The range among the parity groups was from 70% to 75%.

Regarding information about the immunization schedule, nearly 12% of women in the free section were given such instructions, compared to no one in the paying section. In contrast, 9% of women in the free section were reassured about their baby's good health compared to 17% in the paying section.

Information about the immunization schedule was consistent among all parity groups, ranging from 9% to 13%, except for the group of parity of 2 which was only 2%. Two mothers in the paying section, one who is a first time mother and the other had another child before, complained that there were no pediatricians available, and that no one reassured them about their baby's health. One mother from the free section appeared to have seen a pediatrician and he or she examined her baby, and she was given clothes, but without providing other information about their health. Another woman started by saying that she was not given information about her baby's health, and then elaborated by that she was given information about immunization only, she was told to bring her son after two months. She was also instructed in breastfeeding and told that her son was in good health. The nurse gave her this information, but nothing about risk symptoms. Two mothers, one in the free and the other in the paying section were given brief information about their sons' condition and the need to be put in an incubator, however the reason for this was not always given in detail, except for the case of the mother in the paying section, as she knew that her son had blue skin.

D. Information Provided about the Mother's Health

The pattern of not providing information to the mothers about their babies' health is also repeated with their own health status. The percentage of women in the free and paying sections who were not given any information about their health at the time of the interview ranged from 72% to 75%. As for a comparison of parity groups, it ranged from 67% in the zero parity group, to 83% in the group having parities of 3 and higher. Tables 8 and 9 show these results in more detail.

The following three accounts were from mothers in the free section. The first one was told that she was in good health, when she asked them about the risk

symptoms, she wasn't told any information regarding this by her delivering physician. The second mother was shown the position of her uterus by the physician and was instructed to massage it and not to worry from bleeding. Since severe bleeding is considered a health risk, it may be assumed here that she was told not to worry about normal rates of bleeding that occur after any birth. This previous example was of a mother who gave birth to her second child, so she had some experience in the past. For a third mother, her physician instructed them (presumably the group of women at the ward) to breastfeed their babies. They were also told that if they had bleeding or fever, that they should come to the hospital. On the other hand, one mother, also in the free section, did not mention that she was given any information, despite the physician coming to check on her every now and then in the ward. For two mothers in the paying section, the information provided depended on their circumstances. One of them, a mother who gave birth to her first child, was told that she was in good condition by her physician, and she added that she felt able to clean herself. Another first time mother, aged 40 was told by her doctor that her baby has a risk of dying, citing her age, which may have been considered a reason for this high risk, but she did not elaborate on this.

As for mothers who did not receive any information, the communication with medical staff was minimal. One mother in the paying section said that she hardly spoken to anyone, and that the delivering physician told her husband that she was in a good condition but would have to stay in the hospital for 6 hours to be under observation. In the free section, one mother was asked by the doctor if she was bleeding a lot, when she said she wasn't he left her and went out of the ward.

E. Opinion on the General Services

Tables 10 and 11 summarize women's opinions about the service level at the hospital. Women have been asked about their opinion of the service levels in the hospital generally, and their answers shed light on how they experienced the birth itself, the attention from the medical team, whether from physicians or nurses, and the nature of communication between them and herself. Mothers also gave many comments regarding the way the hospital is prepared to provide medical care, in terms of facilities available, in addition to visiting procedures, level of cleanliness, the kind of service received from workers, and the physical setting of the hospital itself. The positive and negative comments regarding each aspect are not mutually exclusive, and there are overlaps as a number of women report both negative and positive experiences.

1. The situation of birth and the medical team

Mothers admitted to the free section were overall more satisfied with the medical aspect of their birth and the medical team who cared for them. The positive comments were recorded for two-thirds of the mothers in the free section, compared to 42% in the paying section. Negative sentiments were reported by one third of each group. Across parity groups, there is not much difference regarding women's satisfaction of their birthing experience or with their medical team as 53% to 62% of each parity group were satisfied, whereas 22% to 38% gave negative comments about this aspect, so there is no clear support of a hypothesis linking satisfaction and parity.

2. Communication

There was not much difference seen between the groups, 8% of women in the free section said they felt there was good communication, compared to 12% in the

paying section. The percentages are almost the same for the negative comments regarding communication aspects. A slightly clearer picture emerges for the comments about communication with staff and health care providers in the hospital. Mothers of the lowest parities, were least likely to give positive feedback about information exchange or general treatment, satisfaction levels rose with each increasing parity group. And negative feedback was highest for women in the zero and one parity groups (at 15% and 13% respectively) while it was lowest for women of parities 2 and 3 or higher (at 2 and 4% respectively).

3. Overall quality of service:

Mothers who entered the free section, were overall more satisfied with the quality of services, as nearly 7 out of 10 reported positive aspects of it, compared to only 44% in the paying section. Similarly, negative comments about the service, were reported by 41% of women in the paying section, compared to just under a quarter of women in the free section. When looking at the quality of service, and feedback, there were quite some discrepancies between the free and paying sections, however it is not as clear in the comparison between parity groups. In each parity group, positive comments ranged from 51% to 66% of the respondents within. Negative comments were slightly more clear, as women of parities 1 and 2 were more dissatisfied with the service (32-39% giving negative feedback) compared to only 22% in the zero and 3 or higher parity groups.

4. Hospital Facilities

As with the satisfaction of quality of services, there is a similar pattern regarding women's comments about the facilities and equipment available at the hospital. In the free section, one quarter of the women had positive comments about

the service, compared to only 10% giving negative feedback. In the paying section, 20% of mothers gave positive feedback, compared to 29% who faced a problem and made a complaint about it. There is no clear trend in the positive feedback about health facilities across parity groups, as the percentages of women within each of the four groups ranges from 19% to 27%. In terms of negative feedback about hospital facilities, the differences are slightly more clear, as 9% of zero parity mothers are dissatisfied with the hospital and its facilities, compared to 13% among women of parities 3 or more. The highest percentages though are for women of parities 1 and 2, as the rate is just over 20%. There has also been feedback from mothers about medical aspects of the service and the extent to which their progress and well-being were monitored.

F. Mothers' Recommendations for Improvement

Women were asked to give their recommendations for improving any aspect of the hospital's service that they felt was inadequate. They gave positive and negative comments about the service, and so the negative feedback is taken to be the areas that require improvement. The results are summarized in Tables 12 and 13.

Comments have been given about the delivering physician, the pediatrician, the nurses, the general service level at the hospital, and other miscellaneous comments. When comparing between the free and paying section, the main discrepancy is seen in the complaints about the physician, as stated by 27% of women in the free section, compared to just under a half of this proportion (12%) in the paying section. The other areas which were deemed to require improvements were almost equal for the free and paying sections, where nearly half the women complained of the service level at the hospital, 12-13% complaining of the nurses and nearly 8% having negative feedback regarding the pediatrician.

There were not as many clear patterns to compare women's feedback across the parity groups, except for the negative feedback regarding pediatricians and the service level at the hospital. Nine percent of new mothers had a complaint about the pediatrician, compared to 4% with women of higher parity (3 or more). Women of lower parity were less satisfied with the type of service available at the hospital compared to women of a parity of 2 (46%) and 3 or more (35%).

The physician could be considered the main health care provider for the mother giving birth in the hospital. Therefore any problems that were faced by mothers, or complaints regarding the delivering physician, would have a strong impact on their overall impression of the hospital and their experience as a whole. Problems that mothers faced with their physicians which they felt needed improvement, include the kind of treatment they received, the style of communication, lack of follow-up or neglect during or after birth.

Medical care for the newborn was not always present, even in the paying section. Several mothers stated that the pediatrician must pass by them to examine their baby and to be sure that they are in good condition. In addition to the examinations, a mother may also ask that her baby get their immunizations before leaving the hospital.

As well as complaining about the physicians, nurses have not always provided a positive experience to the mothers who came to give birth at Al Omouma hospital. One mother in the paying section for example stated that the physicians treated her very well, unlike the bad treatment from the nurses. A couple of mothers wanted an easy method to call for a nurse, by using a bell attached to their beds for example, but this was not available, so they were not able to have the nurse come and see them when they needed her. Another mother in the paying section did not like the way

nurses treated the patients in general, and added “when we ask for something, they should respond to our needs, they must pass by and see us after we have given birth”. In a few cases, the negative feelings towards nurses were also grouped with similar experiences from the workers or security personnel, even in the paying section. Basically, the mothers required more attention from the nurses, to take care of their needs, especially after birth, but this has also been a demand by one of the first-time mothers towards the physician as well, to come and check on her more often. Another complaint about nurses comes from a mother of two, who gave birth to her third child that day in the free section. She had negative feedback about the workers as well. She stated that

the nurses don't want to do anything in the delivery room, I called them many times to come and dress the baby and here [in the postpartum ward] there are no nurses. The nurses and workers shout at us because I fell and was bleeding, I asked for a piece of cotton but she didn't answer me. The doctors are very good and are doing a great job.

Women do not just complain of one aspect of the service, and give suggestions for its improvement, sometimes they mention several points relating to the medical staff, the services available at the hospital and its management, such as with the visiting regulations. For example, one mother in the paying section, who came to give birth to her second child, said that “the paying section is okay but the toilets need to be fixed and the air conditioner if possible, and there need to be more chairs outside the rooms and in the reception. There should also be a meal available”. On the other hand, in the free section, the relatively larger number of beds was a cause of discomfort for some women, such as this mother of two who elaborated on her complaints:

the beds are stuck next to each other and aren't clean, every two or three [women] are sharing a bed. The toilets are very far from the ward, by the time we get there we become very tired and dizzy. There's no source of water near us, so if I want to wash my hands or to drink I wouldn't find water. No one

came to tell me what to do with the baby or how to feed him or when. The patient beside me told me to feed him after two hours.

While some women complained of neglect by the medical team, others have complained that they were examined by too many practitioners, such as the account of this mother of three at the free section who said: “I wish one doctor and a nurse would follow me all the way through because today three male doctors and a female doctor and three nurses were all examining me and this caused some discomfort for me”. A final example about the hospital’s overall cleanliness comes from a mother in the free section, she wanted the hospital staff to “care for the cleanliness of the hospital and the toilets. They should take care of our hygiene and cleanliness after birth. They should also allow a relative to stay with us throughout and after birth. There are so many cockroaches around us”. There was a less frequent mention of workers, either in a positive or negative sense. One mother in the paying section complained that workers would follow family members of mothers to get tips from them.

The lack of privacy was a concern voiced by some women, even in the paying section where the mothers didn’t wait in large wards, but in smaller rooms. One mother of two older children wished “there would be partitions between beds so no one would be embarrassed, especially when I have visitors. Meals should be available; this is the paying section so they must take care of its patients”. Another mother, also in the paying section, noted that even though the hospital charged money to allow a companion to visit her, there was no space for them. A first-time mother felt the need to have her own mother or another relative as her companion because she felt “scared when we’re on our own. Also, all the patients are in the same ward and it increases our feeling of being scared and worried with all the screaming and loud voices. They shouldn’t leave the women on the delivering bed for too long, it’s true

that the girls cleaned it but after a long time”. A mother who gave birth to her third child, in the paying section, was very satisfied overall with a few negative comments:

this is the best hospital, everything is good here and the doctors are good because in the reception at night they are not good and no one could be found there, and the doctor is shouting, I wish they could improve reception at night. [Regarding visitors’ tickets ...] the money should be taken at the ground floor because the security men took five pounds so they would allow them to go in without tickets, then later when they went in the ticket inspector stopped them. They told him that they paid earlier downstairs, better than paying twice. The workers exaggerate in the amount of money they ask from us. When the patient’s mother gave them 15 pounds, they asked for more and she said she doesn’t have money with her. They told her keep the baby with us and get money from her husband.

After giving birth, a mother would feel exhausted and in need of food and drink, however this was not always available to all mothers. One of the mothers who was in the paying section said “No one gave us any food or drink. They even told us that there should be a place for the baby. We didn’t even get a glass of juice. The water here is very hot, no cold water, we want to get cleaned up but we can’t, the water is too hot for us”.

The setting of the hospital was also the subject of several complaints from mothers. The following two complaints were from women in the paying section. The first one comes from a woman who had three children before, and was satisfied by the reception she got during admission, however she wished that the hospital would provide separate beds for herself and her baby. As for the service, she said it was good but wished it would be better, she was satisfied by the fact that she received medications, and the treatment from staff members was seen as a positive aspect of her experience. Another mother who had a parity of one, also complained about the lack of beds for the babies, because if he was placed by her legs he could fall out of bed. She also complained about the lack of diapers, and was willing to pay for them, as long as they were available in the hospital.

There have been a number of complaints from mothers who were not satisfied by the kind of care they received after giving birth. One mother in the paying section stated that the hospital staff “should care for the patients after birth. They should provide a bed for the baby. When we ask for cotton they should provide it promptly instead of us begging for it. Someone should come and give me pain relief from the abdominal pain”, therefore her problems were related to medical care as well as the facilities and supplies, and also the inability to reach a staff member or nurse when they were needed. Similarly, one mother in the free section, who came that day to give birth to her second child, stated that the a nurse “should be available so we can ask her for anything, even for a piece of cotton. We should have a clean bed to sleep on with the baby, and not sleep beside another woman on a bed that is stained with blood, this of course is very bad for me and the baby”.

G. Discussion

This section provides a review of the three hypotheses to determine whether they were supported by the data or not, or if there were mixed indicators which cannot give a consistent picture relating the independent variables with the dependent ones.

The first hypothesis to be reviewed stated that women who had higher parities would have higher expectations of the childbirth in the hospital compared to mothers with lower parities. In terms of fearing childbirth at the home setting, the lowest proportion, of 27% was reported in the group of zero parity, although the highest percentage was not in the group of parity of 3 or more. Also the expectation that a hospital is better equipped is expressed almost equally among women of parities zero to two (approximately 57% for each group), as opposed to only 30% for women of highest parity, at 30%. Therefore the hypothesis is not supported in this case.

The second hypothesis argued that women who were admitted to the paying section report an overall more positive experience than women in the free section. There is not much support for the hypothesis regarding women's satisfaction with their delivering physician, as a higher percentage of women in the free section were satisfied by them. In most other cases of positive feedback about physicians, the percentages are nearly the same.

In terms of discomfort regarding lack of pain relief, use of cold instruments or when the physician makes sutures (stitching of a wound or surgical cut), more women in the free section had complaints about it, there was a mixed picture in the results so it cannot be stated with confidence that the hypothesis was supported. This is because, when women stated they felt no discomfort, there was higher satisfaction among mothers in the free section. On the other hand, when they explicitly stated that they felt pain and discomfort during the birth and other procedures, there was a lower level of dissatisfaction among mothers in the paying section. The same contradictory results could be found when comparing accounts of positive or negative communication. With positive communication, mothers in the free section were more satisfied so this did not support the hypothesis, whereas with mentions of negative communication, the percentages were almost equal for the free and paying sections, so there is no clear support.

There were not many differences between the free and paying sections in response categories such as having known the information from television or being told that the baby had a health risk. Nearly 12% of women in the free section were given instructions about the immunization schedule of their child, compared to none in the paying section. In contrast, 9% of women in the free section were reassured about their baby's good health compared to 17% for the paying section.

In terms of recommendations for improvements to the hospital, comments have been given about the delivering physician, the pediatrician, the nurses, the general service level at the hospital, and other miscellaneous comments. In terms of recommendations relating to the delivering physician, Table 12 shows that there is support for the second hypothesis, as fewer proportions of mothers in the paying section had recommendations to improve the kind of service they receive from the delivering physician, compared to mothers in the free section. The other areas which were deemed to require improvements were almost equal for the free and paying sections, where nearly half the women complained of the service level at the hospital, 12-13% complaining of the nurses and nearly 8% having negative feedback regarding the pediatrician.

The third hypothesis argues that women who have a higher parity (number of children previously borne) report a more positive birthing experience than first-time mothers.

In terms of communication, mothers of the lowest parities, were least likely to give positive feedback about information exchange or general treatment, satisfaction levels rose with each increasing parity group and this supports the third hypothesis. Other data which supports the hypothesis concern the negative feedback which was highest for women in the zero and one parity groups while it was lowest for women of parities 2 and 3 or higher.

In terms of satisfaction with the quality of service and women's parity, there is no clear pattern to support the hypothesis. This is the same for positive comments regarding hospital facilities across parity groups. Negative feedback about the availability of pediatricians was not clearly in support or disagreement with the second hypothesis.

In terms of information exchange about the baby's health and immunization schedule, there were no major differences between the parity groups, and therefore this element of the hypothesis is not supported, as women of higher parity were not given more information. This is the same for information provision about the mother's health condition, at the time of the interview. Mothers of lower parities (zero and one) were more dissatisfied, and gave comments on how to improve the quality of service in the hospital, compared to mothers of higher parities (2 or more). Satisfaction with the pediatrician increased only slightly with each parity group.

Chapter 5 presented the results of the quantitative analysis of interview data with 172 mothers in the postpartum ward. It started by looking at why the women decided to seek obstetric care at the hospital, instead of staying at home. This is taken as a reflection of their expectations of hospital births. Their experiences are investigated in several dimensions, documenting their opinions on the hospital as a physical setting and its facilities, the health care providers who are the obstetricians and nurses, in addition to supporting staff such as the cleaners and security personnel. Communication with the mothers was an important factor in the quality of care, and therefore it was important to see how much information was given to the mothers regarding their own health and that of their babies. In the last part of the interview, the mothers were asked if they had any suggestions to improve the quality of services at the hospital, and this helped to provide more information on what they felt was missing, and which may not have been covered by previous questions. The following concluding chapter aims to interpret the results and hypotheses and link them with the theoretical perspectives which were reviewed in chapter 4. Following this is a discussion of how these findings could influence policy and the provision of health services which are concerned with patients' opinions, not just clinical outcomes.

VI. Chapter 6: Conclusion

A. Summary of Findings

Overall, there is a high level of satisfaction with the physicians at the hospital as nearly three quarters of mothers said their physician was good, but we could see less satisfaction with the supporting services, such as in the provision of information about the mother's and newborn's health. In terms of following up on a woman's condition, there was more positive feedback regarding this point than negative feedback saying there was neglect. Going back to the theory of critical medical anthropology, and relating it to women's expectations of hospital births, we find that the influence of biomedicine as the dominant form of medicine is quite high, with over half of the women stating that hospitals are a better setting for giving birth. This is a skewed sample however, since it comprises women who already came to the hospital, but the increasing trends in Egypt of giving birth with a skilled attendant or in a health facility support this view.

B. Revisiting the Theories

Critical medical anthropology is concerned with ways in which biomedicine influences peoples' lives and access to health care. In applying this to the respondents' experiences, it is important to note that the women in the free section were not allowed to have a companion with them in the delivery room, as opposed to the ones who paid money on admission. The woman giving birth in the delivery room feels lonely without her support group, such as her mother or husband, and this is a reflection of the statement by Singer and Baer which discussed biomedicine, arguing that

by transforming person into depersonalized patient (cut off from normal social networks, settings, status symbols, abilities, in short, one's identity as a person), and then reducing and objectifying the patient as disjointed organ or disease ... or good 'material' on which to practice surgical techniques, biomedicine reproduces and thereby reinforces the hierarchical, mechanistic, standardized, alienated, privatized, and atomistic reality of capitalist production [Singer and Baer 1995: 83]

This statement relates closely to teaching hospitals, where medical students try to apply their theoretical knowledge on as many delivering women as they can, in the absence of a clear medical team.

The first hypothesis, which stated that mothers of higher parities would have higher expectations of the hospital, was not supported by the data. The influence of biomedicine and its power within society was a strong attraction for women to come to the hospital, as they described its facilities as being an advantage over the home setting. There has also been a fear from the home setting in some mothers' accounts which I believe is also due to the same kind of power of the dominant healing system.

Biomedicine, as a culture of health care, went hand in hand with capitalism to spread itself worldwide (Baer et al. 2003) and as a prevalent system in Egypt as well, its products and tools have become highly desirable, and women have sought them out in the form of pain relief medications, ultrasound equipment and fetal heart monitors, to name a few. The majority of women across the parity groups have stated that the home is not a place in which they would feel safe to give birth, citing the lack of equipment as one of the reasons. The desire to have such technologies present during birth may reflect a greater awareness among women of higher parities, either because they have seen them before during the birth of an older child, or they would like to try something new, in case they had a home birth in the past. However the women with the lowest parities are the ones who expressed the greatest fear of home births, and it may be due to their shorter experience.

Regarding the second hypothesis, which stated that mothers in the paying section had a more positive experience than ones who were admitted to the free section, there was a mixed picture which cannot be generalized across all themes. I found contrasting patterns of answers about the delivering physician, for example when mothers were asked whether they were good or not, the hypothesis was not clearly supported. However, when asked to give recommendations for changes to the hospital, feedback about the delivering physician showed lower satisfaction levels for mothers in the free section. Also, in terms of providing comfort and preventing pain and the nature of communication between the mother and her delivering physician, there were contradictions which cannot give us a clear support for the hypothesis. As stated in Chapter 4 in the section concerning critical medical anthropology, the theorists who developed it were aware that economic factors affect peoples' access to health care and their experience of it (Singer and Baer 1995). However there is no clear explanation for why a person who has paid less, may have an experience equally positive or better than someone in the paying section. A deeper analysis of the data would be a further step, by looking at every interviewee and compare her own expectations and experiences, as opposed to looking at aggregate data of women in the each section as a unified group.

With the third hypothesis, there was also a mixed picture regarding communication with the delivering physician. When mothers gave positive feedback, it was at a higher rate in the free section, but the same was also true for negative feedback, as 5% or none of mothers in higher parities had mentioned it.

From a public health perspective, providing information to mothers about their health and that of their child, is vital during the postpartum period. This starts at the hospital in the wards of the free section before they get discharged. A small

proportion of women have received the information which may save their lives and improve their infants' health if they were encouraged and taught how to breastfeed them.

In terms of women's satisfaction with their delivering physician, relating the findings to the biomedical model is relevant, to see how medical education and practice are reflected among the practitioners.

C. Policy Implications and Future Research

The results above tell us about women's needs regarding childbirth services in the public sector in Egypt. Overall, there were higher levels of satisfaction with the delivering physician compared to the nurses and workers. However, there is a need for a more efficient distribution of the caseload between the medical teams since some women complained that they have not been seen by a physician for a long time, to the extent of giving birth alone in bed, and others were examined repeatedly by medical students who needed to practice their profession as much as possible.

There has also been dissatisfaction with the quality of service from nurses, as nearly 13% of mothers said there was a need to see improvements in the medical care provided by them in addition to the nurses' attitude and the way they communicated with the mothers. The nature of the service at the hospital has also left a lot to be desired, just over half of the mothers have given feedback about the need to improve the overall cleanliness, to regulate and allow visitors especially before giving birth, and to have access to food, drink and cotton for their hygiene.

In Chapter 2 of this thesis, I reviewed statistics about maternal and child health indicators, including mortality rates. It cannot be denied that the increase in institutional deliveries in Egypt has contributed to higher survival rates, with the availability of blood supplies and incubators, as examples of life saving tools for

mother and child respectively. However, a number of practices in the hospital appear to counter the benefits of giving birth there, such as the low incidences of information provided to the mothers. Physicians or nurses might consider an experienced mother to be already aware of risk symptoms, and when to seek care at a hospital for themselves during the 6 weeks following birth, for their babies. However, for first time mothers, most of them did not receive information about their health condition at the time of their interview. Similarly, concerning newborn health, just over two-thirds of new mothers did not receive information concerning their condition. Health care providers should not depend on a mother's family and friends to provide this information.

When comparing Egypt's current birthing practices with other societies, my opinions have been shaped regarding what I would like to see provided for women in Egypt. The ability to have access to a safe facility that provides basic obstetric services should be a basic right and within their financial means, and if the need arises for referral to a more specialized facility, the transfer must be easy and in time to offer life saving emergency obstetric procedures. In terms of basic obstetric services, these could be offered in hospitals or even at home, wherever a woman prefers to give birth as long as her safety and that of her child are not compromised. In my opinion, hospitals are the type of facility best suited for providing emergency obstetric care and therefore they need to be easily accessible, but not every single woman has to give birth in them. This may be a solution for the overcrowding of hospitals.

These suggested changes might not contribute to increased use of hospital facilities to give birth, since these are already rising due to the availability of modern equipment and physicians who are considered more qualified. However, they will

allow mothers to have more fulfilling experiences of childbirth, to feel cherished and enjoy her first few hours with her newborn.

While conducting the analysis for this research, I realized that there is potential for further research into this topic. Women's experiences of childbirth practices could be revisited nearly a decade after this study has been conducted, to understand that changes that have occurred since then in the quality of the health care services, and whether women's expectations differed from 2001. In-depth ethnographic research could be conducted with mothers-to-be from earlier stages of their pregnancy up to their childbirth and a month or two after giving birth, to provide a wider range of answers about their perceptions of antenatal care (if they have access to it), their choice of childbirth location and provider, and what kind of knowledge they have gained after giving birth and caring for their infant. Comparisons need to be made between different socioeconomic classes in urban and rural areas of Egypt, as well as in frontier governorates.

Appendix A: Tables of Results

Table 1: Number of women in each parity and hospital section group

Parity	Free Section	Paying Section	Both Sections
0	32%	32%	32%
1	24%	44%	31%
2	29%	14%	24%
3	8%	10%	9%
4	5%	0%	3%
5	2%	0%	1%
Number of women	113 women	59 women	172 women

Table 2: Respondents' education level by section

	Free Section	Paying section
Illiterate	20%	5%
Literate / primary / preparatory school certificate	36%	19%
Secondary school certificate / secondary school technical diploma / Nursing school / secretarial school	41%	64%
University degree	1%	12%
No reply / unknown answer	2%	0%
100%	113 women	59 women

Table 3: Reasons for not giving birth at home by parity

	Parity = 0	Parity = 1	Parity = 2	Parity = 3 or more
No one can save the mother at home / scared of home births / hospital is better equipped	82%	89%	90%	61%
Given advice to give birth at the hospital by her doctor / midwife / family member / mass media	15%	4%	2%	39%
No one gives birth at home these days	4%	2%	2%	0%
Not categorized / no answer	0%	4%	5%	0%
Number of Women	55 Women	53 Women	41 Women	23 Women

Table 4: Feedback about the delivering physician by hospital section

	Free Section	Paying Section
"The physician was good"	73%	78%
The physician was not good	6%	5%
No pain/ no discomfort	37%	29%
Felt pain / discomfort during procedures	23%	14%
Positive communication	47%	39%
Negative feedback on communication	9%	10%
Constant follow-up / no neglect	18%	8%
Neglect / lack of follow-up	9%	2%
	113 Women	59 Women

Table 5: Feedback about the delivering physician by parity

	Parity = 0	Parity = 1	Parity = 2	Parity = 3 or more
"The physician was good"	71%	79%	73%	74%
"The physician was not good"	5%	6%	5%	9%
No pain/ no discomfort	29%	40%	34%	35%
Felt pain / discomfort during procedures	25%	19%	15%	17%
Positive communication	49%	42%	46%	35%
Negative feedback on communication	11%	15%	5%	0%
Constant follow-up / no neglect	16%	13%	17%	9%
Neglect / lack of follow-up	7%	9%	0%	17%
100%	55 Women	53 Women	41 Women	23 Women

Table 6: Information exchange regarding the baby's health by hospital section

Percentages may add up to less than 100 due to rounding down to the nearest whole number.

	Free Section	Paying Section
No information given to the mother / no information given but she knew from television or nursing school	73%	71%
She was informed about immunizations	12%	0%
She was told the baby had a health risk	1%	3%
She was given information about illnesses and how to care for the baby	4%	8%
She was told the baby was in good health	9%	17%
Not categorized	1%	0%
	113 Women	59 Women

Table 7: Information exchange regarding the baby's health by parity

Percentages may add up to more or less than 100 due to rounding the fractions to whole numbers.

	Parity = 0	Parity = 1	Parity = 2	Parity = 3 or more
No information given to the mother / no information given but she knew from television or nursing school	75%	72%	73%	70%
She was informed about immunizations	9%	9%	2%	13%
She was told the baby had a health risk	2%	2%	0%	4%
She was given information about illnesses and how to care for the baby	2%	6%	10%	4%
She was told the baby was in good health	13%	11%	12%	9%
Not categorized	0%	0%	2%	0%
	55 Women	53 Women	41 Women	23 Women

Table 8: Information exchange regarding the mother's health by hospital section

Percentages may add up to more than 100 due to rounding up

	Free Section	Paying Section
No information given to the mother (although she may have known from television or family, or she was feeling well in any case)	72%	75%
She was told she was in good health	10%	10%
She was given instructions to care for herself	8%	12%
She was told she had a health risk / She was told she needed to stay in the hospital	4%	2%
Not categorized	7%	2%
	113 Women	59 Women

Table 9: Information exchange regarding the mother's health by parity

	Parity = 0	Parity = 1	Parity = 2	Parity = 3 or more
No information given to the mother (although she knew from television or family, or she was feeling well)	67%	75%	71%	83%
She was told she was in good health	11%	13%	10%	0%
She was given instructions to care for herself	13%	8%	5%	13%
She was told she had a health risk / She was told she needed to stay in the hospital	4%	2%	2%	4%
Not categorized	5%	2%	12%	0%
	55 Women	53 Women	41 Women	23 Women

Table 10: Opinions on the quality of service at the hospital by hospital section

	Free Section	Paying Section
Birth / Medical team – positive comments	65%	42%
Birth / Medical team – negative comments	32%	34%
Communication – positive comments	8%	12%
Communication – negative comments	8%	14%
General service level – positive comments	69%	44%
General service level – negative comments	23%	41%
Hospital / Facilities – positive comments	26%	20%
Hospital / Facilities – negative comments	10%	29%
Miscellaneous comments	3%	5%
	113 Women	59 Women

Table 11: Opinions on the quality of service at the hospital by parity

	Parity = 0	Parity = 1	Parity = 2	Parity = 3 or more
Birth / Medical team – positive comments	62%	53%	56%	61%
Birth / Medical team – negative comments	33%	38%	32%	22%
Communication – positive comments	7%	8%	12%	13%
Communication – negative comments	15%	13%	2%	4%
General service level – positive comments	51%	64%	66%	65%
General service level – negative comments	22%	32%	39%	22%
Hospital / Facilities – positive comments	27%	19%	24%	26%
Hospital / Facilities – negative comments	9%	21%	22%	13%
Miscellaneous comments	7%	2%	2%	0%
	55 Women	53 Women	41 Women	23 Women

Table 12: Aspects of the hospital requiring improvement by hospital section

	Free Section	Paying Section
Recommendations concerning the delivering physician	27%	12%
Recommendations concerning the pediatrician	7%	8%
Recommendations concerning the nurses	13%	12%
Recommendations concerning the hospital	50%	54%
Other Recommendations	14%	15%
	113 Women	59 Women

Table 13: Aspects of the hospital requiring improvement by parity

	Parity = 0	Parity = 1	Parity = 2	Parity = 3 or more
Recommendations concerning the delivering physician	29%	21%	10%	30%
Recommendations concerning the pediatrician	9%	8%	7%	4%
Recommendations concerning the nurses	9%	15%	20%	4%
Recommendations concerning the hospital	55%	60%	46%	35%
Other Recommendations	55%	60%	46%	35%
	55 Women	53 Women	41 Women	23 Women

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