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Title	Humanisation in pregnancy and childbirth: a concept analysis
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Publication date	2019-12-25
Original Citation	Curtin, M., Savage, E. and Leahy-Warren, P. 'Humanisation in pregnancy and childbirth: A concept analysis', Journal of Clinical Nursing, 29(9-10), pp.1744-1757. https://doi.org/10.1111/jocn.15152
Type of publication	Article (peer-reviewed)
Link to publisher's version	https://onlinelibrary.wiley.com/doi/abs/10.1111/jocn.15152 - 10.1111/jocn.15152
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Download date	2026-10-06 17:46:57
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Humanisation in Pregnancy and Childbirth: A Concept Analysis

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There is no conflict of interest to declare related to this work.

This article has been accepted for publication and undergone full peer review but has not been through the copyediting, typesetting, pagination and proofreading process, which may lead to differences between this version and the Version of Record. Please cite this article as doi: 10.1111/JOCN.15152

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Article type : Discursive Paper

Discursive Article

Title: Humanisation in Pregnancy and Childbirth: A Concept Analysis

Abstract:

Aims and Objectives: To undertake a concept analysis of Humanisation in Pregnancy and Childbirth

Background: Humanisation in pregnancy and childbirth has historically been associated with women who do not require medical intervention. However, the increasing recognition of the importance of emotional and mental health as well as the physical outcome of pregnancy has meant that there is a need to identify clinical attributes and behaviours that contribute to a positive emotional outcome. Failure to support and protect the emotional health of the woman in pregnancy and childbirth can have effects on the long-term mental health of the mother as well as the long term physical and mental health of the child.

Design: Concept Analysis

Methods: Eight step method of concept analysis proposed by Walker and Avant.

Results: Defining attributes include being a protagonist, human being interaction and benevolence. Antecedents identified were a recognition of women's rights, birth models, professional competence and the environment. Consequences were identified for women and healthcare professionals. For women, increased feelings of confidence, satisfaction of the experience and safety. For healthcare professionals, increased satisfaction and confidence in their job and increased esteem in their profession.

Conclusions: Humanisation of pregnancy and childbirth now encompasses all women regardless of care pathway. Humanisation does not obstruct the prioritization of life saving procedures or the use of medical intervention where required.

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Relevance to clinical practice: Women who are able to identify their rights when accessing maternity care will be better equipped to ensure their care planning is individualised. The identification of humanised care practices, attributes and behaviours can support healthcare professionals in the clinical area who wish to identify a pathway of humanised care in pregnancy and birth.

Keywords: Humanisation, Pregnancy, Labour, Birth, concept analysis,

What does this article contribute to the wider global community?

- This concept analysis allows humanisation in pregnancy and childbirth to be either technical or non-technical and supports the prioritisation of life saving measures over humanisation
- The identification of clinical practice attributes and behaviours that can be recognised as humanised in pregnancy and childbirth for healthcare professionals working within maternity services.
- Humanisation should not be considered in opposition to the biomedical model of childbirth

Main Text:

1. Aims

The aim of this concept analysis is to clarify the concept of humanisation in pregnancy and childbirth using the eight-step process by Walker and Avant (2011).

2. Background

The concept of the humanisation of childbirth grew from the need to minimise the effects of the patriarchal and biomedical model of childbirth on women, which has been the predominant model in use since birth moved from the home to the hospital in the middle of the twentieth century (Prosen & Tavčar Krajnc, 2013). The emotional health of a woman in pregnancy has already been identified as a precursor for positive mental health in the antenatal period. Furthermore, poor mental health within the antenatal period has been identified as a risk for increased mental illness in the postnatal period, such as postnatal depression, as well as increased long term detrimental effects outside of the puerperium. In addition to this, there are long term negative outcomes such as the increased risk of low

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birth weight, reduced growth and poor psychological outcomes for their child (der Waerden et al., 2017; Eastwood et al., 2017). Navaratne, Foo, and Kumar (2016) found that women who score highly for depressive symptoms in pregnancy are more likely to have poorer outcomes at birth for their neonate. The promotion of positive emotional health of the mother at the time of labour and birth have also been identified as integral to the provision of care provided by healthcare professionals (*World Health Organisation*, 2018). Therefore, there is a need to minimise where possible, negative interactions between the woman and healthcare professionals (e.g. midwives, obstetricians or obstetric nurses) that women may find negative in both pregnancy and birth to protect both short- and long-term adverse health outcomes for the woman and her infant.

Following birth, women are required to recover from the physical challenges of birth as well as begin the adaptation to the psychosocial changes that are associated to their new role of motherhood (Fahey & Shenassa, 2013). Historically, this recovery of pregnancy and birth focused on the physical recovery (Byrom, Edwards, & Bick, 2009) but due to an increasing body of evidence identifying the mistreatment and disrespect of women during pregnancy and childbirth, the emotional and psychological impact of pregnancy and birth is gaining attention (d'Oliveira, Diniz, & Schraiber, 2002; Savage & Castro, 2017). The Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE-UK) report (2015) identified mental health as the only increasing direct cause of maternal death within the first six weeks of birth. Furthermore, due to the detrimental effect of poor mental health on both the woman and child there has been a change in narrative to now encompass the importance of empathy and care for women in pregnancy and childbirth such as 'Respectful Maternity Care' whilst emphasising negative practices such as 'Obstetric violence'. There is continued debate in reaching consensus when attempting to define terms such as 'normal' and 'high risk' and this contributes to the blurring of lines in the clinical practice arena. However, regardless of the definition of normal and/or high risk, pregnant women have consistently requested care that provides confidence, trust, respect and privacy, decision making and control (Bell & Andersson, 2016; Berg & Dahlberg, 1998; Hodnett, 2002). This suggests the attitudes and behaviours in pregnancy and birth are more important than the definitions and practice of normal, high risk and/or physiological birth. However, the specific attitudes and behaviours are yet to be identified by the term 'respectful maternity care' (Shakibazadeh et al., 2018). Due to the broadness of this term,

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humanisation is being assessed as a separate entity to 'respectful maternity care' in this paper.

Humanisation in the context of childbirth has been criticised for becoming a term synonymous with low risk or normal birth only (Behruzi, Hatem, Goulet, & Fraser, 2014; Lindsay, 2006). However, healthcare professionals have not made this assumption (Behruzi, Hatem, Goulet, et al., 2010). This assumption may have gained traction where humanisation of childbirth has been advocated to reduce over medicalised birth. The gynaecological and obstetrical technological developments in the second half of the twentieth century did not coincide with evidence based research which has led to the excessive use of and over reliance on medical practices that are not always necessarily beneficial or evidence based (Miller et al., 2016). Villar et al. (2006) argued that this has contributed to iatrogenic morbidity and increased the dehumanisation of care for women. Due to this, humanisation is often considered as the antithesis of the biomedical model and has been suggested as the 'saviour' of women from what is potentially an otherwise technocratic experience of childbirth (Malheiros, Alves, Rangel, & Vargens, 2012).

According to Lindsay (2006) women considered to be of high obstetric risk by clinicians in pregnancy and birth may find that their 'optimum care' centres around the medical technology available for maternal and fetal monitoring rather than on the holistic care required to support the woman emotionally as well as medically. The emotional needs of women who are categorised as 'high risk' may be of particular importance considering they are more likely to experience negative emotions and hardship (Mackenzie, Murray, & Lusher, 2018). Yet, regardless of the risk status of the woman, the experience of care should be considered as important as the clinical care provision (Downe, Finlayson, Oladapo, Bonet, & Gulmezoglu, 2018). Furthermore, the non-clinical intrapartum practices such as emotional support in labour which is relatively inexpensive to implement is an essential component of the experience but may not always be regarded as a priority in many care settings (World Health Organisation 2018).

Humanisation has been used in a number of different spheres of healthcare and can therefore be described as 'polysemic' meaning that the word humanisation may have more than one meaning or connotation depending on its application. The multiple uses across health systems implies there is no clear definition for the concept of humanisation. In particular, there have been multiple definitions of humanisation identified relating to

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pregnancy and childbirth (Behruzi et al., 2014). However, Behruzi, Hatem, Goulet, et al. (2010) found that healthcare professionals, identified as midwives and obstetricians, do not feel that humanised birth can be limited to a specific definition of list of tasks and is instead an individual process for each woman. Therefore, the concept of humanisation relating to pregnancy and childbirth specifically would benefit from a clearer understanding in the clinical area in order to support the formulation of future policy and care planning for women in pregnancy and birth.

3. Design

3.1 Walker and Avant method

Walker and Avant (2011) eight step method was used in order to analyse the concept of humanisation in pregnancy and childbirth. The eight steps required to complete the concept analysis can be seen in Table 1.

According to Walker and Avant (2011), concept analysis is a process of examining the basic elements of a concept, defined as a formal, linguistic exercise to determine defining attributes of a concept. Therefore, an analysis of a concept may create an expression that will characterise particular behaviours which can be further evaluated in the future.

4. Method

4.1 Search Strategy

A systematic search of the databases was conducted using the Preferred reporting items for systematic reviews and meta-analyses principles ("PRISMA," 2015) of the electronic databases including CINAHL, Medline, PsychInfo, and SocINDEX (See table 2). The terms used were ‘humanis*’, ‘humaniz*’, ‘humane’, ‘humanism’, combined with ‘pregnancy’, ‘perinatal;’, ‘antenatal’, ‘antepartum’, ‘labour’, ‘birth’, ‘childbirth’. The database search was completed in May 2018. The search yielded 1581 papers and after accounting for duplicates and removing articles relating to ‘humanitarianism’ or ‘humanitarian’ there were 1174 papers remaining which were reviewed via their abstract for suitability. Inclusion criteria were primary and secondary research regarding pregnancy and childbirth that had some focus on: humanisation, actions and behaviours of healthcare professionals, the perspectives of

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women. In addition, papers and scholarly books that addressed an element or a definition of humanisation and those available in full text written in the English language were included. The exclusion criteria consisted of publications such as commentaries, letters, opinion papers and editorials. Other papers excluded were those that discussed humanisation outside of pregnancy and childbirth (including the postnatal period), focused on animals instead of human subjects, stillbirth or humanitarianism. The number of papers gleaned from the search strategy was one hundred and sixty-two. Two authors (MC, PL-W) independently screened the articles and discussed their decisions and ensured agreement on the final fifty-seven papers that were included. The third author (ES) adjudicated where final consensus was needed. The screening was facilitated using EndNote X8 with shared folders for transparency between authors. This robust search strategy ensured the literature was assessed independently and reduced the risk of researcher bias.

4.2 Uses of the concept

There were fifty- seven research articles, one book chapter and the Oxford English dictionary definition of humanisation included in the analysis.

The fifty-seven final sources included thirty-five qualitative studies, ten quantitative (one RCT) and one mixed methods study. In addition, there were a number of reviews which were either descriptive, integrative or retrospective and a conceptual framework (n=11) which included papers that gave a particular context, narratives of women or a historical perspective. The papers were from a total of eighteen countries (see table 3). The majority of countries were upper middle (4) or high income (11) countries in accordance with the World Bank identification of low, middle- and high-income studies. The country with the highest number of humanisation studies was Brazil with twenty-seven studies ("World Bank," 2017) (Table 3).

Humanisation and relevant uses of the concept have been reported in a number of different subject areas such as theology; genetics and immunology; abortion and work organisation as well as the discipline of midwifery. Humanisation has been defined (under ‘humanise’) as to ‘make something more human’ and to ‘give it a human character’ signifying that the concept revolves around the human nature of the person (Humanize, 2019)

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4.3 Defining Attributes

Three defining attributes were identified from the papers analysed. Characteristics that appeared repeatedly within the literature were identified by researchers (MC, PL-W) until consensus was reached. Defining the attributes ensures the differentiation of the concept from a related or similar one. The defining attributes that were identified were: Human Being Interactions; Benevolence and Being a Protagonist (See figure I).

4.3.1 Human Being Interaction

The interaction of human beings encompassed communication, attentiveness, sensitivity, encouragement and collaboration. For the healthcare professional, this will result in a reduction of authoritarianism and an increased climate of trust (Table 4).

4.3.2 Benevolence

Benevolence has been defined as a desire to do good to others or kindness (Benevolence, 2019). In the analysis, recurring themes were identified that encompassed behaviours and attitudes when considering the practice of humanisation in pregnancy and childbirth. Benevolence included patience, tolerance, politeness, caring and strength whilst acknowledged the need for a positive attitude and optimism in order to support the woman and her family (Table 4) .

4.3.3 Being a protagonist

The analysis identified the presence of at least one protagonist in order for humanisation to occur in pregnancy and childbirth. The protagonist may be a healthcare professional or the woman (de Lima Escobal et al., 2018; Rubia Coelho & Maureira Vergara, 2015) but is required to ensure that the woman retains her active potential in pregnancy and birth, meaning that the woman maintains a level of control and decision making throughout her pregnancy and birth (Almeida & Tanaka, 2009). In the intrapartum period particularly, this also involves an increased need for a positive working relationship with the care-giver that promotes shared decision making (Hastings-Tolsma, Nolte, & Temane, 2018; Nepomuceno de Paiva, Lemos, & de Souza, 2017) (Table 4).

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4.4 Case Examples

The case examples are presented using the defining attributes to further extricate the concept of Humanisation in Pregnancy and Childbirth. These are hypothetical cases based on the author's experience in clinical practice.

Emily is 39 weeks pregnant and in spontaneous labour. She has attended the labour ward to confirm that she is in established labour. On arrival to the delivery suite, she is welcomed by the midwife with positive regard who ensures that she is as comfortable as possible. The midwife discusses Emily's pregnancy and asks questions regarding her spontaneous labour whilst also showing understanding that Emily is having some pain and needs some extra time to formulate her responses. Emily prepared a birth plan where she has documented her preferences for birth and has requested within the plan that consent is gained prior to any procedure being undertaken. Emily has requested, if possible, to avoid episiotomy. The midwife reviews the information on the birth plan and discusses her pre-labour requests to identify if there are any contraindications. Emily and the midwife agree that they will continue with the birth plan and in the result that any deviation is required they will discuss together to find an agreeable solution.

4.4.1 Model Case

Rationale;

This model case encompasses each of the defining attributes within the concept analysis. Emily and the midwife interacted and communicated with each other with benevolence showing both attentiveness and sensitivity whilst using a collaborative approach for the ongoing plan of care. The midwife showed patience and politeness within her interaction with Emily. Emily was the protagonist of her care by writing and communicating her birth plan with her preferences for birth. Although Emily remained as an active participant in her care, the midwife assumed a shared responsibility for decisions going forward, which Emily was in agreement with and supported.

4.5 Additional Cases

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Anna is admitted to the hospital in labour. Her cervix is five centimetres dilated. She had planned to use non-pharmacological methods of pain relief but has now decided to opt for epidural analgesia. Due to a shift changeover, a new midwife is now present. The midwife has introduced herself and spoke to Anna on arrival but has since been working in silence on the computer within the room. Anna is waiting for the midwife to complete her tasks but has some questions regarding her ongoing care now that an epidural has been sited such as 'Can I got to the toilet?' and 'Can I get up and move?'. Anna tells the midwife that she has some questions, but the midwife does not answer immediately. When she does respond she replies, 'Just one minute'. Anna is uncertain of what to do next as she feels that the midwife is not communicating with her as she should be.

4.5.1 Borderline Case

Rationale;

This is a borderline case as the attribute of human being interaction is absent. Anna has shown the ability to be a protagonist by altering her birth plan to suit her needs to labour from non-pharmacological to pharmacological pain relief. There is also evidence of benevolence as the midwife and Anna have spoken and began a relationship with positive regard for each other. However, the lack of human being interaction disrupts the humanisation of care.

Josephine has been admitted to the labour ward in labour with some pain. She is twenty-eight weeks pregnant and further to an assessment is not currently in labour. Josephine calls the midwife as she feels that something is between her legs and she thinks her membranes have ruptured. On arrival, the midwife diagnoses a cord prolapse. Josephine is told to adopt the knee chest position and the emergency bell is pressed. The midwife tells Josephine that she will require an emergency caesarean section urgently. The obstetrician arrives and speaks to Josephine requesting verbal consent and explaining the risks of caesarean section verbally. This conversation occurs whilst Josephine is on a bed, which is being transferred to the theatre. On arrival to theatre, the multi-disciplinary team are present, and Josephine is verbally consented for a general anaesthetic by the anaesthetist.

4.5.2 Related Case

Rationale;

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This is an example of a related case as there is human being interaction, but it is not in an ideal manner as only verbal consent is gained for caesarean section and general anaesthetic whilst the woman is on a moving bed. The woman is also in a position that, although beneficial to the fetus, makes it difficult to communicate with others. The urgency of the situation meant that there is little time to build a relationship to support the defining attribute of benevolence or the equal human being interaction. The urgency also means that there is no time for discussion regarding the information she is told. However, although this could be considered as non-humanised, by default that the defining attributes are not met, the life-saving requirements of the action mean that the humanisation relationship was not affected. The attribute of 'Being a protagonist' in this scenario is absent and any decision making the woman makes is for life saving purposes and not due to choice.

4.5.3 Contrary Case

Elizabeth is having her second baby and has been admitted to a four bedded antenatal ward after administration of prostin gel for an induction of labour. Her cardiotocograph (CTG) following this procedure was reassuring and has been discontinued. Elizabeth is now mobilizing and awaiting further events. Approximately one hour later, Elizabeth presses the call bell as she feels that she is contracting and in labour. The midwife arrives and Elizabeth explains to the midwife that she thinks the baby is coming soon. The midwife comes to the bedside for a short time and informs Elizabeth that it is too soon to have the baby as yet and in conversation also tells Elizabeth that the labour ward is very busy, and she will need to wait until she is much further in labour. The midwife does not provide further support and encouragement, equipment to support labour or offer pain relief. Elizabeth does not wish to upset the midwife so does not call again. After a short time, Elizabeth presses the bell again to tell the midwife that she feels she needs to push. On inspection, the vertex is visible, and a live female infant is born on the four bedded bay in the antenatal ward.

Rationale;

This is a contrary case as it is a clear example of what humanisation in pregnancy and childbirth is not. Elizabeth did have some human being interaction, although minimal, and it did not provide Elizabeth with the attentiveness, sensitivity, encouragement and reassurance she required. Furthermore, even when human being interaction is short it can still contain benevolence. The defining attribute of benevolence was not present in this example as Elizabeth was not provided with any caring or politeness. This can be seen when Elizabeth was not asked if she required support with the use of analgesia or equipment for

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labour such as a gym ball for pain relief. There was no protagonist in this case example, shown by the lack of supportive measures offered or given, and the lack of accepting shared responsibility of the care Elizabeth was provided.

4.6 Antecedents and Consequences

4.6.1 Antecedents

The antecedents of humanisation identified in the literature are 1. Recognition of women's rights, 2. Birth models, 3. Professional competence, 4. Environment (See figure II).

Recognition of women's rights

The recognition of women's rights was identified through the need for respecting the woman by healthcare practitioners and supporting their beliefs and values. The acknowledgement that women are not passive objects is a recognition of their rights in maternity care. Healthcare professionals require updating on the rights of woman in pregnancy and labour as a matter of course in their practice. Mabuchi and Fustinoni (2008) suggest that women's wishes should be goals to be obtained whilst the importance of spirituality and a willingness for healthcare professionals to deal with the wider cultural beliefs of the women rather than those that are in the physical domain only have also been documented (Table 5).

Birth Models

The availability of a range of birth models to meet the needs of all women regardless of their medical need or risk status ensures that all women can access humanised care practices when and where necessary. This is different to the original emergence of the concept, which was considered to be in direct opposition to the medical model of childbirth. This change allows the women who require the use of technology, a medical model of pregnancy and childbirth and the potential need for lifesaving practices to access and demand humanisation practices in pregnancy and childbirth as well as those who do not. In short, this research allows humanisation to be either technical or non-technical and supports the prioritization of life saving measures over humanisation. Although this is a

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positive step, as it encompasses all women, the use of technology must be appropriate and its rationale for use must be evidence based. The presence of a companion during birth also featured throughout the data. There was also a particular focus on family-centred care in contrast to women-centred care only (Table 5).

Professional Competence

Professional competence was identified by women and healthcare professionals. Midwives and obstetricians highlighted the need to self-critique and reflect on their practice to ensure their ability to uphold safe practice and be open to changes in practice. Both women and their care-givers recognised the need for emotional skills as well as the competent practice skills of the midwives and obstetricians providing care. Therefore, there was a need to ensure healthcare professionals were adequately educated in humanisation practices (Table 5).

Environment

The antecedent 'environment' was wide ranging and included the practice setting such as the hospital, home, birth centre and also the physical environment provided to the woman and her family such as lighting and equipment. The environment needs to be welcoming, private, safe, peaceful and supportive (Table 5).

4.6.2 Consequences

There were six consequences identified regarding the concept of humanisation in pregnancy and childbirth which can be separated into those for women and for healthcare professionals. For women, consequences were: satisfaction of experience (D'Ambruoso, Abbey, & Hussein, 2005), increased feelings of confidence (also identified as empowerment) (Behruzi, Hatem, Goulet, et al., 2010; Sandall, Devane, Soltani, Hatem, & Gates, 2010; Torres de Melo et al., 2017), and feelings of safety (Suarez-Cortes, Armero-Barranco, Canteras-Jordana, & Martinez-Roche, 2015).

For healthcare professionals, the three consequences were satisfaction of the job which included all areas of medicalised and non-medicalised care provided (Conesa Ferrer, Canteras Jordana, Ballesteros Meseguer, Carrillo Garcia, & Martinez Roche, 2016). An

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increase in the esteem of their profession and in their practice (Fujita et al., 2012) and the empowerment of staff which built confidence in changing practice.

4.7 Empirical Referents

The quantitative measurement of 'humanisation in pregnancy and childbirth' has been assessed in a number of ways including the use of the childbirth companion intervention (Brown, Hofmeyr, Nikodem, Smith, & Garner, 2007) and the Women's views of birth and labour satisfaction questionnaire (Conesa Ferrer et al., 2016). Questionnaires used in the research were validated for their reliability using pre-testing (Baldisserotto, Filha, & Gama, 2016; Oliveira Morais, do Nascimento Paz, & de Matos Bezerra, 2017). The majority of the qualitative research was undertaken using semi-structured interviews (Behruzi, Hatem, Fraser, et al., 2010; Behruzi, Hatem, Goulet, et al., 2010; Behruzi et al., 2014; Colomar et al., 2014; Fujita et al., 2012; Jimenez, Mc, Hivon, & Mason, 2010; Morais et al., 2016; Nogueira Giantaglia et al., 2017; Possati, Prates, Cremonese, Scarton, Alves, & Ressel, 2017; Quadros, Reis, & Colomé, 2016; Torres de Melo et al., 2017; P. Vargas et al., 2014) whilst four studies were undertaken from a phenomenological perspective (Bondas, 2002; de Cássia Versiani, Barbieri, Gabrielloni, & Fustinoni, 2015; Mab, Gm, & Vp, 2007; Mabuchi & Fustinoni, 2008). The timing of the data collection in both qualitative and quantitative research was varied from the antenatal period to the postnatal period (Araújo Rocha et al., 2015; Oliveira Morais et al., 2017; Silva, Fernandes, Silva Louzada Paes, Souza, & Aparecida Almeida Duque, 2016; P. Vargas et al., 2014). There were also specific timings in the postnatal period such as the first twenty four hours (Araújo Rocha et al., 2015), within 48 hours (Cipolletta & Sperotto, 2012) between 3-5 days (Boryri, Noori, Teimouri, & Yaghobinia, 2016), and in the first 6 months (Hastings-Tolsma et al., 2018) affirming that there is no fixed timeframe to interview women after birth. One qualitative study collected data in both the antenatal and postnatal period (Jimenez et al., 2010). There were also a range of inclusion criteria such as primigravida only (Cipolletta & Sperotto, 2012; Silveira de Quadros, da Rosa dos Reis, & Silveira Colomé, 2016; Suarez-Cortes et al., 2015) or vaginal birth only removing women of higher risk and/or who had undergone caesarean section (Araújo Rocha et al., 2015; Bernardino Foster, Almeida de Oliveira, & Oliveira Caixeiro Brandão, 2017; Boryri et al., 2016; Knupp Medeiros et al., 2016; Oliveira Morais et al., 2017; Silveira de Quadros et al., 2016; P. Vargas et al., 2014). One study included women who were of low risk antenatally

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and had a spontaneous labour or an induction of labour (Baldisserotto et al., 2016). All studies requested that women were over 18 years old except for one study specifically researching teenage pregnancy (P. Vargas et al., 2014). There was only one mixed methods study thereby highlighting the dearth of research integrating both qualitative and quantitative data (Binfa, Pantoja, Ortiz, Gurovich, & Cavada, 2013). Identifiers for the concept of humanisation in pregnancy and childbirth in practice could be considered as:

1. The use of a birth plan which would support the defining attribute of being a protagonist for both the woman and the midwife who uses the plan to provide care in labour.
2. Continuous care audits showing appropriate midwife to birth ratios and recognising the defining attribute of human being interaction as protected so that the relationship between the woman and the midwife can be established. An evaluation of care provided by women who use the service and of the workplace by healthcare professionals. As these are considered direct consequences of humanisation practices, the outcomes may point towards where changes are required. Evidence of individualised care practices such as multidisciplinary meetings for specific requests outside of normal practice and supportive pathways for women to discuss their wishes
3. The access to a range of birth models that are safe, occurring in differing environments.
4. The support of a birth companion as and when the woman requests.

5. Discussion

It is important to note that the concept of humanisation assesses the attitudes and behaviours of healthcare professionals in clinical practice rather than identifying the human nature of women. The ongoing change in the concept of humanisation within pregnancy and childbirth centres on the fact that it has widened its scope to include all women regardless of their medical need or risk status. However, the research, at times, continues to exclude women who are not considered 'low risk' or who are multigravidas. This expansion of the concept to include all women, is further supported by the increasing acknowledgement that

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the physical outcomes of a pregnancy, although important, should not be considered in isolation and without consideration of the emotional and mental impact of pregnancy and birth. In order for women to feel that their care is individualised from the beginning of their pregnancy, women must have access to a choice of birth models which are easily changeable if required. Therefore, care provided should be by the right person at the right time maintaining the safety of the woman and her fetus at all times. Birth plans continue to give a voice to women in labour and act as the protagonist for their care allowing the maintenance of individuality and should therefore be promoted and encouraged. However, women also need to be briefed on the need for collaboration in pregnancy and childbirth so that they can adjust their plans accordingly if their needs or the needs of the fetus change. This is of particular importance in tertiary level maternity units where life-saving measures are more likely required due to the complications women may experience in their pregnancy. Such decisions can only be made if the concept of humanisation is fundamental to all midwifery and obstetric practice and the biomedical or technological model of birth is only considered as and when required. This concept analysis has identified that neither women, midwives or obstetricians perceive the use of medicalisation as obstructing their ability in providing humanised care. In fact, the opposite was found to be the case; that the use of technology was highly valued – if it was used appropriately. Although initially, the identification of supporting life-saving measures as a part of humanised care rather than opposed to it may seem counter intuitive, women have identified a transparency of information as integral to continuing humanised care even when life saving measures are required. Moreover, the research also identified the agreement of women, midwives and obstetricians on the need for professional competence regardless of the model of birth or the technology used and ongoing education so that all healthcare professionals can provide humanised practices with or without a medical model of care.

The research confirms that although important, the physical outcome of birth should not be considered the only outcome. Women are content with the need for emergency care and the priority of life saving care over humanisation, but this should not impact the overall care provided. Although this concept analysis has also identified a number of benefits to the confidence and self-esteem of healthcare professionals who practice humanisation, healthcare professionals will also require the appropriate training in order to build on their

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own professional practise and uphold the professional values associated with their professions.

6. Conclusion

Humanisation must no longer be considered as a concept opposed to the biomedical model of childbirth but instead must be the first and fundamental approach applied by care providers for all women. In the event that women require medical intervention, humanisation practices should continue in conjunction with the biomedical model. Women, as well as healthcare professionals have a responsibility to strive for more individualised care that is both evidence based and safe whilst meeting their specific needs. However, this can only be provided if women have a clear understanding of their rights available to them in pregnancy and childbirth. Education of both healthcare professionals and women on this matter as well as the concept as a whole is required. Further research is required to specifically identify humanisation in the clinical practice area to further promote and advocate it for all women in pregnancy and childbirth and this should take into consideration the risk status and gravida of women.

7. Relevance to Clinical Practice

For women:

A stronger vision of their expectations in pregnancy and childbirth and the need for a collaborative approach with their care giver. In order for this to be provided, women must become familiar with their rights within the country and the sphere of maternity services they plan to give birth in so they can begin to identify humanised practices in the healthcare professional.

For healthcare professionals:

This analysis has provided some identification of practice attributes and behaviours that can be recognised as humanised in pregnancy and childbirth for healthcare professionals working within maternity services. A clearer understanding of these behaviours is likely to

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promote further satisfaction for women and increased self-esteem in the professional role. Healthcare professionals should not be concerned with over-riding humanisation in times of life saving procedures as women have identified the need for professional competence in the first instance.

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Tables:

Table 1: Walker and Avant eight-step method

The eight-step method: Walker and Avant (2011)	
1	**Select a concept**
2	Determine the aims or purposes of analysis
3	Identify all uses of the concept that you can discover
4	Determine the defining attributes
5	Identify a model case
6	Identify borderline, relative, contrary, invented and illegitimate case
7	Identify antecedents and consequences
8	Define empirical referents

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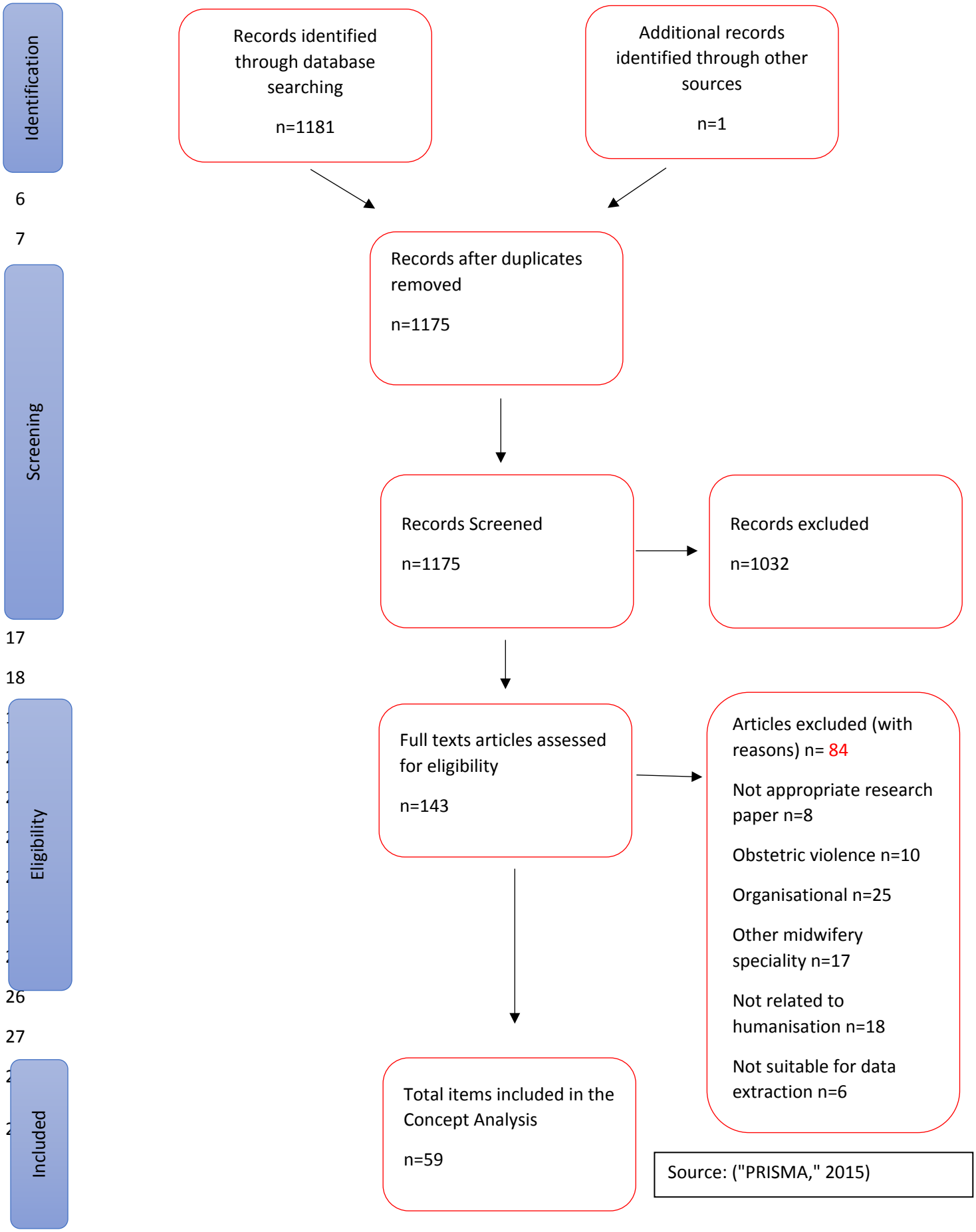
Table 2 - PRISMA



Source: ("PRISMA," 2015)

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1

2 Table 3: World Bank Data

World Bank Data			
Higher Income	**Upper Middle Income**	**Lower Middle Income**	**Lower Income**
Canada	Brazil	Ghana	Benin
Chile	Iran	Nicaragua	
Czechoslovakia	Mexico		
Denmark	South Africa		
Finland			
Italy			
Japan			
New Zealand			
Slovenia			
Spain			
United Kingdom			

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Table 4:Defining Attributes

Defining Attributes					
Human Being Interaction	**References**	**Benevolence**	**References**	**Being a Protagonist**	**References**
Communication	(Araújo Rocha et al., 2015; Baldisserotto et al., 2016; Behruzi, Hatem, Fraser, et al., 2010; Behruzi, Hatem, Goulet, Fraser, & Misago, 2013; Behruzi et al., 2014)	Patience	(D'Ambruoso et al., 2005; P. Vargas et al., 2014)	Presence	(Baldisserotto et al., 2016; Basso & Monticelli, 2010; Carvalho de Matos et al., 2017; Cordeiro Xavier de Barros et al., 2018; Fujita et al., 2012; Mabuchi & Fustinoni, 2008; Possati, Prates, Cremonese, Scarton, Alves, & Ressel, 2017; Silva et al., 2016; Suarez-Cortes et al., 2015; Torres

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					de Melo et al., 2017; P. B. Vargas et al., 2014)
Attentiveness	(Almeida & Tanaka, 2009; Carvalho de Matos et al., 2017; Evans, Watts, & Gratton, 2015; Mab et al., 2007; Overgaard, Fenger-Gron, & Sandall, 2012; Sandall et al., 2010; Schultz Camillo et al., 2016)	Tolerance	(Bondas, 2002; D'Ambruoso et al., 2005)		
Sensitivity	(Antunes Ramos, Costa Aguiar, Conrad, Pinto, & Mussumeci, 2018; Freitas, Atherino dos, Collaço Sorgatto,	Politeness	(D'Ambruoso et al., 2005),		

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	Granemann, & Bona, 2011; Lenho de Figueiredo Pereira, de FÃ¡tima da Silva AraÃºjo Nagipe, Parrilha Vieira Lima, Damazio do Nascimento, & da Silva Ferreira Gouveia, 2012; Nepomuceno de Paiva et al., 2017; Page, 2001; Possati, Prates, Cremonese, Scarton, Alves, & Ressel, 2017; Torres de Melo et al., 2017),				
Encouragement and Collaboration	(Cipolletta & Sperotto, 2012; D'Ambruoso et al.,	Caring and Strength	(Behruzi, Hatem, Goulet, et al., 2010; Behruzi et al., 2014;		

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	2005; Newnham, McKellar, & Pincombe, 2018)		D'Ambruoso et al., 2005; da Motta, Rinne, & Naziri, 2006; Freitas et al., 2011; Schultz Camillo et al., 2016; P. Vargas et al., 2014)		
Reduction of authoritarianism	(Carvalho de Matos et al., 2017; Cipolletta & Sperotto, 2012).	Positive attitude/Optimism	Cordeiro Xavier de Barros et al. (2018)		
Increased climate of trust	(Carvalho de Matos et al., 2017; Cipolletta & Sperotto, 2012).				

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Table 5: Antecedents

Antecedents							
Recognition of Women's rights	**References**	**Birth Models**	**References**	**Professional Competence**	**References**	**Environment**	**References**
Updating of the rights of women in pregnancy and labour in practice	(Baldisserotto et al., 2016; Behruzi et al., 2014; Carvalho de Matos et al., 2017; Dodou et al., 2014; Knupp	Life saving measures over humanisation	(Behruzi, Hatem, Goulet, Fraser, & Misago, 2011; Behruzi et al., 2014; Versiani, Barbieri, Gabrielloni, &	Need for competence in practise	(Behruzi et al., 2011; Bondas, 2002; Colomar et al., 2014; Page, 2001;	Physical: Lighting, equipment, venue	(Bernardino Foster et al., 2017; Evans et al., 2015; Lenho de Figueiredo Pereira et

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	Medeiros et al., 2016; Nepomuceno de Paiva et al., 2017; Newnham et al., 2018; Possati, Prates, Cremonese, Scarton, Alves, Ressel, et al., 2017; P. Vargas et al., 2014)		Fustinoni, 2015)		Rubia Coelho & Maureira Vergara, 2015; Wagner, 2001)		al., 2012; Newnham et al., 2018; Overgaard et al., 2012; Sandall et al., 2010)
Importance of spirituality and wider cultural beliefs	(Behruzi et al., 2011; Boryri et al., 2016)	Use of technology appropriate and evidence based	(Behruzi, Hatem, Goulet, et al., 2010; Sreenivas, Cohen, Magaña-Valladares, & Walker, 2015; Torres de Melo et al., 2017;	Self-critique of practise	(Fujita et al., 2012; Smith, 2016; Sreenivas et al., 2015)	Welcoming	(Bernardino Foster et al., 2017; Lenho de Figueiredo Pereira et al., 2012; Mabuchi &

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			Wagner, 2001)				Fustinoni, 2008; Torres de Melo et al., 2017)
		Presence of a companion	(Antunes Ramos et al., 2018; Baldisserotto et al., 2016; Brown et al., 2007; Carvalho de Matos et al., 2017; Colomar et al., 2014; da Motta et al., 2006; Dayana Dodou et al., 2014; de Cássia Versiani et al., 2015; Knupp Medeiros et al.,	Need for emotional as well as practical skills	(Mab et al., 2007; Nepomuceno de Paiva et al., 2017)	Private	(Bernardino Foster et al., 2017; Oliveira et al., 2017)

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			2016; Koller Kologeski, Strapasson, Schneider, & Renosto, 2017; Lenho de Figueiredo Pereira et al., 2012; Mab et al., 2007; Mabuchi & Fustinoni, 2008; Newnham et al., 2018; Nogueira Giantaglia et al., 2017; Oliveira, Assis, Amaral, Falone, & Salviano, 2017; Overgaard et al., 2012; Silveira de				

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			Quadros et al., 2016; Torres de Melo et al., 2017; P. Vargas et al., 2014)				
		Family centered care	(Behruzi et al., 2011; Behruzi et al., 2014; Bondas, 2002; Cordeiro Xavier de Barros et al., 2018; Fujita et al., 2012; Jimenez et al., 2010)	Education of humanisation for health care professionals	(Schultz Camillo et al., 2016; Sreenivas, Cohen, Magaña-Valladares, & Walker, 2015)	Safe	(Behruzi, Hatem, Fraser, et al., 2010; Behruzi, Hatem, Goulet, et al., 2010; Colomar et al., 2014)
						Peaceful	(Cipolletta & Sperotto, 2012; Evans et al., 2015; Torres de

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							Melo et al., 2017)
						Supportive	(Behruzi, Hatem, Fraser, et al., 2010; Fujita et al., 2012)

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Figure Legends

Figure I: Defining Attributes

Figure II: Antecedents

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Figure I:

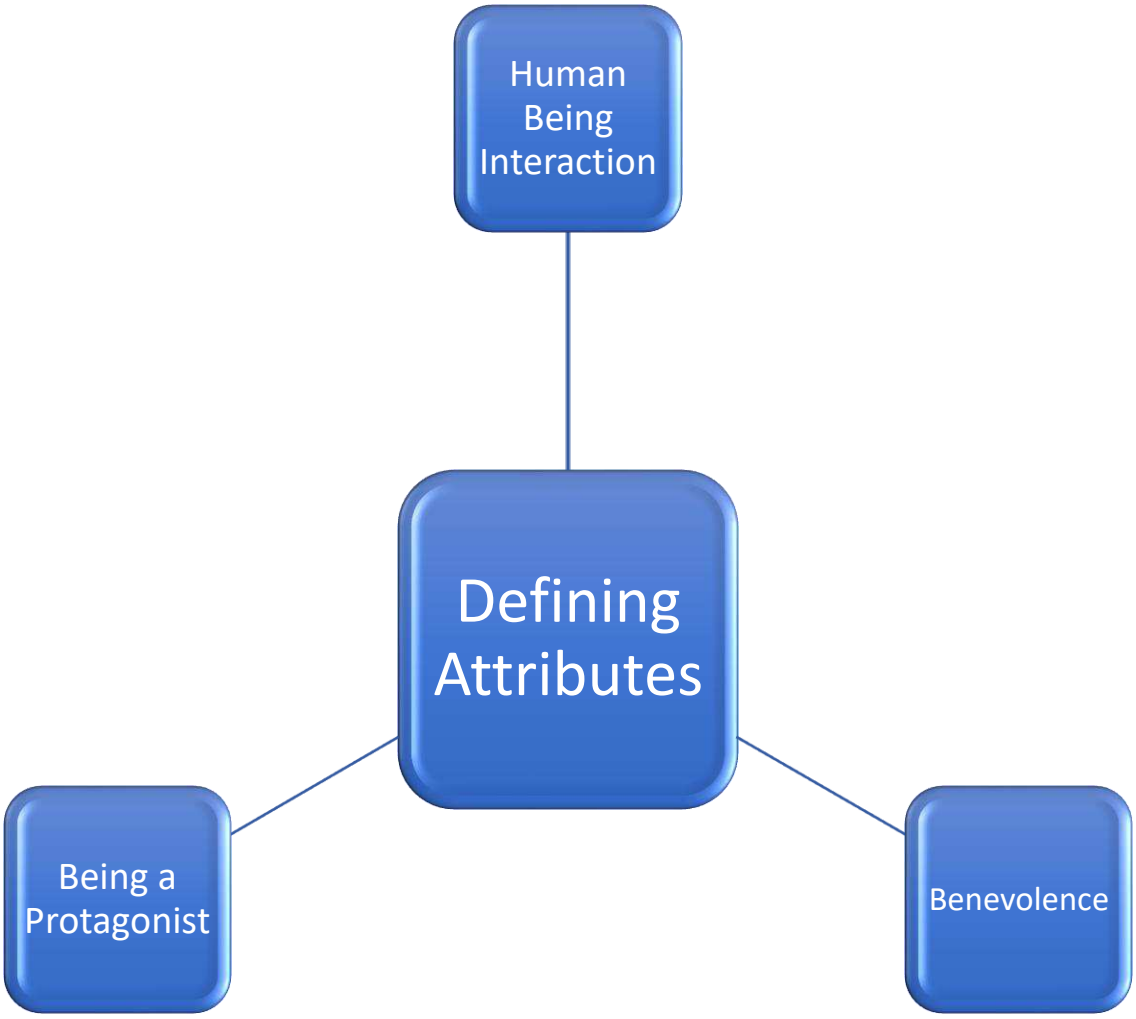

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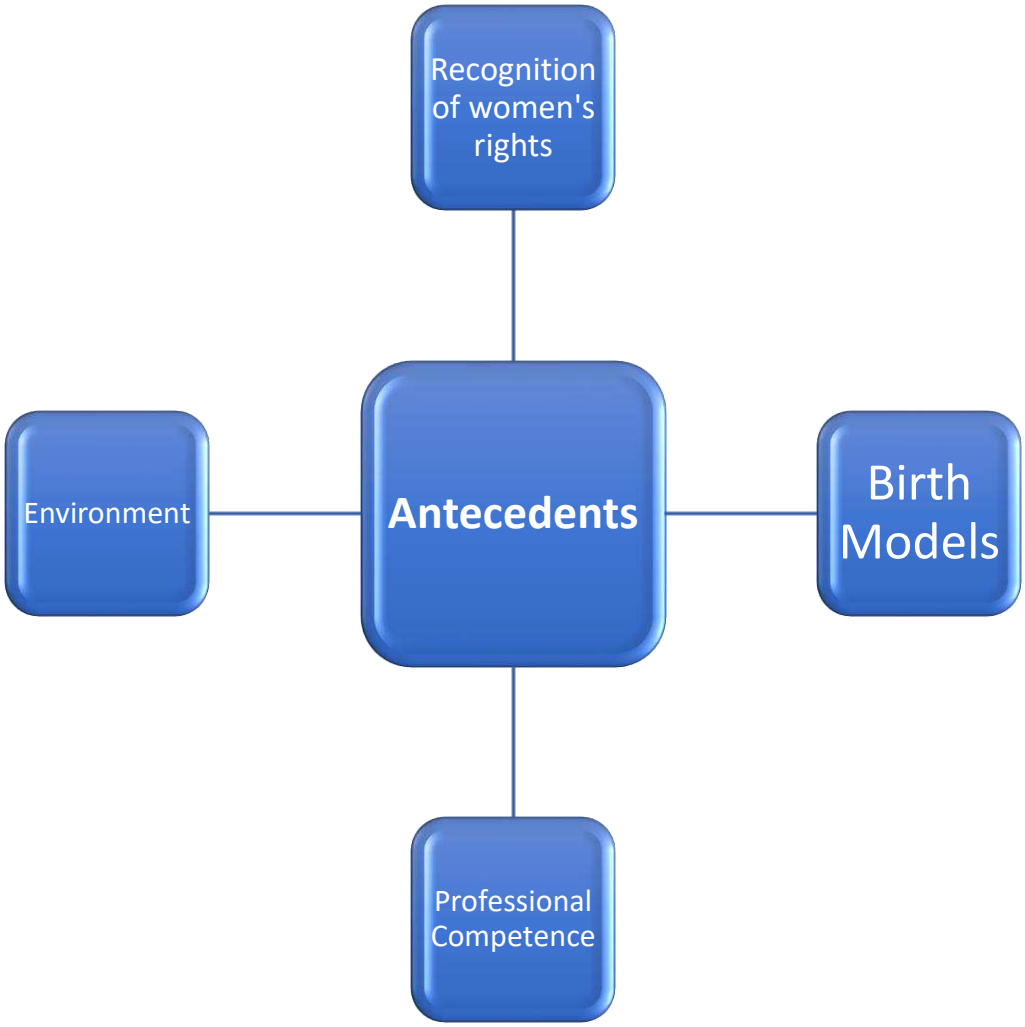
Figure II:



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