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A meta-synthesis of the perspectives and experiences of healthcare professionals on the humanisation of childbirth using a meta-ethnographic approach

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ABSTRACT

Problem: The humanisation of childbirth has been identified as a practice of care focusing on the physical, psychological, and emotional wellbeing of women. Healthcare professionals (HCPs) are expected to understand and embed humanised practice when supporting women in childbirth.
Aim: The aim of this paper is to present a meta-synthesis of the experiences and perspectives of HCPs who undertake care for women at the time of birth regarding the humanisation of childbirth.
Methods: A systematic search of the electronic databases CINAHL, Medline, PsycINFO, and SocINDEX were conducted in July 2020. Qualitative studies exploring HCPs' experiences and perspectives of humanisation in childbirth were eligible. Studies were synthesised using a meta-ethnographic approach.
Findings: Fourteen studies involving 197 participants were included. Two themes were identified: 'Women at the centre' and 'Professional dissonance'. Two line of argument synthesis were identified: 'invisible boundaries' and 'unconscious undermining'.
Discussion: HCPs recognised that women required positive interactions which met both their emotional and physical needs. Human touch supported bonding between HCPs and women. HCPs understood humanisation as the reduction of unnecessary intervention and/or technology but had difficulties enacting this and often used disempowering language when discussing women's choices. The management of pain and the presence of a companion were considered important by HCPs.
Conclusion: This synthesis revealed that HCPs do understand the humanisation of childbirth but have difficulties in enacting it in practice. Women classified as high risk were identified as having specific needs such as increased emotional support. Further research is required for women classified as high risk who may require technology and/or interventions to maintain a safe birth.
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Statement of significance

Problem

Humanisation may support the positive emotional and mental health of women in childbirth, but it is unclear how healthcare professionals enact this for women.

What is already known

Humanisation of childbirth has been identified as a practice of care focusing on the physical, psychological, and emotional wellbeing of women. The requirement to maintain a safe birth includes the prioritisation of life saving measures over humanisation.

Abbreviations: HCP, healthcare professional; NPMPR, non pharmacological methods of pain relief; PMPR, pharmacological methods of pain relief.

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What this paper adds

Although healthcare professionals have an understanding of humanisation there are difficulties enacting it. Women classified as high-risk, in particular are a cohort requiring further research due to their need for increased interventions and/or technology to maintain a safe birth.

1. Introduction

Humanisation in pregnancy and childbirth may help contribute to decreasing mental and emotional distress women may face during labour. The humanisation of childbirth has been identified as a practice of care focusing on the physical, psychological, and emotional wellbeing of women. Healthcare professionals (HCPs) are expected to understand and embed humanised practice when supporting women in childbirth. A recent concept analysis reported that the humanisation of childbirth supports the practice of care that focuses on the interaction between human beings and the ability of women to advocate for themselves or be advocated for by HCPs or a companion [1]. There is a need for women and HCPs to collaborate with each other to achieve the most effective and appropriate care for women as individual human beings. A partnership must be developed to build a mutual trust for shared decision making [2–5]. To enact the humanisation of childbirth, HCPs need to recognise how their behaviours and attitudes that can impact on women's psychological and emotional well-being [1]. There is consensus in the literature that all women are entitled to humanised practices regardless of the technological or non-technological supports required to maintain a safe birth [6,7]. The requirement to maintain a safe birth includes the prioritisation of life saving measures over humanisation [8]. Prioritisation of care in this way may be of particular importance for women who have their pregnancies classified as 'high risk'. A 'safe' birth may no longer be identified as the only outcome of survival. Instead, emotional and psychological safety as well as continued physical safety throughout the birthing process are required [9].

A number of qualitative studies have previously explored women's perspectives of humanised childbirth [10–15]. Although, there is a growing body of qualitative research regarding humanisation of childbirth from the perspective of the Healthcare Professional (HCP) [7,16–18], to date, there has been no synthesis of this research. This is of particular importance as HCPs are expected to understand and embed humanised practices when supporting women during labour and birth. Walsh and Downe [19] have identified the use of integrated qualitative data using meta-synthesis to bring fresh insights into supporting decision making in maternity care. Humanised practice has been proposed as a method to mitigate the consequences of large scale health systems, creating a more individualised standard of care. Therefore, humanisation may support the positive emotional and mental health of women in childbirth [1,20]. The aim of this paper is to present a meta-synthesis of the experiences and perspectives of HCPs regarding the humanisation of childbirth.

2. Participants, ethics and methods

2.1. Research design

Noblit and Hare's meta-ethnographic approach was chosen to synthesise the data. Their seven-step approach has been further developed using France et al. approach and was used in conjunction with Noblit and Hare's seminal work (See Table 1). The seven step approach asks the researcher to initially become familiar with the selected studies and then determine how studies are related. Once this stage is complete the concepts that relate the studies are translated into one another. A meta-ethnograpic synthesis is a development of an overall translation (step 6) of a collection of translated studies (step 5). These synthesised translations, as well as a line of argument synthesis, or narrative, contains a new conceptualisation in line with Noblit and Hare's seven steps (See Table 1). A review protocol for this study was published in PROSPERO (The International Prospective Register of Systematic Reviews), registration number CRD 42020153255. Ethical approval was not required.

2.2. Search strategy and selection criteria

A systematic search of the electronic databases CINAHL, Medline, PsycINFO, and SocINDEX was conducted in July 2020 using the Preferred Reporting Items for Systematic Reviews and Meta-Analyses principles (PRISMA) (see Fig. 1) [21]. The terms used, including truncations, were 'humanis*', 'humaniz*', 'birth', 'labour', 'childbirth', 'healthcare professional', 'midwi*' and 'obstet*'.

This search strategy used the 'SPIDER' tool: Sample, Phenomenon of interest, Design, Evaluation, Research type [22] (See Table 2). The search was limited to English language papers. No limitation on date of publication was applied.

Selection criteria included any qualitative research of healthcare professionals (e.g. midwife, obstetric nurse, obstetrician) who undertake care for women at the time of birth, and their perspectives and experiences of the humanisation of childbirth.

Table 1
The seven steps of a meta-ethnographic approach [27,35].

	Seven steps of Noblit and Hare's meta ethnography (Noblit and Hare [27])	Approach used for phases four, five and six (France et al. [35])
1	Getting started	
2	Deciding what is relevant to the initial interest	
3	Reading the studies	
4	Determining how the studies are related	a) Listing of data and how they relate to each study account b) Comparing data across the studies c) Using data to determine the relationship between studies
5	Translating the studies into one another	a) Studies were ordered chronologically b) Translation of data using a constant comparative method c) Identify reciprocal and refutational data
6	Synthesising translations	a) Synthesis of translations b) Line of argument synthesis produced c) Narrative containing new conceptualisation combined with visual diagrams
7	Expressing the synthesis	

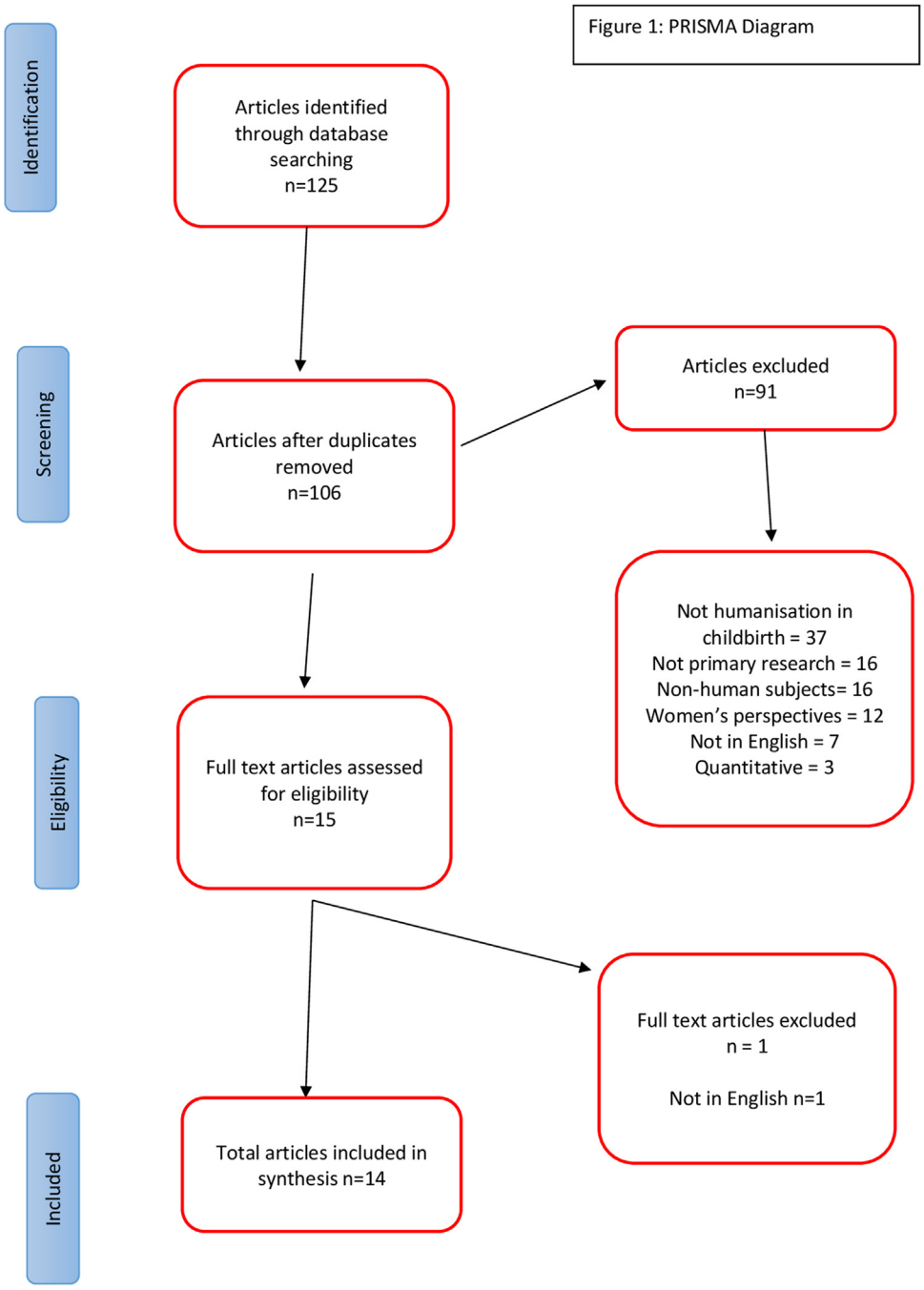


Fig. 1. PRISMA diagram.

Table 2
The SPIDER tool [22].

SPIDER tool	Inclusion criteria
Sample	Any healthcare professional who undertakes care for women at the time of birth including midwife, obstetrician, nurse-midwife, obstetric nurse, student midwife
Phenomenon of interest	The experience and perception of healthcare professionals regarding the humanisation of childbirth
Design	Any type of qualitative data collection
Evaluation	Presence of a humanised approach which benefitting a woman's emotional well-being.
Research type	Qualitative research or the qualitative aspect of a mixed methods study

2.3. Screening and quality appraisal

In total, 125 papers were imported from the databases into the Covidence software, 19 duplicates were removed leaving 106 papers for title and abstract review regarding eligibility for inclusion. The papers were screened by two authors (MC, PL-W). A third author (ES) adjudicated where a final consensus was required. During title and abstract review, 91 papers were excluded and following a full text review of 15 papers, 14 studies were deemed eligible for inclusion (See Fig. 1 and Table 3). The Joanna Briggs Institute (JBI) Checklist for Qualitative Research was used to appraise the quality of included studies [23]. Quality appraisal was completed by MC and ES and adjudicated by PL-W as needed. All studies were included regardless of their methodological quality to

Table 3
Breakdown of included studies.

Author	Purpose	No. of participants	Methods	Study locations
Binfa et al. [31] Japan DOI: https://doi.org/10.1186/1471-2393-10-25	Explore the Japanese experiences of childbirth practice in different birth settings where the humanisation of birth has been implemented as an institutional goal, and also to explore the obstacles and facilitators encountered in such practice	5 Obstetricians 1 Paediatrician 1 Academic midwifery professor 12 Clinical nurse-midwives 5 Midwifery students are MSc level	Observation, field notes, semi-structured open-ended, in-depth interviews. Conversational interviews, focus groups and documentary data Inductive content analysis	9 Birth centres in 6 different areas of Japan: 2 — Level 4 highly specialised hospitals 3 — Tertiary university affiliated hospitals 2 — Level 2 private hospitals 1 — Level 1 private hospital
Monteiro et al. [32] Japan DOI: https://doi-org.ucd.idm.oclc.org/10.1007/s11019-009-9220-0	To define the professional's perceptions related to humanised birth in high-risk pregnancies, and the factors that may facilitate or prevent the provision of this kind of care in a high obstetric risk situation.	2 Obstetricians 1 Professor of healthcare administration 1 Academic midwifery professor 3 Clinical midwives 2 Focus groups of clinical midwives (group of 3) 1 Focus group of nurse midwifery students (5) 1 Focus group of midwives in a birthing centre (3)	Focus groups, in-depth, open-ended semi structural interviews. Nine individual and four focus group interviews Content analysis	2 Tertiary university affiliated hospitals 1 Level 3 private hospital 2 Level 2 hospitals 1 Private clinic 1 Birth centre 2 Universities
Behruzi et al. [6] Canada	The aim of this study was to explore the organisational and cultural factors, which act as barriers or facilitators in the provision of humanised obstetrical care in a highly specialised, university affiliated hospital.	(Not defined further)	Semi structured interviews, field notes, participant observations a self-administered questionnaire documents and archives Deductive content analysis	Highly specialised university affiliated hospital
Behruzi et al. [8] Canada	To identify the perceptions of professionals, administrators, and women, on the humanisation of childbirth care in one particular tertiary hospital to identify the factors that might have hindered the implementation of such care in these hospitals	6 Nurses 3 Obstetricians 1 Paediatrician 1 Anaesthetist	In-depth, open-ended semi structured interviews. Interview guides pretested and validated. interviews 40–90 min duration Content analysis	Tertiary university affiliated hospital
Biondi et al. [33] Chile	Explore professionals' perceptions of this humanised assistance during labour and childbirth	40 Midwives 29 Obstetricians	Focus groups conducted into each site separated according to midwives, obstetricians, and women. Notes from discussions taken wherever possible to confirm or contradict information. Groups no larger than 8. Content analysis	9 Major regional hospitals
France et al. [35] Brazil	To learn the interrelation between the implementation of care practices proposed in the PHPN and the WL present in the WP of nurses in obstetric centres and maternity hospitals.	14 Nurses	Semi structured script, open ended questions anonymity maintained Content analysis	2 Hospital and teaching hospitals
Mabuchi and Fustinoni [17] Brazil	To understand the meaning the healthcare professional in charge of the woman in childbirth gives to labour and humanising delivery	7 Physicians (speciality not further identified) 4 Nurses	Non-directive, open-ended interviews recorded with healthcare professionals Amadeo Giorgi model	Obstetric centre public hospital
Najafi et al. [34] Brazil	To understand the practice of obstetric nurses in childbirth care for high-risk pregnant women	7 Obstetric nurses	Semi structured interviews, Open ended questions Content analysis	Obstetric public maternity centre
Behruzi et al. [30] Tanzania	Describe the perceptions and practices of nurse-midwives and obstetricians on humanising birth care and barriers and facilitators to respectful maternal care in Tanzania	6 Midwives 2 Obstetricians	Semi structured interviews. Open-ended questions and probes. Notation of non-verbal expressions taken. Thematic coding	Two district hospitals
Nicholls et al. [36] Iran	The aim of the review was to argue the maternity supportive care paradigms of the past century and to closely analyse each paradigm	Not defined	Historical review of the previous century	
Nogueira Giantaglia et al. [18] Brazil	To identify the care offered to women, under the watch of humanisation in childbirth, and puerperium by nurses	6 Nurses	Semistructured interviews, recorded and transcribed. Directed by a roadmap for the interview after a pilot test Bardin content analysis	City hospital
Possati et al. [16] Brazil	What is the meaning attributed to humanised childbirth by nurses of an obstetric centre	6 Nurses	Semi-structured interviews lasting 20–25 min. Recorded and transcribed	Obstetric centre of a teaching hospital
Torres Vilela et al. [7] Brazil	Unveiling the perception of obstetric nurses about humanized childbirth.	10 Obstetric nurses	Semi-structured interviews lasting 20 min. Recorded and transcribed. Content analysis	Maternity ward

Table 3 (*Continued*)

Author	Purpose	No. of participants	Methods	Study locations
Vega [47] Mexico	How people who self-identify as indigenous leverage their own racialized identities to use the commodification of indigeneity to their favor; to signal the historical underpinnings at play when ethnomedicine is usurped by transnational humanized birth practitioners.	Birth attendants and physicians Sample not defined	Iterative process using open coding to identify emergent themes and synthesis higher order constructs	Rural and cosmopolitan area of Mexico Mexican states included Guanajuato, Guerrero, Jalisco, Mexico, San Luıs Potosı, Veracruz, Chiapas, Oaxaca, Quintana Roo, Morelia, Queretaro, Puebla, Michoacan, and Nuevo León

avoid exclusion of important descriptive findings due to methodological weakness [24].

2.4. Reflexivity

Reflexivity is a key component of ensuring trustworthiness in qualitative research [25]. MC, MM and PL-W are registered midwives. In order to limit the effect of the researchers' bias on the study, the primary researcher (MC) kept notes whilst working through the meta-ethnographic stages providing an audit of decision making. MC kept a notebook of ideas and thoughts that arose in the process. The authors met at regular intervals and the primary researcher received critical feedback during the meta-ethnographic process, continuously challenging attitudes and assumptions made throughout the process. Minutes of all meetings were taken and sent to the authors to ensure an accurate reflection of discussions.

2.5. Data extraction and synthesis

Data were extracted from fourteen studies using a tabular format in Google sheets. Once the database was complete, the synthesis was completed manually using a large white board and 'post-it' notes. Each stage of the seven step process was colourised to ensure accuracy. To preserve the meaning of data reported in the original study, the authors preserved the exact language when extracting the data. Concepts and themes from each individual study were identified (step 3). The researcher then determined how the studies are related (step 4). This has been identified as a 'key judgement call' as the next stage of synthesis is dependent on the relationships established between studies [26,27]. After the relationship was determined, the studies were translated (step 5). Translation was completed by organising the concepts identified by the researcher in step 4 and using a constant comparative method. Translated themes were identified. The presence of reciprocal or refutational data is also identified at this stage of the synthesis. The themes identified from the translation (step 5) are then subjected to a synthesis which produces an overall translation (s) and a line of argument synthesis as a new single comprehensive set of findings.

3. Results

This meta-synthesis set out to synthesise the qualitative data on the experience and perspectives of HCPs regarding the humanisation of childbirth. A total of 197 participants were sampled across the studies consisting of 72 midwives [28–31], 41 obstetricians [8,28–31], 53 nurses [7,8,16–18,32,33], 10 student midwives [29,30], 7 physicians [17], 2 paediatricians [8,29], and 1 anaesthetist [8]. One study did not identify individual professional roles [6] although all healthcare professionals identified and included in the study provided care to women in childbirth. Study settings varied, for example, from birthing homes to university affiliated tertiary hospitals. Thirteen of the fourteen studies were undertaken in either high or upper middle-income countries. The countries represented were Brazil (6 studies), Japan, (2 studies), Canada (2 studies), Chile (1 study), Tanzania (1 study), Iran (1 study) and Mexico (1 study). A summary table of data extraction can be found in Table 3. Quality appraisal identified the overall quality of the included studies to be of low methodological strength. However, this may be reflective of the reporting rather than the conduct of research [24]. See Table 4 for the results of the quality appraisal.

Two themes emerged: '*The woman at the centre*', which encompassed the sub-themes of; the interactions between women and HCPs, meeting the emotional needs of women, and the presence of human touch (see Fig. 2a); and '*Professional dissonance*', recognised by the sub-themes of the use of technology at birth, reducing interventions, high risk care, and the impact of the environment (See Fig. 2b). HCP's did have an understanding of what to do to enact humanisation in childbirth and recognised the importance of the woman as the focus of the care they provide. However, HCP's felt they were impeded in enacting this care and therefore at times they did not do so. The inability of the HCP's to enact the humanisation of childbirth through their practice created a dissonance for the HCP.

4. The woman at the centre

4.1. Interactions between women and HCPs

Developing a relationship with women involved HCPs providing information, choice, and a secure environment [8,16–18,28–30,34]. Providing information was found to be fundamental to humanisation and enabled women feel safe in the care received:

> 'If we took just a few minutes with the patient to explain what we're doing to them, I think it would eliminate tension and bring about a greater sense of security' [8] (Nurse, Canada)

The importance of intimacy and trust between the woman and the HCP was the foundation of a relationship and supported the creation of a bond [6,8,18,33]:

> 'I think that the first care we have about humanisation is the formation of the bond that we create with the pregnant woman, the family and the partner' [18] (Nurse, Brazil)

The '*right to choose*' was viewed by HCPs as important because this ensured that women played an active role in the birth of their child [8,18,29,30]. This could be achieved in various ways both physically and emotionally for women to make decisions in guiding the direction of their care [7,18,29,34]:

> 'Let her choose a little bit and be her owner, not only in the exercises she will perform but in the choice of position, who wants to stay with her, how she wants to stay' [18] (Obstetric Nurse, Brazil)

Table 4
JBI Quality appraisal.

Authors of included articles	Is there congruity between the					Is there a statement locating the researcher culturally and theoretically	Is the influence of the researcher on the research and vice-versa addressed	Are participants, and their voices adequately represented	Is the research ethical according to current criteria or ethical approval	Do the conclusions drawn in the research report flow from the analysis or interpretation of the data
	Philosophical perspective & research methodology	Research methodology & research Q or objectives	Research methodology and the methods used to collect data	Research methodology and the representation and analysis of data	Research methodology & interpretation of results					
Binfa et al. [31]	U	Y	Y	Y	Y	Y	Y	Y	Y	
Monteiro et al. [32]	U	Y	Y	Y	Y	U	N	Y	Y	
Behruzi et al. [6]	U	Y	Y	Y	Y	Y	N	Y	Y	Y
Behruzi et al. [8]	U	Y	Y	Y	Y	Y	Y	Y	Y	Y
Biondi et al. [33]	U	Y	Y	Y	Y	Y	N	N	Y	Y
France et al. [35]	U	Y	Y	Y	Y	N	N	Y	Y	Y
Mabuchi and Fustinoni [17]	Y	Y	Y	Y	Y	N	N	Y	Y	Y
Najafi et al. [34]	U	Y	Y	Y	Y	Y	N	Y	Y	Y
Behruzi et al. [30]	U	Y	Y	Y	Y	Y	Y	Y	Y	Y
Nicholls et al. [36]	N/A	Y	N	N	N	N	N/A	N/A	N/A	Y
Nogueira et al. [18]	U	Y	Y	Y	Y	Y	N	Y	Y	Y
Possati et al. [16]	U	Y	Y	Y	Y	Y	N	Y	Y	Y
Torres Vilela et al. [7]	N	Y	Y	Y	Y	N	N	Y	Y	Y
Vega [47]	Y	Y	Y	Y	Y	Y	Y	N	N	Y

Y = yes, N = no, U = unclear, N/A = not applicable.

To '*be her owner*' of care implies a belief that women have autonomy to choose. However, to *'Let her choose a little bit'* suggests a hesitancy indicating the need for boundaries around a woman's freedom to choose in relation to her care. This may be especially the case when HCPs exercise their preferences for the care offered to women [6,8,28,29]:

> 'I prefer the lithotomy position . . . this allows me to control a mother when assisting her during delivery [28] (Unknown, Brazil)

The quote identifies refutational data, where accounts were found to stand in direct opposition of each other, suggesting that HCPs, at times, undertook practices that by default gave them control over the woman. The woman's choice was limited within the boundaries of the HCPs practice. However, it was also suggested that the woman's ability to make decisions for her care would be an individual factor which may have ideological influences depending on culture, race or religion [29]. Furthermore, this may impact on their ability to voice their opinions:

> ' . . . You see that the Japanese are more likely to obey decisions made by others. Patients also have difficulty talking to doctors, they are afraid to talk to them, they usually just say 'thank you very much', even when they have a problem or a question' [29] (Healthcare professor, Brazil)

However, if women were able to articulate their wishes clearly, HCPs still considered it within their remit to decide whether to allow it:

> . . . Although most of time we advise them to lie with their back. But if she wants to squat, you have to allow her' [28] (Skilled health personnel, Tanzania)

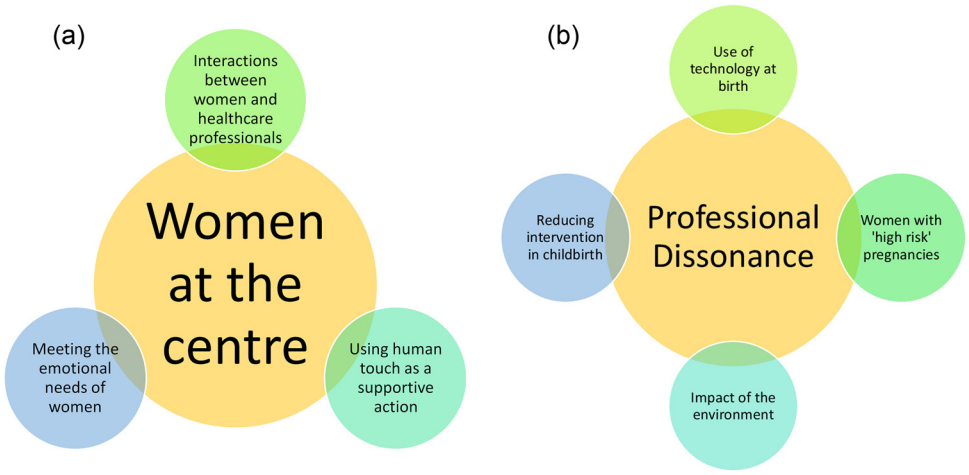


Fig. 2. Themes identified in the meta-synthesis.

4.2. Using human touch as a supportive action

HCPs depicted the humanisation of childbirth through the use of consensual and supportive touch which was perceived to be beneficial, giving women strength at key moments during labour and birth:

> 'We get closer to women, touch them, hold their hands when we try to motivate them . . . ' [32] (Obstetric nurse, Brazil)

Increased physical contact also increased *'biological exposure'* of HCPs which some considered increased their workload [33]:

> If their water breaks when we are helping them to stay on the ball, we get soaked . . . so you expose yourself more to those biological aspects [33] (Nurse, Brazil)

HCPs physical support of labouring women resulted in pain reduction [17,28,29]. Specific behaviours for supportive physical measures were identified:

> 'We provide a comfortable environment and give massages, baths, put pressure on vital points on the woman's body, warm up the mother's feet, and help her relax [29]' (Midwife professor, Japan)

'*Physical contact*' and '*a warm intimate contact'* were titled *'humanely caring'* by one researcher [8]. It was also considered to be a comforting factor that '*transcends barriers'* and helps to establish a good relationship between the women and the HCP [33].

4.3. Meeting the emotional needs of women

A humanised approach to childbirth was described as meeting not just the physical needs of women but also their emotional needs:

> 'we were educated about importance of maintaining privacy, ensuring the woman in labour is constantly supported physically and emotionally by providing psychological support and managing pain' [28] (Skilled health personnel, Tanzania)

HCPs perceived humanisation as contributing to a positive emotional state during labour and birth, supporting women to overcome fears, anxieties and tensions. This also was described as augmenting a positive experience for women [7,8,29,32–34].

The presence of a companion for women classified as high risk was considered positively:

> . . . because we know that in this emotional aspect the companionship is 100% of good use . . . [32] (Obstetric nurse, Brazil)

Supporting the psycho-emotional wellbeing of labouring women was considered to affect women's experiences of pain and reduce the need for pain management. '*Managing the pain*', '*removing the pain'* and '*helping them experience less pain'* were key to supporting women in labour and maintaining an emotional calmness [6,8,17,28,29,32]:

> ' . . . . but it is true that removing the pain helps the woman, perhaps it makes her more ready to handle her baby' [8] (Anaesthetist, Canada)
>
> 'I believe that the ball, the bath help delivery occur faster . . . for the woman to feel less pain' [17] (Unknown, Brazil)

For some women, a decision to opt for epidural analgesia was due to a perceived lack of continuous emotional (and physical) support [8].

Although the HCPs recognised the needs of women, at times, it was difficult to respond to those needs giving rise to 'Professional dissonance'.

5. Professional dissonance

5.1. Use of technology at birth

The use of technology as an intervention was thought to remove women from the focus of care, shifting the focus HCPs and their ability to provide task-oriented care:

> 'Care based on interventions and use of invasive procedures and technologies may result in women playing only a secondary role and shifting the leading role to health professionals' [16] (Researcher, Brazil).

The use of technology was found to be particularly important in tertiary level hospitals due to the complicated care needs of women classified as high risk at the time of birth. HCPs recognised their duty to place women above technology and used the practice of humanisation as a method to keep women at the forefront of their priorities [8,16,33]. Humanisation was considered to validate both technical and humane competencies keeping good communication and interpersonal relationships despite the use of technology [6,8]. Refutational data were identified in this subtheme; the use of technology was perceived as acceptable when required but HCPs also articulated a wish to minimise its use where possible.

5.2. Reducing intervention in childbirth

A recognition of the physiology of birth was considered integral to humanisation [7,18];

> 'the humanization of care is as a whole and, in childbirth it is linked to what is physiological, to let physiology act, to let women give birth' [7] (Obstetric nurse, Brazil)

However, this did not limit the pre-requisite for a safe birth and this distinction was a principal focus for the HCP:

> 'when I know that I gave the patient humanized care is when she and the baby are safe, right? . . . when I respect the patient as much as possible and intervene as little as possible . . . . and safety, their safety is the most important to me.' [7] (Obstetric nurse, Brazil)

In order to limit interventions, non-pharmacological methods of pain relief (NPMPR) were offered to women although all NPMPR could only be performed within the *'limits allowed to them within the institution'* [18]. Pharmacological methods of pain relief (PMPR) limits were not identified in the synthesis. The reduction of interventionist practice was seen as key in the provision of humanisation [16,18,29]. The presence of a companion was perceived to be an aspect of NPMPR by some HCPs [17,18,32]. Refutational data were identified through the need for HCPs to respect the physiology of birth and actively reduce intervention whilst simultaneously articulating that there were limits to the provision of NPMPR compared to PMPR.

5.3. Women with 'high risk' pregnancies

For women classified as 'high risk', humanisation in labour and birth was particularly challenging for HCPs as they may require increased emotional supports in their labour and birth [32]. This group of women were perceived to be at risk of losing control over their body and so there was a need to find the balance between medical intervention and the perception of a 'psychological normality' for women [30]. In high-risk care, midwives identified this as a primary focus of the care they provided:

> 'In high risk cases, there are not many things one can do. Perhaps the most important things are done on a psychological level: to accompany, comprehend and support the women.' [30] (Midwife, Japan)

Comprehension and support were identified as *'being with the woman'*, *'being present'*, and *'being available on demand'* [8]. Midwives were identified as key HCPs in creating a 'psychological normality' where the need for a physical connection for the woman and her baby after cesarean birth was articulated:

> 'After the cesarean section, the baby was shown to the mother and the midwife touched the mother's hand with the baby's lips' [29] (Unknown, Japan)

The physical contact between mother and infant was seen to recreate psychological normality. The midwife was required to physically enact what the woman was unable to initiate by herself. Humanisation enhanced high risk childbirth:

> 'Humanised birth is not a case without any medical intervention. Sometimes we need medication . . . we should marry humanised birth with medical intervention just by explanation, communication and maintaining confidence' [30] (Midwife, Japan)

Furthermore, HCPs recognised interventions such as caesarean section birth as humanised practice:

> 'Depending on the case, I think that caesarean section is also part of humanisation, isn't it? I think that, if it gets to a point where there is no more hope for normal delivery, the caesarean is also a relief for the patient' [17] (Unknown, Brazil)

The quote identifies further refutational data suggesting that although the biomedical model was not perceived as opposed to humanisation, there has to be *'no more hope'* of a vaginal birth before humanisation is possible at caesarean birth. Refutational data were also identified where humanisation was identified as needing to be *'as natural as possible'* [18].

Furthermore, HCPs identified women in this cohort as being at risk of non-evidence-based or outdated practice without rationale:

> 'We come across professionals that . . . still insist on an episiotomy, kristeller maneuver . . . ' [32] (Obstetric nurse, Brazil)

5.4. Impact of the environment

The environment impacted on the ability of HCPs to provide humanised birth care [6,8,17,28–30,32]:

> 'When we get a surplus number of births compared to the number of beds, our response may take away a little bit from the humanised care approach...at this point I do not feel very humane when I tell the mother: I'm going to pack your stuff up and take you to the front door' [30] (Nurse, Japan)

The first part of this quote points to a withdrawal of humanised care as the presence of the woman has been removed from the narrative of birth. The latter part of the quote suggests this may be a strategy for HCPs to cope with the competing demands put upon them. The individual needs of a woman are pitted against the safety of a group of women when faced with an infrastructural environment that does not meet their needs.

HCPs attempted to mitigate any lack of infrastructure in the environment and articulated the importance of a friendly, welcoming environment that gave women privacy but also commented that, at times, the environment undermined their efforts for humanised birth [6,17,28,29,32]. The quote below identifies this mitigation where the HCP acknowledged the lack of partitions so stresses that the curtains are closed '*very well*':

> 'Here at our facility, we use curtains to maintain privacy . . . .in our labour ward there are no partitions, so we close the curtains very well' [28] (Skilled health professional, Tanzania)

A tour of the maternity unit considered as humanised practice did not happen for high-risk women who birthed in an obstetric centre because of *'restrictions of the unit which has direct access to the operating room'*. These women were also required to change rooms close to the birth because of deficiencies in the physical infrastructure [32].

Although a companion was perceived as a positive addition in childbirth, suggesting it can reduce tension and support pain management [17], HCPs found this difficult to enact in practice [7,17,18,29,33]:

> 'About the permanence of a partner, this is a bit difficult, even because of the physical space, the accommodations, it's small, there are no dividing walls... [17] (Unknown, Brazil)

6. Line of argument synthesis

Through an iterative process, a line of argument synthesis was developed, connecting all elements of the synthesis [35]:

Invisible boundaries surround women's choice in childbirth. Pain management is important in maintaining emotional equilibrium by any means required. The use of disempowering language suggests that choice for women may be related to HCP preferences.

HCPs identify strengthening supportive measures such as physical touch, yet engage in an **unconscious undermining** of physiology. This undermining occurs by reducing or acquiescing to a limited availability of NPMPR (including the presence of a birth companion) to women within the institution. Women with pregnancies classified as high risk are most impacted.

7. Discussion

This meta-synthesis identified the perspective of the HCP and their understanding of humanisation. The importance of the interactions between women and HCP's through physical and psychological methods was integral to humanisation being enacted. HCP's perceived barriers to enacting humanisation were the use of technology and intervention, the impact of the environment and HCP's had particular difficulty providing humanisation to women classified as high risk. The results have shone a light on the continued use of disempowering language towards women during labour and childbirth [8,28,29]. Words such as 'patient', 'allow', and 'let' suggest that women do not have the choice that HCPs may believe they have. Instead, the decision of the HCP may be the primary indicator as to whether a woman is 'permitted' a particular choice. This concurs with a recent UK observational study of 9 obstetricians and 3 midwives which found that consent for interventions were dominated by clinical framing and risk rather than a woman centered narrative [36].

The concept of humanisation has been used in healthcare across a range of specialties as a process of optimising time, respecting difference, and ensuring a quality in routine procedures whilst maintaining the dignity of those who require the service [20,37]. Understanding the psychological and physical needs of service users in a health facility has previously be recognised as key to a humane health structure and may favour the relationship with HCPs positively [38,39].

The management of pain, either pharmacologically or non-pharmacologically was important for the emotional and physical needs of the women in labour. The requirement for emotional support is aligned with literature on humanisation with agreement that emotional security is essential to care [20].

However, there was a caveat for NPMPR in the synthesis that the provision must be within the scope of the institution. The same caveat was not noted for PMPR. Moreover, the use of PMPR may also increase the compliance of women in labour as their mobility or consciousness is reduced perpetuating the invisible boundaries around choice.

Although HCPs recognised the importance of NPMPR and the impact it may have on reducing intervention by supporting the physiology of childbirth, it may carry less weight with HCPs and be perceived as 'extra' rather than 'standard'. HCPs were comfortable with the use of PMPR even though they were aware of the increased likelihood for intervention in childbirth. For example, the use of NPMPR has been shown to reduce the number of women opting for epidural analgesia [40] and evidence suggests that women may use epidural analgesia to feel more in control of their labour and be less reliant on a midwife [41]. The lack of NPMPR provision and usage may indicate the high rates of medicalisation and the lack of developed midwifery-led care in the countries included in this meta-synthesis. Even so, our findings concur with maternity care literature from the Republic of Ireland, which historically has been obstetric-led with women experiencing a lack of information around NPMPR and little encouragement to investigate alternatives antenatally or in labour [42]. Similar findings have been identified in Australia where midwifery-led care is established [43].

Humanisation of childbirth does not restrict the use of technology or medical intervention. Rebuilding 'midwifery technology', known as the art and skill of midwifery has been proposed as a method to reduce intervention and increase the support of physiology [44]. The increased use of technology in labour and birth may inadvertently and accidentally create a 'force-field' around the labouring woman, adversely impacting the physical relationship between the woman and the HCP. Physical contact between human beings was found to be a visible manifestation of bonding between HCPs and women. In particular, women classified as high risk were identified as a cohort more likely to have their choices reduced, experience lack of evidence based practice [32] and suboptimal humanised practice [30,32]. Yet, although this group may require increased physical and emotional supports, loss of human interaction may arise because of the technological 'forcefield'. In our synthesis there was evidence of HCP 'hiding' technology to provide a '*more natural*' and '*less stressful*' environment [30]. Yet, the literature suggests that some women may see technology in a positive light, finding it a source of security [45].

In times of increased clinical activity, a lack of humanisation manifested. Although HCPs must work towards meeting the needs of each woman, they are also required to maintain safety for all women in their service. Therefore, at times, the needs of the individual may be diminished in favour of the group. This has previously been identified in the literature as 'institutional momentum' [46].

The identification of refutational data in this synthesis are a strength, identifying areas for further development such as the relationship between humanisation and the introduction of intervention through operative or technological means when physiology deviates from the norm. A strength of this synthesis is that HCP's have reiterated their view that humanisation in childbirth is for all women. Furthermore, the synthesis has brought attention to the differences that women classified as high-risk experience in the quest for humanisation. The environmental factors that impede HCP's in providing humanisation in childbirth are outlined and provide information to institutions as well as individuals on the provision of humanisation in childbirth. Limitations of the synthesis are the methodological quality of the studies sampled as well as their location. A prevalence of obstetric-led medicalised services in this meta-synthesis means the concept of humanisation in countries with a well-developed midwifery led service is not known.

8. Conclusion

The study has identified the need for further clarity between the relationship of humanisation in childbirth with choice, technology, and intervention. Refutational data suggested opposing viewpoints in this synthesis. This is particularly important for women classified as high risk whose choices may be limited, may require increased access to technology and an increase in intervention for a safe birth. Boundaries around choice and the use of NPMPR require investigation for all women.

Conflict of interest

None declared.

Ethical statement

Ethical committee approval not required. No humans or animals were directly involved in this research.

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Authors' contributions

MC, ES and PL-W contributed to the design and implementation of the research. MC, ES, MM and PL-W contributed to the analysis of results and the writing of the manuscript. All authors reviewed the final manuscript prior to submission.

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