



Experiences and Wishes of Women of Midwifery Care in Developing and Developed Countries: A Systematic Review of Qualitative Study

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Abstrak

Kemitraan bidan dan perempuan adalah filosofi asuhan kebidanan pada pemeberian asuhan kebidanan. Pelayanan kebidanan sering terjadi kekerasan dan tidak saling menghargai terutama saat melahirkan di negara berkembang. Tujuannya untuk mengeksplorasi pengalaman perempuan dan bidan, strategi dan harapan perempuan dan bidan dalam pelayanan kebidanan. Metode penelitian ini menggunakan basis data bibliografi elektronik. Penelusuran PubMed, Sciencedirect, Proquest dilakukan secara sistematis sejak 2008 hingga 2018. Artikel berkualitas dipilih berdasarkan kriteria inklusi dan Critical Appraisal. Berdasarkan hasil review ditemukan pengalaman perempuan dan bidan untuk pelayanan di negara berkembang kurang baik karena tidak ada persalinan yang menemani, ada kekerasan fisik atau verbal, dan fasilitas rumah sakit yang tidak mendukung, sedangkan pengalaman perempuan dan bidan di bidan negara maju, baik karena masa kritis sekarang, ada rasa kepedulian dari bidan yang menjadi mitra bagi perempuan. Bidan dan perempuan memiliki harapan bahwa layanan kebidanan dapat diberikan secara maksimal, berkualitas dan menunjukkan rasa saling pengertian dan rasa hormat satu sama lain. Kondisi asuhan kebidanan di negara berkembang perlu perhatian khusus. Pentingnya kehadiran bidan, asuhan yang berkelanjutan dan bermitra dengan perempuan dapat menekan kekerasan di pelayanan kebidanan. Pemerintah perlu memberikan pelatihan kepada bidan tentang keterampilan konseling, membangun hubungan interpersonal, dan kepemimpinan yang efektif dalam layanan kebidanan.

Kata Kunci : Pengalaman dan harapan, Bidan dan Perempuan, Asuhan yang berpusat pada Perempuan

Abstract

Partnership midwives and women is the philosophy of midwifery care in midwifery care pemeberian. Obstetric care often violent and respectful, especially during childbirth in developing countries. The aim is to explore the experiences of women and midwives, strategies and expectations of women and midwives in maternity care. This research method using electronic bibliographic databases. Search PubMed, Sciencedirect, Proquest carried out systematically from 2008 to 2018. The quality articles are selected based on the inclusion criteria and Critical Appraisal. Based on a review found the experiences of women and midwives to care in developing countries is not good because there is no accompanying childbirth, physical or verbal violence, and hospital facilities that do not support, whereas women experience midwives and midwives in developed countries, because of a critical period now, there is a sense of concern of midwives partner for women. Midwives and women have the expectation that midwifery services can be provided to the maximum, qualified and show mutual understanding and respect one another. Condition of midwifery care in developing countries need special attention. The importance of the midwife, ongoing care and partnering with women to suppress violence in maternity

care. The government needs to provide training to midwives about counseling skills, interpersonal relationship building and effective leadership in obstetric care. Midwives and women have the expectation that midwifery services can be provided to the maximum, qualified and show mutual understanding and respect one another.

Keywords: *Experience and expectations, Midwives and women, Women-centered care*

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INTRODUCTION

The philosophy of partnership is a relationship of trust, reciprocity, and equality between Midwives and women. Every midwife tried not to force the profession and personal strength in women. Instead, through negotiation, a midwife trying to build a relationship in the which every woman is the primary decision maker. Decision-making is a shared responsibility between women, families, and midwives. The practice of midwifery is done by placed women as a partner with a holistic understanding, as one experiences physical, psychological, emotional, social, cultural, spiritual and their reproduction (1–4). In 2015, the World Health Organization (WHO) declared the abolition of torture and the taste is not appreciated during the birth process with dialogue and advocacy of human rights (5). Results of the study (6) states that to improve services for all women and girls, everywhere, requiring Appropriate actions and prioritize quality health services, WHO in 2018, Provides Recommendations on the care intrapartum to experience nurturing positive where Respectful Maternal Care (RMC) Contribute to reducing the morbidity and mortality of women and reduce inequality service, maintaining the dignity, privacy and confidentiality, protected from persecution and fear / trauma and Allows selection of information and ongoing support for care (7). This is consistent with previous studies (6) emphasizes that mutual respect and violence

is not the time of delivery is a global problem in some developing countries. Result study findings in South Africa and Ethiopia indicated resources to 21% of postpartum women reported not respected (8) harassed, and without consent (9) (17.7%), lack of privacy (15.2%), and 82% of occurrences appreciate at a health facility (10) in Ethiopia, lack of psychosocial support, are the decisive factor for deciding women give birth or not giving birth in a health facility (11,12). Several studies highlight the importance of quality during delivery (13–16). Showed that women experience and hear other people's experiences, both valued and unappreciated during labor (17,18). Globally, the past 15 years, policy makers recommend maternity services centered on women, the Woman Centered Care (WCC). This care has been Adopted by England, Belgium (7) and Australia (19). This implementation approach proved beneficial where women have choices and positive care experience (20–22).

MATERIALS AND METHODS

Search Articles through a systematic search system (Systematic Literature Search) since the year 2008 to 2018, free full text, human species, and scholarly journals were identified by electronic database of PubMed, Proquest and ScienceDirect. The author uses Boolean (OR or AND) as a conjunction incorporate the keywords in the search, and more focused and relevant results in PubMed. This method is adapted to

the other database. Examples of search terms that are identified by means this is the childbirth experience, labor and birth or other variations, combined using Boolean AND with the word partnership, relationship or other variations. Articles are selected According to the inclusion and exclusion criteria (Tab.1). Analysis Critical Appraisal approach literature then performed the data extraction.

Criteria	inclusion	exclusion
Population / Problem	• Mother with low-risk pregnancies and midwife • Mother with spontaneous labor and vaginal-midwife	• Mother with complicated pregnancies and midwife • Mothers with mental disabilities and midwife • Mother with violence between partners and midwife • Mother with ethnic, religious, racial and inter-group conflicts and midwife • Mother with early pregnant and midwife • Mothers with artificial insemination and Midwives
Exposure / Event	Mother and midwife in Midwifery care	
outcomes	Experience, perspective and views	
Study Design	qualitative study	

RESULTS AND DISCUSSION

Search Result

Initial literature search identified 856 articles (Fig. 1). After the removal of duplicates, 847 articles remained. With the title and abstract review, 730 were issued on the basis of irrelevant. Review of the full text of articles remaining 117 to be 102. The number of Articles in accordance with the criteria for inclusion are 15 articles, then performed a critical appraisal (23) issued 5 articles and the remaining 10 relevant articles.

Tab. 2 The key word in the search literature Appropriate for systematic assessment of critical literature.

outcome	risk Factory
Childbirth experience	Partnership
Labor and birth	Relationship
Midwifery services	Midwife-mother
Midwifery care	Midwife and mother

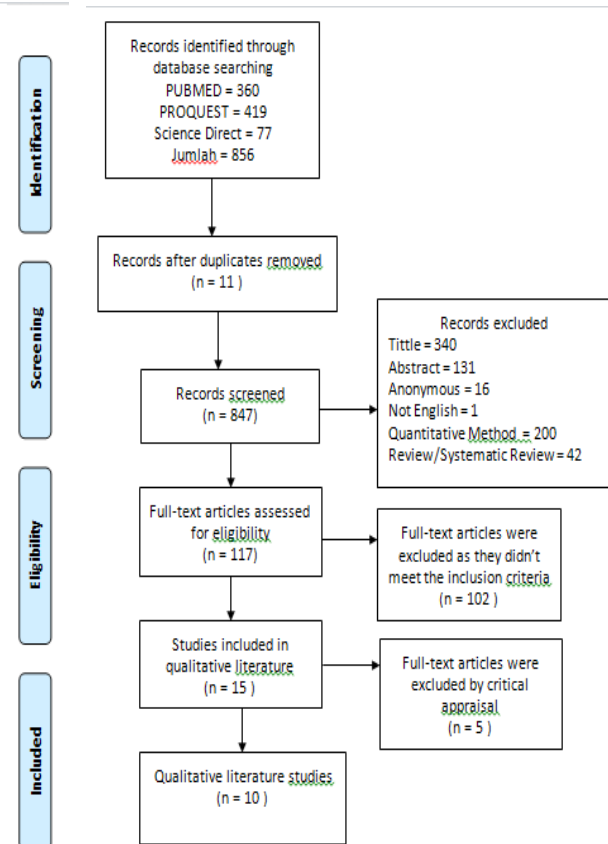


Fig 1. The different stages of the systematic Literature review

Content Analysis

The findings of the systematic searches obtained articles published up to 2008, grouping the findings article consists of seven articles in the developed countries (Sweden, Germany, Ireland, Netherlands, Norway, and Western Australia) and 3 articles in developing countries (Africa, Ethiopia , Tanzania). All quality literature Q1 and using qualitative research methods. Participants in the relevant literature are midwives, obstetricians, midwifery students who were practicing in obstetrics ward and women receiving midwifery

Tab.2 Details of papers included in the systematic literature review

NO	Author / Year	Country	Types of research	Data collection	participant
1	Lilian T. Mselle / 2018	Tanzania.	Qualitative Study.	Semi-structured interviews	Midwife (n = 6) and gynecologists (n = 2), the which works in two district hospitals of Tanzania.
2	Jaki Lambert, et al / 2018	Limpopo, South Africa.	Phenomenological descriptive.	In-depth interviews and focus group discussions (FGD)	In-depth interviews (IDI), focus group discussions (FGDs) and key informant interviews (KII) conducted by women, health care providers, managers and policy makers.
3	Sahai Burrowes, et al / 2017	Debre Markos, Ethiopia.	qualitative Study	All interviews were conducted in Amharic, the audio was recorded, then simultaneously translated and transcribed	In-depth interviews with Midwives, Midwifery students, and women who have given birth in the past year.
4	Thelin, et al / 2014	Swedish west.	Phenomenological descriptive.	Data were collected with a written narrative and interviews.	10 Midwives were recruited from a university hospital with two units of a referral hospital in western Sweden.
5	Michelle M. Butler / 2017	British Columbia	interpretative fenomenalologi	Semi-structured individual interviews.	14 experienced midwife who deliberately chosen from in a variety of practices, geographical, and the rural / urban to Participate.
6	Lesley Kuliukas, et al / 2016	Western Australia	descriptive phenomenological	Giorgi method focuses on the description of individual experience	15 women were interviewed up to 8 weeks postpartum (July to October, 2013).
7	Unn Dahlberg / 2016	Norway.	qualitative Study	Focus group interviews were recorded and transcribed verbatim with the help of a systematic text condensation.	6 focus group interviews (n = 24). The women were both primiparous and multiparous, aged 22-37, and living with Reviews their spouse.
8	Andrew Hunter, et al / 2017	Ireland.	qualitative descriptive	Data were collected through face-to-face or telephone interviews and Focus Group Discussion (FGD)	The of participants (n = 31) were purposely sampled from diverse stakeholder groups
9	Elke Mattern, et al / 2017	German.	Exploratory qualitative hermeneutic approach of Gadamer	The focus groups were systematically documented digitally Analyzed by the hermeneutic scheduled.	50 women Participated in 10 focus groups in five German states.
10	Susanne Lohmann, et al / 2018	German.	qualitative studies	Conversations were recorded digitally	20 qualified Midwives heterogeneous with regard to age, level of education, professional experience, type of Midwifery care given.

care. Data collection was conducted in-depth interviews and focus group discussions (FGD).

Discussion

Women lack access midwifery care in developing countries. Related to this review, research has been conducted by Freedman *et al* (22); Freedman and Kruk (21), that women feel unappreciated, experience loneliness and are

not supported, physical violence and speech and less given autonomy in decision making. Based on the results of Lambert *et al* research (24), organizational and structural challenges such as staff shortages, many cases were referred and poor referral pathways, supply shortages, hospital layout and structure (25–27) are often barriers that do not allow midwives to do what they know about good practice (15,19). Based

on the results of research by Burrowes *et al* (28) and Bayes *et al* (19) the mistreatment of women during childbirth in the form of verbal abuse, rejection of assistance and lack of choice in the position of birth, and when midwives find women who do not comply. Therefore, they need for professional ethics training where ethics and patient rights are not evenly covered in the midwifery curriculum. Some steps may change to advance the process of humanizing births, including midwife education, institutional norms designed to support ongoing clinics during labour, the benefits of having a partner or family become active participants, and respecting women's desires when appropriate (29).

Women get good midwifery care in developed countries. Midwives make women feel comfortable when faced referrals, giving care is a good partner for postpartum women with a place to share experiences from pregnancy to delivery (1,2,8,30). Research in Australia conducted by Thelin *et al* (8) and Behruzi *et al* (25), that midwives can develop relationships that respect each other, trust and relationships between women and midwives. The presence of midwives for women becomes very important in providing continuity of obstetric care and calming influence. Studies conducted in Australia by Kuliukas *et al* (31) and Kennedy *et al* (6) that when women are referred in labour, women feel disappointment and anxiety about the condition of the fetus. The sensitivity of midwives to the cues associated with women in labor feel communication and remain calm and connected, to improve the relationship between the presence of women and midwives can increase awareness and trust in the experience of childbirth. Furthermore, from the research of Felix and Filippin (32) it is necessary to increase awareness and psychological adjustment for women to have and undergo confinement of safety support and guarantees for other women. Emotional experiences experienced by women

and midwives (33) postpartum conditions require communication of their emotional expressions to prevent psychological stress. Women tend to trust midwives' expertise and advice when there is ongoing care (34).

There are differences in women's experiences in obstetric care in developing countries (10,16,24,27,28) and developed countries (1,17,31,34–37). Midwives in developing countries have similar care characteristics. In addition, women must confront the workers' culture alone. Midwives in these three countries do not give women's autonomy rights in decision making. Speech or physical violence is common. Existing facilities in hospitals in three countries are inadequate. Midwives in developed countries give priority to women who care, respect, and become 'friends' sharing care experiences. Midwives in developed countries give priority to ongoing care in early pregnancy and the promotion of normal births to reduce the incidence of Sectio Caesarean (SC). The results of Mounier-Jack, Mathew and Mays (38) research on health care in developing countries have a narrower and less ambitious scope, while health services in developed countries have broader efforts to coordinate various services including those outside the system health care. Developing countries focus more on funding and efficient access to services, while in developed countries the quality of care, experience, and reducing dependence on hospital care is more expensive.

Women expect midwifery care to be sufficient information in midwifery care, assessment with normal classroom material, midwife competencies, hospital births, supported midwifery care, family / relative meetings, empowerment of health care centred on women (17,39). Women need to be provided with information about midwifery services, midwife competencies, licensed interventions and rights and choice of care, not only for individual consultations, but also through written agreements

or online platforms that are easily accessible, effective translation and communication and participation between midwives and backup doctors and ongoing care of female midwives obtained from early pregnancy to weaning (40). The results of a study conducted by Indah Muflihatin (41) at the Panti Community Health Center, Jember Regency said that the satisfaction in regarding, information received and waiting times and services for pregnant women as a whole is known to have strong associations with a willingness to come check again.

Midwives hope that midwifery care is an understanding of the professional profile of midwives, maximization in providing midwifery care and preventing interprofessional conflicts in care (29). Midwives see themselves as caregivers for women who experience physiological pregnancy, birth and the puerperium/breastfeeding period. Promotion of normal births and advocacy for women is very challenging for midwives who work in hospitals where a strict hierarchical system and midwives are needed to obey obstetrician's orders. Midwives are urged to treat more than one woman in a short period of time and limit their goals for caring for women individually and dissatisfaction with the care provided (7).

CONCLUSION AND RECOMMENDATION

Partnership women and Midwives is part of the philosophy of Midwifery. The philosophy of Midwifery care partnerships in providing a positive experience, the lack of a sense of trauma and post-natal depression and an Increase in the rate of breast-feeding. Women feel safe when Midwives handle since pregnant are the same person and to know its history. Midwives became 'friends' for women in addition to husband / family. Psychologically perceived comfort women can reduce Maternal Mortality Rate (MMR) due to the complications that occur when postpartum.

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