

Meta-Synthesis of the Needs of Women Cared for by Midwives During Childbirth in Hospitals

Gloria Anderson, Maurizio Zega, Fabio D'Agostino, Maria Luisa Rega, Sofia Colaceci, Gianfranco Damiani, Rosaria Alvaro, and Antonello Cocchieri

Correspondence

Gloria Anderson, RM, BMidwif, Department of Biomedicine and Prevention, University of Rome Tor Vergata, Via Montpellier 1, Rome 00133, Italy.
andersongloria0@gmail.com

Keywords

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ABSTRACT

Objective: To identify and meta-synthesize results of qualitative studies on the needs of women cared for by midwives during childbirth in hospitals.

Data Sources: MEDLINE, Cumulative Index to Nursing and Allied Health Literature (CINAHL), Embase, and the Cochrane Library.

Study Selection: We restricted the bibliographic search to articles published in English to July 31, 2020. The initial search yielded 6,407 articles, and after 2,504 duplicates were removed, we screened the titles and abstracts of 3,903 articles. We conducted a full-text review of 89 articles and included 13 qualitative studies about the needs of women who were hospitalized during childbirth and had midwives as their primary maternity care providers.

Data Extraction: We extracted data (e.g., authors, publication date, type of study, sample size, results, and quotes) from the full text of each article into a standardized table. Two authors reviewed all articles using the Critical Appraisal Skills Programme tool to assess study quality and to independently score each study.

Data Synthesis: We analyzed the findings of each study and synthesized them to develop themes. We found 14 major themes that reflected the needs of women during hospitalization for childbirth: *Nutrition, Hygiene, Privacy, Information, Bodily Respect, Respect for Social Role, Family Intimacy, Shelter, Pain Management, Partnership, Movement, Reassurance, Support, and Empowerment*. We categorized these themes in Maslow's hierarchy of needs to better understand the phenomenon.

Conclusion: We identified 14 needs that midwives and nurses can meet when they care for women in hospitals during childbirth. Standardized methods to assess these needs and to link them to specific interventions can be used by midwives and nurses, which will likely affect women's satisfaction with their experience and overall quality of care.

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Gloria Anderson, RM, BMidwif, is a PhD student, Department of Biomedicine and Prevention, University of Tor Vergata, Rome, Italy.

Maurizio Zega, RN, PhD, is Director of Nursing Services, Fondazione Policlinico Universitario A. Gemelli, IRCCS, Rome, Italy.

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Meeting women's needs is rudimentary to a positive experience of maternity care (Beecher et al., 2020), and the degree to which a woman feels in control and midwife support are strong predictors of her satisfaction during childbirth (Bryanton et al., 2008; Kifle et al., 2017). Tailored intrapartum care from skilled and experienced midwives improves short- and long-term maternal outcomes such as spontaneous vaginal birth (Isbir & Serçekuş, 2017; Sandall et al., 2016; Souter et al., 2019), breastfeeding initiation (Sandall et al., 2016), regional analgesia (Isbir & Serçekuş, 2017; Sandall et al., 2016), and an intact perineum (Sandall et al., 2016; Souter et al., 2019). The midwifery care process is a

scientific method that is similar to the nursing care process, provides a systematic guide to midwives in woman-centered care (International Confederation of Midwives, 2018), and is based on the assessment of women's needs and problems. Needs can be defined as women's necessities or demands that midwives can address (Chiappero-Martinetti, 2014), and although each woman's childbirth experience is subjective and unique (Olza et al., 2018), certain needs are common to all women. Abraham Maslow (1954) developed a hierarchy based on fundamental human needs that are innate to all individuals in which he posited that physiologic needs must be met before higher needs, such as

self-actualization needs, can be achieved. Maslow directly linked the fulfillment of needs to the quality of life, and his framework is used widely in the research and clinical literature to understand clinical needs in particular (Liu et al., 2020; Ryan et al., 2020; Scerri et al., 2020).

A systematic assessment of women's needs that are subsequently met with standardized methods and tailored interventions can improve satisfaction and maternal outcomes. However, we did not find a clear definition and operationalization of women's needs when hospitalized for childbirth in the literature. Without a shared, univocal definition and classification of women's needs, the process of needs assessment remains ambiguous (Devane et al., 2019) and may be left to individual interpretation by midwives and nurses around the world who care for childbearing women.

Midwives are encouraged to meet women's needs and expectations through constant improvements to their skills and competencies (National Academies of Science, Engineering and Medicine, 2019; Renfrew et al., 2014). However, the care women expect to receive from their providers often does not align with the actual care received (Bohren et al., 2017). Women are often dissatisfied with intrapartum care because their needs and expectations are not met (Kifle et al., 2017). Moreover, in a recent review, Bohren et al. (2019a) reported that women's negative perceptions of birth persisted over a long period of time and increased the likelihood of adverse maternal outcomes, such as postpartum depression and fear of subsequent birth (Garthus-Niegel et al., 2013; Poote & McKenzie-McHarg, 2015). Vedam et al. (2019) highlighted the frequent mistreatment of women during childbirth in hospital settings in the United States, which was often related to unexpected medical interventions. In hospital care in particular, where the medicalization of childbirth is a growing phenomenon (Bohren et al., 2019b; Johanson et al., 2002; Pazandeh et al., 2017), systematically assessing women's needs is a valid method to help midwives and nurses respect women's wishes, tailor their care, and promote a positive birth experience (World Health Organization, 2018). Thus, the purpose of our review was to identify and meta-synthesize results of qualitative studies on the needs of women cared for by midwives during childbirth in hospitals.

A clear classification of the most common needs expressed by women who were hospitalized during childbirth could improve midwifery and nursing care processes.

Methods

We systematically searched the research literature to identify all qualitative studies available in the fields of medicine, midwifery, and nursing consistent with method recommendations by Sandelowski and Barroso (2007) and Dixon-Woods et al. (2006). To ensure transparency in synthesis reporting, we reported the methods and findings in accordance with the Enhancing Transparency in Reporting the Synthesis of Qualitative Research guidelines (Tong et al., 2012). The main research question used to guide our meta-synthesis was the following: What are the needs of women that midwives can attend to and fulfill during hospitalization for childbirth?

Sampling Criteria and Procedures

Two authors (G.A. and M.L.R.) independently searched MEDLINE, Cumulative Index to Nursing and Allied Health Literature, Embase, and Cochrane databases for articles published up to July 2020. Because to our knowledge there are no MeSH terms for *needs*, after consulting with a medical librarian, we chose to add different synonyms for the keywords (see Supplemental Appendix S1). We restricted bibliographic searches to studies reported in English. To guarantee that all relevant studies were included, the only time limitation was publication before July 31, 2020. Two authors independently reviewed each citation found in the databases through a titles-first approach to obtain records for the abstract screening. Inclusion criteria were primary qualitative studies in which the needs of women who gave birth in hospitals were explored and in which midwives were the primary intrapartum caregivers. Studies were excluded if midwives did not participate alone or in multidisciplinary teams in women's care or if participants were women who birthed outside of hospitals. All records were screened with the support of the reference management software Mendeley (Mendeley Ltd. [2019]. Mendeley [Version 1.19.4] [Computer Software]. https://www.mendeley.com/?interaction_required=true).

Data Extraction and Analysis

The first author (G.A.) extracted the following descriptive data from the studies: the location of the study, aims, design, sample size, participant

Fabio D'Agostino, RN, PhD, is an assistant professor, Department of Nursing, Saint Camillus International Medical University, Rome, Italy.

Maria Luisa Rega, RN, PhD, is a lecturer, Department of Nursing, Università Cattolica del Sacro Cuore, Rome, Italy.

Sofia Colaceci, RM, BMidwif, is an assistant professor, Department of Midwifery, Saint Camillus International University of Health and Medical Science, Rome, Italy.

Gianfranco Damiani, MD, is an associate professor, Faculty of Medicine at Università Cattolica del Sacro Cuore, Rome, Italy, and assistant medical director of Hospital Hygiene Unit at Fondazione Policlinico Universitario A. Gemelli, Rome, Italy.

Rosaria Alvaro, RN, MSN, FESC, is an associate professor, School of Nursing, Tor Vergata University, Rome, Italy, and vice president of the Italian Society of Nursing Science.

Antonello Cocchieri, RN, PhD, is an assistant professor, Faculty of Medicine, Università Cattolica del Sacro Cuore, Rome, Italy.

characteristics, health care providers involved, data collection methods, and analytical strategies used (see Supplemental Table S1). Then, a second author (A.C.) independently checked the extraction process. If necessary, the two researchers discussed any discrepancies with two more authors (S.C. and M.L.R.) and resolved them through consensus.

The findings of each study were analyzed using line-by-line coding by three authors (G.D., M.Z., and F.D.) who applied at least one code to each sentence. Codes were then grouped into a hierarchical structure from which similar data were synthesized, and new themes were subsequently developed (Thomas & Harden, 2008). New themes were derived inductively, defined, and then categorized following Maslow's (1954) hierarchy of needs because prioritization is a central tenet of need identification (Endacott, 1997). The theme synthesis was conducted manually by two authors (G.A. and A.C.) and afterward discussed among all the authors to reach intercoder agreement. Then, to assess the relative magnitude of the findings, we evaluated themes as they emerged, and the intrastudy intensity and interstudy frequency effect sizes were calculated by

three authors (F.D., G.D., and M.Z.), as suggested by Sandelowski and Barroso (2007). The categorization following Maslow's hierarchy was chosen after the theme synthesis to provide a conceptual order to the structure of the findings. Which theme matched which need was discussed thoroughly among all authors.

Quality Appraisal

Two authors (M.L.R. and S.C.) independently assessed the methodologic quality of each study using the Critical Appraisal Skills Programme (CASP; 2018). Although there is no agreement about how or whether quality should be reported within a meta-synthesis (Atkins et al., 2008), the CASP's 10 appraisal items were followed because they allow for an assessment of the trustworthiness, relevance, and results of synthesized studies. At the end of the evaluation process, the CASP's items were scored with a value of 1 for *yes*, 0.5 for *unclear*, and 0 for *no* (Satink et al., 2013). Higher overall scores suggested higher quality. New themes were not introduced to the meta-synthesis if they were only found in studies with low-quality scores.

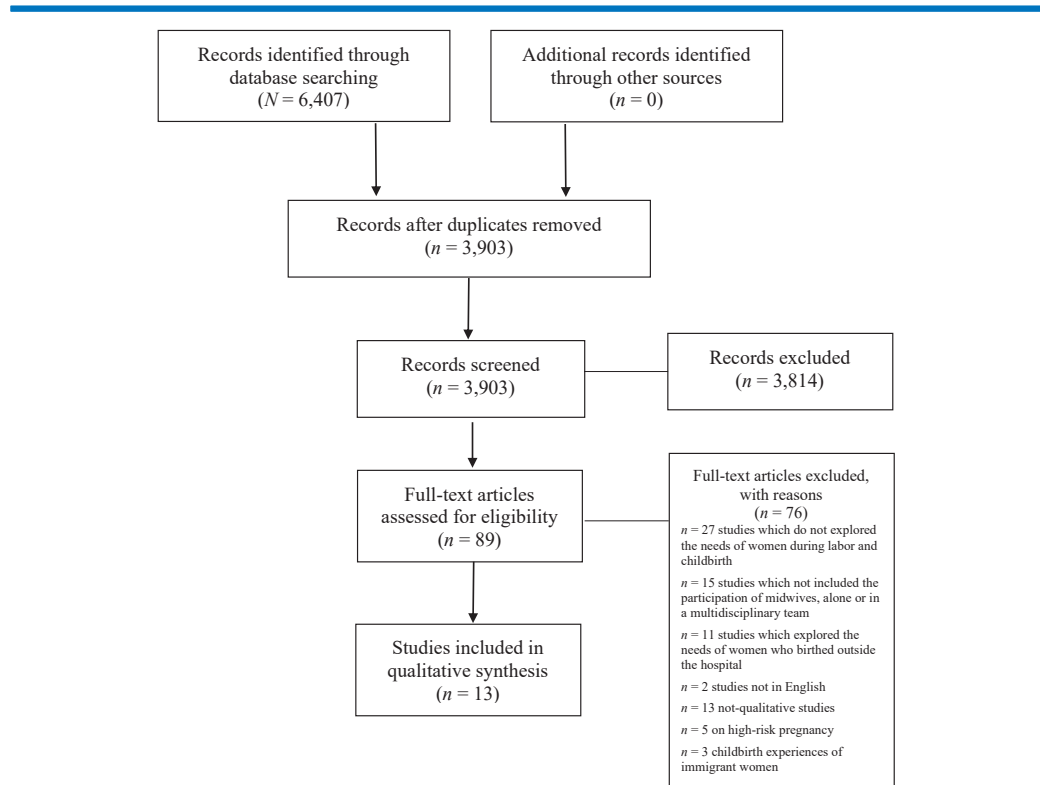


Figure 1. The flow chart of the search strategy and results.

Results

Database searches yielded 6,407 articles during the initial phase. After duplicates were removed and the titles and abstracts were screened, we assessed 89 full-text articles, 13 of which met inclusion criteria. Therefore, our meta-synthesis included a total of 13 studies (see [Figure 1](#)) published between 1999 and 2019.

In all of the included studies, researchers aimed to explore or provide a description of women's experiences, needs, or perceptions of their intrapartum care provided by midwives (see [Supplemental Table S1](#)). The studies were conducted in Europe ([Fraser, 1999](#); [Karlstrom et al., 2015](#); [Lavender et al., 1999](#); [McNeils, 2013](#)), the Middle East ([Aktas & Aydin, 2019](#); [Askari et al., 2014](#); [Deliktas Demirci et al., 2019](#); [Irvani et al., 2015](#)), Asia ([Anwar et al., 2014](#); [Khreshheh et al., 2019](#); [Kuo et al., 2010](#)), and Africa ([Afaya et al., 2017](#); [Chadwick et al., 2014](#)).

Designs varied across studies, whereas data collection methods were similar and were based mainly on semistructured or in-depth interviews (see [Supplemental Table S1](#)). The total sample of participants included 648 women, and nearly half of them were primiparous and between 17 ([Deliktas Demirci et al., 2019](#)) and 46 years of age ([Karlstrom et al., 2015](#)). In two studies ([Anwar et al., 2014](#); [McNeils, 2013](#)), participants were assisted only by midwives during their intrapartum care (midwife-led), whereas in all of the other studies, participants discussed midwives, obstetricians, doctors, and nurses.

We evaluated the methodology quality (see [Supplemental Table S2](#)) as high in all studies (score = 7.8–10), except for one, which scored just over six in the quality rating ([Lavender et al., 1999](#)). Research aims and methods were appropriate in most studies. Recruitment strategies were unclear in four studies ([Askari et al., 2014](#); [Karlstrom et al., 2015](#); [Lavender et al., 1999](#); [McNeils, 2013](#)), whereas researchers clearly reported data collection methods for most studies. Not all researchers clarified whether they critically examined their own roles, potential biases, and influences in formulating research questions and collecting data. However, researchers assessed ethical issues in all studies and included rigorous data analysis and clear statements of findings. The main reason for our fairly low-quality judgment of the study by [Lavender et al. \(1999\)](#) was that the qualitative data were part of a

We identified 14 needs that should be assessed, met, and evaluated to improve women's childbirth experiences in hospitals.

larger randomized controlled trial and published separately. Some key information was unclear (e.g., researcher role or recruitment strategies). However, [Lavender et al. \(1999\)](#) was deemed a significant study for the present meta-synthesis, with a high representation of subthemes (see [Supplemental Table S3](#)) and an intrastudy intensity of 71% and clearly stated results. The intrastudy intensity is the number of findings in each study divided by the total number of findings across studies.

Data abstraction and synthesis of the selected studies produced 14 major themes reported from the least to the most represented: (see [Table 1](#)) *Nutrition, Hygiene, Privacy, Information, Bodily Respect, Respect for Social Role, Family Intimacy, Shelter, Pain Management, Partnership, Movement, Reassurance, Support, and Empowerment.*

Nutrition

During labor, caloric intake and hydration are necessary for women to maintain their strength. Participants in three studies reported a lack of food and water and as a result felt weakened and exhausted ([Aktas & Aydin, 2019](#); [Anwar et al., 2014](#); [Askari et al., 2014](#)). Findings showed that hunger and thirst reduced participants' strength and made labor more difficult to bear ([Aktas & Aydin, 2019](#)). However, the need for nutrition was reported in only five articles with an interstudy frequency effect size of 38% and was the least common theme. It was mostly expressed by participants in the early stages of labor.

Hygiene

Participants expressed the need to keep themselves clean during childbirth to preserve their dignity and sense of comfort. Women in labor can vomit or excrete involuntarily ([Chadwick et al., 2014](#)), and hyperhidrosis is also common and leaves women feeling damp ([Askari et al., 2014](#)) and unclear ([Khreshheh et al., 2019](#); [Kuo et al., 2010](#)). Participants defined the need to be clean as natural and said that something as simple as a change of clothes would be helpful ([Askari et al., 2014](#); [Chadwick et al., 2014](#); [Khreshheh et al.,](#)

Table 1: Synthesis of the Main Findings

Need	Description Women's Need During Labor to	Categorization		Interstudy Frequency Effect Size (A), %
		Labeled Following Maslow's Hierarchy as	Related Need(s)	
<i>Nutrition</i>	Be provided with the caloric intake and hydration necessary for maintaining their strength.	Physiologic need	<i>Movement</i>	38
<i>Hygiene</i>	Keep themselves clean during childbirth, preserving their own dignity and sense of comfort.	Physiologic need	<i>Shelter</i>	46
<i>Privacy</i>	Feel that their bodies and experiences of labor were being preserved and protected.	Safety need	<i>Shelter</i> <i>Support</i> <i>Reassurance</i>	53
<i>Information</i>	Be explained the basic and practical aspects of the ongoing childbirth process.	Safety need	<i>Shelter</i> <i>Pain Management</i> <i>Support</i> <i>Reassurance</i>	69
<i>Bodily Respect</i>	Feel respected as sentient individuals able to understand and partake in the interventions associated with childbirth.	Esteem need	<i>Information</i> <i>Privacy</i> <i>Support</i> <i>Pain Management</i> <i>Shelter</i> <i>Partnership</i>	69
<i>Respect for Social Role</i>	Feel respected not just as patients, but also as human beings with a personal background, a social role, and religious beliefs.	Esteem need	<i>Information</i> <i>Shelter</i> <i>Family Intimacy</i> <i>Partnership</i>	69
<i>Family Intimacy</i>	Be accompanied during childbirth by a member of their family, such as their partner, husband, or mother.	Social belonging need	<i>Pain Management</i> <i>Support</i> <i>Partnership</i>	69
<i>Shelter</i>	To have a comfortable and private environment, which enhanced their sense of security and control during childbirth.	Physiologic need	<i>Movement</i> <i>Hygiene</i> <i>Pain Management</i>	76
<i>Pain Management</i>	Be helped when coping with pain during childbirth.	Physiologic need	<i>Movement</i> <i>Shelter</i>	76
<i>Partnership</i>	Develop a mutual, equal, and sincere understanding with the midwife who cared for them.	Social belonging need	<i>Pain Management</i> <i>Privacy</i> <i>Information</i> <i>Reassurance</i> <i>Support</i> <i>Family Intimacy</i>	76
<i>Movement</i>	Feel unrestrained during childbirth.	Physiologic need	<i>Pain Management</i> <i>Shelter</i>	84
<i>Reassurance</i>	Be frequently reassured during childbirth.	Safety need	<i>Shelter</i> <i>Pain Management</i> <i>Information</i> <i>Support</i>	92

(Continued)

Table 1: Continued

Need	Description	Categorization		Interstudy Frequency Effect Size (A), %
		Labeled Following Maslow's Hierarchy	Related Need(s)	
<i>Support</i>	Receive proper care during childbirth, which they strongly related to the need to receive constant support by attendant midwives.	Safety need	<i>Nutrition</i> <i>Hygiene</i> <i>Movement</i> <i>Pain Management</i> <i>Information</i> <i>Reassurance</i>	92
<i>Empowerment</i>	Feel in control of their own birth experience.	Self-actualization need	<i>Nutrition</i> <i>Hygiene</i> <i>Privacy</i> <i>Information</i> <i>Bodily Respect</i> <i>Respect for Social Role</i> <i>Family Intimacy</i> <i>Shelter</i> <i>Pain Management</i> <i>Partnership</i> <i>Movement</i> <i>Reassurance</i> <i>Support</i>	92

Note. A = representation of subthemes in single studies (number of finding in each study/total number of findings across studies per 100).

2019). Although participants focused less on their own hygiene and more on the characteristics of the environment around them or on the support provided by midwives or health care providers as labor progressed, research findings suggested that a clean environment helped participants cope with labor progression (Kuo et al., 2010). Even if hygiene was a rarely represented theme with an interstudy frequency effect size of 46%, it was strongly expressed by participants during the first stage of labor and was linked to the need for shelter.

Privacy

Synthesized findings showed a need for women to feel that their bodies and labor experiences were being preserved and protected by midwives and other health care providers. In other words, in a delicate moment such as childbirth, participants did not want to feel embarrassed (Aktas & Aydin, 2019; Chadwick et al., 2014; Deliktas Demirci et al., 2019). Some participants reported labor in crowded wards, listening to the shouts of other women in labor (Aktas & Aydin, 2019), and becoming increasingly nervous and anxious as a result. During childbirth, participants

expressed an acute aversion to being surrounded by an unnecessarily large number of unknown people (McNeils, 2013) and a desire for a comforting and private environment (Askari et al., 2014; McNeils, 2013) in which to labor and give birth assisted by a noninvasive and professional presence, such as a midwife, or supported by a family member or partner (Aktas & Aydin, 2019; Chadwick et al., 2014; Deliktas Demirci et al., 2019). The need for privacy was expressed by participants in half of the included studies, with an interstudy effect size of 53%, and was linked to the needs for shelter, support, and reassurance.

Information

Findings showed that women sought an explanation of the basic and practical aspects of the ongoing childbirth process. Information on any necessary interventions (Anwar et al., 2014; Deliktas Demirci et al., 2019; Karlstrom et al., 2015) and the newborn's health (Deliktas Demirci et al., 2019) appeared to be of particular concern. Because nearly half of the participants were primiparous, most expressed

the need for knowledge as a means of navigating the unknown (Deliktas Demirci et al., 2019). Without information, participants reported that they felt scared or invalidated (Anwar et al., 2014; Chadwick et al., 2014; Iravani et al., 2015) and developed a resistance to interventions typically performed by maternity care providers (Deliktas Demirci et al., 2019; Iravani et al., 2015; Lavender et al., 1999). The absence of information during labor and birth also led to a sense of guilt for the newborn's welfare (Deliktas Demirci et al., 2019), rumination over possible wrongdoing, and a sense of angst (Lavender et al., 1999). This need for information was present in participants in more than half of the studies, with an interstudy frequency effect size of 69%. Often, a participant's need for information during childbirth was related to some other more complex need, such as the needs for reassurance, partnership, respect for social role, bodily respect, and empowerment.

Bodily Respect

Bodily respect is women's need to feel respected as individuals able to understand and partake in the interventions associated with childbirth and is linked to an ethical dimension of intrapartum care. Too often, participants described medical interventions received during childbirth as unnecessary (Iravani et al., 2015; Lavender et al., 1999), painful (Aktas & Aydin, 2019; Lavender et al., 1999), and traumatizing (Askari et al., 2014). Conversely, participants reported that they readily accepted medical interventions in labor and during childbirth and repeated vaginal inspections if their maternity care provider clearly explained the rationale (Afaya et al., 2017). Moreover, participants complied easily with interventions if the maternity care provider conducted them with sympathy and respect (Kuo et al., 2010; McNeils, 2013). Otherwise, participants reported experiencing fear and discomfort (Aktas & Aydin, 2019; Iravani et al., 2015; Lavender et al., 1999) and feeling forced to bear medical interventions almost as though subject to violence (Askari et al., 2014; Chadwick et al., 2014; Deliktas Demirci et al., 2019). This need for bodily respect emerged in more than half of the included studies, with an interstudy frequency effect size of 69%, and in participants' narrations, it was often coupled with the medical interventions received during labor and at birth.

Respect for Social Role

Women's accounts revealed a need for respect not just as patients but also as human beings with

a personal background, a social role, and religious beliefs. Participants often lamented that maternity care providers who cared for them during childbirth did not respect this need (Afaya et al., 2017; Aktas & Aydin, 2019; Fraser, 1999). Participants reported that they felt reprimanded during labor (Chadwick et al., 2014) and shouted at by maternity care providers (Afaya et al., 2017; Chadwick et al., 2014; Khresheh et al., 2019) despite experiencing pain or fear. Some participants reported that they felt irrelevant during their own childbirth (Chadwick et al., 2014). Participants also expressed a need to be treated fairly during labor as adult women with self-confidence and, in some cases, as established professionals. Despite the need to be reassured during labor and birth, participants still wanted to be treated as mature individuals, fully capable of making their own decisions (Kuo et al., 2010). Participants also wished to be respected for their cultural and religious beliefs, as opposed to being classified by their skin color or otherwise stereotyped. Moreover, participants expressed a desire for maternity care providers to enable celebration of the joy of childbirth following their own precepts, such as praying (Deliktas Demirci et al., 2019; Khresheh et al., 2019). The need for respect for social role was represented in the included studies as much as the need for bodily respect, with an interstudy frequency effect size of 69%.

Family Intimacy

Participants expressed the need to be accompanied during childbirth by a member of their family, such as their partner, husband, or mother. They also reported that they felt safer with a familiar presence nearby (Iravani et al., 2015; Lavender et al., 1999) and wished to have the option of acknowledging this familiar presence to remain physically close during labor (Aktas & Aydin, 2019), even in a hospital. Facing labor alone made participants feel belittled or abandoned (Aktas & Aydin, 2019; Deliktas Demirci et al., 2018). Some participants expressed a desire to share childbirth specifically with their partner (Chadwick et al., 2014; Deliktas Demirci et al., 2019; Iravani et al., 2015) for physical support or involving the partner in the birth with acts such as cutting the umbilical cord (Kuo et al., 2010; Lavender et al., 1999). This need for family intimacy not only applied to the process of birth but was also equally an expression of the need to share a precious moment with someone close. Without a family member or partner nearby, participants experienced feelings of loneliness or

worthlessness (Deliktas Demirci et al., 2019) and, as a consequence, became angry or scared in some instances (Khreshheh et al., 2019). The need for family intimacy was a common one, being present in more than half of the included studies with an interstudy effect size of 69%.

Shelter

Shelter represents women's need for a comfortable and private environment, which enhanced their sense of security and control during childbirth. Participants who gave birth in hospitals wished to be welcomed into a sheltered environment (Iravani et al., 2015; McNeils, 2013) because its confidential and familiar atmosphere (Deliktas Demirci et al., 2019) improved their tolerance during childbirth (Askari et al., 2014). Conversely, an unknown or overly crowded environment increased participants' anxiety. Participants stated that they were unsettled by the sight and sound of other women in labor (Askari et al., 2014), and they expressed a desire for maternity care providers to show them the labor ward and make adjustments to it. For example, adjusting light intensity or playing music were adjustments that reportedly improved participants' sense of security. The need for shelter was a highly represented theme in the studies, with an interstudy frequency effect size of 76%. The need for shelter is common in laboring women, and it appears to be associated with the needs of privacy and information.

Pain Management

Women felt the need to be helped when coping with pain during childbirth. Participants appeared to use a great variety of approaches to pain management, ranging from nonpharmacological to pharmacological methods. However, almost all participants in the selected studies referred to the need to be encouraged (Afaya et al., 2017; Anwar et al., 2014; Iravani et al., 2015; Kuo et al., 2010) or comforted (Anwar et al., 2014; Chadwick et al., 2014; Khreshheh et al., 2019; Kuo et al., 2010; McNeils, 2013) by a noninvasive presence (Afaya et al., 2017; Anwar et al., 2014; Kuo et al., 2010). The feeling of being left alone increased participants' fear and, in some cases, rendered pain intolerable (Afaya et al., 2017; Aktas & Aydin, 2019; Askari et al., 2014; Chadwick et al., 2014; Khreshheh et al., 2019; Kuo et al., 2010). Some participants sought nonpharmacological methods of pain relief, such as breathing methods or massages (Anwar et al., 2014; Karlstrom et al., 2015; Kuo et al., 2010; Lavender et al., 1999). For other participants, having taken

a prenatal course (Kuo et al., 2010) and being mentally prepared for labor pain (Karlstrom et al., 2015) appeared to help considerably. Pharmacologic pain-relief methods also helped participants to endure labor pain; however, some participants lamented the lack of information surrounding these methods (Lavender et al., 1999), as well as the resistance on the part of maternity care providers to administer drugs even if asked in some settings (Khreshheh et al., 2019). The need for pain management was a highly represented theme, with an interstudy frequency effect size of 76%. It appeared to be linked to the needs for support, partnership, and empowerment.

Partnership

Women needed to develop a mutual, equal, and sincere understanding with the midwife who cared for them during childbirth. Moreover, this understanding was perceived as being akin to a relationship that (Kuo et al., 2010) must last from labor until birth and was built on confidence, acceptance, and trust (Iravani et al., 2015; Karlstrom, 2015). Participants requested a midwife who assisted them (Anwar et al., 2014; Askari et al., 2014; McNeils, 2013), who acknowledged and responded to their needs (Afaya et al., 2017; Kuo et al., 2010), who was capable of guiding them in the process of birth, and who made them feel safe (Karlstrom et al., 2015). Furthermore, participants wished to be cared for and supported by someone they trusted and who understood them (Fraser, 1999; McNeils, 2013). Therefore, the needs for information, privacy, support, social role respect, and bodily respect appeared to be linked to the need for partnership. Moreover, participants associated the creation of a partnership with their own process of empowerment. The beginning of a shared relationship between the participant and the midwife during intrapartum care, definable as partnership, helped participants feel in control of their own birth. The need for partnership had an interstudy frequency effect size of 76%, indicating its considerable importance during childbirth.

Movement

Movement refers to women's need to feel unrestrained during childbirth. Participants expressed the need in labor to feel free to assume whatever position they wished, provided that their health conditions allowed for it and that there was no risk of harm to the fetus (Anwar et al., 2014; Chadwick et al., 2014; Deliktas Demirci et al., 2019; Fraser,

1999; Khresheh et al., 2019; Kuo et al., 2010). Often, participants suffered because of the lack of information from maternity care providers about why they were required to change position or lay down. As a result, participants felt forced to either lay on the bed or to move from it, often against their wishes (Chadwick et al., 2014). Movement in labor was highly valued by participants because it helped them to withstand pain (Kuo et al., 2010) and enhanced their sense of control (Afaya et al., 2017; Fraser, 1999). During childbirth, participants also wished to be involved in the choice of the optimal birth position (Anwar et al., 2014; Kuo et al., 2010). Thus, participants' need for movement appeared to be related to the freedom of changing positions, walking, moving, or resting. Moreover, the need for movement had a high interstudy frequency effect size (84%) and was present in almost all of the studies.

Reassurance

Women expressed the need to be frequently reassured by midwives during childbirth. Participants wished to feel as though maternity care providers were truly overseeing them (Anwar et al., 2014; Chadwick et al., 2014; Fraser, 1999; Lavender et al., 1999) and to be periodically reassured that the labor was progressing normally (Deliktas Demirci et al., 2019; Iravani et al., 2015; Kuo et al., 2010). They also wanted to be frequently reassured of the fetus's safety, especially after a medical intervention, such as a vaginal examination or a cardiotocography check (Aktas & Aydin, 2019; Anwar et al., 2014; Chadwick et al., 2014; Deliktas Demirci et al., 2019; Iravani et al., 2015; Khresheh et al., 2019). Participants always connected medical interventions to a sense of uncertainty, and the participants who experienced interventions needed to know that the labor was progressing normally, that the fetus was healthy, and that they were doing everything properly. Participants expressed concern during childbirth of unexpected complications, which they feared being incapable of emotionally managing (Iravani et al., 2015). A lack of knowledge of events, especially about interventions (Khresheh et al., 2019), increased participants' anxiety and worries (Deliktas Demirci et al., 2019). Participants who were nervous appeared to be particularly sensitive to maternity care providers' body language, and even the lack of a smile reportedly affected them (Khresheh et al., 2019). Participants wished to be cared for by midwives with a good predisposition and a positive attitude and who could

reassure them with both verbal and nonverbal language. Participants also wanted to be involved in the decision-making process during childbirth (Anwar et al., 2014; Iravani et al., 2015; Kuo et al., 2010; Lavender et al., 1999) and yet, in high-risk situations, felt reassured seeing maternity care providers in control (Karlstrom et al., 2015). This need for reassurance emerged as one of the three most represented themes in our analysis, with an interstudy effect size of 92%, being frequently expressed in the included studies and seemingly linked to the needs for information, support, and partnership.

Support

In most of the studies, women expressed the need to receive proper care during childbirth, which they strongly related to the need to receive constant support by attendant midwives. Participants seemed to demand personalized care rich with information and respect, which in turn helped them to manage their own individual fears (Kuo et al., 2010). Indeed, participants needed to feel secure and patiently listened to (Iravani et al., 2015; Kuo et al., 2010) and to be taken care of by midwives who assisted them while being present and attentive. Participants wanted a midwife able to accompany them in their own journey to birth at their side (Afaya et al., 2017; Anwar et al., 2014; Iravani et al., 2015; Kuo et al., 2010) who would help them meet their needs and support them during childbirth. Moreover, being supported in labor helped participants cope with pain (Afaya et al., 2017; Anwar et al., 2014; Deliktas Demirci et al., 2019; Iravani et al., 2015; Khresheh et al., 2019) and increased their confidence. At birth, the need for support was strongly related to the need for partnership. Participants wanted midwives who cared and supported them during the long hours of labor and with whom they had established a trust bond to rely on during birth (Anwar et al., 2014; Kuo et al., 2010). This need for support was represented in most of the studies, with an interstudy frequency effect size of 92%. It was linked not only with the need for partnership but also with the needs for empowerment and information.

Empowerment

Empowerment is women's need to feel in control of their own birth experience. In most of the studies, participants unceasingly asked the midwives to inform, respect, and support them through labor until birth. Indeed, participants expressed a wish to be encouraged and informed and provided with all of the explanations

needed to make decisions about their own bodies (Askari et al., 2014; Deliktas Demirci et al., 2019; Iravani et al., 2015; Karlstrom et al., 2015; Kuo et al., 2010). However, participants also wanted midwives to put trust in their instincts (Karlstrom, 2015) and help them feel in control during the birthing process (Anwar et al., 2014; Iravani et al., 2015; Kuo et al., 2010; McNeils, 2013). Participants sought midwives capable of empowering them, making them feel brave (Deliktas Demirci et al., 2019), and discussing the birth process with them rather than around them (Fraser, 1999). If participants were listened to, supported, and respected, they trusted maternity care providers, were more compliant and cooperative, felt less pain, and were calmer and more in tune with their own bodies (Aktas & Aydin, 2019; Iravani et al., 2015; McNeils, 2013). When all of these requirements were respected, participants said they felt in control and empowered. Conversely, participants who were not empowered did not know what to do (Aktas & Aydin, 2019) and constantly felt forced (Askari et al., 2014; Fraser, 1999; Lavender et al., 1999), fearful (Fraser, 1999), or weak (Lavender et al., 1999). Thus, empowerment helps women to go through labor and achieve a satisfying birth (Karlstrom et al., 2015; Kuo et al., 2010). The need for empowerment emerged in all of the studies (except for one) and was one of the most expressed needs, alongside the needs for reassurance and support, as well as one of the most clearly defined, with an interstudy frequency effect size of 92%. Empowered participants felt that their experience of childbirth was improved even during unexpected medical complications. The need for

empowerment was related directly or indirectly to all of the other needs that emerged in the analysis.

Categorization

All 14 of the themes were categorized following Maslow's (1954) hierarchy of needs and assembled into physiologic needs, safety needs, social belonging needs, self-esteem needs, and self-actualization needs (see Figure 2). Maslow's hierarchy of needs was selected as an organizational framework shortly after the emergence of themes for several reasons. First, after the analyses, themes varied in their prevalence and importance. Some needs were more complex than others, and some were anchored less to a physiologic dimension of childbirth and more to a psychological one. Moreover, some of the themes that emerged bore a resemblance to Maslow's categorization of needs, such as the needs for nutrition, movement, or shelter.

The 14 needs were placed in Maslow's five categories based on whether their definition matched Maslow's requirements. Categorization was necessary to define the prioritization order and the complexity of women's needs. For example, needs such as movement or hygiene, categorized as physiologic needs, are less multifaceted and complex than the need for self-esteem or self-actualization for example (see Figure 2). Indeed, needs like reassurance appeared to be met only if other needs, such as pain management or information or support, were already met. Some needs, such as the need for shelter or nutrition, retraced the ones defined by

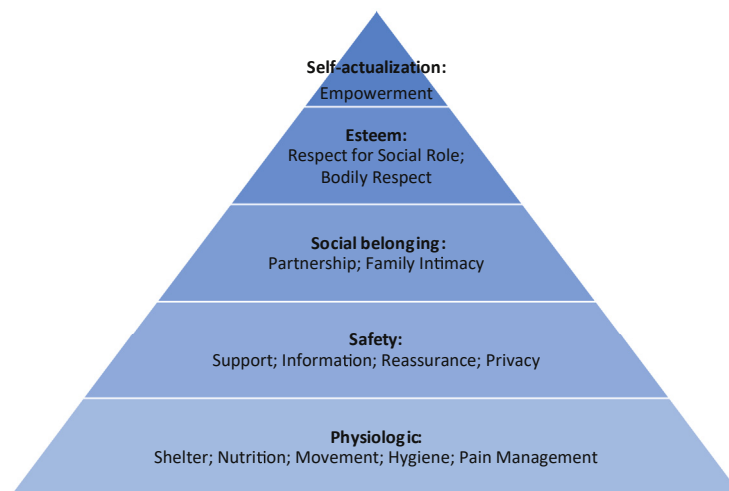


Figure 2. The categorization of hospitalized women's needs using Maslow's hierarchy.

Further research is needed to develop and test standardized methods and instruments for the assessment of women's needs during childbirth.

Maslow and were categorized accordingly. Others were specific to women in childbirth and were categorized through an in-depth analysis. For example, women's need for pain management during childbirth was categorized as a "physiologic need," consistent with the definition of labor as "a period of time characterized by regular painful uterine contractions" (World Health Organization, 2018, p. 3). However, there is a complex interplay between physiologic needs, such as the need for pain management, and needs higher up the pyramid (e.g., support, empowerment, and partnership).

Discussion

Our meta-synthesis allowed for the identification and categorization of 14 needs of women that midwives can meet during hospitalization for childbirth. The 14 identified needs had different interstudy frequency effect sizes, distinctive attributes, and different complexity levels, as shown by their categorization through Maslow's hierarchy of needs. The most represented needs were those for reassurance, support, partnership, and empowerment, and these findings were consistent with the current literature (Attanasio et al., 2014; Larkin et al., 2017; Taheri et al., 2018) and health policies (World Health Organization, 2018). However, our structured classification of the needs of women hospitalized for childbirth provides a clear insight into what women want during childbirth. Moreover, our findings highlight the fact that needs, such as the need for self-actualization, are only likely to be met if midwives, nurses, and other maternity care providers have already satisfied women's lower hierarchy needs, such as physiologic or safety needs. Therefore, the present classification provides an order of prioritization of hospitalized women's needs to help midwives empower women during childbirth.

Understanding women's needs during hospitalization for childbirth can lead to practical responses in the midwifery care process (International Confederation of Midwives, 2018) and improve women's satisfaction (Srivastava et al., 2015) and a hospital's care quality (Devane et al., 2019). Women's satisfaction is one of the most frequently reported outcome

measures for intrapartum quality of care (Sawyer et al., 2013), but it is a complex, subjective concept with several dimensions and components (Jafari et al., 2017). However, women whose expectations are met appear to have greater satisfaction rates (Bryanton et al., 2008; Goodman et al., 2004; Kifle et al., 2017). Thus, developing and testing standardized methods and instruments to assess women's needs during hospitalization on the basis of the present categorization could be an effective way to improve women's satisfaction and midwifery care.

Moreover, the categorization of the 14 needs provides a clear insight into what women need when laboring and giving birth in hospitals. Women value the presence of midwives who are supportive but nonintrusive, and needs such as privacy, bodily respect, or respect for social role highlight the importance for women of feeling respected both culturally and physically during childbirth. Midwifery is strongly related to respect for women's cultural and religious leanings (Phiri et al., 2010) and to a holistic (Hollander et al., 2019) and "person-centered" (Fontein-Kuipers et al., 2018; Taylor, 2015) dimension of care. Women entrust themselves to the care of midwives during childbirth and hope to receive respectful care without unnecessary or unwanted interventions or discrimination, which may be perceived as abuse (Jardim & Modena, 2018; Vedam et al., 2019). Moreover, women associate their specific needs to potential interventions midwives could undertake to care for them (e.g., providing information on childbirth development or on the newborn's welfare to meet women's need for reassurance). However, some needs, such as the need for pain management, are clearly related to higher needs, such as the need for partnership, and both can be addressed through the use of the same kind of intervention (e.g., massages). Future research should be focused on finding distinctive elements to assess hospitalized women's needs and link these to specific midwifery interventions to improve midwifery care.

In all of the included studies except one (McNeils, 2013), midwives worked in a team with other maternity care providers (e.g., doctors and nurses) to meet women's needs during childbirth. Often in hospital settings, multidisciplinary teams strive to ensure a good quality of care for women with both low- and high-risk pregnancies (Downe et al., 2010). Moreover, in many developed countries (e.g., in North America), physicians

rather than midwives are the primary health care providers and decision makers in hospital settings, with nurses taking a large share of responsibility for meeting women's needs during childbirth (National Academies of Science, Engineering and Medicine, 2020). When midwives are not available, either because they need to manage multiple women in labor or because they are not part of the maternity care team, nurses are often at women's bedside meeting their needs. Our categorization could help nurses and other maternity care providers meet women's needs during childbirth, aiding the provision of care in different settings or countries.

Limitations

Limitations to our work include the scarce description of the participants' characteristics in some articles (Lavender, 1999; McNeils, 2013), which made it impossible to determine possible differences in representation between the needs of primiparous and multiparous women. Moreover, six of 13 studies were conducted in Middle Eastern countries, four in European countries, only one in an Asian country, and none from the Americas, which could have led to an overestimation or underestimation of the interstudy frequency effect size of some of the 14 needs. The absence of studies from the United States is most likely due to our inclusion criterion, which identified midwives as the main maternity care providers during childbirth and searched primarily for studies that were focused on women's needs and experiences. Indeed, U.S. midwives face numerous regulatory barriers (Vedam et al., 2018), and many of the excluded American studies were focused on assessment of women's satisfaction within the context of intrapartum care rather than on investigation of women's experiences of it. Because some data included in the meta-synthesis came from retrospective reports, two of the studies (Fraser, 1999; Kuo et al., 2010) contained some insight on antenatal care. However, our research team determined that these studies (Fraser, 1999; Kuo et al., 2010) were relevant and were therefore included.

Implications

Implementing strategies to fulfill the 14 needs could be an effective method to improve women's satisfaction and, consequently, the quality of midwifery care. Further research should investigate each of these needs to acquire a better comprehension of their specific characteristics, distinctive elements, and differences; to improve the midwifery care process by linking each need

to specific interventions and outcomes; and to develop standardized methods for their assessment. Moreover, further research should address the literature gap on hospitalized women's needs during childbirth in the U.S. and investigate any changes in the interstudy frequency effect size of the 14 needs.

Conclusion

Our findings synthesize what women need during hospitalization for childbirth when cared for by midwives. Clearly understanding what women need during hospitalization can help midwives and other providers, particularly nurses, tailor their care and shape the midwifery care and nursing care processes. Each of the 14 needs has distinctive elements, different interstudy frequencies, and a specific definition. Using Maslow's (1954) hierarchy of needs as an organizational framework, we provide a clear classification and order of prioritization of women's needs during labor and birth in hospitals, which could help midwives, nurses, and other maternity care providers improve their care and their competencies.

Supplementary Material

Note: To access the supplementary material that accompanies this article, visit the online version of the *Journal of Obstetric, Gynecologic, & Neonatal Nursing* at <http://jognn.org> and at <https://doi.org/10.1016/j.jogn.2020.10.005>.



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