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Original Article

Qualitative Exploration of the Needs of Pregnant Women to Manage the Fear of Childbirth

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Abstract

Background: Some women experience the Fear of Childbirth (FOC) during pregnancy, labor, and birth which can have consequences for their health and well-being. To provide the right conditions for having a positive experience of childbirth, the needs of pregnant women must be correctly recognized. The present study was conducted with the aim of investigating the needs of women in managing the FOC with a qualitative design. **Materials and Methods:** This qualitative study was conducted using conventional content analysis from January to November 2021. To this aim, 15 pregnant women, 21 healthcare providers, and four maternal health policymakers were purposefully selected from Kermanshah health centers, with maximum diversity. Data were collected through in-depth semi-structured interviews. Data accuracy was guaranteed using Lincoln and Guba criteria. The MAXQDA software was used for data analysis. **Results:** From the analysis of the data obtained from the interviews, three main categories emerged concerning the needs of mothers to properly manage the FOC: "need to provide awareness and empowerment of mother and family," and "the need to pay attention to the mental health of pregnant women," and "supporting needs (seeking support)." **Conclusions:** Identifying and paying attention to woman's needs in the areas of education, mental health, and support can help them manage crisis-ridden situations, including the FOC. In response to the needs of mothers to empower them in managing the FOC, it is recommended to formulate special guidelines in this field.

Keywords: *Delivery, fear, needs, qualitative research*

Introduction

In addition to the positive feelings of the mother towards the birth of a child, the feeling of fear and worrying about childbirth and its consequences can cause anxiety in some of them.[1] According to various studies, several factors are involved in creating specific fears related to childbirth, including worries and fears about the health of the baby and mother, fear of pain, fear of unexpected problems and death, staff health care, family life, and previous negative experiences of pregnancy and childbirth.[2,3] Some studies have suggested that a strong fear of Normal Vaginal Delivery (NVD) is an important factor in a pregnant mother's desire to have a cesarean section.[4,5] Some studies have shown that a variety of counseling, support, and personal care programs with the presence of one or more members of the healthcare team such as midwives are effective in reducing mothers' fears and reducing mothers' requests for cesarean section.[6] The purpose of interventions designed to reduce the FOC is to help control the anxiety associated with pregnancy and childbirth so as to reduce the Stressful factors for making better adaptations in pregnancy.[7]

To design the right interventions, it is necessary to know the real needs of pregnant women.[8] By recognizing the needs of women suffering from FOC, healthcare providers can support them and help them have a positive birth experience.[9] Although the FOC can have significant effects on the health of the mother and family,[1] few studies have addressed the needs of mothers to properly deal with the FOC during pregnancy. In only one study, the experiences and needs of women being afraid of childbirth during pre-pregnancy have been examined and solutions have been provided to eliminate women's fear and encourage them to start pregnancy.[10] Reflection on the available

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sources shows that the majority of available studies on FOC during pregnancy are quantitative and have investigated the methods that may reduce the level of fear and its complications in pregnancy, but the different needs of pregnant women to manage the FOC dimensions have been neglected in most of them.[11] Since FOC during pregnancy has different cultural, social, economic, and medical dimensions,[12] qualitative studies focusing on the specific cultural differences of each region are essential for thoroughly discovering the real needs of women with FOC. Kermanshah City, Iran, with a variety of different ethnic and cultural groups is a suitable environment for this study, based on the results of which strategies can be designed to improve the health and manage the fear of giving birth in affected women. Therefore, the aim of this study was to explain the needs of pregnant women in the management of the FOC with a qualitative design in the Iranian sociocultural context.

Materials and Methods

The present study is a qualitative phase of a sequential qualitative–quantitative exploratory study on the views of pregnant women and health team members on the needs of pregnant mothers in the management of the FOC. This qualitative study was conducted from January 2020 to October 2021. In the systematic review section of this study, effective interventions in reducing the FOC in pregnant women were investigated.[13]

In this study, people's opinions about the needs of pregnant women to manage the FOC were explained by conventional qualitative content analysis. Participants were 15 pregnant women, 21 health service providers, and 4 maternal health policymakers in Kermanshah who met the inclusion criteria and were purposefully selected. Inclusion criteria for participation of pregnant women include age over 18 years, singleton pregnancy, low-risk pregnancy, gestational age more than 32 weeks and Interest in participating in the study. History of psychiatric hospitalization or addiction and lack of interest in cooperation at each stage of the study were considered as exclusion criteria. Purposive sampling was performed with a maximum variation of sampling in terms of age, education, marital status, parity, ethnicity, religion and continued until data saturation. Inclusion criteria for health service providers, and maternal health policymakers include: at least 3 years of work experience providing health care or hospital services to pregnant women, willingness to participate in the study and having the required communication skills. Health team staff were also selected from various departments providing health services to pregnant women including academic centers and non-governmental hospitals, comprehensive health services centers, as well as offices of gynecologists and midwives. The policymakers were selected from the Maternal Health Units of Kermanshah University Vice Chancellors of Health and Clinical Affairs. The policymakers were selected from the Maternal Health Units of Kermanshah University Vice Chancellors of Health and Clinical Affairs. In-depth semi-structured interviews were used to collect the data. Initially, with the help of several pilot interviews and after reviews by the research team, the interview guide questions were identified. The interview guide prepared for this study is provided as attachment file 1. Each interview began with an open-ended question (Have you ever thought about giving birth? Explain to me how you feel.) and the next questions were asked to clarify the women's answers to the FOC. Also, probing questions were used such as: "Would you explain in more detail?" and "What do you mean?" To take notes in the field during, before, or after the interviews, the researcher paid attention to the verbal and non-verbal behaviors of the participants and wrote them down. Interviews were continued until no new data was extracted from the interviews (data saturation). The interview setting was, depending on the participants' preferences, a private room; and interviews with health providers in health centers and private offices were conducted by the main researcher of the study (AB). The interviews began in January 2021 and ended in November 2021, lasting between 40 and 105 min (mean 50 min).

The data were analyzed using the content analysis method with a conventional approach.[14] Immediately after each interview, the researcher listened to them carefully and then typed the interviews word for word into Word. To get immersed in the data, the researcher read the transcriptions repeatedly, checking them with the recordings, finally important sentences and phrases were named (coded). After coding each interview, to extract and separate the codes from the interview text, the Word file was imported into MAXQDA software. The data analysis was performed in six stages: (1) getting familiar with the data; (2) generating the initial codes; (3) searching for the themes; (4) reviewing the themes; (5) defining and naming the themes; and (6) producing a report. To do so, the initial codes were extracted from the meaning units (participants' quotations). Then, the main codes, which were more abstract, were named based on the similarities of these codes and subsumed, in terms of their common characteristics, under congruent subcategories. Then, each set of related subcategories was put under the main category. Briefly, in line with the research objectives, after analyzing the content of the interviews, categories of data from this study emerged, being about the concept of the FOC management and its coping strategies. Phrases and sentences of each interview were organized separately from other interviews and according to the commonalities, in the form of subcategories and common categories.

The rigor of the data was ensured using the four criteria proposed by Lincoln and Guba.[15] The credibility of the data was confirmed through prolonged engagement with the data for one year and giving reflective commentaries; then for addressing further rigor, the data

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was member-checked. Afterward, the codes and extracted categories were peer-checked to reach a consensus. The three data collection methods (in-depth individual interview, observation, and note-taking) were applied at different times and places, and participants with maximum variation (e.g., age, education, occupation, marital status, parity, ethnicity, religion) were selected. The extracted codes were reviewed by the participants (after coding each interview, the participant would receive the results to check the codes and interpretations). Moreover, to make sure of transferability, concepts and categories were provided to a few individuals similar to the participants (not among the participants) to comment on how similar they found the participants' experience to their own experiences. To improve confirmability, the details of the study process were recorded and the coding process was examined by other research team members and a few faculty board members familiar with qualitative studies. so that, the transcriptions of the initial interviews were recorded by two colleagues with PhDs in reproductive health. Ultimately, a 95% consensus was achieved through an external check, peer check, and dependability items.

Ethical considerations

Ethical approval to conduct this study (IR.SHMU.REC.1399.135) was granted by the Ethics Committee of Shahroud University of Medical Sciences, Iran. After obtaining the details of the participants, verbal and written consent to participate in the research and, if necessary, subsequent interviews, and permission to record the interview were obtained. Before the interviews, the purpose of the research was explained to the participants, they were informed that the interviews would be recorded, and they were also assured of the confidentiality of their personal information. They were informed that their participation in the research was optional and that they had the right to withdraw from the study at any stage.

Results

The participants were 15 pregnant women whose demographic characteristics are shown in Table 1. Other participants to this study include 21 healthcare providers (six midwives, five gynecologists, one perinatologist, four experts of reproductive health, four psychologists and psychiatrists, one general practitioner) and four policymakers of maternal' health. The majority of providers of health care were in the age range 30–54 (Average age 44 ± 6 years) and with Job experience range 4–30 years [Table 1].

As a result of the initial coding, 1500 codes were extracted from the text of the interviews, which in the process of continuous analysis and comparison of data were reduced to 1000 codes, 33 subcategories, ten categories, and three main categories. With the formation of their sub-themes in the form of concepts obtained from interviews, different dimensions of the needs of pregnant mothers (educational, psychological, and supportive) for the proper management of the FOC were discussed [Table 2].

Main category 1: The need to provide awareness and empowerment to the mother and family

1-1 The Lack of Awareness of Mothers about Pregnancy and Childbirth

One of the common experiences of the participants was their ignorance of the process of pregnancy and childbirth. They did not have a correct understanding of the physiological changes during pregnancy and the way of childbirth, and expressed their fear of the unknown

Table 1: Participants' characteristics

Participants	Age (year)	Education	Occupation	Pregnancy Status G*P**Ab***	Gestational age (week)	Time of marriage (year)	Ethnicity	Religion
P1	32	Bachelor's degree	Employee	G2P1Ab0	39	6	Lor	Shia
P2	33	Ph. D	Teacher	G1P0Ab0	35	4	Fars	Shia
P3	19	High school	Housewife	G1P0Ab0	35	2	Kurd	Sunni
P4	30	Associate degree	Housewife	G2P1Ab0	36	6	Fars	Shia
P5	28	Associate degree	Housewife	G4P1Ab2	38	7	Lak	Shia
P6	26	Diploma	Housewife	G1P0Ab0	35	9	Urami	Sunni
P7	33	Bachelor's degree	Employee	G1P0Ab0	34	1	Fars	Shia
P8	33	Diploma	Housewife	G2P1Ab0	35	5	Lak	Shia
P9	37	Associate degree	Non-government job	G3P0Ab1	34	10	Fars	Shia
P10	34	Elementary school	Housewife	G4P2Ab1	34	12	Kurd	Ahle Hagh
P11	25	Bachelor's degree	Housewife	G1P0Ab0	35	4	Fars	Shia
P12	26	Bachelor's degree	Housewife	G1P0Ab0	40	5	Jaf	Sunni
P13	20	Master's degree	Employee	G1P0Ab0	35	2	Kurd	Ahle Hagh
P14	23	High school	Housewife	G2P0Ab1	33	5	Fars	Shia
P39	24	Diploma	Housewife	G1P0Ab0	35	3	Urami	Sunni

*G: Gravidity. **P: Para. ***Ab: Abortion

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Table 2: Main and subcategories obtained from the analysis of participants' interviews

Main categories	Categories	Subcategories
1-Need to provide awareness and empowerment of mother and family	1-1 The lack of awareness of mothers about pregnancy and childbirth	Mother's ignorance of the pregnancy and childbirth process
		Inadequate maternal information on the advantages and disadvantages of NVD* and C/S**
		Lack of knowledge of preparation methods for childbirth
		Need to learn about pain relief methods
	1-2 The need to achieve more knowledge in reducing the fear of childbirth	Need to know the facts of childbirth in different ways
		Lack of sensitivity of the couple to the specific conditions of pregnancy
		Improve the situation and reduce fear seeking more cognition
		Conscious choice of delivery method following cognition increase
	1-3 Educating and informing mothers and families	The effect of education on the mother's physical and mental preparation
		Need to train spouse and family
		Continuous improvement of the training process taking into account the training needs
2-Need to pay attention to the mental health of pregnant women	2-1 The effect of maternal attitude on the process of pregnancy and childbirth	The role of positive perceptions and thoughts in reducing the fear of childbirth
		The role of beliefs, previous experiences, and negative mentality of the mother towards childbirth
		The importance of the impact of psychological factors and thoughts on pregnancy acceptance
		The influence of previous beliefs, experiences, and indoctrination of others in choosing the method of delivery
	2-2 The psychological burden of experiencing fear in mother and family (healthy transition anxiety)	Persistence of previous experiences of fear in life (rooted phobia from childhood to adulthood)
		Fear experience in the first sexual intercourse (wedding night experience)
		Unpleasant experience of previous delivery and experiences of others (family and friends)
	2-3 Experience of psychological trauma in pregnant women	Experience coping with fear
		Consequences of fear of childbirth
		Threat to married life
3-Supporting needs (seeking support)	3-1 Pay attention to the role of the husband in supporting the mother	Psychological and emotional support and sympathy from the husband
		Husband's inattention to wife
		Husband's companionship and attention to the mother's needs
	3-2 The importance of family support	Need for family support
		The need for family presence during childbirth
		The importance of empathy and family companionship
	3-3 The importance of supporting medical staff (health team)	Need to support from health care providers and midwives
		Need to support the midwifery team during delivery
		The importance of maternal support by obstetricians
	3-4 The need for social support	Cultural and welfare activities to support pregnant women in society
		The importance of using communication media
		The impact of using cyberspace

*NVD: Normal Vaginal Delivery. **C/S: Cesarean Section

process of childbirth: *"Mothers like me who do not know anything, think that they will enter a torture room where they are to suffer all kinds of tortures and eventually perish, and they think so because it is something unknown to them..."* (Mother-P5).

Healthcare providers also stressed the importance of informing mothers:*" Many fears are rooted in lack of awareness. When someone knows the nature of something, she is less afraid of it, and her fear becomes a real fear and is no longer a false fear..."* (Midwife- p17).

1-2 The Need to Achieve More Knowledge in Reducing the Fear of Childbirth

To control their fears, women need to know more about the facts concerning childbirth to deal with the misconceptions that cause fear. Sensitizing the mother and family by giving them information can play an important role in consciously choosing the method of delivery. *"Before pregnancy, I did not have much information. Like me, many mothers as soon as the pain starts, expect to be given an injection that would silence the pain. Mothers need to know what childbirth is and what the steps are to increase their tolerance"* (Mother- p39).

Another participant said: *"In the beginning, I was always thinking about childbirth, I used to fall into tears all at once. until I took childbirth classes and did a lot of research myself. Now my condition is very good and I am preparing for natural childbirth..."* (Mother- p6).

Lack of familiarity with the facts of childbirth causes the mother to be surprised and afraid when she encounters childbirth*: "In some cases, the mother cries out and says that they have lied to me about giving medicine during childbirth, and not being in pain anymore. The mother*

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is more afraid when she sees duality, this confusing her "(Midwife- p19).

1-3 Educating and Informing Mothers and Families

The mother and the family are empowered to manage the FOC if they receive appropriate training according to the mother's needs. Participants' statements showed that the mother's readiness for a rational delivery was influenced by the mother's correct information.*".... I had a lot of questions about different issues that I had to read about. In my opinion, it would be much better if the clinic staff told us the important points about everything they do* "(Mother-p13).

On the other hand, the participants spoke about the urgent need to educate the family about the special needs of the mother during pregnancy and childbirth and the need to properly inform the spouse about the appropriate response to these needs. *"I think the father should also have information. Nobody has thought about this issue at all. At least two brochures should be given to the fathers so that they would also know what they should do in terms of preparing for their wife giving birth, or they could even show them a short film."* (Mother-p14).

Main category 2: The need to pay attention to the mental health of pregnant women

2-1 The Effect of Maternal Attitude on the Process of Pregnancy and Childbirth

The formation of a proper attitude in pregnant women leads to a rational embracing of affective beliefs, creating a positive mindset about childbirth. Some pregnant women cited the feeling of motherhood and the influence of a good mindset as factors boosting the morale and preparation for childbirth: *"The sweetness of having a baby and thinking about the baby has made me stop thinking about the pain of childbirth. I have forgotten my fears and I am ready to face childbirth "* (Mother-p39).

The mother's previous beliefs can influence her reaction to the current situation and her deciding on the type of delivery: " *I can't accept that natural childbirth is harmless for the mother, I think that there are a series of problems that do not occur during a cesarean section. In my opinion, everyone has an opinion for themselves."* (Mother-p13).

2-2 Psychological Burden of Experiencing Fear in Mother and Family (Healthy Transition Anxiety)

Facing fear and stressful situations is an unpleasant experience that leads to a series of emotional and psychological responses. Experiencing fear in other periods of life can be the cause of fear with different intensity during pregnancy and childbirth. So it is believed that the roots of fear remaining from many years ago cause fear to appear in current unfamiliar conditions. "*When I was a child, I was afraid of the dark and the night. I still have some fear. I find the same feeling when thinking of childbirth, just like the feeling when I think of the dark. I can't control it* "(Mother-p14).

"Previous issues of women should be considered. Many cases of fear of childbirth stem from a history of sexual abuse. These women are also afraid of their first sexual intercourse, they are also afraid of childbirth " (gynecologist- p30).

Fear of experiencing the first sexual intercourse (wedding night experience) is mentioned in the conversations of participants (especially mothers). *"Because I have a bad memory of the pain of the first intercourse, I think I can't relax at all during childbirth and the anxiety makes me feel bad"* (Mother-p7).

2-3 Experiences of Psychological Trauma in Pregnant Women

In facing the FOC, expectant mothers experience certain psychological conditions that can have negative effects on the outcome of their pregnancy process. One of the important results of mother's exposure to fear is their self-efficacy in controlling stressful situations. Some of the participants were able to control the situation, and in other cases, they expressed their inability in this field. "*I had no control over my previous fears. When I see that my husband has no desire to help me, I feel even worse. I think there is nothing I can do about this fear of childbirth"* (Mother-p1).

"Sometimes I comfort myself that I have to go this way and I comfort myself because I say that it is better than going down this path with fear. It is enough for mothers if they can stop negative thoughts from entering their minds" (Mother-p1).

One of the major problems of women is the consequences of fear, which can affect the body, mind, and quality of life of women years later: *"It was very hard; I was very stressed mentally. I am afraid of childbirth, I only dream of childbirth and when I wake up, I can no longer sleep, I am always anxious during the day"* (Mother-p9).

Main category 3: Supporting needs (seeking support)

3-1 Paying Attention to the Role of the Husband in Supporting the Mother

Participants in their experiences mentioned the irreplaceable role of the spouse. Having a sense of support to deal with certain stresses during pregnancy by the spouse has a positive effect on women's psychological and physical health. "*A pregnant woman has her issues. She may be happy or depressed some days, or she may have physical changes such as weight changes or blemishes on her skin. Women like their husbands to understand them and not regularly ask them, why have you got like this?"* (Mother-p12).

Unfortunately, some mothers complained about their husband's negligence during their pregnancy: "*My fear is*

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more of loneliness.... Many times, I would like my husband to be by my side, but he prefers his job. I did not expect the rest of the family, I just expected my husband to pay attention to me" (Mother-p10).

3-2 The Importance of Family Support

Family members can play an important role in accompanying a pregnant woman. This support is very effective in responding to the physical and psychological needs of the mother and in her acceptance of the role of motherhood.*" I liked to be noticed by my family and my husband during pregnancy. At first, I could not tell them how I felt. I would have liked them to pay more attention to me, but now I talk to them very easily"* (Mother-p6).

During childbirth, women tended to be accompanied by someone they knew to reduce the feeling of loneliness and fear of entering an unfamiliar situation. *"..... My friend said: My mother, who was by my side for half an hour during the delivery, made me feel very good. I would like to be allowed to call my family by phone. I am sure this will reduce my fear* "(Mother-p10).

3-3 The Importance of Supportive Medical and Healthcare Staff (Health Team)

Members of the health team have a significant role in supporting mothers due to their special ability to provide the necessary services. Pregnant mothers considered their expectations in responding to different needs as a kind of support of health personnel:" *Support means that I am relieved that they are taking care of me. This makes me less stressed and stops me from overthinking about delivery* "(Mother -p13).

During childbirth, women expressed respectful care of the mother and preservation of privacy as an important Supportive need. " *I expect the hospital staff to give me some psychological help with the necessary guidance. I think it is very important to have a good attitude, kindness, and peace*" (Mother- p14).

3-4 The Need for Social Support

Social support as a moderating factor reduces the negative effects of stressful factors and increases the ability to cope with the challenges. *"Our mothers usually come from low social levels. They should be supported to eat properly. Many of these mothers have problems and come with a subconscious full of stress. We should not expect a happy delivery"* (Midwife -p24).

Despite the important impact of the media, participants, including pregnant mothers, emphasized the inefficiency of mass media, including television:*". Everyone says that TV does not have a program that is useful for pregnancy and postpartum. I occasionally did I look at a program that talked about healthy baby nutrition, but it didn't help me much."* (Mother- p11).

Discussion

This study investigated the needs of expectant mothers in managing the FOC. Findings indicated that there are different needs for managing the FOC in pregnancy, which fell into three main categories, namely the need to raise awareness and empower the mother and family, the need to pay attention to the mental health of pregnant women, and support needs (seeking support). The mother's ignorance of the pregnancy and childbirth process and her lack of awareness in this regard in our study are the main causes of mother's FOC and one of the important obstacles to accepting the role of the mother and creating psychological problems. In this study, the narrations of the participants showed that raising awareness and information is one of the most important needs due to women's poor knowledge of the processes related to pregnancy and childbirth. In previous studies, women's poor knowledge of the birth process has been identified as one of the underlying causes of their fear.[16,17]

A former study also showed that the needs of primiparous women were providing relevant, appropriate, and timely information so that they would be able to gain positive experiences childbirth.[18] Since insufficient knowledge of pregnant women about the delivery can be factored in reducing the desire of pregnant mothers for natural childbirth, creating sensitivity in the mother and family to increase awareness leads to conscious choice of delivery method.[19] In our study, participants cited increasing maternal cognition about childbirth as a factor in improving mental health and reducing the FOC and stated that mothers and families will be empowered to manage childbirth fear if they receive appropriate training. In this regard, an earlier study with an emphasis on the educational needs of mothers have stated that the use of educational opportunities to increase the awareness of women is a good measure to reduce fears.[20] Also, another study stated that Kurdish adolescent mothers who have low information and high anxiety about childbirth due to their young age have a high need for awareness and information that can reduce their fear of the unknown.[21] According to the current study, due to the fact that the birthing process is unknown to mothers, the need to provide educational and information programs was raised. Teaching the mother and her family, including her husband, can prepare them to properly manage this process and its problems. Over the past decades, empowering women to improve their knowledge and skills in the field of pregnancy and childbirth has been one of the most important strategies in promoting natural childbirth.[22] On the other hand, it is necessary to provide correct information to mothers, regardless of any professional judgment or prejudice. Spouse education to involve men during pregnancy is one of the topics that lead to improving the consequences of childbearing, which was emphasized in our study. In line with these findings, an earlier study reported that education

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with the presence of a spouse during pregnancy can have positive results in reducing fear, changing the mother's attitude toward childbirth, and reducing the rate of cesarean section.[23] Other studies also show a greater effect of education of spouses with pregnant women on reducing their anxiety and worry during pregnancy compared to education of women alone.[24]

The need to pay attention to the mental health of pregnant women was one of the categories based on the experiences of our study participants. Because of the influence of mothers' perceptions, thoughts, ideas, and experiences of psychological trauma on pregnancy acceptance and maternal role, the need for psychological support has been raised. Awareness of women's attitudes can help midwives and physicians adjust their interactions with women to reassure them of their ability to give birth and become mothers.[25] In our study, one of the major concerns of women is the fear of repeating a previous unpleasant experience. Some other studies have shown that women were afraid of repeating previous experiences in their pregnancies. Their negative experiences often result from a traumatic delivery, a delivery longer or shorter than expected, and a lack of staff support.[26,27] However, another study reported that negative personal experience of suffering is not necessarily a factor that affects FOC and showed that previous negative experiences did not affect the FOC.[28] In case of problematic deliveries, the mother's mental condition can be balanced with emotions such as feeling safe and caring during childbirth, thus preventing the creation of a negative attitude in the mother.[29] On the other hand, giving birth without a medical complication can be considered a negative experience if the woman does not feel safe or is not well cared for.[30] It seems that in the case of FOB during the next pregnancy, the experience of mental delivery is more important than the complications of obstetrics.[31] The experience of fear in the past can cause fear. In this study, it was pointed out that these fears are rooted in the events of adolescence, and even childhood, which can sometimes be caused by sexual abuse in the past. In this regard, a former study highlighted that FOC is associated with a history of sexual abuse, so nulliparous women with a history of childhood abuse had more severe FOC than women without such a history.[32] Another study also reported that sexually abused women often requested C/S without any other medical indication.[33] Due to the specific culture of the region and the lack of appropriate education for girls of marriageable age, the experience of fear in the first sexual intercourse at the time of marriage is associated with the FOC, which was mentioned in our study. This issue is not mentioned in any of the studies reviewed by the research team. It is necessary for health planners to pay special attention to the needs of young women in the studied society, considering the cultural conditions of the region. Analysis of interviews in our study showed that pregnant mothers experience very vulnerable conditions in terms of mental health, which pointed to the need to pay attention to and respond to these needs. Participants in our study believed that from the beginning of pregnancy, the mental state under study while paying attention to common mental health problems, the issue of fear of pregnancy should be addressed specifically. Understanding the beliefs and attitudes of women during childbearing is an important focus of international maternal health policy that should be given special attention. The terms "woman-centered care" and "conscious choice" indicate that in addition to the physiological aspects of pregnancy and birth, there are unique psychological and psychosocial aspects to the individual life experiences of pregnant women.[19]

Supporting needs (seeking support) was another main category found in our study. Experiencing specific conditions of women during pregnancy requires the support of their husbands and family, friends, and related social organizations. Participants in our study emphasized that husband support can help pregnant women gain the information they need, increase their self-confidence, and reduce stress and the FOC. The results of the former study show a negative correlation between FOC and social support. In this study, spouses are the main source of social support that women value more.[34] In this regard, the findings of another study have shown that the support that pregnant women receive from their husbands and parents plays an important role in reducing FOC in pregnancy.[35] Many of the medical team members in this research emphasized on that husband support can help a woman manage childbirth anxiety and minimize the FOC, thus increasing mothers' psychological well-being. Consistent with our findings a previous study emphasized that healthcare providers should involve the spouse during the delivery preparation cycle to address sociocultural issues.[18] Support and companionship from the spouse and parents can give the mother more sources of attention and help to increase happiness so that they are fully convinced that they have a lot of support.[36] According to the participants in the current study, pregnant mothers consider their expectations in responding to the different needs of the mother as a kind of support of health personnel that can have beneficial effects on creating peace and psychological support for mothers. In a previous study about women who needed the support of the health team, it was noted that despite their desire to become mothers, they suffered silently due to low information about pregnancy and the fear of experiencing childbirth. Because they received information about childbirth mainly from traditional sources, they had different feelings, and their desire to become a mother was challenged by the feeling of pregnancy discomfort.[18]

In our study, healthcare providers play an important role in deciding which method to use for giving birth. The most common cause of fear is a lack of trust in the delivery staff. Common reasons include concerns

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about being left alone, unfriendly behavior of maternity staff, and lack of involvement in decisions.[27] A former study also stated that despite the great value that women place on the health team, there are unfortunately some personnel who negatively affect the experience of women with FOCs. The evidence available in the world and in Iran shows the unique role of midwives, in facilitating the process of pregnancy and childbirth along with their emotional support.[37] One of the strengths of this study is the simultaneous use of the expectations and desires of mothers as the main beneficiaries and the opinions and views of health team members working in academic centers, private sector, social security and not only government. The limitation of this study is that, like any other qualitative study, the generalizability of the study is low. The structures obtained in this study are dependent on the sociocultural context (Iran) which may affect the transferability of the findings. However, sampling was performed with maximum diversity. Limited access to the pregnant women who had the criteria to enter the study (due to the spread of the coronavirus) was another limitation of the research.

Conclusion

The psychological status of women with FOC can affect their ability and likelihood of following instructions and taking care of themselves during and after pregnancy. Our results highlighted a wide range of needs of pregnant women, helping them manage the FOC. These findings can be used to design appropriate prevention strategies to manage and control the mental health problems of these women to turn their pregnancy into a pleasurable experience. Lack of attention and response to them plays a significant role in the formation of the mental cycle of inefficiency and the FOC and ultimately the process of mothers' decision to choose the type of childbirth. According to this, researchers are trying to combine the results of this study with the evidence in clinical sources and guidelines in this field, and then design a clinical guide according to the needs, expectations, and skills of stakeholders in the context of Iranian culture. This clinical guide can be used for providing services during pregnancy, childbirth, dealing with anxious conditions, and helping mothers manage the FOC.

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Conflicts of interest

Nothing to declare.

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