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Satisfaction with birth experience at home compared with other birth settings

Charitou Anastasia (Χαρίτου Αναστασία)

Maia, MSc in Advanced and Evidence Based Midwifery Care - Community Midwifery

Background: The number of women choosing home birth is increasing. High quality maternal birth care cannot be realized unless the childbearing woman is satisfied. The purpose of this study was to compare satisfaction with the birth experience among women planning birth at home versus in alternative planned places of birth.

Methods: A systematic search of the electronic databases (Medline, Cochrane, CINAHL, EMBASE, and Scopus) was undertaken. Finally, only 4 articles were chosen in accordance with the selected criteria.

Results: Satisfaction was higher for women who had both planned to deliver in a home or a birth center, and who had actually delivered in a home or a birth center, compared with those who ended up planning to deliver in a hospital or had planned a home birth or birth center birth and actually delivered in a hospital.

Conclusion: Being respected, in control and listened to, are important constructs of birth satisfaction and were rated highly by the childbearing women. From this study, we have found that the environment can affect a woman's birth satisfaction, and how we can apply certain positive features from the environment to each woman's labour and delivery.

Keywords: Satisfaction in labor, birth experience at home, birth center

1. Introduction

Women's satisfaction with maternity care is important to healthcare professionals, hospital administrators and policy makers (Sawyer et al. 2013, Jenkins et al. 2014). In addition to the outcomes of maternal and infant morbidity and mortality, addressing components that constitute women's satisfaction with maternity care should be a focus of maternity services in the 21st century (Lewis et al. 2016). Women who have had increased obstetric intervention such as induction of labour are generally less satisfied with their care (Henderson and Redshaw 2013). Indeed, a study comparing satisfaction with mode of birth found most women prefer a vaginal birth and that maternal satisfaction with vaginal birth was high (Dunn etHerlihy 2005). A systematic review suggested continuous support from caregivers markedly improves maternal satisfaction (Hodnett 2002; Lewis et al. 2016). This finding is unsurprising as continuous support has the capacity to improve comfort, emotional

support, information and advocacy, thereby enhancing the perception of control (Hodnett et al. 2013).

Recently there has been an increase of out-of-hospital births (e.g., Homes, Birth Centres) occurring in the industrialised world (Hodnett et al. 2010; Olsen and Clausen, 2012; MacDorman et al. 2014).

Several studies comparing home and hospital birth have shown that home birth is just as safe as hospital birth (Ackermann-Liebrich et al.1996; Borquez et Wiegers 2006; Wiegers et al. 1996; Olsen 1997; Janssen et al. 2002) for both the mother and the baby. Researchers have found that fewer interventions and less medication were given to women who delivered at home compared with women who delivered in the hospital. Women who planned to deliver at home were also less likely to have an epidural, have an induced labour, have their labours augmented with oxytocin or prolactins, or have an episiotomy (Ackermann-Liebrich et al., 1996; Borquez et Wiegers 2006).

High quality maternal birth care cannot be realized unless the child bearing woman is satisfied (Fleming et al. 2016). Although numerous studies have examined perinatal outcomes associated with homebirth, and none have found an elevation in risk associated with homebirth, (Chamberlain et al. 1999; Janssen et al. 1994,Wiegers et al 1996, Ackermann-Liebrich 1996, Gulbransen et al 1999, Janssen et al 2002) few comparison studies have examined women's satisfaction with birth in the home environment (Janssen et al.2006). Research quantifying women's birth satisfaction using a valid and reliable tool is limited and has been primarily focused on hospital births (Hollins Martin and Fleming,2011; Hollins Martinetal.,2012; Hollins MartinandMartin,2014; Barbosa-Leiker et al. 2015; Vardavaki et al.,2015; Hollins Martin and Martin,2015; Fleming et al. 2016).

Prior research related to the decision to give birth at home indicates that women may feel more comfortable in their own surroundings, may feel it is safer, or may wish to avoid unnecessary medical intervention (Boucher et al. 2009; Cheyney 2008; Borquez 2006; De Freitas Calvette et al. 2011; Catling-Paull et al. 2010; Christiaenset Bracke 2009; Janssen et al. 2006; Lindgren et Erlandsson 2010; Sjoblom et al. 2006) and may wish have freedom to move (Boucher et al 2009).

Lock and Gibb (2003) studied the relationship between birth setting and overall birth experience; they found that the feelings of women who entered the foreign place of the hospital to have their children were those ofalienation and disempowerment, whereas women who delivered in the familiar territory of their home reported stronger feelings of security and support. Green and Baston (2003) found that feeling in control during labour often correlates with a greater satisfaction with the birth experience. It is also known that women who have given birth in a specific birth centre were less satisfied than those who have given birth at home (Borquez et Wiegers 2006; Hitzert et al. 2016). In Australia, women giving birth at home rated their midwives higher than women giving birth at a hospital, with women giving birth in a birth centre generally scoring between the other two groups (Cunningham 1993). Recently it was suggested that transfer of care during labour affects patient satisfaction particularly among women who plan home birth (Chervenak et al. 2013). It is speculated that transportation from the home to a hospital during labour might contribute to this (Geerts et al.2017).

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The aim of this study was to examine the childbirth experience in relation to the environment and determine whether there is a difference in the perception of women's labour and birth satisfaction between women who delivered without complications: at home and in alternative planned places of birth.

2. Methods

A systematic search of the electronic databases (Medline, Cochrane, CINAHL, EMBASE, and Scopus) was undertaken, to identify related studies, using the terms "place", "birth", "satisfaction", "home" in combination. Additional searches were conducted based on the references of the selected researches. Initially, 426 articles were found . Titles and abstracts were examined for relevance to the review objective. Following the assessment of the titles and abstracts, 381 references were excluded because they were not relevant to the objective of the study. Finally, only 4 were chosen in accordance with the selected criteria. Studies that met the inclusion criteria were then evaluated for methodological quality.

Inclusion criteria were:

1) English language.
2) Studies that measured satisfaction of home birth using a valid instrument.
3) Quantitive studies.
4) Studies took place between 2006-2017.

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3. Results

Table 1. Methodological characteristics of included studies

Author information and year	Title	Country	Sample Size	Sampling (kind)	Follow up
Fleming et al. 2016	Birth Satisfaction Scale/Birth Satisfaction Scale-Revised (BSS/BSS-R): A large scale United States planned home birth and birth centre survey.	United States	2229 women	Via electronic linkages	No
Christiaens et Bracke 2009	Place of birth and satisfaction with childbirth in Belgium and the Netherlands.	Belgium and Netherlands	611 women.	Convenience sample	A total of 833 women completed the questionnaire at 30 weeks gestation; a second questionnaire was completed by 611 of these women the first 2 weeks after birth.
Geerts et al 2017	Satisfaction with caregivers during labour among low risk women in the Netherlands: the association with planned place of birth and transfer of care during labour.	Netherlands	2251 women.	Not mentioned.	Three questionnaires: one before 34 weeks gestation (the 1st questionnaire), one between 34 weeks gestation and birth (the 2nd questionnaire), one approximately 6 weeks postpartum (the 3rd questionnaire).
Janssen et al. 2006	Satisfaction With Planned Place of Birth Among Midwifery Clients in British Columbia.	British Columbia, Canada	670 women.	Not mentioned.	No follow up : questionnaire was onlycompleted prior to 6 weeks' Postpartum.

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Table 1. (Continued)

Randomization	Research	Intervention	Inclusion criteria	Response rate
No	Survey	Questionnaire completion	Not mentioned	Not mentioned
No	Comparative study	Questionnaire completion	Inclusion criteria were speaking and understanding Dutch and age 18 years or older.	The estimations ranged between 19% and 68% for hospitals, and between 38% and 100% for the midwifery practices.
No	Prospective multi centre DELIVER (Data eerstelijns verloskundige) cohort-study	Questionnaire completion	Participants with singleton term pregnancies that were in midwifery care at the onset of labour were selected. Exclusion: Women who had care transferred for prolonged rupture of membranes (>24 h without contractions) were excluded. birth < 37 or > 42 weeks Transfer of care during pregnancy Medium risk at start of labour.	The response rate for participation was 62%.
No	Prospective cohort study	Questionnaire completion	Singleton fetus, cephalic presentation, term gestation (>36 and <42 completed weeks), and no more than one previous cesarean delivery. Exclusion criteria included preexisting serious medical conditions (e.g., cardiac or renal disease, insulin dependent diabetes, proteinuric preeclampsia or eclampsia, symptomatic placental abruption or placenta previa, or active genital herpes).	In the homebirth group response rate was 64%. In the hospital group, response rate was 76%.

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Ethical Approval	**Statistical Analysis**	**Sample size per group**	**Tools**
July 2015 an application was submitted to Seattle University's Internal Review Board (IRB). The IRB deemed that this survey was eligible for exempt status. Written Informed consent from all women.	Data was analysed using IBM SPSS version 22. Associations between variables were assessed using Pearson's r correlation coefficient. Internal consistency was assessed using Cronbach's alpha. Comparisons between groups were conducted using Mann–Whitney Independent-Samples and Kruskal– Wallis Independent-Samples tests. T-test and One-way Analysis of Variance (ANOVA) were used.	Home Birth group :1436 Birth Centre group: 441 Hospital group: 344	30-item Birth Satisfaction Scale (BSS) and the 10-item Birth Satisfaction Scale-Revised (BSS-R).
Written informed consent was requested from participants. Anonymity was ensured as no personally identifiable data were collected. The Committee for Ethics of the University Hospital approved the study.	Analysis of variance. Scheffe test for a variable combining country and planned place of birth.	265 were Belgian and 346 Dutch.	Mackey Childbirth Satisfaction Rating Scale.
The participants gave informed consent.	Baseline and pregnancy related characteristics and labour outcomes were compared between low risk women who planned to give birth at home versus women who planned to give birth in hospital using student's t-test for continuous and chi-square test for categorical characteristics. The association between planned place of birth and satisfaction with the caregiver during labour was analysed using multilevel logistic regression analysis. A sensitivity analysis was performed including women with and without discrepancies in the definition for start of labour in primary care. The analysis were performed using SPSS 20.0 and Stata 10. Statistical significance was considered with a p-value <0.05.	1372 women planned a home birth (61%) and 829 (37%) women planned a hospital birth. Planned place of birth was unknown in 50 women (2%).	Consumer Quality index.
Approval for the study was obtained from the University of British Columbia Clinical Research Ethics Board. Clients provided written informed consent to participate in the study.	Total scores for the Labour Agentry Scale were compared by using the *t* test. Scores for questions using a five-point Likert Scale were compared by using a nonparametric statistic, the Mann- Whitney *U*. Categorical variables were compared by using the chi-square statistic and Fischer's exact test. Cluster analysis was performed to determine whether there were identifiable groups of women who reported similar feelings in labor agentry. The chi-square statistic was used to test the association between cluster membership and planned place of birth.	Women who had planned a homebirth (n= 550). Women planned birth in hospital (n= 108)	Labour Agentry Scale among

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Table 1. (Continued)

Results	Conclusions
Significant differences were found between groups differentiated by birth setting (setting: home birth versus birth center versus hospital birth) on the BSS total score, x^2 (3)=544.09, p<0.001, BSS stress during labour subscale score, x^2(2)=452.89, p<0.001, BSS quality of care subscale score, x^2 (2)=553.78, p<0.001, and the BSS women's attributes subscale score, x^2 (2) = 367.86, p < 0.001.Further,similar statistically significant differences were observed in the BSS-R total score, x^2 (2)=388.07, p <0.001,BSS-R stress during labour subscale score, x^2 (2)=340.87, p<0.001,BSS-R quality of care subscale score, x^2 (2)= 292.87, p<0.001,and the BSS-R women's attributes subscales core, x^2 (2)= 272.50, p<0.001.The Dunn-Bonferroni post-hoc tests revealed these differences are significant between home births and hospital births where home births had higher total and subscale scores. There were no significant differences in birth satisfaction scores between mothers who delivered at home and mothers who delivered at a birth center. Satisfaction was higher for women with vaginal births compared with caesareans deliveries. Mothers planning to have a home birth and a birth center delivery had significant higher total and subscale scores when compared to mothers who planned to give birth at a hospital. Significant differences were found between mothers who had planned to give birth at home or at a birth center and ended up giving birth at a hospital, on the BSS total score (U =33,906, p<0.001). No significant correlations were detected between mothers' current age and BSS total scores.	Total birth satisfaction scores were positive and high for the overall sample. Satisfaction was higher for women with vaginal births compared with caesareans deliveries. In addition, satisfaction was higher for women who had both planned to deliver in a home or a birth center, and who had actually delivered in a home or a birth center, compared with those who ended up planning to deliver in a hospital or had planned a home birth or birth center birth and actually delivered in a hospital. Being respected, in control and listened to, are important constructs of birth satisfaction and were rated highly by the childbearing women of this study.
In both countries, women were least satisfied with self-related aspects of birth, with 48.1% in Belgium and 30.4% in the Netherlands. In Belgium, midwife support accounted for the largest percentage of satisfied women (85.5%), compared with support of the partner in the Netherlands (69.0%). However, in both Belgium and the Netherlands, more women reported being (very) satisfied with the support and skills of the midwife (85.5% and 66.1%, respectively) than with the doctor (71.7% and 47.9%, respectively). In general, the percentage of satisfied or very satisfied women was greater in Belgium compared with the Netherlands. Belgian women planning for a home birth were more satisfied than the others (i.e. Belgian women planning for a hospital birth, Dutch women planning for a home birth, and Dutch women planning for a hospital birth) at the 1% significance level. Dutch women planning for a home birth lagged behind in comparison with the Belgian women planning for a home birth. For the other subdimension of satisfaction with childbirth (the baby, the midwife and the partner), Belgian women showed significantly higher means compared with Dutch women (baby: F = 13.542, p<0.001; midwife: F =36.428, p<0.001;partner: F = 10.664, p<0.01, in that order). It is clear that homebirths brought about higher satisfaction scores compared with hospital births (baby: F = 13.946, p<0.001;midwife: F = 20.396, p<0.001; partner: F = 5.426, p<0.05). Multiparous women were more satisfied with child birth in general (F = 25.206, po0.001) and relation to the self (F ¼ 8.860, po0.01) and the baby (F =37.197, p<.001). No significant differences were reported in satisfaction about the midwife(F = 3.537, p>0.05) or partner (F =3.385, p>0.05)	Women who had planned a home birth were the most satisfied (in both countries), but Belgian women had higher satisfaction scores than Dutch women. This is paradoxical because a non-medical home context has a beneficial effect on satisfaction, whereas the Dutch non-interventionist approach in maternity care does not yield the same effect.

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Primiparous women who planned a home birth significantly more often had a high rate (9 or 10) for 'general satisfaction with caregiver' (adj.OR 1.48; 95% CI 1.1, 2.0). Also, primiparous women who planned a home birth and had care transferred during labour (331/553; 60%) significantly more often had a high rate (9 or 10) for 'general satisfaction' compared to those who planned a hospital birth and who had care transferred (1.44; 1.0–2.1). Furthermore, they significantly more often rated 'quality of treatment by caregiver' high, than 276/414 (67%) primiparous women who planned a hospital birth and who had care transferred (1.65; 1.2–2.3). No differences were observed for multiparous women who had planned home or hospital birth and who had care transferred.

The current study shows that planned home birth among low risk women does not lead to reduced satisfaction with caregiver compared to planned hospital birth. In addition, a transferred planned home birth compared to a transferred planned hospital birth does not lead to a more negative experience of care received from the caregiver.

Overall satisfaction with the birth experience was higher among women planning birth at home, 4.87± 0.42 versus 4.80 ± 0.49 on a scale of 1 to 5, although this difference was not statistically significant; $P = .06$. Among women whose actual place of birth was congruent with where they had planned, overall satisfaction was higher in the homebirth group, 4.95 ±0.20 versus 4.75 ± 0.53; $P < .001$.

Although satisfaction with the birth experience was high in both the home and hospital settings, women planning birth at home were somewhat more satisfied with their experience, particularly if they were able to complete the birth at home.

4. Discussion

In this review revealed that satisfaction was higher for women with vaginal births compared with caesarean deliveries. In addition, satisfaction was higher for women who had both planned to deliver in a home or a birth center, and who had actually delivered in a home or a birth center, compared with those who ended up planning to deliver in a hospital or had planned a home birth or birth center birth and actually delivered in a hospital.

Sense of control is known to be an important component of satisfaction with childbirth (Green et al. 1990). Women who had planned to give birth at home more often felt competent, responsible, secure, adequate, relaxed, victorious, good about their behavior and open and receptive to the experience than women who had planned birth in hospital. The homebirth group was more able to deal with labor. More than the hospital group, they experienced a sense of being with others who cared, of actively striving, of having a sense of perspective on what was happening, and of having a sense of success (Janseen et al. 2006). Researchers (Cunningham, 1993; Ackermann-Liebrich et al.,1996; Longworth et al., 2001) have found that women delivering at home were older, more educated, more feminist, and more willing to accept responsibility for their health; these women were also found to have greater self-determination, greater desire to influence and determine the birth themselves, and sought greater intimacy in the birth setting than women delivering in the hospital (Borquez et al. 2006).

It is likely that, within the home, control, continuity and choice are easier to achieve in the absence of pathology and structures of constraint, such as thr changing shifts of the hospital staff, hospital routines, continuous monitoring and other medical technologies. Medical technology offers options for women who experience difficulties during labour and birth; in such cases, erosion of control, continuity and choice is considered a price worth paying in exchange for greater safety (Cahill, 2001). However, in cases of normal spontaneous birth, the medical

equipment limits options such as moving around, thereby constraining the freedom of the women during labour. Home births, offer less opportunity and fewer temptations to use technology, and the risk of iatrogenesis is therefore reduced (Cahill 2001).

We expected to find higher satisfaction scores among women having home births than women having hospital births, because midwifery practice encourages the continuity of care, involvement in decision-making and feelings of control (Hyde and Roche-Reid, 2004). The three Cs (continuity, choice and control) have been identified as the most important determinants of a pleasing birth (Hundley et al., 1997).

In a hospital setting, noise, lack of privacy, dissatisfaction with food, and the involvement of a number of different caregivers are all factors that contribute to dissatisfaction (Janssen et al. 2000) and women planning hospital birth may have underestimated the impact of these factors (Janssen et al. 2006).

Satisfaction with childbirth was associated with the place of birth (or the level of practice), but also with the ideology of maternity-care systems, even after adjustment for place of birth (Christiaenset Bracke 2009). Belgian women planning for a home birth were more satisfied than the others (i.e. Belgian women planning for a hospital birth, Dutch women planning for a home birth, and Dutch women planning for a hospital birth). Perhaps Dutch women have higher expectations about continuity, decision-making and control, which are not easily attained in the hospital context. In contrast, Belgian women having a hospital birth may not expect continuity of carer, nor involvement in decision-making, because they believe the doctor knows best.

Research regarding birth satisfaction is limited, particularly as it relates to birth center and home birth (Fleming et al. 2016) and for this reason further research is needed.

5. Conclusion

The perception of women's birth experiences is an important part of evaluating the labour and delivery process and outcome as a whole. Being respected, in control and listened to, are important constructs of birth satisfaction and were rated highly by the childbearing women. This study has shown that the environment can affect a woman's birth satisfaction, and how we can apply certain positive features from the environment to each woman's labour and delivery. Further research should address ways to prevent or mitigate the anxiety, uncertainty, and lack of control experienced in the hospital setting. Midwives may counsel their clients that women are generally happier with the birth experience after planning a homebirth, although satisfaction with the birth experience, including midwifery care, is high in both settings. The current study challenges midwives to try to address those aspects of the hospital environment that are less satisfying to their clients.

References

Ackermann-Liebrich, U., Voegeli, T., Gunter-Witt, K., et al.(1996) Home versus hospital deliveries: follow up study of matched pairs for procedures and outcome. British Medical Journal 313, 1313–1318.

Barbosa-Leiker, C.,Fleming,S.,HollinsMartin,C.J.,Martin,C.R. (2015) Psychometric propertiesoftheBirthSatisfactionScale-Revised(BSS-R)forUSmothers. Journal ofReproductiveandInfantPsychology33,504–511. http://dx.doi.org/ 10.1080/02646838.2015.1024211.Borquez H. A., Wiegers T.A. (2006) A comparison of labour and birth experiences of women delivering in a birthing centre and at home in the Netherlands, Midwifery,22: 339–347.

Boucher D, Bennett C, McFarlin B, Freeze R. (2009) Staying home to give birth: why women in the United States choose home birth. J MidwiferyWomens Health, 54:119–126.

Cahill, H.A.,2001.Male appropriation and medicalization of childbirth: an historical analysis. Journal of Advanced Nursing 33, 334–342.

Catling-Paull C, Dahlen H, Homer C. (2010) Multiparous women's confidence to have a publicly-funded homebirth: a qualitative study. Women Birth., 24:122-128

Chamberlain G, Wraight A, Crowley P. (1999) Birth at home: A report of the national survey of home births in the UK by the National Birthday Trust. PractMidwife ,2:35–9.

Chervenak FA, McCullough LB, Brent RL, Levene MI, Arabin B.,(2013) Planned home birth: the professional responsibility response. Am J Obstet Gynecol., 08(1):31–8.

Cheyney MJ.,(2008) Homebirth as systems-challenging praxis: Knowledge, power, and intimacy in the birthplace. Qual Health Res., 18(2):254-267.

ChristiaensW, Bracke P. (2009) Place of birth and satisfaction with childbirth in Belgium and the Netherlands. Midwifery, 25:e11-e19.

Cunningham, John D., (1993) Experiences of Australian mothers who gave birth either at home, at a birth centre, or in hospital labour wards. Social Science & Medicine, 36,475–483.

De Freitas Calvette M, Atherino dos Santos EK, SorgattoCollaco V, Granemann B, De Bona Dario L.(2011) Planned homebirth in Brazil with nurse-midwife assistance: Perceptions of women and companions. Midwifery Today., 98:55-60.

Dunn E, Herlihy C., (2005) Comparison of maternal satisfaction following vaginal delivery after caesarean section and caesarean section after previous vaginal delivery. Eur J ObstetGynecolReprod Biol.,121(1):56–60.

Fleming S.E ,Donovan-Batson C., Burduli E.,Barbosa-Leiker C.,.Hollins Martin C.J , Martin C. R., (2016) Birth Satisfaction Scale/Birth Satisfaction Scale-Revised (BSS/BSS-R): A large scale United States planned home birth and birth centre survey, Midwifery 41:9–15.

Geerts C.C.,,Dillen J.,Klomp T., Lagro-Janssen A. L.M., and Ank de Jonge, (2017) Satisfaction with caregivers during labour among low risk women in the Netherlands: the association with planned place of birth and transfer of care during labour, BMC Pregnancy and Childbirth,17:229.

Green, J.M., Baston, H.A., (2003) Feeling in control during labor: concepts, correlates, and consequences. Birth 30, 235–247.

Green J, Coupland V, Kitzinger J.(1990) Expectations, experiences,and psychological outcomes of childbirth: A prospectivestudy of 825 women. Birth,17:15–23.

Gulbransen G, Hilton J, McKay L, Cox A.,(1997) Home birth in New Zealand 1973–93: Incidence and mortality. N Z Med J.,110;87–9.

DOI:

Henderson J, Redshaw M., (2013) Women's experience of induction of labor: a mixed methods study. ActaObstetGynecol Scand.,92(10):1159–67.

Hitzert M., Hermus M. A. A., Scheerhagen M. , Boesveld I. C., Therese T.A., Akker-vanMarle M.E, , Dommelen P., K. M.van der Pal-de Bruin, , Graaf J. P. , (2016) Experiences of women who planned birth in a birth centre compared to alternative planned places of birth. Results of the Dutch Birth Centre Study, Midwifery 40:70–78.

Hodnett E., (2002) Pain and women's satisfaction with the experience of childbirth: a systematic review. Am J Obstet Gynecol., 185 (5 SupplNature):S160–72.

Hodnett E., Downe, S., Walsh, D., et al., (2010) Alternative versus conventional institutional settings for birth.Cochrane Database of Systematic Reviews, D000012.

Hodnett E, Gates S, Hofmeyr G, Sakala C.,(2013) Continuous support for women during childbirth. Cochrane Database of Syst Rev.,7:CD003766.

Hollins Martin,C.J.,Fleming,V., (2011) TheBirthSatisfaction Scale(BSS). International JournalofHealthCareQualityAssurance24,124–135.

Hollins Martin,C.J.,Martin,C.R., (2015) Asurveyofwomen'sbirthexperiencesin Scotland usingtheBirthSatisfactionScale(BSS).EuropeanJournalforPerson CenteredHealthcare3,478–486.

Hollins-Martin, C.J.,MartinC., (2014) Developmentandpsychometricpropertiesof the BirthSatisfactionScale-Revised(BSS-R).Midwifery30,610–619. http://dx. doi.org/10.1016/j.midw.2013.10.006.

Hollins Martin,C.J.,Snowden,A.,Martin,C.R., (2012) Concurrentanalysis:validation of thedomains withintheBirthSatisfactionScale.JournalofReproductiveand Infant Psychology30,247–260. http://dx.doi.org/10.1080/ 02646838.2012.710833.

Hundley,V.A.,Milne,J.M.,Glazener,C.M.,A.,etal., (1997) Satisfaction and the three C's: continuity, choice and control, Women's views from a randomized controlled trial of midwife-led care. British Journal of Obstetrics and Gynaecology 104,1273–1280.

Hyde, A., Roche-Reid,B.,(2004) Midwiferypracticeandthecrisis of modernity: implications for the role of the midwife. Social Science &Medicine58,2613–2623

Janssen P.,Carty E. A, Reime B., (2006) Satisfaction with Planned Place of Birth among Midwifery Clients in British Columbia, Journal of Midwifery & Women's Health, 51:91–97, doi:10.1016/j.jmwh.2005.10.012.

Janssen P, Harris S, Soolsma J, Seymour L, Klein M. (2000) Single room maternity care and client satisfaction.Birth, 27:235– 43.

Janssen P, Holt V, Myers S. (1994) Licensed midwife-attended, out-of-hospital births in Washington State: Are they safe? Birth, 21:141– 8.

Janssen, P.A., Lee, S.K., Ryan, E.M., et al., (2002) Outcomes of planned home births versus planned hospital births after regulation of midwifery in British Columbia. Canadian Medical Association Journal 166, 315–323.

Jenkins M, Ford J, Morris J, Roberts C. (2014) Women's expectations and experiences of maternity care in NSW-what women highlight as important. Women Birth, 27(3):214–9.

Lewis L., Hauck1 Y.L., Ronchi F., Crichton C., Waller L., (2016) Gaining insight into how women conceptualize satisfaction: Western Australian women's perception of their maternity care experiences, BMC Pregnancy and Childbirth,16:29.

Lindgren H, Erlandsson K. (2010) Women's experiences of empowerment in a planned home birth: A Swedish population-based study. Birth., 37(4):309-317.

Longworth, L., Ratcliffe, J., Boulton, M., (2001) Investigating women's preferences for intrapartum care: home versus hospital births. Health and Social Care in the Community 9,404–413.

Lock, L.R., Gibb, H.J., (2003) The power of place. Midwifery 19,132–139.

Τόμος 01, Τεύχος 02, 4η Περίοδος

DOI:

MacDorman, M.F., Mathews T.J.,DeclercqE., (2014) TrendsinOut-of-HospitalBirths in theUnitedStates,1990–2012.NationalCenterforHealthStatistics,Hyattsville, MD,NCHSdatabrief,no144.

Olsen, O., (1997) Meta-analysis of the safety of home birth. Birth, 24, 4–16.

Olsen, O., Clausen, J.A., (2012) Planned hospital birth versus planned home birth. Cochrane Database Systematic Review 9, CD000352.

Sawyer A, Ayres S, Abbot J, Gyte G, Rabe H, Dudley L (2013) Measures of satisfaction with care during labour and birth: a comparative review. BMC Pregnancy Childbirth,13:108.

Sjoblom I, Nordstrom B, Edberg AK. (2006)A qualitative study of women's experiences of home birth in Sweden. Midwifery 22:348-355.

Wiegers, T.A., Keirse, M.J.N.C., van der Zee, J., et al., (1996) Outcome of planned home and planned hospital births in low risk pregnancies: prospective study in midwifery practices in the Netherlands. British Medical Journal 313, 1309–1313.

Δυσκοιλιότητα;

Η αποτελεσματική, ήπια
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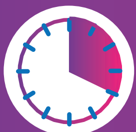
Πολλαπλά οφέλη



Δρα σε μόλις 5-20 λεπτά

Αρκεί μόνο 1 την ημέρα

Κατάλληλο στην εγκυμοσύνη & το θηλασμό από την 1η ημέρα

Εύκολο στη χρήση

Σημαντικά πιο λεπτό από υπόθετο

Εύκολη & υγιεινή εισαγωγή χωρίς τη χρήση χεριών

1. ΟΝΟΜΑΣΙΑ ΤΟΥ ΦΑΡΜΑΚΕΥΤΙΚΟΥ ΠΡΟΪΟΝΤΟΣ Microlax®
2. ΠΟΙΟΤΙΚΗ ΚΑΙ ΠΟΣΟΤΙΚΗ ΣΥΝΘΕΣΗ. Κάθε 5 ml ορθικού διαλύματος περιέχει:

Σορβιτόλη, υγρή (κρυσταλλική)	4,4650g
Κιτρικό Νάτριο	0.4500g
70% Θειοξικό Λαουρικό Νάτριο	0.0645g

4. ΚΛΙΝΙΚΕΣ ΠΛΗΡΟΦΟΡΙΕΣ 4.3 Αντενδείξεις Υπερευαισθησία στα δραστικά συστατικά ή σε κάποιο από τα έκδοχα που αναφέρονται στην παράγραφο 6.1. Μην χρησιμοποιείτε σε περίπτωση εντερικής απόφραξης ή κοιλιακού άλγους αγνώστου αιτιολογίας. Ταυτόχρονη θεραπεία με κατιονανταλλακτική ρητίνη σουλφονικού πολυστυρενίου του νατρίου ή του ασβεστίου (βλέπε παράγραφο 4.5). **4.4 Ειδικές προειδοποιήσεις και προφυλάξεις κατά τη χρήση** Ζητήστε ιατρική συμβουλή εάν τα συμπτώματα επιμένουν για περισσότερο από μερικές ημέρες και αποφύγετε παρατεταμένη χρήση. Η φαρμακευτική αγωγή της δυσκοιλιότητας είναι μόνο ένα πρόσθετο μέτρο σε έναν υγιεινό τρόπο ζωής που περιλαμβάνει: υψηλή πρόσληψη φυτικών ινών και υγρών και σύσταση για σωματική άσκηση και εκπαίδευση του εντέρου. Αυτό το φαρμακευτικό προϊόν δεν πρέπει να χρησιμοποιείται σε συνδυασμό με κατιονανταλλακτική ρητίνη σουλφονικού πολυστυρενίου του νατρίου ή του ασβεστίου (από του στόματος και από του ορθού): κίνδυνος νέκρωσης του παχέος εντέρου, πιθανώς θανατηφόρος. Συνιστάται να αποφεύγετε τη χρήση αυτού του φαρμακευτικού προϊόντος σε περίπτωση έξαρσης των αιμορροΐδων, πρωκτικών ραγάδων ή αιμορραγικής ορθοκολίτιδος. Πρέπει να χρησιμοποιείται με εξαιρετική προσοχή σε ασθενείς με φλεγμονώδεις ή ελκωτικές καταστάσεις του παχέος εντέρου ή με οξέα γαστρεντερικά προβλήματα. **4.5 Αλληλεπιδράσεις με άλλα φαρμακευτικά προϊόντα και άλλες μορφές αλληλεπίδρασης** Η ταυτόχρονη χορήγηση σορβιτόλης και ασβεστίου ή σουλφονικού πολυστυρενίου του νατρίου (χορήγηση από του στόματος / από το ορθό) αντενδείκνυται: ο κίνδυνος εντερικής νέκρωσης είναι δυνητικά θανατηφόρος. Η χρήση άλλων φαρμακευτικών ορθικών προϊόντων θα πρέπει να γίνεται σε διαφορετικές ώρες από τη χρήση του Microlax καθώς μπορεί να εκπλυθεί από τον γαστρεντερικό σωλήνα και να μην απορροφηθεί.

4. ΚΛΙΝΙΚΕΣ ΠΛΗΡΟΦΟΡΙΕΣ 4.3 Αντενδείξεις
Υπερευαισθησία στα δραστικά συστατικά ή σε κάποιο από τα έκδοχα που αναφέρονται στην παράγραφο 6.1. Μην χρησιμοποιείτε σε περίπτωση εντερικής απόφραξης ή κοιλιακού άλγους αγνώστου αιτιολογίας. Ταυτόχρονη θεραπεία με κατιονανταλλακτική ρητίνη σουλφονικού πολυστυρενίου του νατρίου ή του ασβεστίου (βλέπε παράγραφο 4.5).

4.4 Ειδικές προειδοποιήσεις και προφυλάξεις κατά τη χρήση Ζητήστε ιατρική συμβουλή εάν τα συμπτώματα επιμένουν για περισσότερο από μερικές ημέρες και αποφύγετε παρατεταμένη χρήση. Η φαρμακευτική αγωγή της δυσκοιλιότητας είναι μόνο ένα πρόσθετο μέτρο σε έναν υγιεινό τρόπο ζωής που περιλαμβάνει: υψηλή πρόσληψη φυτικών ινών και υγρών και σύσταση για σωματική άσκηση και εκπαίδευση του εντέρου. Αυτό το φαρμακευτικό προϊόν δεν πρέπει να χρησιμοποιείται σε συνδυασμό με κατιονανταλλακτική ρητίνη σουλφονικού πολυστυρενίου του νατρίου ή του ασβεστίου (από του στόματος και από του ορθού): κίνδυνος νέκρωσης του παχέος εντέρου, πιθανώς θανατηφόρος. Συνιστάται να αποφεύγετε τη χρήση αυτού του φαρμακευτικού προϊόντος σε περίπτωση έξαρσης των αιμορροΐδων, πρωκτικών ραγάδων ή αιμορραγικής ορθοκολίτιδος. Πρέπει να χρησιμοποιείται με εξαιρετική προσοχή σε ασθενείς με φλεγμονώδεις ή ελκωτικές καταστάσεις του παχέος εντέρου ή με οξέα γαστρεντερικά προβλήματα. **4.5 Αλληλεπιδράσεις με άλλα φαρμακευτικά προϊόντα και άλλες μορφές αλληλεπίδρασης** Η ταυτόχρονη χορήγηση σορβιτόλης και ασβεστίου ή σουλφονικού πολυστυρενίου του νατρίου (χορήγηση από του στόματος / από το ορθό) αντενδείκνυται: ο κίνδυνος εντερικής νέκρωσης είναι δυνητικά θανατηφόρος. Η χρήση άλλων φαρμακευτικών ορθικών προϊόντων θα πρέπει να γίνεται σε διαφορετικές ώρες από τη χρήση του Microlax καθώς μπορεί να εκπλυθεί από τον γαστρεντερικό σωλήνα και να μην απορροφηθεί.

Οργανικό σύστημα Κατηγορία συχνότητας	Ανεπιθύμητη ενέργεια
Διαταραχές του ανοσοποιητικού συστήματος Μη γνωστές	Κοιλιακό άλγος[α],Δυσφορία ορθοπρωκτικού Χαλαρά κόπρανα
Διαταραχές του γαστρεντερικού συστήματος Μη γνωστές	Αντιδράσεις υπερευαισθησίας (π.χ. κνίδωση)

α: Περιλαμβάνει τους προτεινόμενους όρους: Κοιλιακή δυσφορία, Κοιλιακό άλγος και άλγος άνω κοιλίας.

Βοηθήστε να γίνουν τα φάρμακα πιο ασφαλή και Αναφέρετε
ΟΛΕΣ τις ανεπιθύμητες ενέργειες για ΟΛΑ τα φάρμακα. Συμπληρώνοντας την "Κίτρινη Κάρτα".

7. ΚΑΤΟΧΟΣ ΤΗΣ ΑΔΕΙΑΣ ΚΥΚΛΟΦΟΡΙΑΣ
Johnson & Johnson Hellas Consumer AE
Αιγιαλείας & Επιδαύρου 4, 15125, Μαρούσι, Αθήνα, Ελλάδα
Περαιτέρω πληροφορίες διατίθενται από τον κάτοχο άδειας κυκλοφορίας κατόπιν αιτήσεως.

Johnson & Johnson
ΚΑΤΑΝΑΛΩΤΙΚΑ ΠΡΟΪΟΝΤΑ ΑΕΕ