Exploring the barriers to pregnant women’s engagement in the childbirth process from Iranian midwives’ point of view: A qualitative study

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Abstract
Purpose: Pregnant women’s engagement in the childbirth process increases their satisfaction with childbirth, and in turn leads to a reduction in the frequency of cesarean sections and adverse pregnancy consequences. This study aimed to explore the barriers to pregnant women’s engagement in the childbirth process based on midwives’ perspective.

Methods: This qualitative study was conducted on 24 midwives working in Urmia hospitals in 2019. Data were collected through semi-structured in-depth individual interviews with the midwives. The participants were selected through purposeful sampling. Data analysis was performed using conventional content analysis with MAXQDA 10.

Results: Analysis of the data resulted in two main categories “weakness of pregnant women’s participatory culture” (negative attitude of healthcare staff towards pregnant women’s engagement, ineffective relationships, insufficient engagement in respectful care, lack of pregnant women’s awareness of their rights and low health literacy of the pregnant women, and “managerial factors” (neglect of physiological childbirth aspects and hospital rules).

Conclusion: Pregnant women’s participation in childbirth can be enhanced by promoting pregnant women’s participatory culture by making mothers aware of their rights and providing in-service training for healthcare staff to observe the rights and dignity of pregnant women. Moreover, the promotion of physiological childbirth and the correction of hospital rules can promote pregnant women’s engagement in childbirth.

Keywords
childbirth, patient participation, patient engagement, qualitative research

Introduction
In most countries, hospitals are currently the main place for childbirth.1 Statistics show that a large percentage of patients, in addition to their initial problems, suffer from complications and injuries caused by the provision of services.2 Over the past decade, the importance of patients’ security and safety has become increasingly recognized. Therefore, paying attention to patient participation is a very important and vital issue in the health systems of different countries.3

According to the World Health Organization (WHO), patients should become active partners in improving the safety, quality, and efficiency of health service delivery.4 Patient participation means involving the patient in making decisions or giving feedback about different treatment methods by exchanging information, expressing feelings, and accepting caregiver instructions.5 However, the WHO defines patient participation as involving patients and their families in care by educating them about the risks and benefits of treatments and empowering them to make informed decisions in collaboration with providers.6,7 Patient participation is a central concept of care systems and part of patient safety. High levels of patient participation...
can improve the relationship between healthcare providers, patients, and families in the context of person-centered care, for example, by engaging the patient in shared decision-making and self-care. Patient participation in care is associated with high patient satisfaction and improvement of treatment outcomes. Increasing patient participation in care increases the patient's responsibility and commitment to health behaviors and facilitates care and treatment. On the other hand, participatory decision-making is recognized as a moral and spiritual standard in medical decisions, so that it is necessary to respect the patient's involvement.

Informed and active participation of pregnant women in the process of treatment and medical care increases their satisfaction with childbirth. It can also reduce the number of cesarean sections and adverse pregnancy consequences. Active participation of pregnant women reduces medical errors, unnecessary referrals, and hospitalizations, and also increases patients' satisfaction with treatment, leading to cost-effectiveness and higher returns on investment in the healthcare system.

Despite the positive impacts reported for patient-centered care, there have been some challenges to applying this type of care, including the absence of comprehensive policies, awareness of patients and hospital personnel, ambiguity in the role of different people in providing patient care, lack of focus on all aspects of patients, the ineffective relationship between healthcare providers, and workforce shortage.

The WHO designed an implementation guide to improve the quality of care provided to women giving birth, learning about adverse events and near-misses is essential for enhancing maternity and obstetric care. In Iran, childbirth is generally performed by a midwife. Studies have shown that pregnant women are more inclined to participate and especially to make decisions in their own care. However, pregnant women are not often engaged in the delivery process. Thus, more qualitative studies are needed to explore the barriers to women's participation in the process of natural childbirth.

**Methods**

**Study design**

This qualitative study was conducted with the participation of 24 midwives working in hospitals in Urmia, Iran from April to October 2019. A qualitative approach is effective to provide deep descriptions of a phenomenon.

**Settings, samples, and recruitment**

The present study was conducted in the labor and delivery wards in three public hospitals including Shahid Matahari Hospital, Shahid Arefian Hospital, and Artesh Hospital. The three hospitals are affiliated with the Urmia University of Medical Sciences in Western Azerbaijan Province, Iran. It is noteworthy that all midwives in Iran are female.

Purposive sampling was used to select the participants and continued with snowball sampling. The first and the second participants were senior midwife managers with long clinical experience.

Midwives were recruited in-person at the obstetric unit of three hospitals. Information regarding the research question and the aim of the study was provided face-to-face by first researcher. Participants who expressed an interest in the research received a participant information sheet and a consent form to read before deciding if they wished to participate. Participants were identified and selected according to inclusion criteria and asked to introduce other participants. The inclusion criteria were working three consecutive years in maternity settings and for the willingness to participate in the study, while unilateral withdrawal from the study was the exclusion criterion. The participants were selected with maximum variation in terms of age, work experience, and employment status.

**Data collection**

The data were collected through in-depth, semi-structured, face-to-face interviews using an interview guide. Participants were initially contacted by first researcher by telephone to agree a mutually convenient time for an interview. The interviews were conducted in a private room in the hospital to assure the confidentiality of the participants' information and their comfort. Subsequently, 24 interviews took place. Analysis proceeded simultaneously with data collection by comparing data from one interview with that from another. The interviews continued until the data were saturated, that is, when new findings were not added to the existing data from the last two interviews. Interview duration ranged from 20 to 60 min and, with the consent of the participants, all interviews were audio-recorded, transcribed, and subsequently analyzed.

The interview guide was designed based on the project's goal and the literature review, and the interviews were conducted about factors that would influence pregnant women's engagement in the childbirth process. The guide included general questions such as “May you please describe your experiences of delivery care to pregnant women in your unit?” “What do you think about the participation of the pregnant mother in the delivery process?” “Please tell me about the relationship between midwives and pregnant women in the labor and delivery ward?” “Based on your experiences, please explain the barriers that pregnant women face while involved in the childbirth process?” Based on the participants’ responses to these questions, probing questions were also asked to delve into their experiences. Examples of these questions were “Can you provide explanations about this?” “What do you mean by this?” “How do you describe your perception of this topic?” “What this experience does mean for you?” During the interviews, the participants' facial expressions and non-verbal signals were documented. At the end of each interview, the interviewee was asked whether she wanted to add anything more. Finally, her participation was acknowledged and she was informed about the possibility of a follow-up interview. Since the official language in Iran is Persian, the interviews were conducted in Persian.

**Data Analysis**

First, the author conducted 24 interviews and transcribed them verbatim and imported them into MAXQDA 10, and coded. Data analysis was performed simultaneously with data
collection via conventional content analysis provided by Graneheim and Lundman.20 The analysis steps were as follows: The texts of the interviews were read several times to gain an in-depth understanding. After that, the data were organized into semantic units, and the initial codes were extracted according to the study’s objectives. Next, the initial codes were classified as sub-categories and categories through continuous comparison of the data.

Rigor and trustworthiness

The trustworthiness of the research protocol was checked according to Lincoln and Guba’s criteria.21 These criteria include credibility, confirmability, dependability, and transferability. The credibility of the study was achieved through prolonged engagement with the data, adopting maximum variation in participants’ recruitment, member checking, and peer debriefing. For dependability, a decision trail of the research process was provided, which allowed other researchers to audit the research process. Confirmability of the findings was evaluated through a separate coding procedure done by the authors followed by further discussion and consensus. To maintain the transferability, the main findings of the study were reviewed and confirmed by some midwives who did not take part in the study but had similar characteristics with the participants.

Ethical approval

The procedure used in this study was approved by the Research Ethics Committee of Urmia University of Medical Sciences (IR.UMSU.REC.1397.476). Written informed consent was obtained from all participants before each interview. In the present study, obtaining informed consent, the right of anonymity, confidentiality of the information, and the right of withdrawal from the study at any desired time were taken into account by the researcher.

Results

A total of 24 midwives aged 28–51 years participated in the study. They were working for 4 years–28 years. They held bachelor’s or master’s degrees in midwifery. Two participants were senior midwife managers and others were midwifery staff. Moreover, two participants had the experience of working in private hospitals (Table 1). During data analysis, 226 codes, seven sub-categories, and two main categories were identified (Table 2).

A) Weakness of pregnant women’s participatory culture

Most participants believed that healthcare staff and mothers had not a good conceptualization of pregnant women’s participation in the childbirth process. This category consisted of five sub-categories.

I - The negative attitude of healthcare staff towards pregnant women’s engagement

Most of the participants had a negative attitude towards maternal-centered care. One midwife said, "If midwifery care..."
is to be women-centered and based on her preferences and decisions, there will be chaos . . . and it is not possible to control the ward.” (p7)

Another midwife stated: “We have very busy work shift. . . . We don’t have enough time to answer all the questions asked by women ”(p15).

2- Ineffective relationships

The majority of midwives believed that there is not a warm relationship between healthcare staff and the pregnant women and a few questions and answers are exchanged between them. One participant said:

“Often, there is a cold relationship between healthcare staff and the pregnant women. Healthcare staff, especially doctors, consider themselves very powerful as if they are the owner of the patients. In my opinion, because they look at the patient with contempt, they cannot establish a rapport with the women” (p11).

Another participant said, “The medical staff does not like the patient to ask too many questions. Conversely, if there is a good relationship between us and them, the patient will no longer feel compelled to accept care, and she will not resist the care ”(p11).

3- Insufficient engagement in respectful care

The majority of midwives accepted that they did not have the necessary skills to respect pregnant women. One midwife said, “Even if there is a curtain between the beds, we do not pull the curtain during the examination to protect the mother’s privacy. It looks like paravans and curtains are only for hospital accreditation ”(p9).

Another participant stated, “Despite the approval of the Bill of Pregnant Women’s Rights by the Ministry of Health, these rights are not properly respected by the members of the treatment team for women in labor. We always make decisions for the pregnant women and they have to follow us” (p2).

4- Lack of pregnant women’s awareness of their rights

A majority of the participants believed that most women do not know enough about their rights in the hospital. They believed that women could ask midwives for care if they were aware of their rights. One participant said, “Certainly, mothers are not fully aware of their rights. I think they only know how to complain against healthcare staff ”(p18).

Another midwife said: “Pregnant women do not have the right to decide on treatment, and have access to their medical files. They think that they have to accept whatever the doctor and midwife say” (p5).

5- Low health literacy of the pregnant women

Data analysis showed that inadequate health literacy is an important problem that makes healthcare staff demotivated to involve the client in the care process.

One participant said, “When the pregnant woman has low awareness, healthcare staff is reluctant to ask her opinion about care because they know that an uninformed patient cannot choose the best option for herself” (p16). Another midwife said, “A well-informed mother comments on all of our work. She keeps asking questions” (p19).

B) Managerial barriers

The data of this study indicated the existence of policy-making and planning problems at higher levels of management.

1- Neglect of physiological childbirth aspects

From the participants’ point of view, failure to pay attention to physiological childbirth does not allow the pregnant women to participate in selecting and deciding on the best care procedure.

One of the participants said, “Well, I think most midwives have participated in physiological childbirth courses, but none of us implement it. We have no power for planning and decision-making in the labor ward” (p1).

Another participant said, “Physiological delivery is not a priority for the hospital and there is no protocol for implementing it. We do not perform it in the ward. We routinely insert an IV line for everyone as soon as she enters the ward. We do augmentation” (p6).

2- Hospital rules

Hospital policies such as not implementing doula services, quickly emptying hospital beds, and the disregard for pregnant women’s right to choose a doctor and midwife were other barriers.

One participant said, “It is very good to have a doula service. It is good for both the mother and midwives Doula service is a great plan, but unfortunately, it is not implemented in most hospitals. If it is placed into place, the mother can participate in the delivery process step by step ” (p13). She also said, In general, the pregnant woman has no right for selecting a doctor or a midwife or choosing the method of delivery. Hospital rules do not allow this”.

Discussion

The findings of this study revealed the weakness of participatory culture and managerial problems as barriers to pregnant women’s participation in the childbirth process. One of the barriers to pregnant women’s engagement in childbirth was the negative attitude of healthcare staff towards the pregnant women’s engagement in childbirth processes. In other words, if the midwife has a positive attitude towards the woman-centered approach to care, she allows the pregnant woman to participate in the care. One study showed that the positive attitude of nurses towards patients’ capacities and their intimate relationships had enhanced patient participation.22 Angel and Friedrichsen also found that negative attitudes towards patient participation as one of the challenges related to patient involvement in care. Moreover, the ineffective relationship between healthcare staff and the mother hinders the mother’s participation in care. One study showed that skills in communicating with the patient lead to success in
obtaining sufficient information from the patient, correct diagnosis, gaining trust, and treatment success.\textsuperscript{24} It should be noted that social communication such as small talk aims to build a close relationship with the clients or transfer information to them. What is important for the mother’s participation in the childbirth process is asking questions from the service providers for receiving information about care and self-care.

The midwives stated that there was less respect for women in labor. Few studies were found to assess women’s disrespectful experiences during childbirth.\textsuperscript{25-27} Considering the vulnerability of women during labor, and the fact that disrespect can be associated with fear of NVD and an increased tendency for demanding cesarean sections, midwives should show more respect and support for women during childbirth. The result of one study in Iran showed that nearly 40\% of the mothers selected cesarean section because of their fear of NVD.\textsuperscript{28} Accordingly, the World Health Organization has emphasized the importance of respectful maternity care and women’s rights during pregnancy and childbirth, and the need for immediate attention to this global phenomenon.\textsuperscript{29}

Oxlmark et al. showed that patient participation means listening to the patient, the patient participating, giving the patient some responsibilities, and sharing power and cooperation with patients.\textsuperscript{30} Nilsson et al. also stated that patient participation is learning, therapeutic communication, and interaction, and that knowledge, skills, and attitudes are essential for the patient’s active participation in working with the caregiver.\textsuperscript{31} In a qualitative study, it was shown that caregivers’ behaviors can be effective in mothers’ participation in decision-making.\textsuperscript{32}

In the present study, unawareness of patient rights was one of the barriers to mothers’ participation in NVD. One study showed that the patient’s awareness of the bill of rights is at a low level.\textsuperscript{33} Another study showed that more than 50\% of patients did not have enough knowledge of some provisions of the Bill of Patients’ Rights.\textsuperscript{34} The study of Yousefzadeh et al. (2017) revealed that Most students had moderate knowledge about ethical and legal standards of patient rights.\textsuperscript{35} The awareness of the content of the bill improves the relationship between the patient and the treatment personnel\textsuperscript{36} and prevents irreparable mental and physical injuries.

The results of the present study showed that inadequate health literacy is a serious problem that makes healthcare staff demotivated to involve the client in the care process. It seems that women with competing knowledge sources desire to follow the advice of midwives. Thus, it can be suggested that building good relationships with midwives during labor may reduce tension in midwife–woman relationships for some women. The existing literature shows the midwife–woman relationships affect not only uptake of antenatal care.\textsuperscript{37} but also influence the quality of care received once services have been accessed.\textsuperscript{38} Another important barrier to maternal participation in the safe childbirth process was low maternal health literacy. These results are in line with the findings reported by Chegini et al.\textsuperscript{39}

This study showed that the failure to pay attention to physiological childbirth does not allow the mother to participate in the decision-making process. In a review article in Iran, Makvandi et al. (2019) found that low motivation of midwives in performing physiologic childbirth, manpower restrictions, medical interventions in physiologic childbirth, challenges from the environment and facilities, and educational problems were some challenges of physiologic childbirth program from the perspective of service providers.\textsuperscript{40} Interventions resulting from hospital policies were other factors that led to the non-realization of natural childbirth and consequently maternal participation. The findings were confirmed by other studies.\textsuperscript{41,42}

Limitations

An important limitation in this study was that the participants were selected only from public hospitals from Urmia and, as a result, the findings have limited transferability. The findings have also limited generalizability as only midwives participated in this study. It is possible that the views of midwives who did not take part in this interview study may have differed from the views of those who did.

Conclusion

This study has the potential to raise awareness amongst health professionals and policy makers of the problems that Iranian hospitals face in engaging pregnant women in the childbirth process. Pregnant women’s participation in childbirth can be enhanced by promoting pregnant women’s participatory culture by making mothers aware of their rights and providing in-service training for healthcare staff to observe the rights and dignity of pregnant women. Moreover, the promotion of physiological childbirth and the correction of hospital rules can promote pregnant women’s engagement in childbirth. It is better to adopt policies in different areas such as society and organizations to promote physiological childbirth. Mechanisms that empower pregnant women and make them aware of their rights must be reinforced. However, further research is needed to identify those actions necessary for pregnant women to be engaged in childbirth process issues and to define to what extent the active involvement of patients can be linked to improvements healthcare outcomes.

Authors’ contributions

R Bayrami; Contributed to conception and design. Data collection was performed by R Bayrami. Data analysis was done by R Bayrami and R Baghaei. The first draft of the manuscript was written by R Bayrami and R Baghaei commented on previous versions of the manuscript. All authors read and approved the final manuscript.

Availability of data and materials

Available upon request.
Competing interests
The authors declare that they have no competing interests.

Declaration of conflicting interests
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Ethics approval and consent to participate
This research was approved by the Ethics Committee of Urmia University of Medical Sciences under code (IR.UMSU. REC. 1397.476). Participants signed a research consent form.

Informed consent
Written and informed consent has been obtained from all the patients. Participation in this study was voluntary, and the participants were assured that they could withdraw from the study at any time.

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