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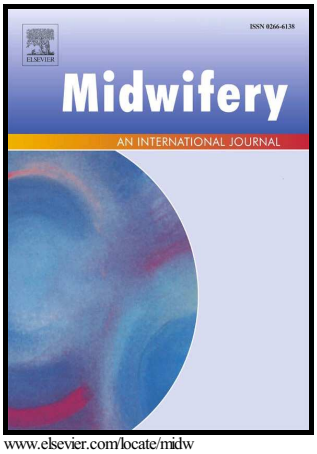

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Farzaneh Pazandeh, Barbara Potrata, Reinhard Huss, Janet Hirst, Allan House

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

Farzaneh Pazandeh [1,2]* Barbara Potrata[3], Reinhard Huss[3], Janet Hirst[4], Allan House[3]

[1]Infertility and Reproductive Health Research Centre (IRHRC), Shahid Beheshti University of Medical Sciences, Tehran, Iran

[2] Department of Midwifery and Reproductive Health, School of Nursing and Midwifery, Shahid Beheshti University of Medical Sciences, Tehran, Iran

[3] Leeds Institute of Health Sciences, University of Leeds, Leeds, UK

[4] School of Health Care, University of Leeds, Leeds, UK

*Corresponding Author: Farzaneh Pazandeh

Email: pazandehf@gmail.com

pazandehf@sbmu.ac.ir

Address: Shahid Beheshti School of Nursing & Midwifery, Vali Asr Ave., Niayesh Cross Road, Niayesh Complex, Tehran, Iran, Post code: 1985717443

Barbara Potrata, Leeds Institute of Health Sciences

Email: b.potrata@leeds.ac.uk

Reinhard Huss, Leeds Institute of Health Sciences

Email: r.huss@leeds.ac.uk

Janet Hirst, School of Health Care

Email: j.hirst@leeds.ac.uk

Allan House, Leeds Institute of Health Sciences

Email: a.o.house@leeds.ac.uk

Abstract

Objective

To understand women's experiences of routine care during labour 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 rates of births, providing services to low and middle-income families.

Participants

Women who had low risk pregnancies and gave birth to a healthy baby by normal vaginal birth.

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. Second 'The reality of fostered medicalisation' which illustrates the process by which interventions during labour affected women's pathway through childbirth, and 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, the state regulatory and organisational framework of maternity services foster medicalised childbirth in Tehran public hospitals. These factors influenced 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 birth. A midwifery model of care combining scientific evidence with empathy may address this need for change.

Keywords: Birth; Experience; Medicalisation; Quality, Iran

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 categorized 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 of 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 medicalisation 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 (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 prenatal 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 baby 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 baby. 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.

Ethical consideration

The study protocol was approved by the Ethics Committees of Shahid Beheshti University of Medical Sciences in Tehran (approval number 92/260). Additionally, permission was obtained from the study hospitals. Postpartum women were informed about the research purpose, length of interview, data confidentiality and participant's freedom to join or leave the interview during the first contact. Women who agreed to participate signed the consent form and gave permission to record their interviews.

Results

Background information of postpartum women

Twenty-six postpartum women were interviewed. The age range was 19-38 years. More than half were 25-29 years. Majority of women were first time mothers, had only finished primary school and were housewives (unemployed) (Table 1).

Table 1: Participant's Characteristics

Age range	**19-38**
Age (Mean)	27.5
Education	
Primary school	11
Secondary school	4
High school	8
Bachelor degree	2
MSc degree	1
Occupation	
Housewife	21
Employee	5
Parity	
1	15
2	7
3	2
4	1
5	1

The average daily births in the study hospitals were four to ten. Women were with others in a public labour room and mostly restricted to a bed; had an intravenous (IV) infusion and Electronical Foetal Monitoring (EFM) attached to their abdomen. Sometimes they were free to change their position in bed and allowed to walk during labour. All women gave birth vaginally and their labour was induced or augmented. All first time mothers except one and most multipara underwent episiotomy (Pazandeh et al., 2015).

Main themes

Two themes emerged under women's perceptions of normal childbirth and experiences of routine care and interventions: 'An ethos of medicalisation' summarises women's perception of childbirth. 'The reality of fostered medicalisation' illustrates the process by which interventions during labour affected women's pathway through childbirth, and resulted in a birth experience which often included a preference for CS rather than vaginal birth with multiple interventions. (Table 2)

Table 2: Examples of codes, sub-themes and themes

Perceptions of normal birth	Experiences of routine care
Themes	
An Ethos of Medicalisation	The Reality of Fostered Medicalisation
Sub-themes	
Expectation of normal childbirth	Unexpected distressing Labour Pain
Decision Making: Normal Childbirth versus Caesarean Section	Inadequate pain management
Passivity	Loss of control
	Challenging part
Codes	
… Admission means without labour pain … Use of Ampolefeshar accepted practice … Cutting below part of normal birth … Seek information about birth methods … Normal birth best option … CS easy and comfortable … Expected CS … Doctors/ midwives know better, make best decision	… Expectation of tolerable labour pain … Unbearable pain caused by Ampolefeshar … Inadequate pain relief … Frequent vaginal examinations … Worry about vaginal damage … Concern about sexual relationship with husband … Advised by friends and relatives to have CS … Requested or planed for CS

Theme One: An ethos of medicalisation

This theme refers to women's knowledge of normal childbirth and their views on childbirth methods. It was evident that women's perception of childbirth was influenced by the medicalised context of childbirth. This made women accept interventions during labour and childbirth as part of a 'normal' birth and CS a method of childbirth which women could select.

Each of the sub-themes under this theme is expanded below.

Expectation of normal childbirth

Women were not involved in decision-making about interventions. They used a special term 'ampolefeshar' when they talked about induction or augmentation of labour by Oxytocin. 'Ampolefeshar' refers to a medicine which initiates contractions, causes labour pain and leads to pushing down. The use of Oxytocin during labour was accepted as part of normal childbirth. Parisa said:

> 'I had a mild labour pain. They started 'ampolefeshar,. 'Ampolefeshar speeds up labour and helps baby to come out quicker' (25, high school, second time mother, TH)

Although women were not informed when they were cut, all of them were aware that they should undergo the procedure. Shireen said:

> 'I knew that it should be cut and sutured. My doctor did not tell me about cutting during childbirth but I had heard that in normal birth, especially in the first one, it is being cut and sutured.' (27yr, high school, first time mother, NTH)

One woman had experienced fundal pressure during her previous childbirth. Azar said:

> 'In my previous birth they helped me and pushed my tummy to help the baby to come out. This time they were around me but they did not help me. I was surprised why they did not help me this time?' (33yr, primary school, fourth time mother, TH)

Decision Making: Normal Childbirth versus Caesarean Section

Women's trajectories toward childbirth had started by making decisions about methods of childbirth. They had detailed discussions about the method of childbirth with their husband, relatives and friends and the advantages and disadvantages of 'normal childbirth' and CS. Ziba explained:

> 'I have heard that normal birth is difficult so I would have preferred to deliver by CS. I talked to women who gave birth by CS. I also talked to the midwives in the prenatal clinic; they said it is better to have a normal birth. I also talked to my husband and then I said 'I will have what the God predestined for me.' (21yr, secondary school, first time mother, TH)

Fatemeh wanted to experience CS because she had been told it was less painful and more comfortable:

> 'I have heard that CS is better because you do not feel the labour pain. I would have liked to experience CS and find out if it is good or not. I could help my daughters to make a decision [about the childbirth method] later.' (37yr, primary school, fifth time mother, TH)

Shive, an educated woman, had come to a public hospital to deliver by normal birth. She could afford to go to a private hospital but she had intentionally rejected CS when suggested to her during prenatal visits at a private hospital. Shiva said:

> 'Normal birth is definitely better [option]. It is right for every woman to bear this pain and find out whether she can deliver by normal birth or not. I think my auntie, who had not been able to give birth in the village and died thirty years ago, needed a CS. They should let women try to deliver by normal birth and, if there is a problem, then they can do a CS.' (29yr, MSc degree, second time mother, NTH).

Passivity

Women trusted their caregivers to make decisions for them. They did not challenge their caregivers and felt that they were more knowledgeable. Women believed that 'they know better than me' referring to obstetricians, doctors and midwives.

Women were advised against getting out of bed, mostly due to the caregivers' concerns about their health and the health of the unborn babies. Most women stated that they did not feel comfortable lying down in bed and would have preferred to move during labour, however they didn't challenge their caregivers. Kimia said:

> 'I preferred to walk during labour and I think I could tolerate the labour better. I might have not been in a condition that they could let me, what they asked me to do was the best for me.' (26yr, primary school, first time mother, NTH)

Women were told that drinking water might make them nauseous when they had pain. They often felt out of energy when they were not allowed to drink or eat in labour. However, they thought that their caregivers had decided what was best for them. Arezoo said:

> 'I was really thirsty and I could drink a jar of water, but they did not allow me. They might know something that they didn't give. I mean it was not suitable for me' (29yr, high school, first time mother, TH)

Theme 2: The Reality of Fostered Medicalisation

This theme illustrates how the medicalised context of childbirth compels more medicalisation towards CS as the best solution. It includes women's experiences with labour pain which was caused by 'ampolefeshar' (augmentation and induction using Oxytocin) without the provision

of adequate pain relief. It also reveals women's feelings about practices and interventions which shaped the feeling of loss of control and challenging part.

Unexpected Distressing Labour Pain

The multipara women unanimously believed that labour pain caused by 'ampolefeshar' was stronger than expected. Women used words like 'exploding' and 'being on fire' when they talked about the pain caused by 'ampolefeshar'. Fatemeh had natural labour pain in two of her previous deliveries. She compared her labour pain in recent birth with her previous childbirth.

> 'The pain caused by 'ampolefeshar' is more severe than natural labour pain. It is so severe, and when it starts, it feels as if you are on fire. The natural pain which starts spontaneously is not that severe.' (37 yr, primary school, fifth time mother, TH)

Some first time mothers also were not prepared for the pain caused by 'ampolefeshar. They felt that labour pain was 'sweet' and can be tolerated. She said:

> 'I'd have preferred to deliver by normal birth. My mother had told me that labour pain starts very slowly which I could cope with and then tolerate. I expected to experience pain but it was really unbearable. I saw death in front of my eyes.' (26 yr, high school, first time mother, NTH)

Women used words like 'terrible', 'unbearable', 'severe' and 'difficult' when they described their labour pain which was caused using Oxytocin. Some women used expressions such as 'being in hell', 'not coming back', 'not surviving', and 'not staying alive'. Yasaman, first time mother, explained:

> 'It was the most severe pain I have ever felt. I cannot describe that, it was terrible and I thought I was dying and I didn't think I would stay alive.' (29 yr, primary school, first time mother, TH).

Inadequate pain management

The interventions to induce or accelerate women's labour had caused women much more severe labour pain, and would require pain relief during labour. Solmaz chose that hospital only because she had heard that different non-pharmacological pain reliefs were provided. She explained:

> 'My sister-in-law had used a birth ball and a warm water shower to cope with pain and feel comfortable when she was in severe pain. I also wanted to use these. When I asked for pain relief and a water birth, they didn't accept my request because they were not provided at night.' (19 yr, high school, second time mother, TH)

Homa said:

> 'My labour pain was getting more and more severe. I was frightened and asked for pain relief. When I insisted, they only injected something and said 'it is pain relief' but it was not effective.' (22yr, high school, first time mother, NTH)

Loss of control

As women's labour was hurried and 'managed actively' to end the process quickly, women also wished that labour finished soon because of birth pain. This notion 'I wanted it [the labour] to have finished sooner', showed itself in different parts of the women's journeys through labour and childbirth. According to evidence-based recommendations women should have the possibility to drink and eat and walk during labour. When women were asked about these useful practices, 'labour pain' was overwhelming and they just wanted to escape. Sahar said:

> 'I had a severe labour pain.[] I could not think about anything else.' I did not think about drinking and eating there, I just wanted it to finish quickly', I did not ask any questions, I was not in that mood, I just wanted it finished soon'. (23 yr, secondary school, second time mother, TH)

Women could not adjust themselves to the situation of induced labour using 'ampolefeshar'. Nasrin said:

> 'The pain I experienced in my previous labour was the pain which had enough intervals, I could deal with that. I wished that my labour had started spontaneously. I started to do some exercises to cope with pain but they would have been more useful if the labour pain had started spontaneously. The pain was more severe and I felt I lost control.' (33, primary school, second time mother, NTH)

Some participant women changed their mind when they were overwhelmed with labour pain during labour and requested to deliver by CS to avoid pain. This is because the induced pain is difficult to tolerate and a CS is believed to be easier. Arezoo said:

> 'I wanted to deliver by normal birth and I was aware of the complications of CS, but when the labour pain got more severe, I couldn't tolerate that; I asked them to take

> me to the operation room. I asked the doctor to take me to CS.' (29 yr, high school, first time mother, TH)

Challenging part

From women's narratives, it was evident that vaginal injury and increased vaginal laxity was their main concern, though women could not always talk openly about it. Women seemed worried about their husbands' future sexual satisfaction. Homa seemed shy to talk about her concern in an open way.

> 'I tolerated the pain and it finished but I was more scared of sutures (looking down). In CS, the body [vagina] remains intact and natural and will not be sutured. I wasn't happy with normal birth, I regretted it.' (22yr, high school, first time mother, NTH).

Women also narrated from other women's experiences that the vaginal injury and pelvic relaxation is one of the reasons why some women would prefer to have CS. Both Ziba and her husband had decided that she would have a normal birth but she commented:

> 'Well, some women don't want to deliver by normal birth because they don't want the shape of their body [vagina] to change. Most men don't like their wives to deliver by normal birth, only because of this reason, ask for CS and pay a lot of money in private hospitals.' (21yr, secondary school, first time mother, TH)

Nasrin believed that after natural childbirth, the healing of vagina will not cause any problem. Nevertheless, Nasrin was concerned about the consequences (her sexual appeal for her husband) after the episiotomy. She commented:

> 'Normal birth is good if woman doesn't have any problem with her husband. If the labour pain starts itself and they give an opportunity to have [natural] labour pain, if it tears spontaneously, [] it can heal and can go back to the previous shape. But when they cut in birth, it would also be worse. I feel my body [vagina] have not returned to the previous shape, and I am concerned about this.' (33, primary school, second time mother, NTH)

Women also reported frequent vaginal examination and referred to them as a difficult part of their experience. These were particularly demanding for first time mothers and younger women who tended to be more embarrassed. Ziba- first time mother unhappy with such frequent interventions, said:

> ‘The labour pain was one side of problem but examinations were another thing. I think childbirth would not be too painful if they examined less. If they don't bother women in the hospital, normal vaginal birth is a better [choice]. ’ (21yr, secondary school, first time mother, TH)

Discussion

Maternity care in Iran: a culture of medicalisation

This study revealed that women’s perception of childbirth is influenced by the medicalised context of childbirth. Mothers who wanted to give birth naturally had their babies in a medicalised environment with multiple technical interventions. As a response many women expressed preference for even more medicalised birth in their future pregnancies similar to findings in other studies (Van Teijlingen et al., 2004, Christiaens and Bracke, 2009). Medicalisation in Iran takes place in the context of a worldwide phenomenon which increasingly defines every birth as a medical and risky ‘event’ (Oakley and Houd, 1990, Lasarus, 1997, Van Teijlingen et al., 2004, Conrad, 2008). Many studies report about increasing medicalisation of childbirth (Rahnama et al., 2006, Naghizadeh et al., 2014, Araban et al., 2014, Pazandeh et al., 2015) and researchers have theorised these findings as a reductionist process in which social bodies are considered solely as biological (Scheper-Hughes and Lock, 1987). Some describe medicalisation as a process created by a public request for medical solutions (Christiaens and van Teijlingen, 2009), others as 'the technocratic model of birth' (Davis-Floyd, 1993) with 'standard procedures' to mould the labour process into conformity with technological standards'.

Women referred to accelerated labour pain as "ampolefeshar" which was stronger than what they had expected or experienced during previous natural births, and expressed decreased satisfaction with their care. This finding is in line with other studies where induced or augmented labour led to less positive birth experiences (Dannenbring et al., 1997, Heimstad et al., 2007, Beech and Phipps, 2008). Interestingly, similar common terms were used, such as ‘artificial pain' and 'Tala' by Turkish and Egyptian women (Turan et al., 2006, El-Nemer et al., 2006).

Tehrani women feared complications such as pelvic floor injury and vaginal relaxation after a normal vaginal delivery. They were concerned about their future sexual appeal and the sexual satisfaction of their husbands. Previous studies reported vaginal damage as one reason for childbirth fear in Iran (Shaho, 2010, Hajian et al., 2013) Turkey (Serçekus and Okumus,

2009) and Arab women in the UK (Bawadi, 2009). Couples in Iran have favoured CS because of their perception of sexual complications due to normal birth and the fact that the state's law does not protect women with such disabilities (Yazdizadeh et al., 2011). However several studies do not indicate changes in sexual function and satisfaction due to vaginal birth and provide no basis for advocating CS as a way to protect women's sexual function after childbirth (Van Brummen et al., 2006, Khajehei et al., 2009, Hantoushzadeh et al., 2009, Boroumandfar et al., 2010, Hosseini et al., 2012) and later in life (Fehniger et al., 2013). Postpartum perineal pain and dyspareunia are the main problems after lacerations and episiotomy during childbirth (Klein et al., 2009). Avoiding routine episiotomy (Carroli and Mignini, 2009), early identification and management of its complications (Sayasneh and Pandeva, 2010) as well as evaluation of women's sexual health can prevent the postpartum sexual problems (Leeman and Rogers, 2012). Advising pelvic floor-muscle training after the puerperal period may improve female sexual function (Citak et al., 2010). There is a great need for couples to get evidence-based information about birth and sexual health, because incorrect information is spread by family, friends and healthcare professionals.

As women's experiences of 'normal' childbirth were not positive, some women in this study changed their minds during labour and asked for a CS or regretted the 'normal' birth and planned for a CS in their next childbirth. The findings from the present study are congruent with other studies in which women childbirth-related fear, a previous negative childbirth experience and substandard childbirth care including persistent use of aggressive and painful procedures during vaginal births have been linked to widespread acceptance of CS as a safe option (McAra-Couper et al., 2010, Karlström et al., 2011). The environment of childbirth, increased labour pain and use of technology lead to more interventions which may prompt many women to prefer even more medicalised birth – the process that we call "fostered medicalisation".

Theoretical implications

Many international drivers of medicalisation are relevant for Iran. Additionally, we have detected several context-specific drivers. We argue that medicalisation of childbirth in Iran is also driven by three processes of objectification – legal, technical and sexual.

"*Legal objectification*" is driven by application of law which stipulates that Iranian obstetricians are personally liable for the outcomes of birth. This means that if a healthcare

professional in charge is accused of medical malpractice leading to disability or death of baby or woman, (s) he is personally responsible for paying substantial monetary compensations to their patients if sentenced, called "blood money" (Yazdizadeh et al., 2011, Bagheri et al., 2012). If patients sue for any reason, the health system does not support the obstetricians in litigation cases and they are legally responsible in case of any confirmed malpractice. Due to the specific Iranian legal system doctors are personally responsible in court if something goes wrong (Yazdizadeh et al., 2011). Therefore, they are very cautious with low risk pregnant women and may encourage early admission to the labour ward, conduct a greater number of examinations and interventions to be on the safe side and aim to finish the normal process of birth quickly. We call this process of reducing birthing women to potential legal liabilities "legal objectification" and as an important driver of medicalisation of birth in Iran.

Second, the process of legal objectification also encourages "*technical objectification*". In such a socio-legal framework the excessive examinations of birthing women and interventions in birth are not only driven by concern for patient safety (Conrad, 2005) but also legal consequences if something goes wrong. Such interventions in childbirth have been described by women in this study as "embarrassing" and "painful" experiences, and by Kitzinger (1997) as yet another way of objectifying women or as a "technical touch" (El-Nemer et al., 2006).

Many women in this study expressed concerns about vaginal damage and sexual satisfaction of their husbands, but not their own sexual satisfaction. They preferred more medicalised birth including CS to prevent vaginal damage and ascertain their sexual appeal for their husbands. We therefore argue that actual or perceived "*sexual objectification*" is potentially a strong driver of "fostered medicalisation".

The Iranian socio-organisational framework and the tripartite process of legal, technical and sexual objectification have an important impact on the role of women who are about to give birth. Many women in this study came with expectations of being able to self-manage the progress of birth to some degree. However, women found coping with augmented labour, examinations and interventions very difficult

Many women in our study believed that doctors knew best and each medical intervention was part of the normal process of having a baby (Campero et al., 1998, Kabakian-Khasholian et al., 2000). Similar to several other studies women in four Tehrani hospitals had become actively involved in their own medicalisation (Downe et al., 2001).

Clinical service implications

Medicalisation of childbirth was the main determinant of perceived quality of care in this study. The change started more than three decades ago when Iran had a high rate of maternal mortality and the safe motherhood program was implemented by training and employing skilled birth attendants. 'Williams Obstetrics' (Cunningham et al., 2014) is the standard reference book which promotes 'active management of labour'. This medical model defines pregnancy as a condition which requires intensive medical monitoring and intervention (Bryar, 1995, Enkin et al., 2004, Hofmeyr, 2005).

Maternity care in Iran has undergone a change to a more interventionist practice. Midwives are marginalised in the health system and not involved in a responsible position during labour and childbirth for low risk women. The midwifery model of care supports pregnancy and birth as a biological and natural process with social, emotional and spiritual dimensions. Care which adheres to this model is based on the idea that 'normal' childbirth is 'natural' birth (Van Teijlingen, 2005), respects and empowers women (Walsh, 2007). Recent evidence shows women who received care from midwives, are more likely to experience spontaneous onset of labour, less interventions and more vaginal births (Sandall et al., 2013). According to the Lancet midwifery series (2014), midwifery was linked to better outcomes when provided by professional midwives. Therefore national investment in midwifery services can improve quality of care (Renfrew et al., 2014, ten Hoope-Bender et al., 2014). To address this issue and increase quality, we suggest that Iranian midwives should be prepared to demand and take up their professional and supportive role and should be allowed to act as practitioners in their own right.

Strengths and limitations

This is one of the rare qualitative studies about women's childbirth experience in middle income countries. Although it is difficult to generalise the findings of qualitative studies, some may be transferable to other countries with similar socio-cultural environments. While it is likely that care in other public hospitals in Iran is similar, this study was carried out only in four public hospitals in Tehran. The selection of hospitals was based on annual numbers of deliveries and diversity of its organisation and management.

Conclusions

This qualitative study demonstrates women's experiences of routine care during labour and childbirth in the Iranian context. It indicates that there is substantial scope to improve the

quality of care during childbirth. Iran's health system has an important effect on medicalisation and consequently needs to play a major role in the change of practice. An important step in achieving this goal is the legal framework related to maternity care. The medical model of care for low risk women is not appropriate for middle income countries such as Iran. The midwifery model based on good scientific evidence can be a better alternative in Iranian hospitals.

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Research Highlights

- The medicalized culture of childbirth made some women accept interventions during labor and childbirth as part of a 'normal' delivery and Caesarean Section (CS) was a method of childbirth which women could select.
- Women's experiences of pain during labor, caused by augmentation and induction without the provision of adequate pain relief plus repeated vaginal examinations and routine episiotomies promoted a pathway towards CS as a better option.
- Contextual factors such as legal issues, regulations and organizational frameworks of maternity services fostered medicalized childbirth.