

# Respect for woman's decision-making in spontaneous birth: A thematic synthesis study

Firoozeh MirzaeeRabor<sup>1</sup>, Fattaneh Mirzaee<sup>2</sup>, Khadigeh MirzaeiNajmabadi<sup>3</sup>, Ali Taghipour<sup>4</sup>

## ABSTRACT

**Background:** Participation of woman in decision-making processes is one of the key indicators of an appropriate relationship between a woman and the health care professionals. This study aimed to recognize the factors facilitating respect for woman's decision-making in spontaneous birth.

**Materials and Methods:** This paper employed a meta-synthesis on articles published in four biomedical databases including MEDLINE, Web of Science, CINAHL, and Cochrane Library. All qualitative studies published after 1990 and directly or indirectly discussing the women's and the health care professional's attitudes toward respect for woman's decision-making in spontaneous birth were searched. Of 5372 citations, 95 full-text papers were considered, of which 14 satisfied the inclusion criteria.

**Results:** In this meta-synthesis, initial codes were obtained through meticulous, line-by-line coding of the findings of the primary studies. Then, thematic synthesis was performed on the codes to search for concepts, and 20 descriptive themes were obtained in the second stage. Finally, through an inductive process, five new interpretations were obtained in the last stage of the thematic synthesis. These interpretations included confidence to health care providers, the central role of midwives in maintenance of women's dignity, childbirth as a natural phenomenon, the impact of contextual conditions, and the political and human factors affecting the delivery management and women seek place of safety for childbirth.

**Conclusions:** Studies suggested that midwives have a central role in maintenance of women's dignity and their experience of childbirth.

**Key words:** Childbirth, dignity, Iran, qualitative study, thematic synthesis

<sup>1</sup>Department of Midwifery, Razi School of Nursing and Midwifery, Faculty of Kerman University of Medical Sciences, Kerman, Iran, <sup>2</sup>Department of Economy, MS School of Management, Faculty of Shahid Bahooonar University of Kerman, Kerman, Iran, <sup>3</sup>Department of Midwifery, School of Nursing and Midwifery, Faculty of Mashhad University of Medical Sciences, Mashhad, Iran, <sup>4</sup>Health Sciences Research Centre, Cancer Research Center, Department of Biostatistics and Epidemiology, School of Health, Faculty of Mashhad University of Medical Sciences, Mashhad, Iran

**Address for correspondence:** Dr. Ali Taghipour, Health Sciences Research Centre, Cancer Research Center, Department of Biostatistics and Epidemiology, School of Health, Faculty of Mashhad University of Medical Sciences, Mashhad, Iran. E-mail: TaghipourA@mums.ac.ir

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## INTRODUCTION

Childbirth is a unique experience for a woman, influencing her dignity for many years.<sup>[1]</sup> A positive experience of childbirth improves the woman's and her family's mental health, increases the rate of successful breastfeeding, and leads to fewer complications.<sup>[2]</sup>

The quality of communication is a significant indicator for mutual decision-making between women and midwives.<sup>[3]</sup> Women have very different prospects toward childbirth that significantly affect their coping with it.<sup>[4]</sup>

Pain management and constant support are two factors that allow women to cope with labor experience. These factors increase women's dignity and improve shared

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decision-making between women and health care providers.<sup>[5]</sup> Enabling women to make informed decisions is a key factor that provides them a positive childbirth experience.<sup>[6]</sup> Furthermore, suppleness, honor, respect for favorite and dignity, and support and reassurance are not only important in assisting women to cope with childbirth<sup>[7,8]</sup> but are more precious than physical support.<sup>[9]</sup>

Nowadays, health care practices tend to reject passive orders, misplace assurance, and make health care decisions on behalf of the patients.<sup>[10]</sup> Childbirth is also interpreted as a process that occurs between women and health care providers.<sup>[10]</sup> Such a partnership is highly supported in the modern health care systems<sup>[10]</sup> and is emphasized in midwifery studies. This attitude has placed woman at the core of midwifery care.<sup>[11]</sup> Midwifery care is defined as a constant, personal, and sensitive service during the entire childbirth process<sup>[3]</sup> that should substitute women's fears with control and self-confidence.<sup>[12]</sup> To this end, a woman's right to participate in decisions regarding her health and care should be the cornerstone of all midwifery care. Then, adequate information should be provided for women by skilled professionals. Such information should provide a range of alternative action modalities that enable women to make the best decisions regarding their health.<sup>[13]</sup>

Although some of the health care professionals are concerned about the reduction of their professional authority, it should be noted that patients' participation in health care decisions and women's autonomy does not mean a reduction in professional authority but reflects a shift in the paternalistic view towards women and other clients.<sup>[14]</sup> As Lothian commented, there is a range of correct health care conducts and health care professionals should enable patients to select the best. In this case, midwives should empower women to select a suitable conduct to give birth, depending on their ideals, attitudes, targets, and psychological facets.<sup>[15]</sup> This is especially important when we know that childbirth is a natural experience and pregnant women are not patients, but are users of a precise service in the health care system; and they are aware of their rights about pregnancy and childbirth.<sup>[16,17]</sup>

Such shared decision-making needs clearness of vision and duties and a feeling of being conducive to debates and talks on an important health care decision.<sup>[18,19]</sup> The growth of an open and credulous relationship may facilitate the process of shared decision-making.<sup>[18,19]</sup>

Studies show that autonomy and shared decision-making are key factors for a positive childbirth experience.<sup>[16,17]</sup> Hence, it is important to recognize factors that facilitate shared decision-making between women and health care professionals. This study aimed to discover the factors facilitating the process of shared decision-making.

## MATERIALS AND METHODS

This study employed a meta-synthesis approach. The study was conducted on articles retrieved from four biomedical databases including MEDLINE, Web of Science, CINAHL, and Cochrane Library.

### Inclusion criteria

The aforementioned databases were searched to retrieve qualitative studies focusing on women's and health professional's experiences and attitudes toward respect for woman's decision-making in spontaneous birth. Access to full text articles in English language was an additional inclusion criteria.

### Search strategy

The databases were searched with keywords including qualitative study, thematic synthesis decision-making, childbirth, and dignity. Depending on the individual databases, the search operators (AND; OR) were used to extract the articles.

### Quality appraisal of studies

The quality of the studies was appraised using a reliable quality evaluation tool (NICE, 2009). The NICE contains 14 criteria and is an appropriate instrument for evaluation of qualitative studies. If a study had all, or approximately all the criteria, it was assigned (+ +). Studies were assigned a (+) if they had a number of criteria and were assigned (-) if they had an inadequate number of the criteria. The latter studies remained in the review but did not affect the conclusion. Therefore, no papers were excluded from this review.

Data extraction and quality appraisal of the studies were carried out by one researcher (MF) and re-assessment was conducted by three reviewers (TA, MK, and MM). Contradictions and disagreements were resolved through consensus by the research team.

### Data synthesis

There are different methods available for synthesis of qualitative studies.<sup>[20]</sup> We used thematic synthesis.<sup>[21]</sup> First, the findings of the retrieved studies were discussed by the review team, and then the data were coded and categorized to obtain themes. The themes were then discussed by the review team until an explanatory framework was formed.

## RESULTS

The initial search in databases brought up 5372 citations; among them 5265 citations were excluded because they did not match the research question. From all the abstracts of

107 articles, only 8 papers matched the inclusion criteria. Another search up to March 2014 yielded 1208 citations, of which 1202 were excluded, and 6 papers were included in the review at this stage. In general, 14 papers were assessed in the present study. Nine studies had very good quality (+ +); four studies had good quality (+); and one had poor quality (-) because it did not report the details of the study but was included in this review for its plentiful findings.

### Characteristics of included studies

The properties of the included studies are summarized in Table 1. Two studies were carried out by the same authors.<sup>[24,31]</sup> Nine studies reported the views, attitude, and experiences of women who had labor, however, three studies explored the viewpoints of health care professionals. One study explained the patients' experience and one study explored the experiences of both midwives and women. Participants were recruited from postpartum wards, maternity units, and women's houses. One study was carried out through email and a number of open-ended questions were added at the end of the questionnaire.<sup>[31]</sup>

The studies were carried out using a variety of qualitative approaches. Four studies only reported that interviews were used as the main data collection method. Other studies used specific qualitative approaches such as ethnography (one paper),<sup>[3]</sup> grounded theory (two papers), phenomenology (four papers), and content analysis (two papers). In addition, there was a study which did not report the experiences of women or health providers but described the patients' dignity as a key element in the process of shared decision-making. Therefore, we did not exclude it from this review. This was done to avoid what Dixon-Wood *et al.*<sup>[20]</sup> cited it as "a malfunction that might result in an imperfect review."

### Data extraction

All the texts under the heading "results" were extracted electronically and entered into the computer software MAXqda(version2007). Each of the research team embarked on coding and analysis separately, and then consensus was used to resolve conflicts.

### Data synthesis

The data synthesis was performed through three inductive phases. In phase 1, the findings of the primary studies were read and coded line-by-line to produce the initial codes. Then, the codes were searched for the pre-existing meanings, and new concepts were created when deemed necessary. In phase 2, the codes were structured into descriptive themes. At this stage, 20 descriptive themes emerged. In phase 3, the descriptive themes were developed into analytic themes, which resulted in 5 new interpretations.

The themes and subthemes that emerged from the synthesis are presented in Table 2.

According to the findings, faith in the information and the ability of midwives influence the shared decision-making between women and midwives. Respect for women and professional training were the two key factors that improve woman's trust in health care professionals.

### Respect for women

Health care providers' respect for women is a key factor in obtaining women's assurance. Trust, in turn, facilitates shared decision-making between women and health care providers. Many factors such as people's attitude, social background, educational values and past experiences also affect shared decision-making and should be respected by midwives.<sup>[12,19,22-26]</sup> Noseworthy *et al.*<sup>[22]</sup> reported that the quality communication between midwives and women plays a vital role in selecting a midwife. Tracey, a participant in this study expressed this point when describing why she selected Penny as her midwife: "She's related to my partner ... she had also done another friend of mine and my partner's sister, and then I found out through my auntie, you [the midwife] also did my auntie." Tracey also chose the midwife because she was from a similar cultural group and could talk the equal language.

### Professional qualifications

It is clear that some women without thinking accept decisions made by health care providers because they trust in their professional competence. Six studies have directly or indirectly expressed the crucial role of professional competence in the process of shared decision-making.<sup>[3,19,23,27-29]</sup> Some studies reported that women may not always know why those decisions have been made but they obey because of the trust they have in the decision maker, regardless of what the decision entails.<sup>[28]</sup> For example, in one case, the subject of eating and drinking was not at all discussed between the midwife and woman, but the woman followed the decision which was made on her behalf. This woman said: "I wasn't allowed anything else (other than water). I don't know why. I just accepted it because they obviously know better than I do what's going to happen, what's best for me and the baby, so I just assumed that was what it was, you know. I didn't argue about it at all. I just assumed they knew best." (laughs).<sup>[28]</sup>

### The central role of midwives in maintenance of woman's dignity

Respect for woman's dignity is a key factor in empowering women to participate in decisions related to childbirth. This gives women a feeling of personal control which consequently influences their approval with childbirth. Woman's dignity in

**Table 1: Characteristics and main themes from included studies**

Study	Focus	Methods, setting, and sample	Main themes
Noseworthy <i>et al.</i> <sup>[22]</sup> (2012)(++)	Decision making with in child birth in general and the third stage in particular	Interviews, urban setting New Zealand, midwives- women pairs. <i>n</i> =8 pairs	The themes included ontological and philosophical influences on decision-making; uncertainty, vulnerability, and relational trust; and socio-political and cultural influences. Inconsistencies in knowledge arising from social, cultural, and familial considerations as well as identities, beliefs, values, conversations, and practices were found to produce uncertainties regarding potential courses of action, expected consequences, and outcomes. "Unplanned" birth experiences decreased client autonomy and increased vulnerability, thereby intensifying relational trust within decision-making. The political context may also open up or close possibilities for decision-making at both national and local levels
Bluff and Holloway <sup>[28]</sup> (1994) (+)	Women's perceptions of midwifery care during labor and child birth	Grounded theory, maternity unit, sought of England, <i>n</i> =11 women	Women trust midwives because the latter are seen as experts who "know best." In doing so, women place themselves in the hands of professionals giving them the authority to make decisions about procedures, drugs, and types of care. Nevertheless, women also want to take an active part in the control of labor. The study identified the need for a flexible relationship between women in labor and their midwives
Walsh <sup>[9]</sup> (1999)(+)	Women's experience of partnership case load midwifery practice	Ethnography, maternity unit England, <i>n</i> =10 women	Women described midwives as friends. Other positive experiences were expressions of delight at their care, midwives' linking of home antenatal care and the appreciation of their existing children, and partners meeting their midwives
Domanjko (2009) (++)	Rhetorical skills are an important quality factor of midwifery care	Secondary analysis of semi- structured interviews; Slovenia, <i>n</i> =4 women	Identified the presence of all three means of persuasion in the interaction between midwives and women. Focusing on midwives, the quality of their awareness and command of rhetorical skills remains questionable. In particular, women experienced lack of a rational account of the situation and decisions made by health-care professionals involved in maternity care
Ebrahimian and <i>et al.</i> (2012) (++)	Explore the perception of patients on respect for their dignity	Content analysis, public hospitals, Iran, <i>n</i> =20 patient	Respondents expressed their expectations and attitudes about dignity by the following themes: seeking a haven; disrespecting privacy; communicating in a vacuum; and disregard for secondary caregivers. They described how respect for their privacy, effective communication, access to facilities, and a regard for the requirements of their companions made them feel that their dignity had been conserved
Gibbins and Thomson <sup>[19]</sup> (2001) (+)	Describe and understand the expectations during pregnancy and subsequent experiences of childbirth in primipar women	Phenomenology, north of England, <i>n</i> =8 women	All women wanted to take an active part in their labor and the feeling of being "in control" was the main finding and the "essence" of this study. This was achieved through support from partners, the positive attitudes of the midwives caring for them during pregnancy and labor, information giving during pregnancy and labor, and being able to make and be included in decision making during labor

contd...



**Table 1: Contd...**

Study	Focus	Methods, setting, and sample	Main themes
Lundgeren and Dahlberg <sup>[29]</sup> (2002) (+)	Describe midwives experience of the encounter with women and their pain during childbirth	Phenomenology, Karolinska, Sweden, n=9 midwives	Five constituents can further describe the essential structure: listening to the woman; giving the woman an opportunity to participate and to be responsible; a trusting relationship; the body expresses the woman's situation; and to follow the woman through the process of childbirth
Blix-Lindström <i>et al.</i> <sup>[25]</sup> (2004) (++)	Women's experiences of participating in decision-making related to augmentation of labor	Modified grounded theory, post natal ward hospitals Sweden, n=20 women	Support and guidance from midwives in combination with knowledge and expectations about the intervention seemed to be important for women's satisfaction with decision-making concerning augmentation of labor. The desire for information exceeded the desire for involvement in decision-making and the majority of women had confidence in the midwives' assessment
Mackinnon and <i>et al.</i> <sup>[23]</sup> (2003) (++)	New understandings of what it means to women in labor for a midwife to be present during childbirth	Hermeneutic phenomenology, urban center, Canada n=6 women	Women attribute multiple meanings to the care provided by intrapartum midwives. However, what stood out in these women's accounts was that a midwife's presence was the way in which a midwife was "there" for them and was a very important part of their childbirth experience
Sleutel <i>et al.</i> <sup>[24]</sup> (2000) (-)	Describe labor support techniques and strategies to enhance labor progress and prevent cesarean birth	Interviews, Texas hospital, labor midwives, no sample number reported	Three major themes: 1- the midwife's approaches to labor, 2- ethical dilemmas: an unwilling partnership 3- midwife-physician conflicts
Sleutel <i>et al.</i> <sup>[31]</sup> (2007) (++)	Labor and delivery midwives' views of intrapartum care, particularly factors that help or hinder their efforts to provide professional labor support	Content analysis, registered midwives at national association of women's health obstetrics and neonatal midwives' conference. n=416 registered midwives	Six themes emerged under the category of factors that hinder midwives' intrapartum care: (a) hastening, controlling, and mechanizing birth; (b) facility culture and resources; (c) women's knowledge, language, and medical status; (d) outdated practices; (e) conflict; and (f) professional/ethical decline. Under the category of factors that help midwives' intrapartum care, four themes emerged: (a) teamwork and collaboration, (b) philosophy of birth as a natural process, (c) facility culture and resources, and (d) nursing impact, experience, and autonomy
Mohseni <i>et al.</i> <sup>[27]</sup> (2009) (++)	To understand woman's experiences to provide a desired postpartum care	Phenomenology, post partum ward, Iran n=15 women	The four concepts extracted from this research are: effective interrelationship, professional care, education and finally, current conditions and available facilities
Matthews and Callister <sup>[30]</sup> (2003) (++)	To understand the perceptions of childbearing women about the maintenance of dignity while laboring and giving birth	Descriptive qualitative study, Western united state n=20 women	The following themes were identified: (a) midwives played a pivotal role in preserving dignity during childbirth, (b) women appreciated feeling valued and respected, and (c) dignity was enhanced by nursing care that gave women their preferred level of control
Kuo SC <i>et al.</i> <sup>[26]</sup> (2008) (++)	To explore women's experiences in interaction with their midwives during their antenatal checks and during labor	Phenomenology, home of study participant, Taiwan n=11 women	Five major themes revealed the essence of women's experiences of their interaction with a midwife during pregnancy and childbirth: (1) being respected, (2) being accompanied, (3) trust, (4) being satisfied, and (5) professional competence

childbirth may differ and depends on personal prospects in relation to the care they will receive. Almost all of the studies

in this review have reported that midwives have an essential role in supporting the woman's dignity.

**Table 2: Themes and subthemes**

Themes	Subthemes
Confidence to health care providers	Respect for women Professional qualifications
The central role of midwives in maintenance of woman's dignity	Attention to women's dignity Midwives have an essential in supporting women's dignity
Childbirth as a natural phenomenon	Medicalized birth Use of old technical procedures
The impact of contextual, political and human factors on delivery management	Midwife's attitude about normal delivery The impact of local organization of maternity services
Women seek haven	Support by midwife Availability of midwife

In a study by Matthew,<sup>[30]</sup> women expressed the significance of the midwife's role in supporting them. The midwife's presence, giving necessary information, support, and their permanence give the woman a sense of respect and dignity. Many women described surprise at the expanded roles of midwives. For instance a woman said: "The birth experience doesn't really matter with your doctor. He's there the last 5 or 10 minutes. It's the midwife that's with you through the whole 12 hours. She plays even a bigger role than the doctor does, because she's the one that's in there all the time with you."

Some women expressed that sincere concern and positive attitude of midwife helped them in delivery. For example, Lindsey said of triage midwife: "She seemed so excited to see us. She said this is so exciting! How long have you been having contractions?" For me it was like, "Oh, I'm so excited. I'm going to have this baby." She made me feel that I was doing a great and noble thing, having a baby."

Midwives, compared with physicians, the more time exhausted with women; therefore, they have a main role in preservation of woman's dignity. Several women expressed surprised that the physicians were not more involved; Mary said she would have appreciated "a little bit more of the doctor's interaction. I just thought he'd be a little bit more involved. He would just poke his head in and sometimes not even talk to me and just talk to the midwife."

Constant care giving during labor induces women a feeling of being supported and valued in women. Kara, a woman with a 12-hour labor, said: "I had the same midwife stay with me the whole time I was in labor. It was really nice to have help from somebody I knew the whole time, and not have they kept switching on me."<sup>[30]</sup>

### Childbirth as a natural phenomenon

Data from the included studies proposed that childbirth is a natural procedure. However, medicalized birth, use

of old techniques and cold body language avoid mutual decision-making between women and health care providers.

### Medicalized birth

A study by Sleutel<sup>[31]</sup> showed that childbirth is a normal and attractive process. Midwives in this study reported that women are empowered and they must be permitted to have a natural birth. For example, a midwife said "I believe in the birth process and pass that on to my patients/family. I introduce myself as their delivery midwife. I love what I do ... Don't spread the word 'CS' so others don't start planning for it and expecting it. Time, let nature take its course. Our docs are pretty good about supporting (or not interfering with) natural birth ... They don't rush to do CS and tend to give patients every chance to have a vaginal birth. Our chief of service is a DO and is very willing to allow any and everything to facilitate a vaginal birth."

Another midwife wrote that medical interventions in the process of a normal childbirth are not only the obstacles to good nursing care but also to professional labor support techniques. Commenting on the barriers to labor support a midwife said "... overuse of technology ties the woman to the bed." Repeatedly, midwives wrote comments such as "MDs use too much Pitocin, especially for induction of labor. [They] do not allow women to come into active labor on their own." Many midwives cited "MDs," or "MD practices" as a barrier to natural birth. Such an attitude is visible in the following quotations "Several new MDs at our facility are 'high techies';" "Many OBs are oblivious to labor support and women's wishes for labor. They all think, 'Just get it out and over with';" "I sometimes see that when patients are up and mobile, physicians will apply internal monitors, which certainly makes them stuck within the length of cables. Obstetricians seem to be ... monitored and 'tinker' oriented."

### Use of old technical procedures

Use of old techniques is one of the factors preventing shared decision-making between women and midwives. Five studies addressed this issue.<sup>[19,23,24,29,31]</sup> This barrier also hindered midwives' supportive interventions during labor. In Sleutel's study,<sup>[31]</sup> midwives took the issue with physicians' and midwives' lack of evidence-based practice and unwillingness to strive for alternative processes. For example, some of the midwives described aggravation when physicians did not allow them to use fetal monitoring or have women labor in chairs rather than beds. A midwife who had recently moved from New Mexico to Pennsylvania wrote: "While I have utilized birthing balls, Jacuzzis, squatting bars, rocking chairs, etc., in NM, Pennsylvania, MDs and midwives do not feel comfortable with such techniques, therefore making it difficult to change practice in [my new] facility. At times I make suggestions, but both MDs and

patients feel more comfortable with old fashioned supine positions." Respondents complained of both physician and midwife colleagues who did not continue with their plan of care, did not keep current, and were resistant to new ideas. In fact, a majority of the studies indicated that "midwives didn't seem to want to try new ideas."<sup>[31]</sup>

Lack of a suitable communication between women and midwives is a barrier to shared decision-making. The included studies show that the cold body language of midwives prevents communication between women and midwives. In Sleutel's study,<sup>[31]</sup> it was described that some of new midwives were not skilled in the art of labor support. Moreover, some of them were lazy, uncaring, or unmotivated. Participants described some unethical aspects of both medical and midwifery care. For instance, some midwives get out of human caring when they avoid being in room with a patient and spend most of their time watching strips at the desk, when a woman is laboring. A respondent also commented: "Midwives [who] sit at the nursing station and the leadership team perpetuate that behavior ... There seems to be an attitude that when the volume is reasonable, midwives should put their feet up—as payback for busier days—instead of staying in the room with their laboring women."

### **The impact of contextual, political, and human factors on delivery management**

A health care decision depends on several factors such as political, setting, social, and civilizing factors. Health reforms have impacted the health care system as budgets are strained and calls for efficiencies are made.<sup>[32,33]</sup> This can result in limitations on choice. According to results of some studies, the medicalization of childbirth and the enhanced use of medicine have been promoted as the norm. In this new culture, options outside the medical technological discourses are risky.<sup>[22]</sup> However, midwives' attitude toward normal delivery is a key factor in organizing the delivery. For example, Cindy (a midwife) said "When I first meet people I actually tell them I am quite a holistic midwife, I'm in to natural birth. If you think you're one of these persons that come in and want an epidural within two minutes of actually going into labour, then I'm probably not the midwife for you."<sup>[22]</sup>

Birthing choices may also be limited by the local organization of maternity services. For instance, in New Zealand, the Canterbury District Health Board funds four primary birthing units, whereas in the Wellington Region, the Capital and Coast District Health Board funds two departments with no primary birthing units. In this situation, most births happen within the secondary or tertiary maternity units in the area.<sup>[22]</sup>

### **Women seek haven**

Data from the included studies indicated indirectly that women seek a haven during childbirth. In this sense, support from a midwife and availability of a midwife help women in their search for a haven.

### *Support by midwife*

Five studies in this meta-synthesis indicated that being supported by a midwife is a vital factor in childbirth.<sup>[19,22,24,25,28]</sup> A decision about childbirth should be based on honoring woman's right and dignity. In a study, delivered women frequently described how the midwives had informed and consulted them before decisions were made about oxytocin infusion or other methods for augmentation of labor, as illustrated in the following quotation: "They (the midwives) asked me about everything; they asked if I want them to rupture the membranes and if I want an enema and all kinds of things" (Interview 19).<sup>[25]</sup>

Several factors affect a woman in feeling certain and being able to manage the childbirth. Being looked after by a midwife gives women a feeling of assurance and being supported. For instance, a woman (Dawen) said "I think it would be good to be looked after in labor by a midwife I know. I like the midwives I have seen. There is one in particular I feel as if I have got on quite well with her. She is very reassuring and I think it would be ideal if she were going to be there, then that would be great. But she won't, it will be a different team of people."<sup>[19]</sup>

### *Availability of midwife*

Midwife's attendance is necessary during childbirth. Women require the midwife to be available, compassionate, and helpful in a particular minute. They also should be active listeners to reduce women's anxiety. Then, they would be able to share the partnership in keeping them safe and exercise a conciliatory role between women's household and their health condition, which would consequently facilitate the process of shared decision-making.<sup>[23]</sup>

All the articles included in this study indicated that the accessibility of a midwife is necessary during childbirth. In Mackinnon,<sup>[23]</sup> when asked about the importance of the midwife's presence during her labor, Janet (a woman who had her first baby) said: "It meant everything to me!"

Women, in this study resolute points where they thought the midwife's presence was not only important but essential in the way things happened. Helen (a woman who had her first baby) commented in this regard "I'm not really aware that changing midwives to a more sympathetic character makes you deliver faster, so that's all total hearsay, but I think that is the impression people are left with in the end."

## DISCUSSION

This meta-synthesis recognized factors that help the process of shared decision-making between women and health care providers during childbirth. We explored five issues that help women and health care providers carry out a safe childbirth. These themes helped us recognize a set of factors that not only support women in decision-making for childbirth but also help health care providers to promote their attitude toward woman's power and dignity.

First, the synthesis established that woman's confidence in health care provider is the main factor in shared decision-making. Assurance causes a woman to trust the information and care provided by the health care personnel. Confidence induces women to converse with health care providers more easily; therefore, health care providers should discuss woman's treatment with her and connect with her for health care decisions. The women usually trust the health care providers' knowledge and ability; which in turn facilitates the communication between women and health care providers.

Second, our review suggested that midwives have a vital role in preserving the woman's dignity. Dignity has diverse meanings in different cultures and societies. Respect for dignity is respect for beliefs, attitudes, and principles. Another meaning of woman's dignity is respect for their desire to control labor pain. It also means respecting their feeling of self-efficacy and involving them in their own health care decisions.<sup>[34]</sup> Giving information to woman about childbirth by a midwife enhances woman's self-confidence, which improves the process of mutual decision-making between woman and midwife.

Third, in this study, it was concluded that childbirth is a natural event; consequently, this phenomenon is a foundation for relationship between women and midwives. In this process, medical intervention is rarely necessary. However, verbal ability of midwives is the key issue in the relationship between the woman and midwife in the process of childbirth. Alternative medicine, such as aromatherapy, acupuncture, and reflexology, can also be used by midwives to reduce labor pain in a natural childbirth. These methods are based on communication and collaboration between the woman and midwife.

Fourth, the present study showed that many factors such as contextual, political, cultural, and human factors affect childbirth management. Nonetheless, our findings might not be generalizable to the childbirth management in the entire world. The management of childbirth might vary in different countries because of differences in values, cultures,

and the structure of health care systems. The proportion of a country's gross national product dedicated to the health care system and to women' and children's health affects the number of workers serving the women during childbirth. Then, a lack of skilled midwives in childbirth centers might disrupt shared decision-making between women and midwives.

Finally, our synthesis suggested that women seek a refuge in childbirth. Childbirth is full of stress and fear for the woman especially due to the labor pain. Educational culture of hospitals and lack of sufficient information regarding delivery are other factors influencing women. In this condition, women need to be protected against fear and stress. Trust in midwife is a suitable haven for woman during childbirth. Therefore, a midwife has a main role in reducing women's fears and stresses upon admission into hospital.

Synthesis of qualitative studies is a new method of reviewing and appraisal, with many challenges, and there is little harmony on how to tackle them.<sup>[13]</sup> In our synthesis, we applied validated methods to search for articles in electronic databases. Synthesis of qualitative studies is also questionable due to interpretation and lack of transparency.<sup>[35]</sup> We tried to maximize transparency by giving a detailed explanation about the structure of the synthesis.

## CONCLUSION

In the recent decades, childbirth procedure has become excessively medicalized. By this definition, shared decision-making is not possible between women and health care providers. Respect for woman's dignity during childbirth is the key factor for an agreeable experience with delivery. This experience affects a woman's decision about the type of delivery performed in the future. Consequently, it is crucial to identify factors facilitating respect for the woman's dignity and shared decision-making during childbirth.

## Authors' contributions

MF contributed to the literature review, data extraction and manuscript drafting. MK contributed to the data analysis, reviewing and editing of the manuscript. MM and TA contributed to the data analysis, reviewing and editing of the manuscript. MF contributed to the development and implementation of the search methods. All authors significantly contributed to the work and approved the manuscript for submission.

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**Conflicts of interest**

There are no conflicts of interest.

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