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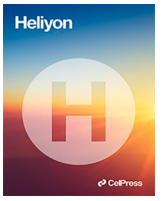

Research article

The childbirth experiences of Iranian women with birth plans

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ABSTRACT

Background: Childbirth constitutes a significant milestone in a woman's life, influencing both her physical and mental well-being as well as her relationship with the child. Employing a birth plan (BP) can contribute positively to obstetric outcomes, enhancing the overall birthing experience for women. BPs are not universally embraced in many countries, and there is limited research on women's experiences with BP in Iran. This study seeks to explore and understand the perspectives of women who have utilized a BP during their delivery.

Methods: This qualitative study included 14 women who had BP and experienced delivery. Data was collected through in-depth, semi-structured individual interviews. The sample selection followed a purposive approach, and data analysis utilized content analysis with a conventional approach facilitated by MAXQDA software version 2020.

Results: The examination of pertinent data concerning women's experiences identified five key themes: preparation, participation, support, emotional well-being, and unmet expectations.

Conclusions: This study's findings indicate that BPs enhance the overall birthing experience, suggesting their potential utility in improving the quality of obstetric care. Nevertheless, additional studies are essential to validate these results on a broader scale and facilitate the nationwide implementation of BPs.

1. Introduction

Childbirth is an important event in a woman's life [1] that affects her physical and mental health, as well as the mother's relationship with her child [2]. A positive birth experience enhances a woman's overall health, elevates her self-esteem, and fosters a positive mother-child relationship [2,3]. On the other hand, negative birth experiences can cause psychological distress and lead to postpartum depression, which can weaken the mother-infant relationship and lead to abnormal physical, mental, and emotional development [2–4]. Traumatic birth experiences also negatively affect breastfeeding [5], women's decisions about their next child [6], and the type of delivery they will have in their next pregnancy. Women who have had negative birth experiences may develop a reluctance to opt for vaginal delivery for their subsequent childbirth and may instead prefer a cesarean section [7].

Pregnancy care has undergone significant transformations over the years, particularly in the latter half of the 20th century, when

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hospital deliveries became more prevalent, marking a shift towards the medicalization of childbirth [8]. The medicalization of childbirth resulted in a rise in interventions during the delivery process, contributing to the adoption of conventional practices like shaving, enemas, episiotomies, etc., many of which are often not scientifically substantiated [9]. A birth plan (BP) is a written document enabling women to articulate their preferences, needs, desires, and expectations for the birthing process. BP may not substitute the information provided by medical professionals and doesn't designate the mother as the primary organizer of the birthing process. Instead, it serves as a tool for the mother to influence negotiable aspects, ensuring that any adjustments align with maintaining the health and well-being of both the mother and the baby [10].

BPs were first developed in the United States in the late 1970s in response to increasing medicalization, which led to women trying to express their preferences [11]. Commonly expressed preferences in a BP often include limitations on common practices such as the use of oxytocin or episiotomy, a preference to avoid cesarean sections, advocating for freedom of movement during labor, and expressing a desire for immediate contact with the baby and the opportunity for initial breastfeeding [12]. Enhancing women's satisfaction necessitates their performance and adherence to BPs [13,14]. Given the low adherence to BPs by health professionals, developing strategies for effective implementation and enhancing acceptance is essential, recognizing them as crucial tools in every delivery [15]. BPs can increase women's satisfaction, promote participation in the birth process, improve communication between pregnant women and midwives, and help mothers make informed decisions [16]. Some authors have found that using BPs can positively impact the mode of delivery and obstetric outcomes [10,13]. In a qualitative study conducted by Alba-Rodríguez et al., women expressed that BP heightened their awareness of their rights and the available options during the childbirth process [17]. In another qualitative study conducted by Whitford et al. both staff and women generally expressed positivity towards the use of BPs [18]. BP can be a vital and effective tool to facilitate physiological birth, optimize the birthing process for better control, and ultimately improve outcomes for both mothers and newborns and satisfaction with the birthing experience. The pivotal factor in realizing these significant benefits lies in elevating compliance with the BP [13,19]. While every woman has the right to decide the type of birth and treatment she desires, it's crucial to acknowledge the inherent unpredictability of childbirth, which may deviate from initial plans. The use of a BP may occasionally give rise to conflicts between women and medical personnel, often stemming from dissatisfaction when expectations are not met [20,21]. The unpredictability of childbirth should not serve as an excuse to deter women from actively participating in decisions about their bodies [22,23].

In the Iranian context, medical interventions in obstetrics are prevalent. For instance, the routine use of oxytocin during labor without obtaining women's informed consent and the standard practice of performing episiotomies are notable examples [6]. Such practices are regarded as obstetric violence [5]. Furthermore, a substantial number of women in Iran (75 %) have reported encountering one or more instances of disrespectful maternal care. Half of these women indicated a lack of autonomy in choosing their birthing position and movement during labor [24]. Moreover, the prevalence of adverse birth experiences among Iranian women (37 %) surpasses rates in other countries. Notably, the fear of vaginal birth emerges as a significant factor contributing to the high rate of cesarean deliveries in Iran (48 %), constituting one of the primary nonmedical reasons for the preference for cesarean delivery [25].

Safe delivery, satisfaction with childbirth, and postpartum care are considered the most important dimensions of reproductive health [26,27]. Poor reproductive health care leads to pregnancy, delivery complications, and maternal and neonatal mortality, whereas most of such mortality and morbidity are preventable [28]. In Iran, compared to developed countries, unnecessary medical interventions (elective cesarean section, episiotomy, and using oxytocin during labor) are still very common during the childbirth process [29,31]. However, a high number of cesarean births pose a potential threat to the subsequent pregnancies of women, especially those lacking access to health facilities [3,5,8]. While the use of BPs is widespread in developed countries, it remains a relatively new concept in developing nations [32]. Although BPs have not been implemented in Iran's maternal health policies, studies in the country indicate positive benefits of BPs [33–35]. For instance, the randomized control trial study showed that women who had BPs in place had increased vaginal births and were satisfied during the delivery compared to those who did not have BPs [34]. In light of the escalating cesarean section rates and existing population policies in Iran in response to population decline and ageing [5,30,31], the inconsistent findings of previous studies on BP use [17,36–38], and the shortage of studies examining Iranian women's views on the impact of BPs on their birth experiences, this qualitative study aims to explore the perceptions of women with BPs regarding their delivery experiences.

2. Methods

2.1. Study design

The current study constitutes the qualitative segment of a larger mixed-methods study utilizing a convergent parallel design encompassing two distinct phases. The protocol for this comprehensive study has been previously published [39]. We will be able to enrich our results by evaluating the effect of the BP through both qualitative and quantitative analyses. This phase was conducted among women who received BP at Taleghani Hospital in Tabriz, Iran, from March 2021 to July 2021. The checklist BP includes women's preferences for labor, mobility, monitoring, pain relief, pharmacological options, acceleration of labor, pushing, breathing, care of the baby, and cesarean section. Pregnant women complete it at 32–36 weeks of gestation in consultation with health care providers or obstetricians and their partners [39]. Implementing the BP has been completely mentioned in the quantitative phase article [35].

2.2. Participants and data collection

Participants in this study were intentionally chosen, within 4–6 weeks postpartum, from among women who received BPs during the initial phase of a mixed-methods study. In the initial phase of the study, the inclusion criteria included: literate women 18 years of age or older, living in Tabriz, 32–36 weeks gestation with a singleton fetus, and a depression score <13, who were planning to have their first or second vaginal delivery at the Taleghani Hospital. The exclusion criteria included indications for C-sections, high-risk pregnancies, stillbirth, and abnormal fetuses. Also, all trial participants were eligible for the current study regardless of age, parity, or type of birth. Women who expressed willingness and capability to share their childbirth experiences and insights on BPs were purposefully selected. Subsequently, these selected individuals were contacted by telephone and invited to participate in the second phase of the previously mentioned mixed-methods study. The demographic details of the participants are presented in Table 1.

Data were collected through in-depth, semi-structured individual interviews conducted by the first author, a caregiver to women in the study (a Philosophiae Doctor student of midwifery). The interview duration was between 25 and 60 min. The interviews were conducted using open-ended, general questions as follows.

1 Please describe your recent delivery and the experience you had during the childbirth.
2 Were you satisfied with your childbirth experience?
3 Did the BP affect your birth experience?
4 Who supported you, and to what extent did this contribute to you having a better or worse birth experience?

Following the initial responses, in-depth exploration questions were employed, including “What do you mean?", “Why?" “Explain more," and “Please give an example to express better what you mean?" This approach aimed to delve deeper into participants’ perspectives and experiences. During the interviews, the researcher recorded nonverbal data such as tone, facial expression, the emotional state of the participants, and the time and place of the interview on a special sheet. Interviews were conducted in the training room in the hospital (a quiet private room).

2.3. Data analysis

MAXQDA software version 2020 was used for data management. This study used conventional content analysis to manage the data according to the steps proposed by Graneheim and Lundman [40,41]. Data analysis was conducted to extract codes, sub-themes, and themes through qualitative content analysis. Qualitative content analysis is the process of organizing qualitative data regarding emerging concepts and themes. Content analysis is more than extracting objective content derived from textual data. Through the themes, one can reveal hidden patterns within the content of the participants’ data [42]. In the current study, qualitative content analysis was conducted as follows: Initially, all interviews were transcribed verbatim. The narratives were identified by reviewing interview transcripts. Meaningful units related to the purposes of the study were identified and coded. Interview transcriptions, all codes, and themes were reviewed several times. Finally, meaningful themes emerged about the BP [41]. The corresponding and first authors developed the themes and coded the data. Also, the rest of the research team checked and made the necessary corrections. The codes were categorized based on differences and similarities to sub-themes and main themes. Examples of content analysis, coding, sub-themes, and main themes are presented in Tables 2 and 3. A professional language editor has translated participants’ statements.

Table 1
Sociodemographic characteristics of participants.

Participants[a]	Age (year)	Education	Number of parity	Sufficiency of income for expenses[d]
P1	19	High school and below	1	Completely sufficient
P2	32	University	1	Somewhat sufficient
P3	29	Diploma	2	Completely sufficient
P4	21	High school and below	2	Somewhat sufficient
P5	35	High school and below	2	Insufficient
P6	23	High school and below	2	Completely sufficient
P7	30	Diploma	1	Completely sufficient
P8	21	High school and below	1	Somewhat sufficient
P9	38	High school and below	1	Somewhat sufficient
P10[b]	19	High school and below	1	Insufficient
P11[c]	20	High school and below	2	Completely sufficient
P12	24	High school and below	2	Somewhat sufficient
P13	18	High school and below	1	Insufficient
P14	25	Diploma	2	Somewhat sufficient

[a] All participants were of Azeri ethnicity and married.
[b] All mothers had a vaginal delivery, except one, who had a cesarean section during the active stage of labor due to the arrest of dilatation.
[c] All participants were unemployed except one.
[d] The sufficiency of monthly income for living expenses was measured by a subjective item including three response options: “Completely sufficient,” “Somewhat sufficient,” and “Insufficient.”

Table 2
An example of the analysis process.

Meaning unit	Code	Sub-theme	Theme
" The staff treated me very well; they understood me very well. I am satisfied with all of them, which made me satisfied with the delivery. "	Mothers' satisfaction due to the midwife's good behavior and being understood by them	Feeling satisfied with the sympathy and behavior of the personnel	Support
"They understood me a lot, and the staff treated me well. I felt like I was at home."	The feeling of being at home and comfortable because of the good behavior of the staff		

Table 3
Classification of main themes and sub-themes.

Sub-themes	Theme
Providing information to the mother	**Preparation**
Raising awareness	
Physical preparation for childbirth	
Mental preparation for childbirth	
Engaging mother and husband in decision-making	**Participation**
Meeting mother's wishes	
Good feeling resulting from participation in the delivery process	
Valuing and being important	**Support**
Obtaining support for breastfeeding	
Feeling satisfied with the professional support and behavior of the personnel	
Feeling happy	**Emotional wellness**
Sense of ability	
Instilling hope	
Reducing fear and stress	
Better pain tolerance	
Dissatisfaction with personnel behavior	**Unfulfilled Expectations**
Simultaneous experience of vaginal delivery and cesarean section	
Lack of accompaniment in labor	

The professional language editor consulted with the authors before or during the translation. The authors then checked the translated text and, if necessary, edited it.

2.4. Trustworthiness of the findings

Guba and Lincoln's [43] criteria were used to increase the validity of the findings in the study. To ensure the reliability of the data, in-depth interviews were conducted at different times and places, and the participants were selected with maximum variation in terms of age, education, job status, number of deliveries, and socioeconomic status. Member check was employed as a method to validate and ensure the accuracy of the data. This technique, also known as participant or respondent validation, involves returning the data or results to the participants. This process allows participants to review the findings, checking for accuracy and resonance with their own experiences, thereby enhancing the credibility of the results [44].

Furthermore, the data were shared with the research team to cross-reference and ensure the consistency of themes with participants' statements. The team provided their written opinions on codes, themes, and analyses. To establish credibility, the research methodology's execution stages were meticulously outlined, presenting the initial codes derived from interpreting participants' experiences and examples illustrating how themes and segments of the interview text were extracted. Regarding transferability, a transparent description was employed to convey the participants' behavior and experiences within the context to an external audience. The diversity among participants in terms of age, education level, and occupation enhanced the transferability of the study's findings. Clear decision-making rules were established in interpreting the data to ensure conformity further.

2.5. Ethical considerations

The Research Ethics Committee (REC) of Tabriz University of Medical Sciences (code number: IR.TBZMED.REC.1399.278) approved this study. The researcher explained the study's objectives and obtained written informed consent from the participants. The time and place of the interview were determined with the consent of the participants. Participants were provided assurances regarding the voluntary nature of their participation in the research. Consent for recording interviews was obtained, and it was emphasized that their identity and information would remain confidential throughout all stages of the study, including the publication phase, where participants' information would be identified solely by a numerical code or nickname. Additionally, participants were explicitly informed of their freedom to refuse participation or discontinue their involvement in the study at any point in time.

3. Results

The interview was conducted until information saturation was achieved, meaning no new information or codes were obtained. This saturation point was reached starting from the 11th interview onward. Ultimately, the total number of participants in the study reached 14 individuals. The analysis extracted 279 codes and 32 sub-themes and subsequently categorized them into five main themes: preparation, participation, support, emotional wellness, and unfulfilled expectations (Table 3).

3.1. Preparation

The attainment of prenatal preparation emerged as a key factor influencing a positive delivery experience. This overarching theme encompasses sub-themes such as "raising awareness," "physical preparation for childbirth," and "mental preparation for childbirth," which were taken from the statements of the majority of participants. Implementing a BP was pivotal in enhancing participants' awareness, facilitating physical and mental readiness for childbirth, and empowering women to make informed choices about a safe delivery method.

3.1.1. Raising awareness

Indeed, possessing knowledge and augmenting mothers' information emerged as crucial factors in fostering positive birth experiences and satisfaction with childbirth. Most participants said the BP significantly heightened their awareness of the labor and delivery process. For instance, one participant highlighted the impact of the BP on her experience, stating, *"The birth plan raised my awareness, and when they saw I was informed, they explained everything to me. They would explain it beforehand, whether it was a procedure or administering any medicine."* This emphasizes how being informed through the BP contributed to a more transparent and communicative healthcare experience during childbirth. (p2).

3.1.2. Physical preparation for childbirth

Participants emphasized the significance of physical preparation for childbirth, noting that practices such as hot showers, massages, and walking played a role in preparing the body for delivery. One participant shared her experience: "*Even my body was ready. I used a hot shower in the delivery room, massaged my back, and walked. The midwife also massaged me, encouraging me by saying it's beneficial, and in this way, you give birth soon; it had an impact."* (p6). This highlights the perceived effectiveness of these physical preparation methods in contributing to a positive birthing experience.

3.1.3. Mental preparation for childbirth

Some participants expressed that having a BP contributed to their preparedness and confidence in undergoing a vaginal delivery. Another participant articulated the impact of a BP on mental readiness for childbirth, stating, *"Having a birth plan, I had quite prepared my mind for a good delivery, and in doing so, I thought I was preparing to help my baby and myself."* (p8). This emphasizes the psychological empowerment and positive mindset that a BP can instill, influencing the overall mental fitness for the birthing experience.

3.2. Participation

Participation has been recognized as a key strategy for enhancing quality, increasing satisfaction with childbirth, and fostering a positive delivery experience. The BP was pivotal in facilitating communication and promoting women's active participation during childbirth. This overarching theme encompasses three sub-themes: "engaging mother and husband in decision-making," "meeting mother's wishes," and "good feeling resulting from participation in the delivery process," which were taken from the statements of the majority of participants. These sub-themes collectively highlight the positive impact of BP in empowering mothers and their partners to contribute to decision-making during the childbirth process.

3.2.1. Engaging mother and husband in decision-making

A participant shared her experience with active participation, noting, *"With the choices I had, and even with my husband, we decided together on what to do and choose. To make informed decisions, I had to study (the information sources about childbirth), and even my husband said, 'You engaged me too in these things,' and she laughed."* (p8). This participant's account emphasizes how the BP enabled collaborative decision-making by involving both the mother and her husband in the childbirth process.

3.2.2. Meeting mother's wishes

Listening to the mother's wishes and needs emerged as a significant factor facilitating women's participation in decision-making.

In this study, women had the opportunity to express their desires concerning giving birth and actively participate in the decision-making process during childbirth. The BP is not routinely implemented in the hospital, so women's preferences and wishes are not taken into account during the birth process. This highlights how women had the opportunity to express their desires concerning giving birth and actively participate in the decision-making process during childbirth.

A participant expressed this sentiment, saying, *"Because of this birth plan, I was able to voice my opinions and wishes; before that, no one had asked us what we wanted and liked or to give our opinion. You listened to my words and opinions."* (*p11*).

3.2.3. Good feeling resulting from participation in the delivery process

In the current study, women expressed a sense of happiness derived from being asked for their opinions and actively participating in the delivery process. One participant described the experience, stating, *"I participated in the birth of my baby. It wasn't like I was lying on the bed and the doctors were doing their jobs without my participation. This participation gave me a good feeling. I was satisfied."* (p3). This illustrates the positive emotional impact and satisfaction resulting from women's active involvement in the childbirth experience facilitated by the BP.

3.3. Support

The majority of participants emphasized the significance of receiving support during childbirth through the implementation of a BP. The BP was instrumental in enhancing the overall feeling and experience of childbirth, particularly through the continuous support provided by midwives. As per women's experiences, continuous support during childbirth and attentiveness to the mother's needs emerged as crucial factors in promoting a positive childbirth experience. This overarching theme comprises three sub-themes: "valuing and being important," "obtaining breastfeeding support," and "feeling satisfied with the professional support and behavior of the personnel," which were taken from the statements of more than two-thirds of the participants. This emphasizes the importance of positive interactions and encouragement from healthcare professionals in enhancing the overall childbirth experience.

3.3.1. Valuing and being important

A participant expressed a sense of value and care during childbirth, stating, "*I didn't hate delivery. When I had my vaginal delivery, I felt I had become a mother. My family and I felt valued. It was very good for me."* This highlights the importance of feeling valued and supported during childbirth, contributing to a positive and meaningful experience for the mother. (*p7)*.

3.3.2. Obtaining support for breastfeeding

Mothers perceive the presence of a midwife as beneficial for receiving assistance with baby care and breastfeeding. A participant shared her experience, saying, *"When they put my baby in my arms, the midwife was next to me, and she was paying attention to the baby. She helped me to be able to hug him completely and breastfeed him. The midwife also helped me a lot at this stage." (p13)*. This emphasizes the supportive role of midwives in facilitating crucial aspects of early mother-infant bonding and breastfeeding during the postpartum period.

3.3.3. Feeling satisfied with the professional support and behavior of the personnel

The sub-theme "Feeling satisfied with professional support and behavior of the personnel" highlights the positive impact of the good behavior and understanding exhibited by staff and midwives on the overall satisfaction of participants. One participant shared her experience: "*I felt I had a little longer delivery, but it wasn't uncomfortable for me because I was treated very well and encouraged. It didn't bother me, and I was delighted. It was good*." (p1). This emphasizes the importance of positive interactions and encouragement from healthcare professionals in enhancing the overall childbirth experience.

3.4. Emotional wellness

Emotional wellness emerged as an essential factor contributing to a positive childbirth experience. This overarching theme comprises five sub-themes: "feeling happy," "sense of ability," "instilling hope," "reducing fear and stress," and "better pain tolerance," which were taken from the statements of more than half of the participants. These sub-themes collectively highlight the multifaceted role of emotional well-being in positively shaping the overall childbirth experience.

3.4.1. Feeling happy

BPs and preparation for what happens in delivery were identified as successful strategies for better childbirth experiences. Participants felt satisfied and happy with having a BP in our study. A participant expressed the positive impact of having a BP on the childbirth experience, stating, "*Delivery with a plan is good; well, women experience it once or twice in their life; when it is planned, you feel it's easier. When we plan for small things in life, childbirth is important, so you'd better plan for this too; I'm satisfied that I had a birth plan."* (p3). This reflects the participant's satisfaction with the sense of organization and preparation a BP provided, contributing to a more manageable and positive childbirth experience.

3.4.2. Sense of capability

Participants expressed a belief in their ability to give birth, particularly when they had the right to choose and actively participate in the childbirth process. One participant highlighted this sentiment, stating, "*My childbirth experience is good because you gave me a birth plan before my delivery, and you said we wrote this plan to implement these measures for you at the time of delivery. These measures were very good. I thought I could give birth; I was hopeful, and I wanted to have a vaginal delivery."* (p14). This illustrates how the sense of ability is intertwined with the empowerment provided by the BP, contributing to a positive outlook on the childbirth experience.

3.4.3. Instilling hope

The sub-theme "instilling hope" highlights the role of healthcare providers, particularly midwives, in fostering a sense of hope during childbirth. Participants mentioned instances where the midwife's empathy, support, and encouragement played a crucial role

in instilling hope during challenging moments of delivery. One participant shared her experience, stating, "*During my delivery, if there were any problems or unhappy things, the midwife would sympathize with me and hold my hand. When I was crying, she talked to me and heartened me more."* (p11). This emphasizes the significant impact of emotional support on cultivating a hopeful mindset during the birthing process.

Another woman noted:

> *"They valued my wishes, which increased my self-confidence."* (p5).

Another woman noted:

> "During childbirth, despite all the problems and discomfort I had, the midwife showed compassion by holding my hand when I cried, talking to me, and giving me hope." (p10).

The hope they received from the healthcare practitioners helped increase their confidence.

3.4.4. Reducing fear and stress

The sub-theme "Reducing fear and stress" emphasizes how having a BP contributed to minimizing fear and stress among participants. Despite negative remarks from those around them, participants expressed resilience and an ability to ignore such comments. One participant stated, *"Because I had a birth plan, I didn't pay attention to the negative things from those around me; for example, they said vaginal delivery is hard and to have a cesarean section, or you might have a problem after giving birth, but I didn't pay attention."* (p12). This highlights the protective role of the BP in shielding mothers from external negativity and contributing to a more positive emotional state during childbirth.

3.4.5. Better pain tolerance

The sub-theme "Better pain tolerance" emphasizes the importance of controlling pain through both pharmacological and non-pharmacological methods, contributing to a reduced sensation of pain in women during childbirth. Participants highlighted how witnessing the midwife's efforts played a role in distracting their minds from the pain, ultimately enhancing their ability to endure it. One mother expressed this sentiment, stating, *"When I saw you trying so hard to ease my pain and have good moments, I also turned to God and tried to distract myself by thinking of my baby and what his face would be like*." (p7). This suggests that a supportive and attentive birthing environment can positively influence pain tolerance and coping mechanisms during childbirth.

3.5. Unfulfilled expectations

The theme of "not meeting women's needs and expectations" reflects instances where participants expressed dissatisfaction due to unmet expectations, contributing to a negative childbirth experience. This overarching theme comprises three sub-themes: "dissatisfaction with personnel behavior," "simultaneous experience of vaginal delivery and cesarean section," and "lack of accompaniment in labor." These sub-themes were taken from the statements of one-third of the mothers, highlighting specific factors that, when not addressed, can lead to a less positive childbirth experience for women.

3.5.1. Dissatisfaction with personnel behavior

Some women, even with a BP, stated that caregivers did not behave appropriately during labor and did not provide support or sympathy to the mother. A participant expressed dissatisfaction with personnel behavior, recounting her experience: *"When I was admitted, they yelled, "Why do you have so many admissions? What's going on?" It wasn't my fault. The delivery ward was crowded when I entered, and the presence of many students caused me stress."* (p14). This highlights the negative impact of unprofessional or stressful interactions with healthcare personnel on the overall childbirth experience.

3.5.2. Simultaneous experience of vaginal delivery and cesarean section

A mother expressed dissatisfaction with her childbirth experience, particularly feeling uneasy about being forced into a cesarean section after an unsuccessful labor that didn't align with her wishes and expectations. She shared, "*My delivery wasn't good because I was in pain and experienced a cesarean section. It wasn't as I wanted. If a cesarean section was possible initially, they could do it from the beginning. It caused my child's heartbeat to drop; even though I had a birth plan and wanted to give birth accordingly, it didn't happen."* (p10). This highlights the impact of diverging from the mother's BP and expectations, leading to a less favorable childbirth experience.

3.5.3. Lack of accompaniment in labor

Participants expressed discomfort that their spouses would not be allowed to be with them. In the study setting, spouses are prohibited from entering the birthing rooms. A mother stated:

> *"Delivery is a critical moment for women, and I wanted my husband to be there with me, but they wouldn't let anyone accompany me, especially my husband. Even during pregnancy, my husband supported me so much; his support heartened me and caused me less stress"* (p4).

The collection of experiences described suggests that formulating a BP according to the mother's requests can lead to exceeding expectations for some women. However, failing to meet these expectations can result in a negative birth experience.

4. Discussion

Results showed that BP improved women's childbirth experiences and increased their satisfaction with childbirth through preparation, participation, support, and emotional wellness. However, some expressed that their expectations were not met.

In a qualitative study conducted by Mohaghegh et al. in Iran, which aimed to explore the effects of using BP, it was found that women who had a BP were satisfied with the results [33]. In a qualitative study conducted by Alizadeh-Dibazari et al. in Iran, which aimed to explore perspectives of pregnant and postpartum women regarding childbirth preparation, it was found that factors such as having an antenatal care plan, improving health literacy, and developing a birth plan were identified as crucial elements for effective childbirth preparation [45]. The results of both the above studies conducted in Iran, in line with the results of the present study, show the importance of implementing a birth plan in the context of Iran. In another qualitative study by Sham et al. in Hong Kong, China, most participants stated positive feelings such as helpfulness, satisfaction, being secured and happiness due to using of BP, which aligns with the findings of our study [46]. It is noteworthy, however, that none of the studies reported any negative experiences related to BPs. In contrast, in the present study, some mothers expressed dissatisfaction because their expectations and demands were not met, that it is because the women ended up giving birth by caesarean section, which they had not planned. It could have been a bad experience for the women, but the doctors made a decision that was good for both the mother and the newborn. It's essential to emphasize that a BP does not guarantee that labor and birth will proceed according to that plan, and unexpected occurrences can happen. This emphasizes the importance of managing expectations and fostering effective communication between healthcare providers and mothers about the potential variations in the birthing process [18]. One of the reasons for the dissatisfaction of the women in the present study was the absence of their husbands in the delivery room, which was due to the hospital's policy of prohibiting spouses from entering the maternity ward in the setting of the study. Understanding women's childbirth experiences is crucial for providing personalized and culturally sensitive care throughout and following labor [47].

The findings of this study indicate that BPs effectively equip mothers for childbirth by offering information as well as physical and mental preparation. Expectant mothers frequently require prenatal education to make informed decisions regarding their delivery preferences, including conditions during childbirth, methods of pain relief, infant care, and breastfeeding. One of the World Health Organization's (WHO) goals is to achieve integrated and quality prenatal care to provide women with positive experiences during pregnancy and childbirth [48]. Malata and Chirwa concluded that information received during pregnancy influences women's satisfaction with care during childbirth [49]. Inadequate information about birth processes, poor communication, and low involvement of mothers in their care plans deprive them of complete control over the situation and increase anxiety, stress, and other emotional tendencies [40]. Therefore, mothers can have positive birth experiences by receiving a BP, which contains information about participating in and paying attention to the wishes and desires of the mother in labor and delivery, in addition to participating in childbirth preparation classes [24]. Some studies suggest that it is useful to discuss the options; women may express satisfaction with using a BP even when their documented preferences are not met [49,50]. Whitford et al. suggest that the opportunity to discuss birth options may be more important in predicting patient satisfaction and delivery outcome than the BP itself [51]. Perhaps the mere fact that BPs are not common in Iran might have led to women feeling satisfied because it was something new they were exposed to.

Another noteworthy theme in this study was the mother's and her husband's active involvement in the decision-making process, responsiveness to the mother's wishes, and the positive sentiment derived from being actively engaged in the delivery process. BPs were established as a tool designed to facilitate communication and promote women's participation in decision-making during childbirth [16]. Shared decision-making was identified as an ideal approach to encouraging patient involvement in health decisions [52]. Participation involves physicians and patients considering existing information about a medical problem and working together to make decisions based on the patient's preferences and values [23]. In Hollander et al.'s study, many women attributed their traumatic birth experience primarily to their lack of control during labor. They believed that better communication and support from their care provider could have lessened or prevented their traumatic birth [53]. According to the WHO's recommendations for having a positive birth experience, women should control the birth process and engage in decision-making interventions [54]. These findings emphasize the significance of engaging in discussions with caregivers to establish a BP about labor and post-delivery care to empower women to keep control during labor.

Another theme that emerged from the participants' statements was support. Building a reliable and supportive relationship through effective communication between women and caregivers is a cornerstone to ensuring respect for women's values and preferences [55]. The majority of mothers attributed their positive experiences and success in using BP to the fact that they and their husbands were involved in the planning, their wishes were taken into account and they were supported by midwives during the birth. However, caregivers' behaviour and attitudes also determine women's birth experiences. Some of the dissatisfaction outlined in the results relates to poor practice and lack of respect for birthing women, regardless of what was agreed in the BP. According to women, the type of assistance that was encouraged by the BP employed in this study includes emotional support and a sense of satisfaction with the professional support. A Cochrane systematic review by Hodnett et al. also shows that supportive care from professional staff or family members can improve the birth experience [47]. A meta-analysis of studies examining obstetric care showed a positive impact of trained attendants on the maternal birth experience. While the educational approaches varied across studies, these interventions' commonalities were the attendant's physical presence and emotional support [56]. The common point of almost all successful strategies is support during childbirth. In some interventions, support is the main component; in others, it is considered a hidden factor [57]. Evidence suggests that pregnant women need more emotional support to avoid psychological trauma during birth. The behavior of delivery room staff plays an essential role in the memories of pregnancy and childbirth [58].

Previous studies on the benefits of BPs support the results of this study. Personal control is the strongest predictor of satisfaction during childbirth [5]. In a qualitative study conducted by Mohaghegh et al. in Iran, the women expressed that improved knowledge

and skills, as well as their increased self-confidence and the feeling that they had overcome their fear of vaginal birth, gave them self-efficacy for vaginal birth. The women also felt that the BP boosted the women's self-confidence as it gave them the right to make their own decisions and participate in the decision-making process [33]. Anderson et al. found that postpartum self-esteem was higher in women who had a BP [59]. Many researchers believe that the perception of control in childbirth is essential for satisfaction and empowerment, even when expectations are not met [60,61]. Although pain management is the best short-term solution to help women cope with childbirth, personal control is a long-term benefit [62]. It has been found that self-confidence promotes positive delivery experiences and is closely related to them [63]. Evidence shows that fear of labor, self-confidence, and a sense of control are closely related [64,65], as well as that background and environmental factors and how women interact with care providers affect their fear of childbirth. Lowe concluded that women with low fear of childbirth have significantly higher self-esteem. Conversely, women with high levels of fear reported learning helplessness and a belief in luck rather than self-control [66]. In another study, women who reported severe fear of childbirth were concerned about their performance during delivery and their bodies' ability to give birth [67]. BP promotes a sense of trust and confidence in women by creating a suitable birth environment without fear [62]. Also, the childbirth program probably increases women's tolerance by informing them about the physiological process of childbirth. As the WHO's 2018 maternity care model recommends, empowering women requires directing women's orientation toward pain management options and demanding their right to experience painless labor [68]. A possible explanation for this finding may be that involving women in deciding on labor and birth can reduce their fear and anxiety [11]. Reducing stress during childbirth can increase the secretion of endorphins and decrease the secretion of adrenaline, which is crucial in speeding up the labor process [69].

Unfulfilled expectations were one of the findings extracted from the participants' statements in this study. The WHO defines the experience of positive childbirth as fulfilling or more than fulfilling the personal and socio-cultural beliefs and expectations of the woman, including delivering a healthy baby in a safe clinical and psychological environment under the constant care and emotional support of a delivery companion and clinically qualified staff [70]. Consistent with the results of a qualitative study in southern Spain in four subgroups, BP benefited some women. Still, two people expressed that it did not help them because their expectations had not been met [17].

A study has reported that the numerous demands of a pregnant woman are associated with an 80 % reduction in her satisfaction. In contrast, the number of women's fulfilled needs positively correlates with the satisfaction of the childbirth experience [71]. The reason for these relationships is not clear. Still, it may be because the woman's higher demands mean having high expectations, and consequently, failing to achieve these expectations decreases their satisfaction with childbirth. It may also be because some women may have conflicting demands from medical perspectives [72]. One of the reasons for the dissatisfaction in the present study is related to the hospital's policy and is a separate issue from the intervention of the BP. Another reason may be related to the caregivers' behaviour and attitudes. Some of the dissatisfaction outlined in the results relates to poor practice and lack of respect for birthing women, regardless of what was agreed in the BP. However, ultimately, studies agree that if women's expectations and preferences are met, they will be accompanied by positive experiences [73]. BPs were created as a way for women to express their desired expectations and preferences. Women can express their expectations in determining and choosing birth options with a woman-centered approach [14]. Birth planning, by preparing women for childbirth and familiarizing them with their rights and rights in labor, improves childbirth experiences and is a solution to improving the quality of services provided to pregnant mothers [22].

4.1. Strengths and limitations

The strength of this study lies in its inclusion of both multiparous and nulliparous women, with no discernible differences in expectations or wishes before birth based on parity. Additionally, the study was conducted in one of Iran's metropolises, adding robustness to its findings due to the high cultural and demographic diversity in this metropolis. However, it's essential to acknowledge certain limitations, such as most informants being young stay-at-home parents with a lower level of education. Another limitation pertains to the potential for interview bias, given that the interviews were conducted by the first author, who also supported women during childbirth, which could impact the study's outcomes. Also, the lack of diversity in participants' ethnicity, employment status, and marital status limits the generalisability of findings. In addition, this study was conducted under COVID-19 pandemic conditions. These conditions negatively affect the psyches of mothers [65], which could affect the study results.

4.2. Implications of findings

Providing care that aligns with the mother's needs and desires is pivotal for enhancing women's satisfaction and the overall quality of care. Therefore, managers and policymakers must endorse the implementation of BPs that are attuned to the mother's preferences, wishes, and needs. Recognizing these factors as key indicators of planning success is crucial. BPs should be regarded as valuable documents in the realm of childbirth care. The authors advocate for active women's participation in labor, asserting that BPs can elevate women's satisfaction with the birthing experience and foster positive relationships between mothers and healthcare providers.

In this context, midwives in all primary care centers should impart up-to-date information about the labor process to expectant mothers. Collaborative negotiations between women and their care providers, particularly midwives, should occur during the development and implementation of a BP. The role of the care provider, particularly midwives, is pivotal in influencing women's self-confidence and decisions related to their birth experience. Emphasizing midwives' support for the BP is integral to ensuring a comprehensive and positive childbirth experience for women.

5. Conclusion

The findings of this study show receiving a BP improves childbirth experiences in women, increases women's participation in the labor process because of increased information and awareness, and strengthens their self-control and self-management. However, a few women expressed that their expectations had not been met. The results of this study can be considered to improve the quality of labor services. However, more studies are needed throughout the country to adopt BP nationally. Perhaps BPs can be used as quality improvement activities to improve client-centered outcomes that potentially affect national cesarean rates. By receiving a BP, the probability of a vaginal delivery is higher. Considering the vital need to reduce the cesarean delivery rate and improve quality standards in midwifery, mother-centered services, and childbirth preparation, BP can be used to achieve these goals.

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Data availability statement

The datasets generated and/or analyzed during the current study are not publicly available due to limitations of ethical approval involving patient data and anonymity. Still, they are available from the corresponding author at a reasonable request.

Additional information

No additional information is available for this paper.

Ethics approval and consent to participate

This study was approved by the ethics committee of the research and technology deputy of Tabriz University of Medical Sciences (IR.TBZMED.REC.1399.278). All participants provided informed written consent. Women consented to data sharing without specifying their names. Participants were free to refuse participation or discontinue the study at any time. All methods were carried out following relevant guidelines and regulations.

CRediT authorship contribution statement

Parivash Ahmadpour: Writing – original draft, Software, Project administration, Data curation, Conceptualization. **Sanaz Moosavi:** Writing – review & editing, Supervision, Conceptualization. **Sakineh Mohammad-Alizadeh-Charandabi:** Writing – review & editing, Supervision, Methodology, Conceptualization. **Shayesteh Jahanfar:** Writing – review & editing, Validation, Methodology, Conceptualization. **Mojgan Mirghafourvand:** Writing – review & editing, Visualization, Validation, Supervision, Software, Resources, Methodology, Investigation, Funding acquisition, Formal analysis, Conceptualization.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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