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Women's experiences of routine care during labour and childbirth and the influence of medicalisation: A qualitative study from Iran

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ABSTRACT

Objective: to understand women's experiences of routine care during labor and childbirth in a medicalised context.
Design: twenty-six in-depth interviews were conducted during the late postpartum period and thematic analysis was applied.
Setting: four public hospitals in Tehran with a high rate of births, providing services to low and middle income families.
Participants: women who had a low risk pregnancies and gave a birth to a healthy infant by normal vaginal delivery.
Findings: two main themes emerged: 'An ethos of medicalisation' which indicates that women's perception of childbirth was influenced by the medicalised context of childbirth. And 'The reality of fostered medicalisation' which illustrates the process by which interventions during labor affected women's pathway through childbirth, and how the medicalisation resulted in a birth experience which often included a preference for Caesarean Section rather than vaginal birth with multiple interventions.
Implications for practice: contextual factors such as legal issues, state's regulations and the organisational framework of maternity services foster medicalised childbirth in Tehran public hospitals. These factors influence the quality of care and should be considered in any intervention for change. The aim should be a high quality birth experience with minimal interventions during normal vaginal delivery. A midwifery model of care combining scientific evidence with empathy may address this need for change.

Introduction

There is strong evidence that reducing interventions improves quality of care during labour and childbirth and makes birth safer (Sandall et al., 2010; Renfrew et al., 2014). WHO recommends universal evidence-based guidelines for women during normal childbirth classifying practices as beneficial, ineffective, harmful or doubtful (WHO, 1996). Recently WHO (2014) published a guideline on the augmentation of labor and categorised the quality of evidence as very low, low, moderate or high and the strength of recommendation as low and high (WHO, 2014).

Some western perspectives appear to have become more women centred (Cumberlege et al., 2016) and maternity policies in countries with midwife-led care have been directed toward promoting normal birth and reducing interventions (Wiegers, 2009; Dodwell and Newburn, 2010, Sandall et al., 2013). However, a technocratic model of care for normal childbirth as described by Davis-Floyd (2001) has been established in many parts of the world with frequent use of interventions during labour and childbirth.

In the past decades global safe motherhood efforts have done much to improve outcomes for women and their babies (Koblinsky et al., 2006; Freedman et al., 2007). However this has led to the medicalisa-

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tion of childbirth in middle income countries similar to that in several high income countries (Khayat and Campbell, 2000; Miller et al., 2016). The physiological event of childbirth has changed into a medical procedure in these countries which prevents women from experiencing birth in their own way (Campero et al., 1998; Kabakian-Khasholian et al., 2000; Miller et al., 2003; El-Nemer et al., 2006; Turan et al., 2006; Cindoglu and Sayan-Cengiz, 2010; Pazandeh et al., 2015; Mobarakabadi et al., 2015).

Study setting

This study is set in Tehran's (capital city of Iran) public hospitals. Iran is a middle-income country (MICs) according to World Bank (2017). The population passed 75 million based on the 2011 census. Iran has good maternal and child health indicators and has already reached the MDG target of 75% reduction in maternal death (UNFPA, 2012). Around one million women give birth each year with 96% of births taking place in health facilities and 97% managed by skilled attendants (MOHME, 2008; UNFPA, 2010). There are many teaching (TH) and non-teaching hospitals (NTH) which provide free or subsidised low cost maternity care for women from low and middle income families and managed by the Ministry of Health and Medical Education (MOHME) and the Social Security Organisation (SSO).

Obstetricians in public hospitals are women with a salaried position and many also work in private practice. The country has a direct midwifery entrance program established a century ago. Midwives are educated, trained and licensed according to international standards (ICM, 2011). However, their role is limited to normal childbirth in non-teaching public hospitals where obstetricians responsible for all births as the lead caregivers. In teaching hospitals, obstetric residents manage all vaginal deliveries and midwives are less involved in normal childbirth (Pazandeh et al., 2015). Midwives provide antenatal care in non-teaching hospitals being supervised by obstetricians and in public mother and child clinics. Those with private office (surgery) and counselling centres also provide antenatal care.

Most Iranian women are educated and play an active role in patriarchal society (Ahmadi, 2008). Women receive information about childbirth from their caregivers in public and private clinics as well as other women with childbirth experiences and the media.

There is a high rate of interventions such as early admission to labour, augmentation or induction of labour and episiotomy (Rahnama et al., 2006; Araban et al., 2014; Pazandeh et al., 2015) with a high proportion of Caesarean Section (CS), 48% in Iran and 74% in Tehran in 2009 (Bahadori et al., 2013). Most deliveries in the private sector are CSs. Increasingly Iranian women are choosing to undergo CS, even when there are no medical risks associated with a normal birth. MOHME (2006) developed and disseminated National Guidelines for Normal Childbirth in order to promote evidence-based practice in all hospitals (MOHME, 2006). However, these guidelines have not yet adequately been implemented (Araban et al., 2014; Pazandeh et al., 2015). Additional efforts were made to support physiological childbirth by informing and training midwives through workshops.

There is a consensus that women's experiences play an important role in quality assessment, improvement and planning of services (Donabedian, 1988; Bruce, 1990; Hulton et al., 2000). There are few qualitative study about women's experiences during labour and childbirth in Iran (Hajian et al., 2013; Abbaspoor et al., 2014; Mobarakabadi et al., 2015). This qualitative inquiry provides a full picture of the quality of care, in terms of women's experiences of routine care during labour and childbirth in the medicalised context of public hospitals in Tehran and discusses the underlying contextual factors that may foster the medicalisation.

Methods

Design and sampling

A descriptive qualitative study using a thematic analysis approach (Braun and Clarke, 2006) was conducted combining data from four public hospitals (two teaching and two non-teaching) in Tehran. These hospitals had a high rate of births and provided services to low and middle income families. This study was conducted from March to May 2012. Two teaching (managed by MOHEME) and two non-teaching public hospitals (one managed by SSO and the other by MOHEME) in North West and South of Tehran were the locations of data gathering.

Participants

Purposive sampling was used to select participant women. Iranian women who had a single, full-term pregnancy and gave birth to a healthy infant by vaginal birth participated, fourteen from teaching and twelve from non-teaching hospitals. Thirty-one women agreed to enlist for the study but five women did not take part in the interviews. Three were outside of Tehran and two women decided not to participate.

Data collection

The first author (FP) met with women to recruit them from the postpartum wards and then they were interviewed 1-3 months after the birth of their infant. FP, a midwifery lecturer, conducted twenty-six unstructured and face-to-face interviews in Farsi at a time and place of women's convenience. All but three in-depth interviews were conducted in the women's homes and lasted from 30–120 minutes. The interview began with a question about women's care experiences during labour and childbirth by asking 'Can you tell me your experiences with ....?' and continued with appropriate probing based on participant's answers. The sample size was determined by sample saturation when no new information emerged from participants (Glaser and Strauss, 1967).

Data analysis

FP transcribed data verbatim in Farsi and then translated into English. She had a researcher-translator role which offered an important opportunity to maintain cross-cultural meanings and interpretations (Temple and Young, 2004). Additionally, a bilingual native Farsi speaker translated selected sections into English to check the accuracy of the translations. Data were organised using NVivo 9 and were analysed using thematic analysis (Morse and Field, 1995; Braun and Clarke, 2006). FP read the transcriptions line-by-line and coded the data, this continued until all interviews were explored and checked. Meaning units as words and sentences relevant to women's experiences during labour and childbirth were identified and labelled with codes; then connections between codes were examined in order to cluster them into meaningful groups capturing the general overview of participants and their patterns of experience (Morse and Field, 1995). These were organised to sub-themes and finally formed themes.

Accuracy and reliability were ensured using four criteria according to Lincoln and Guba (Lincoln and Guba, 1985). Credibility was established by prolonged engagement by conducting in-depth interviews with adequate number of women. First all interviews were conducted and coded by FP. Rigor of coding was verified by BP and a PhD student who were expert qualitative researchers and inter-coded transcripts independently. Additionally, FP and other authors met as a group to discuss and further refine each set of themes, resolve differences, and reach consensus on a coding scheme. Later, preliminary and general findings were discussed with five of the participants and they believed that it accurately reflected their childbirth experiences. Pseudonyms are used to present direct quotations from women.