

Barriers to effective advocacy for normal birth; Ethics in educational strategy of maternity care system: A qualitative study

Ali Ramezankhani (1)

Tayebe Samieizadeh Toosi (2)

Nahid Akbari (3)

(1) Professor of Public Health Department, Health school , Shahid Beheshti University of Medical Science

(2) PhD student in Health education and promotion, Shahid Beheshti University of Medical Science.

(3) Assistant Professor, Reproductive Health Department, School of Nursing and Midwifery, Iran University of Medical Science. Tehran, Iran

Corresponding Author:

Tayebe Samieizadeh Toosi

PhD student in Health education and promotion
Shahid Beheshti University of Medical Science.

Email: samieizadeht@gmail.com

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Abstract

Introduction: Improvement of mothers' and infants' health is a vital issue. Obstetricians and midwives play a key role in health advocacy, so that the commitment of midwives has been emphasized to advocate for normal birth in the international declaration of midwifery care. It can help mothers make correct decisions for type of their delivery, or can change the attitude of stake holders to introducing normal birth as a low-risk and healthy behavior for mother and baby outcome. Therefore, it is necessary to recognize specific barriers to planning, and advocacy for normal birth.

Methodology: This qualitative-exploratory study aimed to explain barriers to advocacy for normal birth, using grounded theory and based on the Strauss and Corbin paradigm. Participants were selected from the obstetricians and midwives involved in normal birth in governmental and non-governmental hospitals as well as private clinics in Tehran, Iran, and 4 mothers who had normal delivery and cesarean section. 22 interviews were conducted among participants during May-January 2016; in depth interviews were conducted, and they took 35-120 minutes.

Analysis: All interviews were recorded and transcribed; they were implemented with MAXQDA 10 Software. Coding and analysis steps were taken using Strauss and Corbin Scale based on grounded theory.

Results: One of the main themes was educational inefficiencies in the maternal care system which is a conditional cause of barriers to advocacy for normal birth, based on the Strauss and Corbin paradigm. This paper aims to explain the category "inattention to ethics in human resource training system".

Discussion and Conclusion: Inefficient teaching in the healthcare system such as weak performance in training human resources in the field of maternal care system prevents obstetricians and midwives as employees of healthcare system from supporting natural childbirth. Some strategies such as changing the educational content and special planning in field of human dignity and professional ethics are necessary in clinical training.

Key words: Ethics, advocacy, normal birth, Clinical Training

Introduction

Type of childbirth and its results like many of modern health implications are subjected to a complicated interaction between several factors including personal, behavioral, social, and economic factors in a woman's life (1). According to scientific evidence in normal conditions, normal birth is the best delivery type for mother and baby health (2). However, the increasing rate of Cesarean in many countries around the world has led to concern of researchers and officials in the field of public health (3). In the opinion of researchers, only 6-16% of cesareans are medically reasonable (4). World Health Organization has declared that the cesarean rates above 10-15% are followed by health risk factors (5). A high percentage of unnecessary cesarean sections is one of the risk factors for health of mother and baby(6).

Researchers have emphasized on the necessity of strengthening public health training about complications of cesarean and social support for women to help them become ready for childbirth (7). On the other hand, obstetricians and midwives play a vital role in advocacy for normal birth. Commitment of midwives to advocate for normal birth has been emphasized in the ICM declaration considering the international philosophy of midwifery care (ICM, 2005a) (8).

The support process is subjected to continuous efforts to translate information related to justifying reasoning, and making good relationships with decision makers. Advocacy process shares strategies through public relationships but usually involves in competitive definition of the subject. Therefore advocates are usually involved in public conflicts. Opponents sometimes are powerful beneficiaries and sometimes are governmental individuals who resist changes (9). A normal birth promotion program consists of committees in governmental and private hospitals and universities in order to create facilities for improvement of delivery environments for mothers, monitoring cesarean rates in these centers, granting reward systems and educational management rules to increase normal birth in Iran (10). Findings obtained from a qualitative study about sponsorship in this field indicated that factors affecting barriers to advocacy for patients were a negative attitude of health personnel to advocacy, non-compliance with instruction as a tool, and lack of sufficient information about advocacy (11).

Health practitioners should cooperate, listen to the mother, pay attention to her voice, and respect her; they must help mothers to make wise decisions about childbirth in order to provide safety (12).

Physicians and midwives are the first lines who mothers refer to for pregnancy and childbirth care; in this regard, they have a high effect on decisions and cooperation of mothers in normal birth. It is essential to find barriers preventing healthcare employees to advocate for normal birth (8). Qualitative analysis of grounded theory which conducts the field of healthcare professionals, midwives

and obstetricians, can identify barriers to advocacy for normal birth, and factors affecting it, as well as the relation between variables.

Methodology

Interviews were tape-recorded, transcribed verbatim, and analyzed using the Grounded Theory method based on the paradigm of Strauss and Corbin [11]. This method seeks to reduce the material to its essential content in a systematic manner by following a four-step sequence model resulting in a summary of the main statements and a paradigm. Based on the recommendations of Strauss and Corbin the qualitative data was used to develop a paradigm that presents the interrelations between barriers and facilitating factors for advocacy to normal birth in the Iranian health care context. To develop the paradigm, the interview statements were divided into several meaning units and categorized according to different content domains. This was followed by the interpretation of the content domains in regard to their impact on advocacy. This process was conducted by a team of researchers independently to allow for researcher triangulation. Results were obtained after reaching agreement with discussion between researchers regarding the interpretation of the data.

Participants were selected targeted among health personnel who had required awareness and experience about normal birth; these individuals tended to participate in research. Hence, obstetricians and midwives who work in private and governmental healthcare centers of universities in medical sciences in Tehran were interviewed to collect data.

The place for interviews was Health care centers and hospitals, obstetricians' clinics, and offices, based on the agreement between researcher and participants. Interviews and sampling continued until researchers reached data saturation when analysis of the data in coding had not new concept. Saturation in data was achieved after performing 22 deep interviews. Inclusion criteria consisted of age, gender, education level, responsibility type, and work place in private and governmental hospitals' clinics of Tehran.

To evaluate validity or accuracy of study, external check and peer debriefing was used. In this regard, the text of interview along with results obtained from coding and extracted categories was given to the research team and one of the experts in qualitative research to find understanding of researcher in order to attract complementary and critical opinions. Research review was also conducted and data were examined by guide professors, and advisors in order to make sure of consistency between categories and opinions of participants (13). In this research, the researcher kept all documents during research steps in order to validate study. Analysis of qualitative data was done using grounded theory approach at the time of interview based on the interviews with participants, coding and interpreting data. Analysis of interviews was based on Strauss and Corbin benchmark (14).

All recorded interviews were implemented word-by-word and text files were prepared in frame of Word then these files of stepwise interview were transferred to MAXQDA10 Software. Analysis was coded (14) the tables were coded and main subjects and categories were prepared. The coded data were used at this step to determine scope and specifications, and relation between categories and main subjects.

Results

954 codes were analyzed. 163 concepts were formed totally. Of these concepts, 45 secondary categories, 16 main categories and 5 important themes were obtained.

One of the main themes was inefficient training in maternal care system as conditional situation, with two main categories of weak human resource training and inefficient community awareness in field of normal birth.

Inefficient training in maternal care system is described in this paper. This category consists of two sub-categories: 1: inattention to ethics in human resource training system and 2: weakness in clinical teaching system; the first option is described in this paper completely. It has three parts:

1-Inattention to ethics in human resource training system

• 1-1: Ignoring human dignity training and inattention to academic teaching for dignity of pregnant woman in university courses.

Participants in this study declare that human dignity training is ignored in teaching issues in our universities, and it must be considered inattention to academic teaching for dignity of pregnant woman in university courses.

One obstetrician and university professor said: "I always tell my students to look at the woman who is giving the birth as a human; she may be at a low socio-economic position but you should seek permission before entering"; she may not like to be seen at that moment. The delivery situation is itself annoying and you should not intensify it. Students should respect the woman who is giving birth. Human dignity should be considered here so that the woman should not be seen as a person who is coming here just to give birth. I always say this, but maybe some other professor does not mention it and students always forget importance of ethics".

• 1-2: weak professional ethics in human resource training

Midwives explained in this field that unethical governance in the teaching system, including humiliating midwifery students by residents, disrespecting the midwife, discrimination between resident and midwifery student in learning opportunities, limiting the power of instructor to attend, interference of resident in work of instructor and destroying the character of midwives. Participants suggested taking professional ethics seriously and selecting ethical individuals for midwifery. In this field, a male obstetrician who had 28 years' work experience in a private hospital described, "Human and ethical criterion

should be considered when selecting medical and midwifery students; otherwise, everybody is not able to work in this profession and should have a conscience. The patients always want us to be calm and kind with them. Nowadays they have credible behavior with us and we must be patient. "

• 1-3: physician dominant in training system

Lack of cooperation and support for clinical instructors, physician-centered teaching, lack of mutual cooperation between midwife and obstetrician in clinical training, humiliation of midwives, and lack of clinical support of midwifery student by obstetricians, the gap between obstetricians and midwife, inattention to midwifery students in educational system, resistance of some attendants and residents against some supportive methods, like aromatherapy for example and so on, for birth in governmental centers, priority of intern to midwifery students in clinical learning, not allowing midwifery students to work by residents, not allowing midwifery students in high risk cases, in petitioning instructors, lack of participation of obstetricians in midwifery clinical training, and inattention of residents to opinion of midwife for physiologic childbirth.

One of the midwives with 20 years' work experience in clinical instruction stated, "there were some attendants who were against us, beside residents. Our student got prepared to do delivery and the resident tended to do this while faced with resistance of attendants. We had even a problem for the final exam. attendants ignore midwifery students. Hence, there is a gap between attendants, midwives and instructors. We never had any meeting to find why the doctor does not allow midwifery students to do delivery, and ignore them in the education system".

Context: Social field, the physician-centered culture and tendency of people for specialists can be named as some factors leading to medical interference in human resource training. Therefore, such culture allows physicians to feel power and less considerate of midwifery students. On the other hand, mothers stimulate the situation.

A midwife with 22 years' work experience in private hospital expressed: "our patients do not like to visit a midwife for prenatal care; unfortunately all of my friends prefer to visit a specialist during their pregnancy, whereas they do not appreciate midwives and normal birth! How they could encourage mothers toward normal birth! ".Poor communication between the physician, midwife and mother has been mentioned by most participants in this study. One 30 years old mother who gave birth in a private hospital said" I had gone to a public hospital at first, the students were very moody and did not pay attention to me with all my pain which I had at that moment. Even they did not talk to me about procedures. But I wanted to consider more."

Discussion

Advocacy to improve mothers' and infants' health in the case of normal birth, for midwives consists of notification, support and protection of women, mediating role between them and obstetricians and their colleagues, midwife sponsorship to help mothers and facilitate their wise choices. Midwives are responsible for respecting human dignity; they look after women as humans with human rights, they have respect for them and make them feel important (ICM, 8) (2005).

It is seen that medical performance is concerned with valuating instead of paying attention to human dignity and academic training to respect pregnant woman's dignity in academic courses has been seen in our data and contexts.

Poor communication between the physician midwife and mother, lack of emotional relationship with mother in preparation classes for childbirth and maternity care, inattention to human dignity, making the women feel embarrassed, not paying attention to privacy of women, observing human principles, and inappropriate behavior with women who are giving birth can be named as barriers to advocacy for normal childbirth. It has been expressed that there is less emphasis on protecting human dignity in educational courses. It is recommended to teach human dignity in clinical courses, change and teach lessons related to sponsorship and communicational skills, strengthening and increasing lessons related to patient and social sciences, teaching behaviors and methods to support the woman in order to use sponsorship skills for improved natural childbirth.

Moreover, professional ethics should be taken seriously when selecting ethical individuals for midwifery. Roxana Behrooz conducted a study in which participants expressed more attention and concentration of physicians on practical skills than to spend their time for the mother. She writes, "the culture of valuating medical performance is a barrier to natural childbirth without interference in specialized hospitals, because high risk pregnancy is more important in specialized medical cases compared to the time spent for the mother. In addition, the attitude of using opportunities for specialized learning development and skill training in these hospitals makes physicians move toward medical interference, because they are valued based on their medical performance" (15).

Barbara writes, "Midwifery model of maternity care is usually done by midwives and can be done also by physicians. Considering the focus on reduced technological interference and individual support, the midwifery care model can reduce the cost without harming delivery safety and can improve delivery results and access to economical health care" (16).

Although the physician dominant culture is seen among people, Jennifer Hall states that 62% of women agree with the following sentence in national survey of Lavender, "I feel insecure if a specialized physician is not available

at the time of my delivery" while 20% agreed with the sentence "I want to be cared by midwife and prefer not to see other physicians in my childbirth" (Jennifer Hall quoted from Lavender) (17&18).

Participants in this research expressed that there is a luxury culture in which, people believe in physician, not midwife. Physician is more recognized by mother compared to midwife in private hospitals, physician dominant culture, tendency of people toward physician and acceptance of the word of physicians about cesarean, while it is recommended to healthcare physicians to create security and trust in planning for mother's childbirth and making mother participate in wise decision-making about care of themselves (12).

In a study conducted by Giorgio, some concepts including lack of professional recognition, defect in basic and continuous education were introduced as barriers to support for natural childbirth. The major educational issues including quality of basic teachings, weak positions of clinical training and inaccessibility to a wide range of practical midwifery skills were determined by midwives. Some midwives expressed that what is presented to women is the medical case so that many were disappointed when saw their failure in natural childbirth despite their effort. They believed that the main reason is that basic teachings do not cover issues related to sponsorship, independence and rehabilitation. Participants introduced issues related to medical dominance in the medical system as a disappointing factor for prominent advocators of natural childbirth (8).

Physician-centered culture in the education system, lack of cooperation and support for clinical instructors are some of the concepts described by participants. Some strategies obtained from analysis of such suggestions to remove these barriers by participants are: physician-centered culture should be removed from the education system, cooperation and support of clinical instructors, giving opportunity to midwifery students, and paying attention to midwifery students in clinical learning by attendants. In this case, midwifery students feel valuable and their skill and self-confidence will be increased. A graduated midwife who could not do delivery perfectly, how can advocate for normal birth?! . Strengthening clinical training system should be done for midwifery students and skilled clinical instructors to enable doing natural childbirth; on the other hand, midwife students should cope with high risk childbirth conditions.

In a qualitative study in Australia researchers found that: The system of maternity care was identified as being dominated by medicine, not evidence based and restricting of women's choices, with midwifery autonomy not recognized or supported(19).

Juybari et al. conducted a study in which, three major common concepts between students and instructors were introduced in field of specifications of efficient clinical instructor; these concepts include scientific and practical capabilities, educational management ability, and good

behavior. Participants mentioned a wide range of barriers to productivity of instructor and effectiveness of clinical learning including inefficient facilities, old educational centers, medicine dominant culture in education centers, and lack of interest of nursing students in their major (20).

Conclusion

Inattention to human dignity training and respect for human honor among midwifery students, and weak professional ethics in human resource teaching indicate inattention to ethics in human resource training in educational hospitals of universities of medical sciences in Tehran, Iran. The mentioned factors are barriers for midwives and obstetricians who graduated within a weak educational context that is ruled by physician dominant culture to advocacy for normal birth. In this regard, sense of security and independence is weak among midwifery students leading to their low self-confidence to play their supportive role in normal birth process for mothers who are giving birth in such hospitals. Moreover, physician-centered culture in people makes them interested in medical interference in natural childbirth so that physicians and midwives are not interested in learning physiologic childbirth skills. On the other hand, difficulty in cooperating with residents who are not desired and have not enough time to spend for physiologic childbirth is a barrier to advocacy by midwives and instructors for normal birth. Lack of ethics in clinical training of midwifery students as lack of equal opportunity for clinical training in physician dominant context leads to weak practical skills of graduated midwives in field of natural childbirth and reduction in their motivation for delivery care and advocacy for natural childbirth.

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