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Childbirth Experiences among High Risk Primipara Women at Mansoura University Hospital

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Abstract: **This study aimed to explore childbirth experiences among high risk primipara women. Design: A descriptive study was utilized. Subjects: A purposive sample consisted of 110 women who met the inclusion criteria. Setting: The study was carried out at labor and delivery unit at Mansoura University Hospital, from February 2017 to July of 2017. Study Tools: The data has been collected using two tools, A structured interviewing questionnaire and the expectation and experience of birth scale. Results: The study result revealed that the Mean± SD of the age was (23.6±14.8), the gestational age among studied sample was ranged from 38- 40 WKs and have different types of high risk condition such as PROM 39.1%, & pre eclampsia 30.9%. 48.2%ofwomen had birth vaginally & 36.3% by CS. Around three quarter (72.7%) had positive experience regarding getting intravenous fluids, more than two third of them had positive experience regarding fetus health will be checked by special instruments, performing vaginal examination for checking cervix dilatation and deliver by a male doctor(70.9%, 70% &69.1%). While more than half had negative experience regarding supportive measures, information given to women and communication between nurses and women (56.3%, 53.7% & 50.9%) respectively. Conclusion: The current study concluded that the majority of studied women had a positive experience regarding food & fluids withhold during labor. While more than had negative experience regarding supportive measures, information given to women & communication between nurses and women. Recommendation: Knowing women's expectations are very important in shaping high risk women's experience during childbirth.**

Keywords: **Childbirth experience, High risk, Primipara.**

I. INTRODUCTION

Pregnancy and delivery are unique experience for women. Mothers and families hold different expectation during childbearing based on their knowledge, experiences, belief systems, culture, and social back ground. These differences should be understood and respected, and care should be adapted and organized to meet womens needs ***(Iravani, etal.,2015).***

High-risk (HR) pregnancy is defined as ―any condition which could increase the likelihood of risks for mothers or fetus‖, such as pre-existing medical disorders, like diabetes mellitus and hypertension, multiple pregnancies, preeclampsia and premature labor.**(van- Stenus, etal., 2018).** Women going through high-risk pregnancies may require complex & especial care involving lifestyle modifications, pharmacological and technical support and even hospitalization. As a result, these women may experience feelings of vulnerability because they have a high-risk pregnancy and thus be more exposed to stressful feelings that affect their health and her fetus. If complications appear, women are transferred to an obstetrician or tertiary care **(Borba et al., 2016)**.

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High-risk pregnancies affect a significant number of women each year. Approximately 22% of all pregnant women are classified as having high-risk pregnancies (**Simmons & Goldberg 2011 and Borba et al., 2016)**. Also, all pregnancies are at risk even though most of the pregnancies and childbirth worldwide are uneventful. Almost 15% of all the pregnant women can develop potentially life-threatening complications which might require skilled care with some requiring major intervention for survival. **(WHO; 2017)** During the prenatal period and delivery, there are five main causes of death of pregnant women: severe bleeding, maternal infections, unsafe abortion, hypertension-related pregnancy disorders such as preeclampsia and eclampsia, and complications, medical conditions such as heart problems, or complicated diabetes complicated by pregnancy. **(WHO, 2018)**

Each pregnancy has its risks. When definite medical conditions occur before or during pregnancy, more careful monitoring is required. Pregnancies are consider "high risk" when there are complications with either the mother or the fetus that requires a team approach and careful monitoring and observation. All of health care providers have the expertise and resources available to manage high risk pregnancies. Women whose pregnancies are at risk are often subjected to emergency hospitalization and threats to themselves and their fetuses, which have a negative impact on themselves and their families. Women with high-risk pregnancies often experience emergency hospitalization and threats to themselves and their fetuses that negatively impact their experiences of pregnancy and childbirth. Several studies have shown that hospitalized women had a much more depressed and negative experience than women in other groups with whom they were compared.**(RISK,2012).**

Management using multidisciplinary care is important because most of these women with high-risk pregnancies require special interventions. Under certain conditions, potentially life-threatening complications or emergencies may occur that need to be identified effectively. Everyone involved in the health team must take effective action to ensure quality and safe maternal and fetal support, affecting their current and future experience **(Medeiros, et al., 2016).** Birth experiences are very individual and have personal meaning for women. Delivery memories are memorized for a lifetime. We often remember universal themes such as pain control and interactions with the health care provider ***(Mensah, Mogale, & Richter, 2014).*** In addition, a positive delivery experience is associated with lasting benefits, a positive relationship with the baby, and a positive attitude toward motherhood, which contributes to a woman's self-esteem.a negative birth experience, may alter future pregnancies by affecting a woman's future reproductive decisions. The mother's experience can affect her attitudes about her future birth pattern and caesarean section rates. ***(Zhang and Lu, 2014).***

Additionally; Childbirth can be an experience that changes women's lives and creates memories for life. Midwives must be aware of the needs of women during childbirth, such as emotional, physical and informational needs. Good interpersonal skills could reduce the fear associated with childbirth and subsequently contribute to a satisfactory delivery experience. ***(Lunda, Minnie, &Benadé, 2018).***

Experiences of childbirth are causing long-term consequences for the health and well-being of women especially high risk women. Birth satisfaction has been associated with several factors, primarily emotional dimensions of care & been shown to affect women's overall evaluation. Emotional support and care given by midwives and other staff helps women to increase the possibility of a positive birth experience. ***(Karlström, Nystedt, &Hildingsson, 2015).*** Also, maternity nurses play a vital role in the provision of obstetric services to mothers and infants. Nurses collaborate with expertise in various aspects of obstetric care such as pain management is needed to achieve safe motherhood which aligning expectations with experience is a crucial element in achieving the goal of promoting women's childbirth experiences. ***(Aziato, Kyei, &Deku, 2017) .***

Significance of the study

Not all pregnancies go smoothly. The pregnancy that poses a danger to the woman or fetus, is classified as high risk. A 'high risk pregnancy' sounds daunting, but like every other issue, knowledge is the key for coping with and treating the pregnancy. When they are coping well have positive experience during their pregnancy and giving without dangerous and feel well so they will have positive childbirth experience A positive experience of childbirth has important implications for maternal health during the postnatal period, as birth experiences are very individual and have a personal significance for women. The memories of giving birth are remembered for a lifetime. Memories of specific events may fade, but others may be remembered forever. Universal themes such as pain control and interactions with caregivers are often

intensely evoked and are associated with women's satisfaction with their birth experiences. Similarly, if these themes are neglected and not achieved, negative feelings may remain in women, which may affect their attitude to future pregnancies and interrupting the progress of labor ***(Pirdel and Pirdel ,2015) .***

Many studies have been done studying practices provided to women in labor and women's satisfaction to care provided. Practices and satisfaction were behind the standardized care. But Egypt Vision 2030, in its way to achieve pillar 6, health for all Egyptians leads to a healthy, safe and secure life through an integrated, accessible, high quality and universal health system that can improve health conditions through early intervention and preventive coverage, reducing MMR 51.8% to 31%. Ensure the protection of vulnerable people and achieve the satisfaction of citizens and employees of the health sector. It will lead to prosperity, well-being, happiness, and social and economic development **(Egypt Vision 2030).** It is important from time to time to assess women's expectation and their real experience in order to achieve the standardized type of care from women's point of views.

Study aim

The current study aimed to explore the experience of high risk primipara women during childbirth

Study question

What are the experiences of high risk primipara women during their childbirth?

II. SUBJECTS AND METHOD

Study design

Descriptive study design was utilized.

Study setting

The study was conducted at the labor and delivery unit at Mansoura University Hospital which considered the most dominate health center in Mansoura city that provide free services to women during reproductive life cycle such as pregnancy, labor, postpartum and family planning. The delivery unit consists of 6 rooms. The first room is small room for pregnant women examination, which it contains 3 beds, supplies needed for examination. The second room is large room for first stage of labor which contains 8 beds, fetal heart rate monitoring machine and supplies. The third room is post partum room which contains 5 beds. The fourth room is high risk room which contains 4 beds. The fifth room is small room for sonar contains bed, machine of sonar. The sixth room is delivery room which it contains 2 beds and equipment with delivery.

Sample type

Purposive sample was used.

Study subject:

The study, subjects included 110 women in delivery unit who met the inclusion criteria include high risk primipara women during labour aged from 18-35 years

Sample size estiation:

To calculate the sample size with precision/absolute error of 5% and type 1 error of 5%:

Sample size = [(Z1-α/2)2.P(1-P)]/d2

Where, Z1-α/2 = is the standard normal variate, at 5% type 1 error ($p<0.05$) it is 1.96.

P = the expected proportion in population based on previous studies.

d = absolute error or precision. So, Sample size = [(1.96)2.(0.923).(1-0.923)]/(0.05)2 =109.2. For this study, a sample size was 110 women in delivery unit

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Tools of Data Collection:

Tool I: A structured interviewing questionnaire: it is designed by researchers after reviewing the related literatures. It consisted of:

Part I: Assessing high risk pregnant women general characteristics such as (Age, education, job, residence, and durationof marriage)**. Part II:** Assessing (types of risk, gestational age, place of follow up, mode of birth, duration of birth).

Tool II: The Expectation and Experience of Birth Scale: EEBS (Slade, et al., 1993)

This tool was adapted from (Scale Slade et al., 1993). It consisted of expectation and experience but in this study take women's experiences during childbirth, consisted of a 36-item which would be assessed by using (not satisfied, low satisfied, moderate satisfied, very satisfied). After modification became 34 item.

The Preparatory Phase:

Obtained all forms of approval form to conduct the study from approval of head of department(woman's health &midwifery nursing), Research Ethics Committee and director of (MUH) after explaining the aim and nature of the study.

Development of Study Tools Validity

*Tools used in the study were developed by the researcher after reviewing of the current local and international related literatures using books, articles and scientific magazines. This helped to be acquainted with the problem, and guided in the process of tools' designing. Tools were reviewed by three jury from experts university professor in maternity nursing field to test the content validity according to their comments modification were considered.

*Modifications of Women's experiences during labor and birth became 34-item based on pilot study modification and omitted 2 items from scale, The first item (I was delivered by a nurse) because the doctor only had the responsibility of perform delivery women in the (MUH) and the second item (I had my husband by my side) because the hospital policy don't allow for husband to be companionship for her wife during labor. The total score ranged from 34 to 136, the level of fulfill positive experiences is considered if the score is 85 and more ***(Pirdel and Pirdel, 2015).***

Reliability

All items of the tool were tested and analyzed for reliability by using Cronbach's α (alpha) and found it(0.764) so, it is reliable .

The Pilot Study Phase:

A pilot study conducted on 10% (11 female) of the sample to test feasibility, clarity and objectivity and applicability of the tools. Modifications were be considered. Also, to estimate the time needed to complete each tool. First tool needed 10 minute for completion and second tool needed 25 minute to complete. The high risk women of pilot study were excluded from the total sample size.

Ethical considerations

1. An ethical Approval was obtained from the head of woman's health and midwifery nursing department then approval from the Research Ethics Committee of the Faculty of Nursing at Mansoura University to conduct the study.

2. An approval was taken from the director of (MUH) and head of delivery unite to obtain the official permission to conduct the study after explaining the aim of the study

3. Prior to the study, written consent was obtained from each (HR) pregnant women enrolled in to the study after clarification of the purpose of the study.

4. The participant had the right to withdraw from the study at any time.

5. Anonymity, privacy, safety and confidentiality were absolutely assured throughout the whole study.

6. Code numbers instead of names of the pregnant women were used for identification.
7. After finishing data collection all sheets were be burned.

Study collection data:

The study conducted for over a period of 6 months from the start of February 2017 to the end July of 2017. Data were collected from delivery unit at (MUH), after obtaining the written approval from the director to conduct the study. The researcher introduced herself to the head of obstetrics and gynecology department at (MUH), took written permission to conduct study after clarification of the study aim. The researcher introduced herself to women, took informed consent of them to be included within the study after clarification of study aim. The researcher interviewed each woman individually for 35 minutes to complete filling of 1st tool , then assess woman's childbirth experiences after delivery. During the interview, the researcher read every item in the sheet of data collection & simplified its meaning to the woman. Women were allowed to ask for any interpretation, elaboration or clarification. The researchers attended the previously mentioned setting three days per week from 9 a.m. to 5 p.m until the calculated sample size of the high risk pregnant woman was obtained.

III. STATISTICAL DESIGN

The data were collected by questionnaires and structured tools, coded, computed and statistically analyzed using SPSS (statistical package of social sciences) version 20 (SPSS, Chicago, IL). All data were categorical data, were expressed in number and percentage as mean+SD and person correlation. Chi square (□2) test was used to compare categorical groups. Statistical significance was set at $p<0.05$.

IV. RESULTS

Part (I): General Characteristics of the studied women

Table (1): Distribution of studied women according to their socio demographic characteristics (n=110)

Items	No	%
Age		
18-23 years	33	30
24-29 years	59	53.6
30-35 years	18	16.4
Mean±SD	25.22±4.04	
Educational level		
Illiterate	21	19.1
Basic education	53	48.2
High education	36	32.7
Job		
Housewife	78	70.9
Employee	32	29.1
Residence		
Rural	82	74.5
Urban	28	25.5
Duration of marriage/months	Mean± SD	23.6±14.8

Table (1) shows that more than half of pregnant women (53.6%) was ranged between (24-29) years old and mean±SD (25.22±4.04). Concerning educational level, around half (48.2%) of women had only basic education. Also, about three quarters of women were housewives (70.9%). In addition to more than two third (74.5%) of them were from rural area and the mean±SD of marriage duration of them was (23.6±14.8) months.

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Part (II): Childbirth data

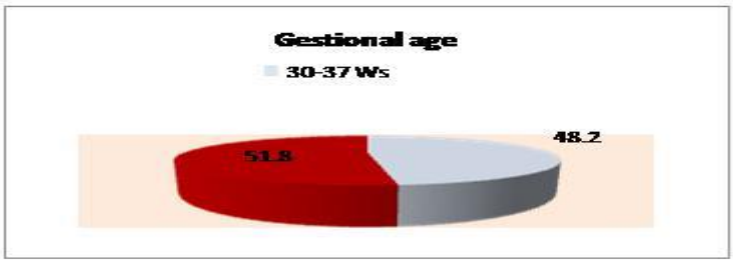

Fig.1: Distribution of studied women according to the gestational age (n=110) .

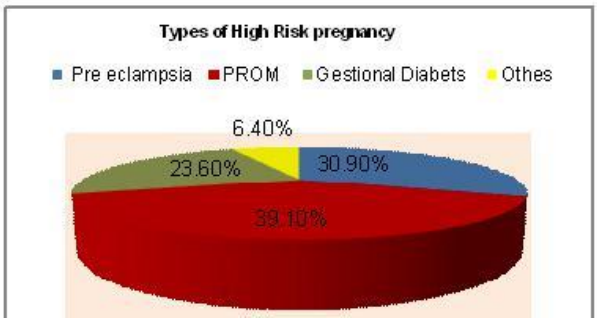

Fig 2: Distribution of studied women according to the types of high risk pregnancy (n=110)

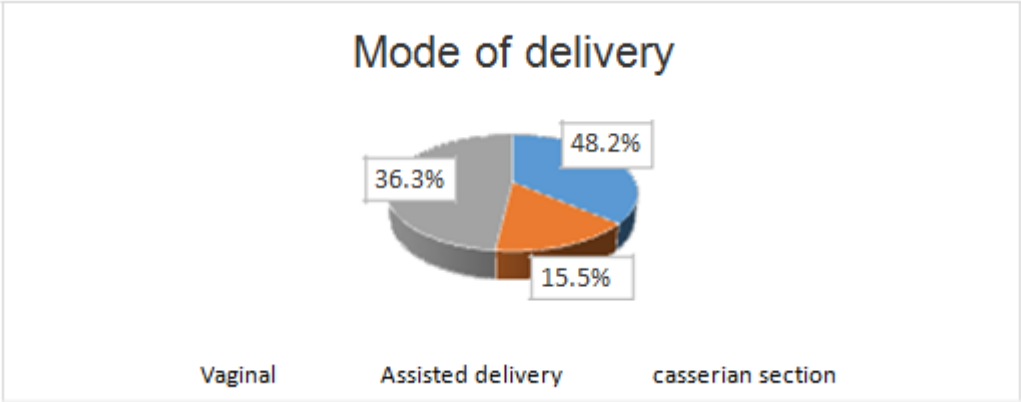

Figure 3: Distribution of studied women according to the mode of delivery(n=110)

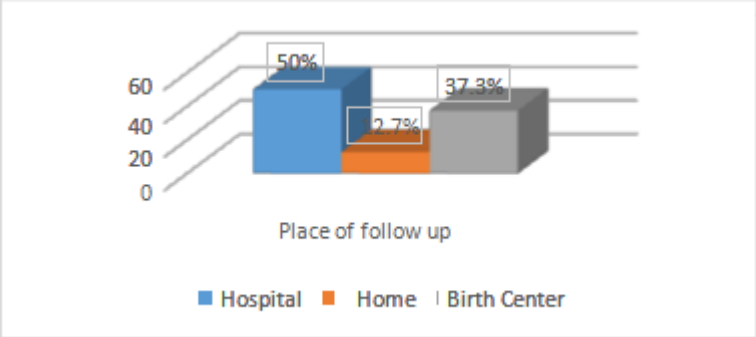

Figure 4: Distribution of studied women according to the place of follow up (n=110)

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Table (2A): Distribution of childbirth experiences regarding hospital practices fluid and care given to studied women. (n=110)

Situation happen during childbirth	Positive experience		Negative experience	
	No	%	No	%
Hospital practices	**(64.7%)**		**(35.3%)**	
Getting medication to reduce labor pain	58	52.7	52	47.3
Getting medication to induce labor	66	60	44	40
Getting intravenous fluids	80	72.7	30	27.3
Food and fluids withhold during labor child birth	94	85.5	16	14.5
Having anesthetic medication before the episiotomy	58	52.7	52	47.3
Care given to women	**(56.8%)**		**(43.2%)**	
My fetus health will be checked by special instruments	78	70.9	32	29.1
Performing vaginal examination for checking cervix dilatation	77	70	33	30
Using special comfortable position during delivery	40	36.3	70	63.6
Delivery occur in a private delivery room	53	48.2	57	51.8
Deliver by a male doctor	76	69.1	34	30.9
Giving birth with assisted forceps or vacuum instruments when I could no longer push	72	65.5	38	34.5
Having an operation to deliver your fetus if there any complications	59	53.6	51	46.4
Having an episiotomy	79	71.8	31	28.2
Doctor will be ready to help at any time when something was wrong during my delivery	50	45.5	60	54.5
Nurses are taking care of me during my labor and birth	43	39.1	67	60.9
My baby and myself were safe during labor and birth	47	42.7	63	57.3
Nurse give a very good care of my baby after birth	52	47.3	58	52.7

Table (2A) shows that more than two third of studied women had positive childbirth experience regarding, having hospital practices (64.7%), the majority among studied women had positive childbirth experience to hold food &fluid during labor (85.5%). While around half (47.3%) of studied women had negative experience about getting medication to reduce labor pain and anesthesia before episiotomy. Additionally, more than half of studied women had positive childbirth experience regarding care given to women (56.8%), the most of them had positive childbirth experience regarding having an episiotomy, fetus health will be checked by special instruments and vaginal examination for checking cervical dilation (71.8%,70.9%,70%,) respectively. While about two third of them had negative childbirth experience regarding using special comfortable position during delivery(63.6%) & more than half of women had negative experience regarding (57.3%) nurses are taking care of me during my labor and birth

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Table (2B): Distribution of childbirth experiences regarding supportive measures, and information given to studied women. (n=110)

Situation happen during childbirth	Positive experience		Negative experience	
	No	%	No	%
Supportive measures	**(43.7%)**		**(56.3%)**	
Presence of other parturient women in the same room during labor	26	23.6	84	76.4
Presence of companionship during labor	43	39.1	67	60.9
Easley contacting with my family member during labor	52	47.3	58	52.7
Get tingsupportive care from nurses during labor	54	49.1	56	50.9
Have a nurse coaching during delivery	46	41.8	64	58.2
My husband and my family having a chance to hold your baby after birth	61	55.5	49	44.5
Information give to the women	**(46.3%)**		**(53.7%)**	
Receiving information from nurses about pain relief method	50	45.5	60	54.5
Receiving information from nurses about my progress of labor	51	46.4	59	53.6
Be informing immediately when something is wrong with me or my fetus	49	44.5	61	55.5
Involving in decision making about my care and treatments during the delivery Process	46	41.8	64	58.2

Table (2B) present that more than half of studied women had negative childbirth experience regarding supportive measures(56.3%) which, found that more than two third of studied women had negative childbirth experience regarding presence of other parturient women in the same room during labor(76.4%,) and(60.9%) regarding presence of companionship during labor. Concerning to information given to women it was found that more than half of women had negative childbirth experience (53.7%) & more than half of studied women had negative childbirth experience regarding involving in decision making about my care and treatments during the delivery process, receiving information from nurses about pain relief method & the progress of labor(58.2% 54.5%&,53.6%) respectively.

Table (2C): Distribution of childbirth experiences regarding communication between nurses and women among studied women. (n=110)

Situation happen during childbirth	Positive experience		Negative experience	
	No	%	No	%
Communication between nurses and women	**(49.1%)**		**(50.9%)**	
Nurses speak to me politely	38	34.5	72	65.5
Nurses deal my family politely	49	44.5	61	55.5
Nurses help me talk with doctor	48	47.3	62	52.7

Nurses contact the doctors for me when I wanted to consult the doctors	44	40	66	60
Nurse was happy to help me	48	43.6	62	56.4
Nurses busy and may not have time to take care me	52	47.3	58	52.7
Nurses bring my baby to me immediately after birth	67	60.9	43	39.1

Table (2C) shows that, more than half of studied women had negative childbirth experience regarding communication between nurses and women, (50.9%) which, more than two third of studied women had negative experience nurses speak to me politely and nurses contact the doctors for me when I wanted to consult the doctors (65.5%,60 %) respectively. On the other hand 60.9% had positive childbirth experience.

V. DISCUSSION

This study aimed to explore childbirth experiences among high risk primipara women at Mansoura University Hospital. This aim was supported by answering the study question (what are the experiences of high risk primipara women during their childbirth?). The findings of the study highlighted that behavioral response of HR pregnant women through their childbirth experiences positive and negative regarding medication &IV fluid and care give to women, supportive measures, information give to the women and supportive communication between nurses and women all of these play an important role on actual childbirth experiences and affect their future motherhood .

In present study around two third of studied women had positive experience regarding medication & IV fluid, and around half had +ve experience toward getting medication to reduce labor pain because the women able to control and cope with pain during labor, their feeling of self-efficacy of pain management this agree with ***(Hermansson and Mårtensson, 2011)*** who study about *"Empowerment in the midwifery context a concept analysis"* This study stated that when the pain was relieved this give the women +ve experience about remained control the pain. Because when the women feel empowered, it will affect their experience positively. This is may be related to women expected it and meet it during their childbirth. This is in the same line. ***(Nilsson et al, 2013***)They reported that mothers described that the body's strength was affected by how they could manage, control and cope with the pain; a feeling of losing control could be worse and intensify pain, but pain relief could affect the feeling of control in a positive way. These results are also strengthen by ***(Lundgren and Berg, 2007***) they describe that mothers experience varying degrees of pain, & anxiety during birth. The mother's ability to manage this, influence their self-confidence. Labor pain is one of the most severe pains that women experience during their life and most of women are afraid of labor pain this reported by ***(Beigi, etal., 2010)*** In addition the present study revealed that more than half of studied women had positive experience regarding getting medication to induce labor where, the women reported that induced medication makes the process of labor faster. This agree with ***(El-Kurdy, Hassan, Hassan, & El-Nemer, 2017)*** studied *"Antenatal Education on Childbirth Self-Efficacy for Egyptian Primiparous Women"* the study highlighted that oxytocin augmentation was administered for the majority of women because it was used as a routine hospital policy.

The current study found that more than two third of studied women had positive experience about performing vaginal examination for checking cervix dilatation. The women reported that the examination was easy compared to their feeling of labor pain. This is agrees with ***(Downe, etal, 2013)*** who reported vaginal examination is the only method of measuring progress of labor. This examination should be carried out only after explanation to the woman, when the practitioner can justify that she believes the findings will add important information to the decision-making process. According to ***WHO,(2012)*** recommends that vaginal examination is performed at regular intervals of not less than 4 hours and only performed when there is a -necessary.

Around two third of studied women had negative experience regarding using special comfortable position during delivery this may be related to only one position can be used is permitted during labor& delivery, so it cause feeling of discomfort, pain,& sensation of tension to them because it required to be a sure in certain position for monitor her fetal condition &

during delivery used Egyptian delivery position(lithtomy).This in agreement with ***(Patrelli, et al., 2011)*** suggested that immobilization for monitoring of fetal wellbeing during labor may increase the incidence of dystocia & labor pain ***(Berretta, et al., 2013 (. Also, (Nieuwenhuijze, etal, 2013)*** studied *"Influence on birthing positions affects women's sense of control in second stage of labour,"* The possibility to change the position in labor might positively influence childbirth experience and also labor outcomes.

Concerning delivery occur a private delivery room and presence of other parturient women in the same room during labor around half of studied women had negative experience because the women reported that presence of many individuals around parturient woman such as another parturient women, medical and nursing students in labor and delivery room and there weren't any privacy. This agrees with ***(Ghani, Mahmoud, & Berggren, 2011)*** who study about carrying out patient's examinations by medical staff in the presence of other people (especially other patients and students) is an alarming practice. Such practices represent a violation of the patient's right to protect their own dignity and intimacy.

In present study more than half of studied women had negative experience supportive measures, regarding getting supportive care from nurses during labor and having a nurse coaching during delivery because women reported that they don't find feel of support or help from nurses during birth. This is agree with ***(Barrett, & Stark, 2010)*** who study about "*Factors associated with labor support behaviors of nurses"* in this study shows that although women may expect nurses to provide continuous labor support, this may not be a realistic expectation and may be due to workload and shortage of nursing staff. Also, ***(Darvill, Skirton, &Farrand, 2010)*** who study about *"Psychological factors that impact on women's experiences of first-time motherhood"* in this study show some women reported feeling frustrated during labor due to a lack of supportive care and information about what was happening to them during birth. According to***(Tinti, Schmidt, &Businaro, 2011)***who study about *"Pain and emotions reported after childbirth and recalled 6 months later: the role of controllability"* confirm the provision of consistent information on the progress of labor gave women a sense of personal empowerment and gave them full control over the process of childbirth, which consider a predictor of childbirth satisfaction

This in agreement with ***(da Silva Lima, et al, 2016)*** they reported that fear is associated with the daily lives of women who undergo high-risk pregnancies, being present from the prenatal period until the puerperium so the healthcare professional can use activities that will help to reduce woman's anxiety, like inform her about the labor progress and ask her about the experience, this aiming to better comprehend her feelings. Information is an indispensable tool for all professionals, especially for nurses.

According to ***(Raynes-Greenow, etal, 2010)*** they recommend that women who are provided with information about labor, such as how to cope with pain, risks, benefits and consequence, it must be given in a way that is easily accessible and understandable, if women are to be adequately prepared for labor pain with support to make informed choices. In the same line ***(Aziato, Acheampong,&Umoar, 2017)*** they found some nurses played a major role regarding labor pain such as giving information, caring and encouraging the women to express her feeling during labor pain so, the women were satisfied with the provide care.

Regarding receiving information from nurses about (pain relief methods, about her progress of labor, be informed immediately when something is wrong with hers or her fetus and involving in decision making about her care and treatments during the labor process) the present study revealed that more than half of studied women had negative experience because women reported that they did not get enough information to help them to adapt with childbirth and to make a decision during their childbirth. Also parturient women exposed to(–ve) attitude from nurses such as, shouting & lack of empathy, which may affect progress of labor.

In the same line ***(Mannava, etal, 2015)*** studied "*Attitudes and behaviours of maternal health care providers in interactions with clients"*. This study reported many cases had been neglected and not respected, , deny pregnant women & their basic rights, as a result of these attitudes & behaviors women are not prefer to access to health services. Some of women experience of frustration and anger about not being take any informations from nurse about labor& delivery. Additionally some women identified negative impact regarding absence of the nurse's helping during their labor stages. So the women were very critical worry about what did happen during their labor stages. this disagree with ***(Karlström, Nystedt, &Hildingsson, 2015)*** who find the women's experience was greatly enhanced by having opportunity to get information from the nurse, this giving feeling of security & safety during labor stages, when nurses open the chanel of

communication & involving in descision making about her care. This in agreement with ***(Rance, et al., 2013)*** studied "*Women's safety alerts in maternity care: is speaking up enough"* This study shows that support and effective communication during labor enhance women's experiences and outcomes of birth.

The current study result found that more than half of studied women had negative experience regarding nurses speak to her politely, nurses deal with her family politely, nurses help her to talk with doctor, nurses contact the doctors for her when she wanted to consult the doctors, nurse was happy to help her and nurses busy and may not have time to take care her because the women reported that they always not take enough care, neglecting and they felt there was a problem in communicating with the nurse and the doctor may be related to they are very busy. This agree with ***(Maxfield, et al, 2013)*** studied *"Confronting safety gaps across labor and delivery teams"* Problems with communication are well-known challenge to patient safety in labor and delivery units. It is often due to communication breakdowns as a "nursing problem" or a "physician problem." However, the sources of communication breakdowns in labor and delivery are complex. Physicians, nurses and midwives are capable of engaging in open communication that is respectful, attentive and collaborative.

This agree with ***(Lyndon, Zlatnik, &Wachter, 2011)***studied effective communication with patients is one of the hallmarks of safe and highly reliable patient care in prenatal and delivery units, this communication that hold patient safety, respect, attentiveness and competence. The nurse ensured feelings of safety & calm for the parturient woman, the significance of these relationships with caregivers is evident in research. Dahlberg writes, "Midwifery care is the best method of creating a positive experience of childbirth for mothers, and midwife's communication skills, knowledge, understanding and their presence are vital to this experience"***(Dahlberg, & Aune, 2013)***"*The Woman's Birth Experience—The Effect of Interpersonal Relationships and Continuity of Care"*. In addition (***Khadivzadeh et al, 2015)*** studied *"Assessment of Midwives' Communication Skills at the Maternity Wards"* this study also confirmed that women who have a good interaction with their midwife feel better about themselves, their delivery and their baby. Confidence in the midwife may be the result of ongoing interaction during the childbirth process.

Finally, the study concentrates on experiences of high risk primipara women during childbirth, so it diverts our attention about Egyptian women childbirth experience.

VI. CONCLUSION

Based on the present study findings, the following can be concluded that:

The studied women more than half their age was ranged from 24-29years and about three quarter were house wife from rural area, more than half their gestational age was ranged from 37-40 weeks, the types of high risk women in the study were more than one third had PROM, followed by pre eclampsia & gestational diabetes. In addition the majority of studied women had positive experience regarding food and fluids withhold during labor. While more than half had negative childbirth experience regarding supportive measures and information given.

VII. RECOMMENDATIONS

Based on the results of this study, the following were recommended:

- Stressing the importance of high risk women expectations and its importance of the experiences of high risk primipara women for women's long life and for future motherhood
- Continuous in-service training for nurses about labor pain management and communication skills to enhance their care of parturient woman and to achieve positive childbirth experience.
- Careful attention to women's cognitions and providing a supportive social environment during labor which may improve women's experiences of labor pain and decrease their need for pain interventions.

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Conflicts of Interests

The authors state that there is no conflict of interests regarding this study.

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