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Syrian Women's Preferences for Birth Attendant and Birth Place

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Abstract

Background—Women's preferences for type of maternity caregiver and birth place have gained importance and have been documented in studies reported from the developed world. The purpose of our study was to identify Syrian women's preferences for birth attendant and place of delivery.

Methods—Interviews with 500 women living in Damascus and its suburbs were conducted using a pretested structured questionnaire. Women were asked about their preferences for the birth attendant and place of delivery, and an open-ended question asked them to give an explanation for their preferences. We analyzed preferences and their determinants, and also agreement between actual and preferred place of delivery and birth attendant.

Results—Only a small minority of women (5–10%) had no preference. Most (65.8%) preferred to give birth at the hospital, and 60.4 percent preferred to be attended by doctors compared with midwives (21.2%). More than 85 percent of women preferred the obstetrician to be a female. The actual place of delivery and type of birth attendant did not match the preferred place of delivery and type of birth attendant. Women's reasons for preferences were a perception of safety and competence, and communication style of caregiver.

Conclusions—Most women preferred to be delivered by female doctors at a hospital in this population sample in Syria. The findings suggest that proper understanding of women's preferences is needed, and steps should be taken to enable women to make good choices. Policies about maternity education and services should take into account women's preferences.

A growing recognition of the importance for health systems to take into account women's individual needs in maternity care has occurred in the last decade. Policy statements in some developed countries have moved toward a more woman-centered service, in which women have greater choice and involvement in decision-making rather than simply being passive recipients of care. Interest in the views of health care users has been dominated by examination of satisfaction, which is now an accepted measure of health care outcomes (1). Furthermore, the topic of patient preference for type of health professional has gained importance in the current health care climate, bearing in mind that patient satisfaction is an important indicator of quality of care.

In the field of women's health, studies from developed countries have shown that female patients prefer female gynecologists, and that a female physician's communication style is different from that of a male, which partially explains higher patient satisfaction scores for female physicians (2–5). Previous studies found weak preferences for physician-patient gender synchronicity when presenting complaints that were not gender specific. Preferences

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for same-gender physicians became much stronger when participants sought help for intimate health problems, including obstetric care (6).

Studies also showed changes in rates of home and hospital deliveries in various countries and different proportions of women who preferred a home or hospital delivery, but a fully functioning system of maternity care with trained caregivers is requisite to consideration of the whole issue of home versus hospital births (7–10). With respect to safety issues, home birth services should be backed up by a modern hospital system (11,12).

Syrian maternity care has received considerable attention, especially after the International Conference on Population and Development, held in Cairo in 1994. Primary changes include a noticeable increase in the rate of births assisted by a skilled attendant and a decrease in the rate of home births. According to the recent Syrian Family Survey carried out in 2001, the proportion of births attended by a skilled birth attendant was about 87 percent, and home births constituted 44.6 percent of all deliveries (13).

To our knowledge nothing is known about Syrian women's experiences of childbirth. As part of a larger study that focused on women's experiences of childbirth, our purpose in this study was to describe Syrian women's preferences for the type of birth attendant and place of delivery.

Background

Syria is a middle-income country in the Eastern Mediterranean with a General National Income per capita equal to \$US990.00 (14). The national health expenditure accounts for 3.2 percent of the national expenditure, and is used to modernize, improve, and maintain the health care system. The population annual growth rate was estimated at 2.7 percent between 1995 and 2000, and 50 percent of the population lives in an urban area. The proportion of women of childbearing age is 24.5 percent of the total population. The Syrian population structure is well known for its religious and ethnic heterogeneity, and is largely Moslem with the remainder comprising Christians. Arabic is the language spoken by all the population.

Syria's public health care system is easily accessible and affordable for its population. Health services are provided free to all, which is a challenge to the maintenance of an acceptable quality of health care, especially in the public sector where services are provided free of charge. The fact that the private sector continues to grow in Syria may indicate the degree to which the difficult challenge of maintaining quality of care has been mastered.

Maternity Care System

Maternity care in Syria is characterized by an unregulated system of care provision. Most or all women chose practitioners who give them the care that suits them. They are either free to go to private physicians if they can afford payment, or they have to go to free services largely provided by the Ministry of Health. Maternity care is provided in nearly 1,465 health centers around the country; although this type of care is poorly used due to the dominance of private physicians. Centers for normal deliveries affiliated with the Ministry of Health (currently 30 centers) were recently established in some areas of major need in the country. Results from the 2001 Syrian Family Survey showed that 71.9 percent of mothers reported that they had visited a health facility at least once during their pregnancy. The average number of antenatal visits was 4.4. The proportion of births attended by skilled health personnel was 87 percent, and 29.9 percent received postnatal care. The private sector dominated, comprising 80 percent of all antenatal care and 49 percent of all facility deliveries in the survey (13).

A review of hospital practices for normal deliveries in Syria showed that many procedures and practices did not comply with best evidence for medical practice, which applied to both private and public hospitals (15). Neither hospital accreditation nor continuous medical education is required in Syria. Furthermore, maternal health care is experiencing overmedicalization of care for childbirth. In a nationwide study that reported results from 57 of 230 hospitals providing maternity care, the cesarean section rate was 12.7 percent in government hospitals and 22.9 percent in private hospitals (15,16).

Nevertheless, a rapid decrease in both maternal and infant mortality has occurred in Syria in recent years. The maternal mortality rate decreased from 107 per 100,000 live births in 1993 to 65.4 in 2001, and the infant mortality rate decreased from 34.6 to 18.1 per 1,000 live births, respectively (13,17).

Methods

Study Population

In this descriptive study, 500 women living in the capital city, Damascus, and its suburbs were interviewed. The total population is estimated at about 3 million. Birth registers were used to recruit women in January and February 2003. A nonprobability sampling (quota sampling) was used to select the participants, and the quota sample was stratified per register and number of births in each register during the previous year.

Women who met inclusion criteria of recent delivery of a healthy baby who was less than 3 months old were selected randomly from the birth register. The main inclusion criterion was the delivery of healthy infant with no apparent birth defect as defined by the person seen at the Office of Civil Registry; this person was usually the newborn baby's father. Birth registration is mandatory in Syria within 15 days of the birth. However, we allowed a period of 90 days to avoid possibly missing any child whose birth might have been registered late. Women's houses were traced according to given addresses, and no losses were reported from the original list of households.

Procedure

Women were interviewed after giving their informed consent, and confidentiality was assured. The interviews took place in the women's houses using a pretested structured questionnaire that was designed and implemented in Arabic. Data were collected on socio-demographic characteristics of the women, and on women's obstetric history, place of delivery, and type and gender of their birth attendants. Women were then asked about their preferred place of delivery and preferred birth attendant. In an open-ended question; women were also asked to give an explanation for their stated preferences, as follows: "Could you please comment on and explain the reasons behind your preferences?" Women were also asked a closed question about their satisfaction with intrapartum care, as follows: "Were you satisfied with the care you received during the intrapartum period?"

To reduce possible sources of errors including biases, rather than medical personnel, 3 young women sociologists, who had received 2 days of training, interviewed the women. Females are more accepted by the community in the local culture.

Analysis of Data

Questionnaires were coded and entered into a personal computer. Analysis was carried out using the software SPSS for Windows, version 10 (18). Missing values were allowed for in the analysis. Descriptive and analytical statistics were used, and the McNemar chi-square test for paired observations was used to examine concordance between actual and preferred

care. Actual care refers to the care the woman received in her recent delivery. A chi-square test was used to study the correlation between categorical variables. To further understand the attributes of study women, bivariate analysis was carried out for the two outcomes, that is, preferred place of delivery (hospital/home) and type of caregiver (doctor/midwife). The level of significance was decided at 0.05. In analyzing the open-ended question, all questionnaires were reviewed manually, and responses were coded into the most frequent categories of responses.

Results

Table 1 shows background characteristics of study participants. Most women (56%) were aged 20 to 29 years. Nearly one-third of study participants comprised women who were unable to read or write and those with 6 years or less of schooling. The mean number of participants' family members was 4.9 (SD = 1.8). Less than one-tenth of participants worked outside their homes. Rural residency was slightly higher than urban (52.8% vs 47.2%, respectively).

Most study women had a normal delivery and gave birth at a hospital, with a 13.6 percent rate of cesarean section. Of the 20.4 percent who gave birth at their homes, 91 percent were attended by midwives (Table 2).

A minority of women (5–10%) expressed no preferences related to childbirth (Table 3). Most women (65.8%) preferred to give birth in hospital, and a similar majority preferred to be attended by doctors compared with midwives (60.4% vs 21.2%). The combination most preferred by women was to have their birth attended by a female obstetrician at a hospital (68.1%), and more than 85 percent of women preferred a female obstetrician.

Table 4 shows the agreement between actual and preferred place of delivery and type of birth attendant as reported by women under study. As can be seen, no significant agreement occurred between actual and preferred place of delivery, or for type of birth attendant. This suggests that women did not report preferences for what they had recently experienced.

Women cited numerous reasons for their preferences (Table 5). Most of those who preferred a female birth attendant indicated that they are shy of males and also that females provided better psychological support. "Female obstetricians are more understanding because of going through childbirth themselves," one woman said. Preferences for male doctors were largely explained by their perceived competency and skill. Results showed that women's economic situation might be related to the choice of home delivery, which is usually supervised by a midwife, but the economic situation is more relevant to preference for delivery in a public or private hospital. In general, women's preferences for hospital delivery were related to safety, whereas preferences for home delivery were related to comfort and privacy.

Bivariate analysis showed that the demographic and socioeconomic variables that were statistically related to stated preference for a hospital delivery included the woman's education (82.6% of literate women preferred a hospital delivery compared with 65.5% among illiterate women, $p < 0.005$); husband's education (80.4% of women whose husbands were literate preferred hospital delivery compared with 70.5% of women whose husbands were illiterate, $p = 0.023$); and the woman's age (89.1% of younger women age <20 years preferred hospital delivery compared with 60.7% of women age ≥ 40 years, $p = 0.034$).

The variables that were statistically related to women's preference for a doctor's attendance at birth versus a midwife's attendance included the woman's educational level (76.6% of literate women preferred a doctor's attendance compared with 68% of illiterate women, $p =$

0.048); and the woman's area of residence (82.9% of urban women preferred a doctor's attendance compared with 65.6% of rural women, $p < 0.005$).

In responses to the question on satisfaction with care, most women (98.7%) reported that they were satisfied with the care they received, despite a lack of agreement between what women experienced in their most recent delivery and what they preferred.

Discussion and Conclusions

To our knowledge this study is the first attempt to describe the preferences of Syrian women in relation to place of birth and type of caregiver. The findings revealed that most participants preferred to give birth at a hospital attended by a female obstetrician. We are not surprised by these results, since the ratio of hospital births to home births has shown an increasing trend in Syria. However, we were able to explore women's reasons for their preferences. Women in Syria and nearby countries like Lebanon (19) state that the feeling of being safe is the main reason for their preferences for hospital delivery. This feeling does not relate to their perception of the risk status of their pregnancy. The literature from developed countries, however, shows a variety of preferences about home versus hospital birth, bearing in mind the type of maternity care systems in Europe or the United States (7–12).

Our findings indicated that preference for a hospital setting was related to the educational level of the woman and her husband; we also suggest that this could be an acceptable proxy indicator for the family's economic level, since we would expect higher income among those who are better educated. The correlation with a woman's younger age could reflect not only better health awareness among women, but also the role of both modernization of present-day needs and acculturation to western life-styles.

It is not surprising that Syrian women prefer caregivers of their gender. Shyness and comfort as well as provision of psychosocial support were the main reasons for preferences according to gender of caregiver stated by women. Gender issues have always been important considerations for individuals, not only in the field of obstetrics and gynecology but also in other medical fields (3,5). Gender issues became less important to some women in our study when professional skills was perceived to be important, such as for cesarean sections. Our findings agree with those of Kerssens et al, where sex preferences were absent for the more "instrumental" health professions such as surgery (20). Shapiro suggested that there might be a general belief that male physicians are more competent, and female physicians more respectful and humane (21).

Although we did not collect data on women's religion, they were mostly Moslems. Study women identified religion as a belief that encouraged them to be attended by female caregivers. This belief is not applicable for other services, such as antenatal care, where the issue of gender of practitioner was less important, as demonstrated by our investigation (unpublished data). It seems that women's worry about the exposure of genitalia is not applicable in antenatal care, since women did not demonstrate any patterns of overuse of female obstetricians' clinics. The study by Zuckerman et al in Brooklyn, United States, also reported that certain groups of women most clearly identified by religion (mostly Moslem and Hindu compared with Catholic), or currently seeing a female practitioner, have a preference for female obstetricians (22). More in-depth studies are needed to explain further whether the issue is related to the religion philosophy itself or to cultural contexts related to religion.

Although our study did not investigate specific interpersonal or communication styles of caregivers, the findings might well suggest that women's preferences for same-gender

caregiver, whether a doctor or a midwife, are likely to be more complex than the physical attributes themselves. However, it was evident that women perceived that competency and good treatment were also necessary attributes.

Study women's high degree of satisfaction with their actual intrapartum care could be explained by how extremely difficult it may be for women to make choices in the prevailing cultural and socioeconomic context of the study, or may be due to the women's passivity or to problems in measuring satisfaction.

Our study has some limitations. First, it only includes Damascus and its suburbs; thus it is restricted to a rather developed part of the country. At the national level, home birth is more prevalent in northeastern Syria, and it was reported by 48.8 percent of women living in rural areas compared with 36.1 percent in urban areas (13). The Family Survey also demonstrated reasons behind the patterns of care. More than 3 percent of women who delivered at home reported that it was due to the unavailability of maternity care, and nearly 6 percent due to high cost (13).

Second, the study used a rather simple method for studying preferences by directly questioning women. Other authors, such as Hundley et al, used the "discrete choice experiment," a technique borrowed from the health economics discipline, to assess women preferences for intrapartum care (1). Qualitative methods, however, might be the most useful in exploring how preferences are constructed and whether the choice made by women is rational. We shall be reporting results on Syrian women's experiences with childbirth using qualitative methods elsewhere (unpublished data).

Without a proper understanding of women's preferences, health policy makers and practitioners might not be able to provide a satisfactory standard of health care. Provision of gender-sensitive health care is an important issue in the modern era. Furthermore, implications of the potential demand for female obstetricians and hospital delivery are necessary considerations. More important, in Syria the policy should be directed toward increasing the number and capacity of female obstetricians and reinforcing midwifery education, and also toward the education and empowerment of women so that they can make better choices in issues related to their health. A good system of maternity care should take into account women's preferences, and should enable women to give birth safely and humanely at home or hospital under the care of competent and supportive birth attendants.

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Table 1Background Characteristics of Study Women ($n = 500$)

<i>Characteristic</i>	<i>No.</i>	<i>(%)</i>
Age (yr)		
<20	54	(10.8)
20–29	280	(56)
30–39	133	(26.6)
40	33	(6.6)
Women's education (yr)		
<6	147	(29.4)
7–9	191	(38.2)
10–12	102	(20.4)
13	60	(12)
Husband's education (yr)		
<6	140	(28)
7–9	207	(41.4)
10–12	61	(12.2)
13	92	(18.4)
Women's work status		
Not working	458	(91.6)
Working and earning	42	(8.4)
Husband's work		
Professional	69	(13.9)
Laborer	228	(45.8)
Small industry	80	(16)
Other	123	(24.3)
Family income (Syrian Pounds) *		
<5000	39	(7.8)
5000–10,000	239	(47.8)
> 10,000	222	(44.4)
Place of residence		
Urban	236	(47.2)
Rural	264	(52.8)

* Family income is reported in Syrian Pounds: 1 US dollar = approximately 50 Syrian Pounds.

Table 2**Women's Actual Care During Childbirth**

<i>Characteristic</i>	<i>No.</i>	<i>(%)</i>
Type of delivery		
Normal	418	(83.6)
Cesarean section	68	(13.6)
Instrumental	14	(2.8)
Actual place of delivery		
Public hospital	160	(32)
Private hospital	174	(34.8)
Clinic	60	(12)
Home	102	(20.4)
Other	4	(0.8)
Person who attended delivery		
Male obstetrician	141	(28.2)
Female obstetrician	223	(44.6)
Midwife	120	(24)
Other, including <i>Daya</i> *	16	(3.2)

* "Daya" is the local word for traditional birth attendant.

Table 3Women's Preferences for Birth Attendant and Birth Place ^{*}

<i>Characteristic</i>	<i>No.</i>	<i>(%)</i>
Preferred place of delivery		
Home	94	(18.8)
Hospital	329	(65.8)
No difference	24	(4.8)
According to circumstances	53	(10.6)
Preferred type of caregiver		
Doctor	302	(60.4)
Midwife	106	(21.2)
No difference	46	(9.2)
According to circumstances	46	(9.2)
Gender preference		
Male obstetrician	59	(12.6)
Female obstetrician	408	(87.4)
Best preferred combination		
Female obstetrician at hospital	337	(68.1)
Male obstetrician at hospital	72	(14.5)
Female obstetrician at home	60	(12.1)
Male obstetrician at home	2	(0.4)
Midwife at hospital	4	(0.8)
Midwife at home	20	(4.0)

^{*} Total does not always add to 500 due to missing values.

Table 4

Comparison of Women's Preferences and Actual Care During Childbirth

<u>Preferred Place of Delivery</u>				
<i>Actual Place of Delivery</i>	<i>Hospital</i>	<i>Home</i>	<i>McNemar χ^2</i>	<i>p</i>
Hospital	278 (95.5%)	21 (24.1%)	1.4	>0.05
Home	13 (4.5%)	66 (75.9%)		
Total	291	87		

<u>Preferred Birth Attendant</u>				
<i>Actual Birth Attendant</i>	<i>Doctor</i>	<i>Midwife</i>		
Doctor	261 (89.1%)	42 (41.2%)	1.1	>0.05
Midwife	32 (10.9%)	60 (58.8%)		
Total	293	102		

Table 5**Reasons for Preferences as Stated by Study Women**

<i>Reason</i>	<i>No.</i>	<i>(%)</i>
Shyness of male obstetricians	76	(17)
It is much safer to give birth at hospital	60	(13.5)
Female obstetricians provide better psychological support	56	(12.6)
Male obstetricians are more skillful	32	(7.2)
No sex preference because competence is more important	28	(6.3)
Home because participant hates the hospital	26	(5.9)
Prefer home because it is cheaper	22	(5)
Prefer home because it is “ <i>astar</i> ” [*]	22	(5)
Feels more comfortable with female obstetricians	20	(4.5)
Hospitals are well equipped if complications occur	18	(4.1)
Prefer hospital for high-risk pregnancies only	18	(4.1)
Does not go to male obstetricians for religious reasons	16	(3.6)
No sex preference because patience is more important	14	(3.2)
Husband does not allow wife to go to a male doctor	12	(2.7)
Feels more comfortable at home	12	(2.7)
Midwives are less skillful	8	(1.8)
Prefers home due to lack of privacy at hospital	4	(0.9)
No sex preference because continuity of care is more important	4	(0.9)
Other reasons	18	(4.1)
Total	466	

^{*}“Astar” is an Arabic word that refers to shyness of male doctors, also to the preference of being exposed to one person rather than many.