Iranian midwives’ awareness and performance of respectful maternity care during labor and childbirth

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ABSTRACT
INTRODUCTION Midwives’ perceptions of Respectful Maternity Care (RMC) play an important role in promoting quality of care. This study aimed to explore the awareness and performance of Iranian midwives of RMC during childbirth.
METHODS A cross-sectional study was carried out from November to December 2020 to evaluate 130 midwives’ awareness and performance of RMC during childbirth at four public hospitals in Urmia province, Iran. Participants were midwives who were working in the labor unit and had at least one year of work experience. The Midwives’ Knowledge and Practice Scale on Respectful Maternity Care was used to assess midwives’ awareness and performance. The quality assessment of questionnaires was based on the mean for each item. A multivariate linear regression approach was developed to evaluate the relationship between midwives’ age, academic education level plus occupational information and their awareness and performance of RMC.
RESULTS This study revealed that Iranian midwives had good awareness but fair performance of RMC. The mean scores of the overall awareness and performance of RMC were 36.07±10.13 and 75.47±35.4, respectively. Midwives’ performance on two domains was fair including ‘Giving emotional support’ and ‘Providing safe care’. The results of multivariate linear regression analysis showed a significant negative relationship between job satisfaction and midwives’ performance on RMC. Also work experience plus a Master’s degree in midwifery had positive significant effects on midwives’ awareness along with performance on RMC (p<0.05).
CONCLUSIONS Promoting respectful maternity care requires essential interpersonal and communication skills and supportive attitudes from midwives.

INTRODUCTION
Pregnancy and childbirth are momentous events in the lives of women and families. Women’s experiences with caregivers at this time have the impact to empower and comfort or to inflict lasting damage and emotional trauma1. Disrespect and abuse of women in maternal healthcare is a prevalent and serious issue in many countries1. A review by Bohren et al.2 found evidence of all seven types of disrespect and abuse of women during childbirth across all geographical regions and income-level settings, but were manifested in different forms depending on the context. Moreover, maltreatment during childbirth reduces women’s satisfaction, which is an important factor to reduce women’s confidence to providers in maternity services3.

Respectful maternity care (RMC) is a universal human right of childbearing women (RMC Charter) and refers to seven domains that have been developed by White Ribbon Alliance (WRA)4. The RMC charter has been used as a tool to educate health workers about maternity care and human rights1.

Women who receive respectful maternity care may be more likely to give birth vaginally and be satisfied and have a shorter labor5. This is because continuous midwives’ support for women during childbirth is an important part of respectful maternity care6. This support includes emotional support (continuous presence, touching, empathy, reassurance, and praise) and information about labor progress. It may also include advice about coping techniques as well as comfort

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Scale on Respectful Maternity Care (MKP-RMC) to assess demographics, and a Midwives' Knowledge and Practice Data collection tools included a questionnaire to record were conducted in convenient places in public hospitals. 9 midwives were excluded from the study. The interviews in four public hospitals, 130 midwives were included and sampling method and finally, among 139 midwives working (9 midwives). Midwives were selected by the census who had less than one year's work experience were excluded least one year's work experience. The participants' midwives in this study were midwives who were working in the labor agreed and signed the informed consent, participated in the study. Regarding the inclusion criteria, the participants 11. Midwives' awareness of principles of RMC has been increased but it is not comprehensive12. A review of existing studies conducted on women's experience of childbirth in Iran showed that women experience some forms of disrespect and carelessness, persistent negative memory of pain and persistent fear of childbirth13-15. Furthermore, all these reported issues, in turn, were associated with the increased demand for elective caesarean birth in Iran. Hence, 50–60% of births are caesarean sections (CS) in Iran16. Evidence suggests that most women would improve their utilization of vaginal delivery in the maternity care system if midwives showed respectful behavior13,17.

The first step to promote RMC is to evaluate the awareness and performance of the RMC providers. With this aim, this study evaluated midwives’ awareness and performance of RMC principles during labor and childbirth in northwest of Iran.

METHODS
Design and setting
This cross-sectional study was conducted to evaluate midwives’ awareness and performance of RMC during labor and birth from November to December 2020 at four public hospitals in Urmia province, Iran.

Sample and recruitment
The study population (130) consisted of all midwives working in four public hospitals in a northwestern province of Iran. All midwives working in the study hospitals were invited to participate in the survey. The participants who agreed and signed the informed consent, participated in the study. Regarding the inclusion criteria, the participants in this study were midwives who were working in the labor unit, had a midwifery academic degree of education, and at least one year’s work experience. The participants’ midwives who had less than one year’s work experience were excluded (9 midwives). Midwives were selected by the census sampling method and finally, among 139 midwives working in four public hospitals, 130 midwives were included and 9 midwives were excluded from the study. The interviews were conducted in convenient places in public hospitals. Data collection tools included a questionnaire to record demographics, and a Midwives’ Knowledge and Practice Scale on Respectful Maternity Care (MKP-RMC)18 to assess midwives’ awareness and performance were handed to them.

Demographic questionnaire
The demographic questionnaire consisted of two sections: 1) demographic data such as age, marital status, academic degree in midwifery, and 2) occupational information including work experience, job satisfaction, interest in the field of study, workplace, working shifts, and employment status.

Midwives’ knowledge and practice scale on respectful maternity care (MKP-RMC)
We used the Midwives’ Knowledge and Practice Scale on Respectful Maternity Care (MKP-RMC) as a valid and reliable tool for measuring midwives’ knowledge and practice of respectful care during labor and childbirth. The scale has two sections (Knowledge and Practice) and has been designed based on three domains18. This scale has 23 items in knowledge and 23 items in practice section that covered the three domains: giving emotional support, providing safe care, and preventing mistreatment. The items’ numbers in domains of awareness sections were 12 (giving emotional support), 8 (providing safe care), and 3 (preventing mistreatment). The items’ numbers in domains of performance sections were 11 (giving emotional support), 9 (providing safe care), and 3 (preventing mistreatment). The awareness scale is categorized as: ‘correct’, ‘I don’t know’, and ‘incorrect’, and scored as 2, 1, and 0, respectively. The performance scale consists of items on a 5-point Likert scale, and categorized as: 5=’always’, 4=’often’, 3=’sometimes’, 2=’rarely’, and 1=’never’. The means of awareness and performance are calculated based on the number of items in each domain. Finally, the scores above the mean are dichotomized as ‘good’ and ‘fair’, and the scores less than the mean are considered ‘weak’. A composite score is then created by summing up all the individual items within each scale. The highest scores of awareness and performance are 24 and 115, and the lowest scores are 0 and 23, respectively. The validity of the Persian version of this questionnaire has been measured by Moridi et al.18. To determine the reliability of the instrument, internal consistency and test-retest methods were used. In order to calculate the Cronbach’s alpha coefficient, the questionnaire was completed by 15 midwives. The obtained scores of the Cronbach’s alpha coefficient of awareness and performance items were 0.78 and 0.87, respectively, indicating a desired correlation between the items. In addition, 15 midwives completed the questionnaire twice with a 2-week interval in order to examine the stability of the scale by calculating the Intra-class Correlation Coefficient (ICC). An ICC of ≥0.8 was considered acceptable.

Data analysis
The data were analyzed using IBM SPSS software (version 24)19. Descriptive statistics, central and scatter indices such as percentage, mean and standard deviation, were used. A multivariate linear regression model was developed to investigate the relationship among midwives’ awareness and performance with age, work experience, academic degree in midwifery, job satisfaction, work place, job
selection by interest, employment status and working shifts. The significance level was set at p<0.05.

RESULTS
Demographics
In all, 139 midwives were selected by census sampling method in four public hospitals in a northwestern province of Iran. Finally, 130 midwives were included in the study. Table 1 presents the demographic characteristics of participant midwives. The mean age was 32.2 years and 50.0% were aged 31–40 years. Majority of midwives were married, had a Bachelor’s degree in midwifery (88.7%) and worked in the labor unit (73.9%) in rotational shifts (70.3%). Their average work experience was 5.42 years. The majority (89.5%) had entered their job selection by interest and a third (35.9%) were completely satisfied with their jobs.

According to Table 2, the mean scores of the overall Iranian midwives’ awareness and performance on RMC were 36.07±10.13 and 75.47±35.4, respectively. The quality assessment based on the mean for overall awareness and performance on RMC showed that Iranian midwives had good awareness and fair performance. The participating midwives had scored good on both performance and awareness in the domain of ‘Preventing mistreatment’. They had also good awareness and fair performance in the ‘Giving emotional support’ and ‘Providing safe care’ domains, respectively.

According to Table 3, the highest and lowest mean scores in the first domain (giving emotional support) of performance section were in the items ‘I welcome laboring woman warmly’ and ‘I establish friendly and appropriate relationship with the laboring woman’, respectively. The highest and lowest mean scores in the second domain (providing safe care) of performance section were in the items ‘I keep medical records and the results of examinations and consultations confidential’ and ‘I provide clear information about progress of labor’, respectively. The highest and lowest mean scores in the third domain (preventing mistreatment) of performance section were in the items ‘I may not shout at laboring woman if she does not cooperate’ and ‘I do allow the laboring woman to have a companion inside the labor unit’, respectively (Table 3).

According to Table 4, the highest and lowest mean scores in the first domain (giving emotional support) of awareness section were in the items ‘Calling laboring woman’s name as she desires’ and ‘Freedom in choosing birthing position’, respectively. The highest and lowest mean scores in the second domain (providing safe care) of awareness section were in the items ‘Keeping medical records and the results of tests and consultations confidential’ and ‘Obtaining informed consent before performing any care and interventions’, respectively.

The highest and lowest mean scores in the third domain (preventing mistreatment) of awareness section were in the items including ‘Physical violence in the case of non-cooperation’ and ‘Attendance of unnecessary person during performing procedure’, respectively (Table 4).

A multivariate linear regression model was used to assess of the relationship between midwives’ awareness as well as performance with the important factors: age, work experience, academic degree in midwifery, job satisfaction, work place, job selection by interest, employment status, and working shifts. The results showed that work experience plus a Master’s degree in midwifery had positive significant effects on midwives’ awareness along with performance. Also, there was a significant negative relationship between job satisfaction and midwives’ performance. In this regard,
Table 2. Survey of midwives’ awareness and performance of RMC in related domains working in four public hospitals in Urmia, Iran, 2020 (N=130)

| Domains                              | Section          | Mean ± SD     | Good | Fair | Weak |
|--------------------------------------|------------------|---------------|------|------|------|
|                                       |                  | Mean ± SD     |      |      |      |
| Overall                              | Awareness        | 36.07±10.13   | 64 (49.2) | 52 (40) | 14 (10.8) |
|                                       | Performance      | 75.47±31.4    | 40 (30.8) | 67 (51.5) | 23 (17.7) |
| Giving emotional support             | Awareness        | 18.5±5.68     | 62 (47.7) | 58 (44.6) | 10 (7.7) |
|                                       | Performance      | 30.63±15.97   | 25 (19.2) | 86 (66.2) | 19 (14.6) |
| Providing safe care                  | Awareness        | 12.2±3.82     | 65 (50) | 56 (43.1) | 9 (6.9) |
|                                       | Performance      | 29.34±13.66   | 41 (31.5) | 77 (52.2) | 12 (9.2) |
| Preventing mistreatment              | Awareness        | 5.37±0.63     | 68 (52.3) | 57 (43.8) | 5 (3.9) |
|                                       | Performance      | 11.25±1.77    | 68 (52.3) | 55 (42.3) | 7 (5.4) |

Table 3. Midwives’ performance of RMC during childbirth in Urmia, Iran, 2020 (N=130)

| Domain/ items                          | Midwives’ performance Mean ± SD |
|----------------------------------------|----------------------------------|
| Domain 1: Giving emotional support     |                                  |
| 1. I welcome laboring woman warmly     | 4.51±0.49                        |
| 2. I introduce myself to the laboring woman | 3.41±0.59                       |
| 3. I show the laboring woman around the labor unit | 3.16±2.84                       |
| 4. I establish friendly and appropriate relationship with the laboring woman | 2.34±1.66                       |
| 5. I support laboring woman by encouraging and calming touch | 3.06±1.94                       |
| 6. I use the name preferred by a laboring woman | 3.36±0.64                       |
| 7. I am continuously or timely available beside her | 3.03±2.97                       |
| 8. I provide laboring woman with correct and clear information about the care, interventions and progress of labor | 3.32±0.63                       |
| 9. I build friendly relationship in a way that she feels comfortable to ask her questions | 3.23±1.77                       |
| 10. I provide a comfortable environment for laboring woman | 3.33±1.67                       |
| 11. I support laboring woman to be in her desired birthing position | 3.2±1.8                         |
| Domain 2: Providing safe care          |                                  |
| 1. I keep medical records and the results of examinations and consultations confidential | 4.33±0.67                       |
| 2. I cover the laboring woman’s body during examinations, using sheets | 2.23±1.87                       |
| 3. I perform all interventions with laboring woman’s informed consent | 2.03±1.97                       |
| 4. I provide equal care to all women, regardless of their socio-economic status, ethnicity, etc | 4.27±0.73                       |
| 5. I support laboring woman to take care of herself and her baby | 4.11±0.89                       |
| 6. I provide evidence-based and up-to-date childbirth care | 2.86±2.14                       |
| 7. I pay attention to laboring woman’s safety in providing care and interventions | 4.27±0.73                       |
| 8. I respect beliefs and culture of laboring woman and her companion | 3.33±1.67                       |
| 9. I provide clear information about progress of labor | 2.01±1.99                       |
| Domain 3: Preventing mistreatment      |                                  |
| 1. I do allow the laboring woman to have a companion inside the labor unit | 1.89±1.13                       |
| 2. I do not beat the laboring woman if she does not cooperate | 4.59±0.41                       |
| 3. I do not shout at the laboring woman if she does not cooperate | 4.77±0.23                       |
increase in a year of work experience, was associated with a 0.968-point rise in midwives’ awareness on RMC. Midwives with a Master’s degree in the midwifery education had a 2.41-point rise in awareness on RMC compared to the midwives with an Associate’s degree in midwifery education. Additionally, increase in a year of work experience was associated with a 1.18-point rise in midwives’ performance on RMC. Midwives with a Master’s degree in the midwifery education had a 0.59-point rise in performance on RMC compared to the midwives with an Associate’s degree in midwifery education. However, a degradation in job satisfaction was associated with a 1.27-point decrease in midwives’ performance on RMC (Table 5).

Table 4. Survey of midwives’ awareness of RMC during Childbirth working in four public hospitals in Urmia, Iran, 2020 (N=130)

| Domain/ items | Midwives’ awareness Mean ± SD |
|---------------|-------------------------------|
| Domain 1: Giving emotional support |  |
| 1. Warm welcoming in entering to labor unit. | 1.43±0.6 |
| 2. Showing around maternity labor unit’s environment. | 1.8±0.3 |
| 3. Establishing friendly communication. | 1.47±0.53 |
| 4. Encouraging and giving calming touch. | 1.6±0.4 |
| 5. Calling laboring woman’s name as she desires. | 1.76±0.24 |
| 6. Providing accurate and clear information about progress of labor, received care and interventions. | 1.56±0.44 |
| 7. Providing friendly environment to ask questions. | 1.55±0.43 |
| 8. Providing comfortable and calming environment. | 1.71±0.29 |
| 9. Freedom in choosing birthing position. | 1.24±0.76 |
| 10. Having companion of choice upon request. | 1.35±0.65 |
| 11. Respecting laboring woman’s and her companion’s beliefs and culture. | 1.56±0.44 |
| 12. Providing appropriate environment for companions. | 1.4±0.6 |
| Domain 2: Providing safe care |  |
| 1. Continuous or timely presence beside. | 1.56±0.44 |
| 2. Keeping medical records and the results of tests and consultations confidential. | 1.85±0.15 |
| 3. Obtaining informed consent before performing any care and interventions. | 1.31±0.69 |
| 4. Providing equal care to all laboring woman regardless of their socio-economic status, ethnicity, etc. | 1.45±0.55 |
| 5. Providing evidence-based and up-to-date childbirth care. | 1.35±0.67 |
| 6. Providing pain relief. | 1.59±0.41 |
| 7. Paying attention to safety in providing care and interventions. | 1.68±0.32 |
| 8. Providing accurate information about progress of labor to companions. | 1.42±0.58 |
| Domain 3: Preventing mistreatment |  |
| 1. Attendance of unnecessary person during performing procedure. | 1.74±0.26 |
| 2. Physical violence in the case of non-cooperation. | 1.83±0.17 |
| 3. Shouting at the laboring woman in case of non-cooperation. | 1.8±0.2 |

Table 5. Multiple linear regression analyses between the combination of the factors with Iranian midwives’ awareness and performance on RMC

| Regression factors | Not standardized coefficients | Standardized coefficient B | t | p |
|--------------------|-------------------------------|-----------------------------|---|---|
| Work experience    | 0.968 0.274                  | 1.617 0.320                | 0.320 | 0.03 |
This study revealed that Iranian midwives had good awareness of RMC but their awareness was not comprehensive on the number of items in each domain and their performance of RMC was fair. The first domain of our questionnaire, ‘giving emotional support’, showed that the participating midwives had a good awareness and fair performance. One of the items of this domain was ‘I establish friendly and appropriate relationship with the laboring woman’ which had the lowest mean score in the performance sections. Previous studies in Iran showed the need to improve midwives’ communication skills for providing better relationships with women during childbirth\textsuperscript{15,20}. Lack of emotional support skills from midwives (included touching, empathy, compassion, reassurance taking mother’s hands, maintaining eye contact, creating a sense of trust and confidence, reduction of fear during labor) is one of the reasons that Iranian women have negative feelings due to pain, fear, and suffering, which would hinder their psychological development in labor wards\textsuperscript{21,22}. The importance of this domain and its items are supported by other studies showing the key role of emotional supportive care by midwives. This would help mothers to relax and control their emotions and fears, and decrease the intensity of pain, shorten the duration of labor, and reduce caesarean birth, instrumental vaginal birth, use of any analgesia, lower the five-minute Apgar score as well as negative feelings about childbirth experiences\textsuperscript{7,23}. Thus, care providers’ training in interpersonal care and emotional support could improve providers’ awareness and sensitize them on how to better offer counseling for women during childbirth, which will improve women’s birthing experience.

The second domain in the questionnaire was ‘providing safe care’. This domain indicates the participant midwives have had a good awareness and fairly good performance. One of the items of this domain is ‘providing informed consent before performing any care and interventions’ which had the lowest mean score in the awareness and performance sections. The importance of this domain and its items are supported by other studies showing the key role of informed consent by midwives. This would help mothers to make informed decisions about their care and interventions during childbirth, which will improve women’s birthing experience.

### DISCUSSION

This study revealed that Iranian midwives had good awareness of RMC but their awareness was not comprehensive on the number of items in each domain and their performance of RMC was fair. The first domain of our questionnaire, ‘giving emotional support’, showed that the participating midwives had a good awareness and fair performance. One of the items of this domain was ‘I establish friendly and appropriate relationship with the laboring woman’ which had the lowest mean score in the performance sections. Previous studies in Iran showed the need to improve midwives’ communication skills for providing better relationships with women during childbirth\textsuperscript{15,20}. Lack of emotional support skills from midwives (included touching, empathy, compassion, reassurance taking mother’s hands, maintaining eye contact, creating a sense of trust and confidence, reduction of fear during labor) is one of the reasons that Iranian women have negative feelings due to pain, fear, and suffering, which would hinder their psychological development in labor wards\textsuperscript{21,22}. The importance of this domain and its items are supported by other studies showing the key role of emotional supportive care by midwives. This would help mothers to relax and control their emotions and fears, and decrease the intensity of pain, shorten the duration of labor, and reduce caesarean birth, instrumental vaginal birth, use of any analgesia, lower the five-minute Apgar score as well as negative feelings about childbirth experiences\textsuperscript{7,23}. Thus, care providers’ training in interpersonal care and emotional support could improve providers’ awareness and sensitize them on how to better offer counseling for women during childbirth, which will improve women’s birthing experience.

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### Table 5. Continued

| Regression factors                  | Not standardized coefficients | Standardized coefficient B | t     | p         |
|------------------------------------|------------------------------|-----------------------------|-------|-----------|
|                                    | Coefficient B | Standard error |                   |
| Awareness                          |                |                |                   |
| Age                                | -0.280         | 0.338          | -0.813          | -0.137   | 0.210     |
| Academic degree in the midwifery   |                |                |                   |
| Master’s                           | 2.41           | 2.18           | 2.11             | 0.167    | 0.036     |
| Bachelor’s                         | 1.37           | 1.01           | 0.1              | 1.33     | 0.098     |
| Associate’s                        | 0.173          | 1.26           | 0.01             | 0.137    | 0.89      |
| Job satisfaction                   | -0.891         | 2.24           | 0.99             | -0.037   | 0.41      |
| Employment status                  | 0.54           | 1.02           | 0.508            | 0.04     | 0.612     |
| Job selection by interest          | 0.109          | 0.043          | 1.607            | 0.240    | 0.09      |
| Working shifts                     | -0.063         | 0.042          | -1.47            | -0.137   | 0.142     |
| Work place                         | -0.066         | 0.075          | 0.886            | -0.065   | 0.37      |
| Employment status                  | -0.063         | 0.07           | 0.901            | -0.065   | 0.369     |
| Performance                        |                |                |                   |
| Work experience                    | 1.18           | 0.260          | 3.279            | 0.433    | 0.002     |
| Age                                | 0.1            | 0.330          | 0.255            | 0.032    | 0.7       |
| Academic degree in the midwifery   |                |                |                   |
| Master’s                           | 0.59           | 0.26           | 2.21             | 0.175    | 0.028     |
| Bachelor’s                         | 0.3            | 0.51           | 0.1              | 1.6      | 0.109     |
| Associate’s                        | 0.23           | 0.188          | 0.09             | 1.26     | 0.207     |
| Job satisfaction                   | -1.27          | 0.53           | -2.41            | -0.19    | 0.017     |
| Employment status                  | -0.15          | 0.54           | 0.283            | 0.21     | 0.77      |
| Job selection by interest          | 0.167          | 0.068          | 1.454            | 0.180    | 0.051     |
| Working shifts                     | -0.076         | 0.074          | -1.024           | -0.075   | 0.307     |
| Work place                         | -0.066         | -0.71          | 0.934            | -0.069   | 0.351     |
| Employment status                  | -0.085         | 0.083          | -1.027           | -0.076   | 0.307     |
management of vaginal birth in Iran. However, Iranian midwives have included evidence-based care into the guidelines for childbirth in public hospitals. In Iranian public hospitals, midwives are trained and licensed according to international standards. However, their role is limited to managing vaginal childbirth. Iran’s health system has participated in the decision-making about their care. Iranian midwives are responsible for all births and obstetric residents manage all vaginal deliveries, and midwives are less involved in vaginal childbirth. Iran’s health system has an important effect on medicalization and thus needs to play a major role in changing the practice.

In our study, the participating midwives had a good awareness but a weak performance to ‘provide clear information about progress of labor’ in the second domain. A recent qualitative study from Iran on midwives’ perspectives of RMC also reported that most midwives considered involving women in the care process and decision making as essential part of the RMC. However, previous studies from Iran show that women did not receive adequate information about the process of labor, procedures, coping techniques and intervention procedures during childbirth that would prepare them to make a decision about their care. This domain indicates that providing information regarding procedures (advice about coping techniques, comfort measures and medical intervention, etc.) and supporting her decision-making are essential components for improving the quality of care and birth satisfaction in Iran.

In this study, midwives had a good awareness but a weak performance to ‘provide evidence-based and up-to-date childbirth care’ of the second domain. Iranian midwives are informed about evidence-based practice in childbirth as the Ministry of Health and Medical Education (MOHME) has included evidence-based care into the guidelines for management of vaginal birth in Iran. However, Iranian women experience a high rate of unnecessary interventions such as early admission in labor, stimulation, induction of labor, episiotomy, frequently vaginal examinations, and caesarean section. This is because within the Iranian birth context, midwives are not autonomous when they look after women in labor and they are not involved in any decision-making process; the care they provide is under the supervision of the obstetrician in charge. Besides, regarding medical dominance in the Iranian maternity care system, obstetricians tend to have some unnecessary interventions during vaginal childbirth in low-risk women, which may increase the rate of cesarean birth and ectopic scars. However, there is strong evidence that the decrease of interventions during vaginal birth in low-risk women can make childbirth safer and improve the quality of obstetric care. In order to provide good quality maternity care, health workers require a well-functioning health system structure which supports evidence-based practice.

The third domain in the questionnaire is ‘Preventing mistreatment’. This domain indicates the participating midwives had a good mean score on both preferences and awareness. In accordance with these results, a number of qualitative studies in Iran show that pregnant women reported that midwives fulfilled all their needs in respectful manner; they even provided equal services for the entire term. One of the items of this domain is ‘I do not allow the laboring woman to have companion inside the labor unit’ had the lowest mean score in performance sections. This is because, presence of women with their companion is prohibited in public hospitals in Iran. A review of the existing literature in Iran also shows midwives who do not necessarily consider mothers’ emotional needs, laboring alone was extremely difficult for many women and reported that negative feelings during labor. Although some certain religious issues have legally prohibited husbands from attending delivery room in Iran, friends and female relatives are good choices for mothers to trust these companions and feel comfortable around them. Based on World Health Organization’s (WHO) recommendations, healthcare administrators should facilitate the presence of a companion during labor. Our findings also suggest that the health system provides the structure where mothers can access good quality care.

The results of multivariate linear regression analysis showed that there was a significant negative relationship between job satisfaction and midwives’ performance on RMC. Work experience plus a Master’s degree in midwifery had positive significant effects on midwives’ awareness along with performance on RMC. In accordance with these results, previous studies from Iran also showed that more experienced midwives have good relationships with women during childbirth and have a positive attitude towards the rights of pregnant women. A study conducted in Iran showed that the midwives with a Master’s degrees displayed greater knowledge or skills and practice of evidence-based practice, which have a more positive attitude towards the rights of pregnant women than those with a Bachelor’s degree. A review of studies from Iran and Korea indicated that there was a good relationship between job satisfaction and job performance of midwives. Midwives, as main caregivers, would have undertaken the vaginal delivery for women at low risk. It would have a positive impact on the job satisfaction of midwifery. Therefore, it is recommended that health system provide organizational support for Iranian midwives.

Limitations

The evaluation of midwives’ performance was based on midwives’ self-administered tool. To overcome this limitation, an observational study is recommended.

CONCLUSIONS

This study has demonstrated that Iranian midwives knew the principles of RMC but their awareness was not
REFERENCES

1. EFFECTIVE ACCOUNTABILITY FOR DISRESPECT AND ABUSE EXPERIENCED BY WOMEN DURING MATUREITY CARE. White Ribbon Alliance; 2015. May 15, 2015. Accessed October 29, 2021. http://www.who.int/woman_child_accountability/ierg/reports/12_WRA_on_behalf_of_RMC_evidence_submitted_IERG_2015.pdf

2. Bohren MA, Vogel JP, Hunter EC, et al. The Mistreatment of Women during Childbirth in Health Facilities Globally: A Mixed-Methods Systematic Review. PLoS Med. 2015;12(6):e1001847. doi:10.1371/journal.pmed.1001847

3. RESPECTFUL MATUREITY CARE: THE UNIVERSAL RIGHTS OF CHILDBEARING WOMEN. White Ribbon Alliance; 2011. October, 2011. Accessed October 29, 2021. https://www.whiteribbonalliance.org/wp-content/uploads/2017/11/Final_RMC_Charter.pdf

4. Miller S, Abalos E, Chamillard M, et al. Beyond too little, too late and too much, too soon: a pathway towards evidence-based, respectful maternity care worldwide. Lancet. 2016;388(10056):2176-2192. doi:10.1016/S0140-6736(16)31472-6

5. Hednott ED, Gates S, Hofmeyr GJ, Sakala C. Continuous support for women during childbirth. Cochrane Database Syst Rev. 2013;7:CD003766. doi:10.1002/14651858.CD003766.pub5

6. Bradfield Z, Kelly M, Hauck Y, Duggan R. Midwives ‘with woman’ in the private obstetric model: Where divergent philosophies meet. Women Birth. 2019;32(2):157-167. doi:10.1016/j.wombi.2018.07.013

7. Bohren MA, Hofmeyr GJ, Sakala C, Fukuzawa RK, Cuthbert A. Continuous support for women during childbirth. Cochrane Database Syst Rev. 2017;7(7):CD003766. doi:10.1002/14651858.CD003766.pub6

8. Amini P, Maroufizadeh S, Samani RO, Hamidi O, Sepidarkish M. Prevalence and Determinants of Preterm Birth in Tehran, Iran: A Comparison between Logistic Regression and Decision Tree Methods. Osong Public Health Res Perspect. 2017;8(3):195-200. doi:10.24171/j.phpr.2017.8.3.06

9. Maternal Deaths Halved in 20 Years, but Faster Progress Needed. The United Nations Population Fund; 2012. May 16, 2012. Accessed October 29, 2021. https://www.unfpa.org/press/maternal-deaths-halved-20-years-faster-progress-needed

10. Ensure healthy lives and promote well-being for all at all ages. Sustainable Development Goal 3. United Nations. Accessed October 29, 2021. https://sustainabledevelopment.un.org/sdg3

11. Parsapoor A, Bagheri A, Larijani B. Patient’s rights charter in Iran. Acta Med Iran. 2014;52(1):24-28. Accessed October 29, 2021. https://acta.tums.ac.ir/index.php/acta/article/view/4746/4561

12. Moridi M, Pazardeh F, Hajian S, Potrata B. Midwives’ perspectives of respectful maternity care during childbirth: A qualitative study. PLoS One. 2020;15(3):e0229941. doi:10.1371/journal.pone.0229941

13. Shirzad M, Shabibazadeh E, Betran AP, Bohren MA, Abedini M. Women’s perspectives on health facility and system levels factors influencing mode of delivery in Tehran: a qualitative study. Reprod Health. 2019;16(1):15. doi:0.1186/s12978-019-0680-2

14. Pazardeh F, Huss R, Hirst J, House A, Baghban AA. An evaluation of the quality of care for women with low risk pregnancy: The use of evidence-based practice during labour and childbirth in four public hospitals in Tehran. Midwifery. 2015;31(11):1045-1053. doi:10.1016/j.mj.2015.07.003

15. Abdollahpour S, Motaghi Z. Lived Traumatic Childbirth Experiences of Newly Delivered Mothers Admitted to the Postpartum Ward: a Phenomenological Study. J Caring Sci. 2019;8(1):23-31. doi:10.15171/jcs.2019.004

16. Sedigh Mobarakabadi S, Mirzaei Najmabadi K, Ghazi Tabatabae M. Ambivalence towards childbirth in a medicalized context: a qualitative inquiry among Iranian mothers. Iran Red Crescent Med J. 2015;17(3):e24262. doi:10.5812/ircmj.24262.

17. Sando D, Kendall T, Lyatuu G, et al. Disrespect and abuse during childbirth in Tanzania: are women living with HIV more vulnerable? J Acquir Immune Defic Syndr. 2014;67(Suppl 4):S228-S234. doi:10.1097/QAI.0000000000000378

18. Moridi M, Pazardeh F, Hajian S, Potrata B. Development and psychometric properties of Midwives’ Knowledge and Practice Scale on Respectful Maternity Care (MKP-RMC). PLoS One. 2020;15(3):e0229941. doi:10.1371/journal.pone.0229941

19. IBM SPSS Statistics for Windows. Version 24.0. IBM;2016. Accessed October 29, 2021. https://www.ibm.com/support/pages/downloading-ibm-spss-statistics-24

20. Bagheri A, Masoudi Alavi N, Abaszadeh F. Iranian obstetricians’ views about the factors that influence pregnant women’s choice of delivery method: a qualitative study. Women Birth. 2013;26(1):e45-e49. doi:10.1016/j.wombi.2012.09.004

21. Shahoei R, Riji HM, Saeedi ZA. Kurdish pregnant women’s feelings: a qualitative study. Midwifery. 2011;27(2):215-226.
Research paper

22. Gheibizadeh M, Abedi HA, Mohammadi E, Abedi P. Iranian women and careproviders' perceptions of equitable prenatal care: A qualitative study. Nurs Ethics. 2016;23(4):465-477. doi:10.1177/0969733015573653

23. Fathi Najafi T, Latifnejad Roudsari R, Ebrahimipour H. The best encouraging persons in labor: A content analysis of Iranian mothers' experiences of labor support. PLoS One. 2017;12(7):e0179702. doi:10.1371/journal.pone.0179702

24. Pazandeh F, Potrata B, Huss R, Hirst J, House A. Women's experiences of routine care during labour and childbirth and the influence of medicalisation: A qualitative study from Iran. Midwifery. 2017;53:63-70. doi:10.1016/j.midw.2017.07.001

25. World Health Organization. Standards for improving quality of maternal and newborn care in health facilities. World Health Organization; 2016. Accessed October 29, 2021. https://apps.who.int/iris/bitstream/handle/10665/250274/WHO-RHR-16.10-eng.pdf

26. National Guidelines for Normal Delivery. Ministry of Health and Medical Education of the Islamic Republic of Iran; 2019. Accessed October 29, 2021. https://irangov.ir/ministry-of-health-and-medical-education

27. Freedman LP, Graham WJ, Brazier E, et al. Practical lessons from global safe motherhood initiatives: time for a new focus on implementation. Lancet. 2007;370(9595):1383-1391. doi:10.1016/S0140-6736(07)61581-5

28. Askari F, Aparodi A, Torabi S, Moshki M. Exploring women’s personal experiences of giving birth in Gonabad city: a qualitative study. Glob J Health Sci. 2014;6(5):46-54. doi:10.5539/gjhs.v6n5p46

29. Zamani P, Ziaie T, Lakeh NM, Leili EK. The correlation between perceived social support and childbirth experience in pregnant women. Midwifery. 2019;75:146-151. doi:10.1016/j.midw.2019.05.002

30. khodarahmi S, Hajian S, Zare E, Nasiri M, Pazandeh F. Investigating the Iranian women's experiences of physiological childbirth. European Journal of Molecular & Clinical Medicine. 2021;8(2):1011-1024. Accessed October 29, 2021. https://ejmcm.com/article_7571_d44258fa87a62a32c384ac57b3959be5.pdf

31. Khamenehchian M, Adib-Hajbaghery M, HeydariKhayat N, Rezaei M, Sabeny M. Primiparous women's experiences of normal vaginal delivery in Iran: a qualitative study. BMC Pregnancy Childbirth. 2020;20(1):1-8. doi:10.1186/s12884-020-02954-4

32. World Health Organization. Companion of choice during labour and childbirth for improved quality of care. World Health Organization; 2016. Accessed October 29, 2021. https://apps.who.int/iris/bitstream/handle/10665/250274/WHO-RHR-16.10-eng.pdf

33. Heidari A, Ahmadpour Z, Gharesh Boughliou Z. Patients and nurses awareness of patient's rights: A comparative study. Health, Spirituality and Medical Ethics. 2014;1(1):1-8. Accessed October 29, 2021. http://jhsme.muq.ac.ir/article-1-3-en.pdf

34. Heydari A, Mazlom SR, Ranjbar H, Scurlock-Evans L. A study of Iranian nurses' and midwives' knowledge, attitudes, and implementation of evidence-based practice: the time for change has arrived. Worldviews Evid Based Nurs. 2014;11(5):325-331. doi:10.1111/wvn.12052

35. Hadizadeh Talasaz Z, Nourani Saadoldin S, Taghi Shakeri M. The Relationship Between Job Satisfaction and Job Performance Among Midwives Working in Healthcare Centers of Mashhad, Iran. Journal of Midwifery and Reproductive Health. 2014;2(3):157-164. doi:10.22038/jmrh.2014.2623

36. Jung GA, Ki. MJ. Work performance and calling as factors influencing job satisfaction among nurse midwives working in the delivery room. Article in Korean. Korean Journal of Women Health Nursing. 2020;26(1):10-18. doi:10.4069/kjwhn.2020.02.27

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DATA AVAILABILITY
The data supporting this research are available from the authors on reasonable request.

AUTHORS’ CONTRIBUTIONS
SH designed the study, collected and analyzed the data and interpreted and drafted the manuscript. FA analyzed the data. FA and AA supervised and critically reviewed the manuscript.

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