

Women's needs and expectations during normal labor and delivery

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ABSTRACT

Background: Pregnancy and birth are unique processes for women. Women and families hold different expectation during childbearing based on their knowledge, experiences, belief systems, culture, and social and family backgrounds. These differences should be understood and respected, and care is adapted and organized to meet the individualized needs of women and families. The purpose of this study was to explore Iranian parturient needs, values and preferences during normal labor and delivery. **Materials and Methods:** An exploratory qualitative study was used. Twenty-four parturient women from three governmental medical training centers in Isfahan, Iran were recruited using purposive sampling. Participants were recruited to low-risk women after they had given birth, but before they were discharged from hospital. Data were collected through semi-structured in-depth interviews, informal observations and field notes. Interviews were transcribed verbatim and analyzed by the conventional content analysis according to Graneheim and Lundman approach. **Results:** Women's needs and expectations fell into seven main categories: Physiological, psychological, informational, social and relational, esteem, security and medical needs. All of the key needs in these data relates to a fundamental need, named "sense of control and empowerment in childbirth." **Conclusion:** Knowing a woman's needs, values, preferences and expectations during normal labor and delivery assists healthcare professionals especially midwives in providing high-quality care to parturient women.

Key words: Childbirth, delivery, evidence-based practice, labor, needs assessment, parturition

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INTRODUCTION

"Birth is a life changing event and the care given to women has the potential to affect them both physically and emotionally in the short and longer term (Royal College of Obstetricians and Gynecologists [RCOG])." The overall objective taking care of women during childbirth is creating a positive experience for a woman and her family while preserving their physical and psychological health, preventing of morbidity and reaction to the emergency situations.^[1] The maternal expectations during labor play an important role in specified a woman's response to her childbirth experience.^[2] Every woman giving birth has expectations. Identifying women's expectations, wishes, needs and fears empower the health care providers to achieve toward a common target of a

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positive birth experience.^[3] Every year, more than 1 million women give birth in Iran that 90% of them receive maternity care in the hospital.^[4] Despite many modifications in the Iranian health care system in the recent decades, there is still more space for enhance in the quality of maternity care.^[5] "Evidence-based practice (EBP) is simply the integration of the best available research-based clinical evidence, clinical expertise, and patient needs, values and preferences to develop a system of quality care."^[6] Although EBP detected as necessary for quality care in developed countries, it is often based on research and clinical evidence and less attention has been paid to the needs and preferences of the parturient women.^[7] There is often a gap between what women expect to receive from their maternity care and the level of services that provided by healthcare professionals.^[8] Furthermore identifying parturient needs, values and preferences requires for quality improvements of care during normal labor and delivery. In this study, we aimed to explore women needs and expectations during intrapartum care.

MATERIALS AND METHODS

This qualitative study was a part of a comprehensive study which aimed to explore parturient needs, values and preferences during normal labor and delivery. We conducted a descriptive exploratory qualitative study in three hospitals of Alzahra, Shahid Beheshti and Ashrafi Esfahani which all be affiliated to the Isfahan University of Medical Sciences. Participants were recruited to low-risk women after they had given birth, but a few hours before they were discharged from hospital. We recruited women using purposive sampling according to maximum variation approach.^[9] In purposive sampling, the researcher is seeking people who have rich experiences of the phenomenon and possess ability and willingness to express them.^[10] The inclusion criteria were as follows: Parturient mothers of 18–45 years of age with a low-risk and full-term pregnancy, having a healthy child, no history of depression before or after giving birth, speaking in Persian and good cooperation during interviews. They were also chosen from different demographic backgrounds.^[9] This study was approved by the Ethics Committee of the Isfahan University of Medical Science (No: 391206) and tenets of the Declaration of Helsinki was followed. The aim of the study was explained to the participants, and their written informed consent was obtained. Furthermore, it was explained that the participants could withdraw from the study at any time.

The data were collected using semi-structured in-depth interviews, informal observations and field notes during April-July 2013. The participants were asked to talk about their preferences and needs during labor and childbirth. All the interviews were conducted in a private room. First, interview was started by a general question: What were your needs and expectations during childbirth? The next questions were based on the participant's response to the first question. Duration of the interviews ranged from 30 min to an hour and 50 min. Field notes were recorded by the researcher in the hospital ward and performed in different shifts. In general,

24 interviews were conducted, and 16 field notes were also recorded. Interviewing stopped when data saturation occurred. Data saturation occurred when no more codes or themes could be emerged in the last two interviews.^[9]

Data analysis

Data analysis was undertaken simultaneously with data collection in order to identify new and important issues that could be addressed during the subsequent interviews. The general principles of qualitative content analysis by Graneheim and Lundman guided data analysis.^[11] First, after transcribing each interview, the researcher reviewed the text several times until a general impression is received. Second, all texts were broken down into meaning units. Third, each meaning unit was summarized to a "condensed meaning unit" and then primary codes were obtained. Fourth, the codes with similar meanings were grouped into subcategories. Similar subcategories were grouped into main categories that are presented as findings in this paper. Eventually, we were determined themes as the expression of the hidden content of the text in the fifth stage.^[11] The findings contain direct quotes from participants, and the narrations are reported as they were spoken by participants without editing the grammar to avoid losing meaning.^[11]

Trustworthiness

To enhance rigor and trustworthiness of the study, these measures were considered: Prolonged engagement with participants in data collection, searching negative cases, member check (confirming samples of coded data by participants), and peer debriefing to enhance the credibility through confirming samples of coded data by experienced qualitative researchers.^[9,11]

RESULTS

The data were obtained from interviews with 24 participants. Also 16 field notes to become immersed in the data. Demographic characteristics of participants have represented in Table 1. During the data analysis, 24 subcategories and 7 main categories including physiological needs, psychological needs, informational needs, social and relational needs, esteem needs, security needs and medical needs emerged [Table 2]. All of key finding in these data relates to the theme, named "sense of control and empowerment in childbirth." Below, the meaning of each category is presented by using the participants' direct quotations.

Physiological needs

One of the extracted categories from the data was physiological needs. It consisted of four sub categories: Nutritional needs, physical environmental conditions, individual and hygienic needs, provision of physical comfort and ensure of privacy.

Women have expressed their desire to eat and or drink through labor. Some women commented that they felt out of energy, and they were worried where they would find their

strength to be able to give birth in that condition. One of the participants said: "I was hungry because I have not eaten anything since yesterday.... And I felt that lost my strength" (P21, 33 years old, G2). The participants indicated that they desired comfort and a pleasant environment. Ward routines, such as control room temperature, control noise, dim lights, control odors, were something that women found difficult to comprehend. One of the women said: "I was annoyed once the lights of ward being switched on early in the morning and kept on until late at night" (P1, 24 years

old, G1). Respondents reported that clean sleeping quarters were an important need for most of them. Women appreciated the need for change bed linens and the change gown. One of the participants expressed that: "Because they are so busy you can't every time you need to change the sheet or once you say can you get me another sheet you don't like that they Buzzing" (P16, 34 years old, G3). Participants also spoke about the need for physical comfort including ambulation, walking, and changing positions. Another woman stated: "I was tired from uncomfortable lying down during labor; I loved the walk, but midwife told me that I should lie down" (P7, 41 years old, G4).

Table 1: Characteristics of participants

Variables	Frequency (%)
Age (years)	
21-30	11 (45/8)
31-40	10 (41/6)
>40	3 (12/5)
Gravidity	
G1	8 (33/3)
G2	11 (45/8)
G3 and higher	5 (20/8)
Job	
Housewife	14 (58/3)
Employed	10 (41/6)
Level of education	
Primary school	2 (8/3)
High school	3 (12/5)
Diploma	12 (50)
University	9 (37/5)

Psychological needs

Another of the extracted categories from the data was psychological needs. The subcategories of this category were empathy and advocacy, constant emotional support and assure and encouragement.

The participants' expected the midwives to show empathy and advocacy, and to give them constant emotional support. One of the women said: "The empathy and kindness of midwife really relaxed me; when she was good-tempered with me, I felt that I was in control" (P14, 31 years old, G2). Another participant stated that "When midwife was beside me, I feel relieved. I really needed that have consistently supported during labor and delivery" (P9, 28 years old, G1). Some of the women expressed they were emotionally comforted by receiving verbal encouragement during their labor and birth. One of the women reported: "When the doctor encouraged

Table 2: Parturient needs and preferences during normal labor and delivery from the Iranian women's perspectives

Theme	Categories	Sub categories
Sense of control and empowerment in childbirth	Physiological needs	Nutritional needs
		Physical environmental conditions
		Individual and hygienic needs
		Provision of physical comfort and ensure of privacy
	Psychological needs	Empathy and advocacy
		Constant emotional support
		Assure and encouragement
		Informational needs
	Informational needs	Inform of women with the ward environment
		Acquaint of women about labor process
		Informing women of the plan of care and procedures
		Basic practical aspects of care for themselves and their baby
	Social and relational needs	Communication to health care professionals (physician, midwife, nurse)
Constant presence of familiar attendant (partner, relative of family, doula)		
Esteem needs	Sense of valued (conveying respect)	
	Sense of confidence (establish trusting early)	
	Sense of competence (self-efficacy)	
	Participation in decision	
	Feel involved in the care	
Security needs	Domination on fear of losing the baby and anxiety about his/her health	
	Domination on fear of childbirth	
	Domination on fear of encounter the unknown and dying	
	Assure of professional expertise of doctor or midwife	
Medical needs (professional medical care)	Relief of pain during childbirth	
	Prevention of unnecessary intervention during childbirth	

me during labor pain, I felt that I could handle more my pain" (P17, 42 years old, G2).

Informational needs

Another category that was derived from the experiences of laboring women was informational needs. The subcategories of this category were "inform of women with the ward environment," "acquaint of women about labor process," "informing women of the plan of care and procedures" and "basic practical aspects of care for themselves and their baby." Familiarity with the labor environment was an essential requirement for many women at the time of admission for childbirth. Inadequate orientation with labor ward often increased women's stresses. A woman explained: "I expected to be informed of basic things, like to be shown around and particularly about things that I need to use in the ward. For example; I didn't know where to go the toilet or bathroom" (P20, 19 years old, G1).

Another information need of women was to get familiar with the labor process. It was observed that the laboring women did not have the basic knowledge about labor and delivery process. The women wanted to know if the labor progress was normal. The participants expected the midwives to explain their actions and findings, and to guide and encourage them on what to do. One woman said: "They should explain to us in simple words because sometimes they say "an action" and we don't know how to do it, and they say that you don't understand. Therefore, they should be taught and clearly explained for our" (P5, 37 years old, G3). Many women wanted information that would help them to develop their confidence in necessary practical aspects of care for themselves and their baby. One woman commented: "Midwives explained anything that I needed to take care of myself and my baby; when they explained things, I got a great sense of quietness" (P19, 25 years old, G2).

Social and relational needs

One of the extracted categories from the data was social and relational needs. It consisted of two sub categories: Communication to health care professionals (physician, midwife, nurse) and constant presence of familiar attendant (partner, relative of family, doula).

The participants emphasized the need for communication to health care providers. They expected, the midwives to give the mothers timely attention and welcome them warmly and listen patiently to their conversations at the time of admission. One of the participants said: "Firstly, I would expect them to welcome me with amiability and ask what my problems are me and what I am there for. I would like explain all things about my condition for the physician or midwife, and she patiently listens to my talks" (P12, 26 years old, G1). Women expressed that all physicians and midwives were busy. There were some expression made about call not being answered, or that they were slow to answer when women called for them. One woman commented: "The physician promised me that herself perform my delivery; she called by telephoning and arriving just when I delivered. I believed that it really

wasn't a good personal relationship" (P15, 29 years old, G1). The presence and support of a partner during labor and childbirth seemed to be of paramount importance for some of the women. Some of the women interviewed believed to the present of partner in the labor ward while some preferred that partner not present in labor and delivery room. One woman said: "If possible, allowing my husband to support me physically and emotionally is the best thing that could happen to me. It's very good" (P8, 24 years old, G1). The presence of the family relative or a friend was important to a woman in labor. Another woman explained: "I felt lonely; I would like my mother to be present during labor. Not too many people in the delivery room" (P6, 31 years old, G2). There was a need for the mothers that see their baby immediately after delivery. One of the participants said: "They must bring my baby before I go to the other ward. I want to see it immediately and really feel that this is my baby" (P2, 42 years old, G3).

Esteem needs

Esteem need was an important part of needs of the mothers during childbirth. The subcategories of this category were sense of valued (conveying respect), confidence (establish trusting early), competence (self-efficacy), participation in decision and feel involved in the care.

The participants emphasized the need for conveying respect and established trusting early of health care providers. A participant said: "I feel like a lucky person to have a doctor that I trust as much as I do. I am comfortable asking her any question. I am very lucky to have found her and have her involved in very important decision in my life" (P3, 32 years old, G2). The women described that they felt calm when they were well informed about their ability to give birth. One of the mother said: "The midwife explained what was going on as I was in labor, and this meant I felt I was in control. Because I was sure that I can" (P10, 22 years old, G1). The women acknowledged the fact that they wanted to participate in decision making. One mother describes it as follows: "I think my expectations changed by participation in decision for care throughout labor. My expectations upon myself to have a labor and deliver this baby, you know, feeling very empowered. So it was really great to see... I think that "yes", I can do this" (P23, 32 years old, G2). The participants commented on the importance of their partner and themselves being involved in deciding on various aspects of care. One of the participants said: "I wouldn't have thought I could have done this (birthed), but after being involved in deciding for care of myself, I knew I could do it and I just found it very good to be with myself during labor. I had a lot of self-confidence" (P13, 27 years old, G1).

Security needs

Security need was a major category that was derived from the experiences of laboring women during labor and delivery process. The subcategories of this category were domination on fear of losing the baby and anxiety about his/her health, domination on fear of childbirth, domination on, domination on fear of encounter the unknown or fear of dying and assure of professional expertise of doctor or midwife.

One of the participants said: "I was fear that something will happen to the child. I also was so scared of losing my baby. Two of my friends have lost babies in the last year. The loss of a child has to be the hardest pain ever to go through" (P18, 19 years old, G1). The women concerned about the risk of childbearing. One woman explained the issue in the following words: "I was afraid of childbirth! I don't deny all risks as may be something happen during the childbirth but I wished to have a comfortable and secure childbirth; I also was very scared that a perineal rupture may occur" (P15, 29 years old, G1). One of woman noted: "I was scared that something unexpected happens and that a state of emergency may occur that might influence my capacity to manage emotionally. Also I was scared to death!" (P11, 35 years old, G2).

Medical needs

Medical needs are another major category. The main subcategories of this category were pain relief and prevention of unnecessary intervention during labor (for example: Frequently use of urinary catheter and vaginal examination; routine use of episiotomy and enema).

One woman acknowledged that: "I had a fear of pain during childbirth. I was afraid that I will not be able to cope with the pain. However, I want the childbirth to be as natural as possible" (P8, 24 years old, G1). Many women believe they're likely to go through labor and give birth without medical intervention. A woman commented that: "I have had this basic attitude that it should all be natural. I didn't want any intervention" (P4, 33 years old, G2). The women described that procedures such as "use of a urinary catheter" were undertaken frequently and routine. One woman said: "The use of urinary catheters for me was really hurts, I would prefer go to the bathroom" (P22, 40 years old, G3). The women also described that procedures such as "vaginal examination" were undertaken frequently and unnecessary. One woman said: "I had a horrendous fear of repeat vaginal examination during childbirth; I think most examination for me was really unnecessary" (P18, 19 years old, G1).

DISCUSSIONS

To our knowledge, this is the first qualitative study that explored and discovered parturient needs and preferences during labor from the Iranian women's perspective. As presented in the results, seven main categories were relates to women's needs, values and preferences during normal labor and delivery. All of key needs in these data relates to a central need, named "sense of control and empowerment in childbirth."

The findings of the current study expressed that intervening to promote physiological needs can positively influenced on the women's sense of control and empowers during birthing. This study demonstrated that some of women were disappointed of restriction of eating and drinking during labor. Limitation fluids and foods during labor is popular practice among many birth centers.^[12] The World Health Organization recommends

that healthcare providers should not admix in restriction of low-risk women for eating and drinking during labor.^[13] Since the evidence shows no benefits or harms, there is no rationalization for the constraint of fluids and food in labor for women when no risk factors are apparent.^[12] A safe and calm environment positively influenced the women's sense of control. Environmental control constructs a comforting and calm space. Balancing room light and temperature while decreasing annoying noises and use of music will help to physical comfort.^[14,15] The participants' believed that the promotion of comfort was an essential need for them during labor. Intervening to promote the comfort of laboring women can empower these women during childbirth. Increasing comfort can decrease labor pain, need for medical interventions and costs.^[16]

Most mothers described the importance of psychological support of health care professionals and family. The participants expected the midwives to show empathy, advocacy, interest and constant emotional and moral support. They believed women who felt that their midwife had supported them had a more sense of control than those who did not feel that support from their midwife. Based on results of a Cochran systematic review:

"Supportive care during labor may enhance physiologic labor processes as well as women's feelings of control and competence, and thus reduce the need for obstetric intervention. Women who received continuous labor support were more likely to give birth spontaneously and give birth with neither caesarean nor vacuum nor forceps. In addition, women were less likely to use pain medications, were more likely to be satisfied, and had slightly shorter labors. Their babies were less likely to have low 5 min Apgar score."^[17]

The participants of this study believed that besides to midwives, nonmedical people such as a husband, family members (mother, sister etc.), friends and doula can provide supports for women at labor.

The participants in this study expressed a need for received information. This study found that childbirth information received by mothers during antenatal period influences their sense of control and empowerment during labor and delivery. Women reported greatest interest in topics such as familiar with the ward environment, familiar with the labor process, informing of the plan of care and procedures and care of themselves and their baby. Other studies from developed countries have also identified similar information needs.^[18] In this study, many women reported not receiving information about these issues. All of they wanted to receive more information. These findings were similar to the findings of the previous studies. Malata^[19] reported that 1st time mothers are not satisfied with the amount of labor and childbirth information given in the birth centers. Blackford *et al.*^[20] reported that most women receive inappropriate and inadequate information about childbirth, and there is a need to discover women's needs to ensure the offering of

appropriate and adequate informational. Also, Malata and Chirwa^[18] found that the mothers did not satisfy of childbirth information that received during the antenatal period. Childbirth information received by mothers during the antenatal period affect their satisfaction of the care during intrapartum care. It is important for the midwives to know the kind of information that satisfies their clients.

In this study, all participants mentioned the importance of their good communication with health care professionals. Also, presence of the physician, midwives or one of family relative such as her husband, partner, mother or friend was highly valued by women. Based on Clinical Guideline Published by the RCOG:

“Developing a rapport, trust and effective communication between healthcare providers and women is important to a woman's positive childbirth experience.”^[1]

The participants emphasized that presence of doctor and midwife in the labor and delivery room was an important component of women's needs during childbirth. The presence of a doctor in a labor ward may decrease the anxiety and fear which parturient women may feel. The most of participation in this study were preferred “mothers” as attendant while in other nations “husbands” are popular companions. It is mostly caused by to cultural and social differences. In Iranian culture, mothers perform a vital role for care during labor and delivery. The World Health Organization recommended that, “the parturient woman should be accompanied by people with whom she feels safe and trust; possibly doula, midwife, her husband or a friend.”^[21]

The participants emphasized that sense of valued (conveying respect), confidence (establish trusting early) and competence (self-efficacy) are important aspects for women during care. The mothers also pointed out that they wanted to participate in decision making and being involved in various aspects of care. Lowe reported that women with low self-esteem don't have the same confidence in their internal resources and also have undeveloped adaptation mechanisms.^[22] She believed that women who indicate greater confidence in their strength to confront with labor also express feeling less pain during labor.^[23-25] She also finds that women with low self-efficacy experience more fear of childbirth as well as fear of losing control during labor.^[22] Also, results of childbirth investigation showed that the self-efficacy influenced woman's compatibility and experiences of childbirth.^[22,26] Based on Clinical Guideline Published by RCOG:

“All women in labor should be treated with respect and should be in control of and involved in what is happening to them, and the way in which care is given.”^[1]

Another need that emphasized in participants' interviews were the need to safety and security. All participants stated that once women of their own safety and their baby were assured,

this issue can lead to their feeling of control and empowerment. Fear of childbirth and low self-confidence affects on women ability for give birth.^[22,27] In a study, Adams *et al.* found that fear of childbirth increased the duration of labor in women.^[28] Also, fear of childbirth often leads to request for an elective cesarean section.^[29] In pregnant women with fear of childbirth, psycho education, focuses on enabling coping strategies and support increases rates of spontaneous vaginal delivery, reduces caesarean rates and improves delivery experience.^[30,31] The participants believed that a professional expertise of doctor or midwife and presence of their in the labor room seemed to be supportive in creating a sense of security for laboring women.

In this study, the most important medical needs of women were pain relief and prevention of unnecessary interventions. Delivery pain is one of the most severe pains that women experience during their life.^[32,33] Leap and Anderson reported that most women are afraid of labor pain.^[34] In our study, the participants expected labor to be painless. In a study of Nilsson *et al.*, the mothers stated that the reduction of pain could influence the sense of control on positively.^[35] In this study, most women believed that they received unnecessary intervention during normal labor and delivery. However, some of women were considered it as a positive factor to their experience especially when abnormal labor occurred. Yet women and their partners are often unaware that many routine interventions can lead to a cascade of unplanned experiences and unwanted side effects.^[36] American College of Obstetricians and Gynecologists declared that:

“Decisions about interventions should incorporate the woman's personal values and preferences and should be made only after she has had enough information to make an informed choice in partnership with her care team.”^[37]

For example, based on the best evidence, vaginal examination during labor should be performed only when necessary, and if applicable, by the same provider. This will reduce the laboring women's unnecessary affliction from pain and discomfort. Providers should protect for women's right to information, respect, dignity and privacy.^[38]

In brief, our findings highlighted many aspects of women's expectations related to childbirth and gave a new insight for midwives and physicians to help these women have a better experience related to childbirth. Our study reflects the viewpoints of a limited number of patients. Therefore, we cannot generalize the findings to other qualitative studies and to all the women undergoing normal labor and delivery.

CONCLUSION

One of the components for both evidence-based care and woman-centered care is women preferences.^[39] Evidence-based care is an important instrument for improving the quality of maternity care.^[40] Woman-centered means that care respects the values, culture, choices, and preferences of the woman and her family, within the context of promoting optimal

health outcomes.^[41] The attempt in order to incorporate women expectations and preferences into midwifery care needs to a multifaceted intervention; multifold levels of health care professionals to organizations and health systems must be targeted.^[39] The finding of this study indicated that there is a need for empowering health care professionals and Iranian women for increased knowledge about obstetric care based on the needs of women in their care. If midwives to explore and discover the expectation and needs of women in their care so that sensible expectations can be encouraged and then, hopefully, complied; this issue could lead to women's empowerment for normal vaginal delivery.

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