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Norwegian midwiveś experiences of encounter and support women with fear of childbirth during birth

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ABSTRACT

Objective: To describe midwiveś experiences of encountering and supporting women with fear of childbirth (FOC) during the birth.

Method: Qualitative study with a phenomenological approach, using 10 individual semi-structured interviews with midwives who had cared for women with FOC during the birth. All midwives worked in birth clinics or maternity wards. The data was analysed using Malteruds systematic text condensation (STC).

Results: The findings present in three main themes: *taking on a professional role as a midwife to take care of women; time matters for safety and trust; and to encounter and see women without prejudices*. Themes to describe a 'professional midwife' included self-confidence, control, competence/experience, independence, promoting normal birth, and motivation. Time played a crucial role in enabling a calm approach and a relationship built on trust, as well as in creating a sense of continuity and being present. Individual care and equality among the women was of importance to prevent prejudices, as was having control of the term FOC. Self-awareness was also important for evaluating the quality of the relationship, and the midwives' wanted clear guidelines for handling women with FOC.

Conclusion: Aspects related to professional midwifery skills, organisational factors such as time to establish safety and trust, and use of the concept of FOC, are all important for midwives when encountering and supporting women with FOC at birth. All these aspects need to be improved in the care of women with FOC, and clearly defined guidelines for handling such cases need to be developed.

Introduction

Fear of childbirth (FOC) is a common problem affecting women's health and wellbeing [1], but there is no clear consensus as to the meaning of this term. A study from 1981, conducted in Sweden, defined FOC as a strong anxiety that impaired women's daily functioning and well-being during pregnancy [2]. Later, a study from Finland went on to define FOC as a health issue for pregnant women, relating to an anxiety disorder or phobic fear, including physical complications, nightmares, and difficulties with concentration, as well as demands for caesarean section [3]. Additionally, FOC can be classified as four different degrees. The study defines mild FOC as when the woman has a mild worry about the upcoming birth. Moderate FOC occurs when the stress is too difficult to cope with and the woman requires external support. Severe FOC is defined as when the strain of the condition has a risk of causing avoidance of pregnancy, avoidance of vaginal birth or can cause further psychological vulnerabilities. Tokophobia is FOC at its most extreme, and can ultimately result in avoidance of pregnancy, vaginal childbirth, and postponement or abortion [4].

Because of its complex nature and difficulties in measurement due to surveys without consensus of definitions, research of FOC becomes highly problematic and requires extensive studies [1]. A systematic review conducted in 18 countries worldwide found the prevalence of tokophobia to be 14 %. In Australia, the prevalence of tokophobia reaches 23 %, compared to 8 % in the rest of Europe, and 12 % in Scandinavia. This study also confirms an increase of tokophobia over thirty years [5]. A recent study from China estimated the prevalence of moderate FOC to be 22 % and severe FOC to be 6 % among pregnant women [6]. A study from 2014 shows a prevalence of severe FOC in Norway, estimated at 12.7 % for primiparous women, and 11.2 % for multiparous women [7]. The cause of these wildly varying results in the prevalence of FOC worldwide could very well come down to cultural differences, several methods of measuring it, and different definitions [1].

The cause of FOC can vary between primiparous and multiparous

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women. Studies describe eight potential causes for primiparous women: fear of not knowing; not being prepared for the unpredictable; fear of harm or stress to the baby; not being able to cope with the pain; being harmed during the birth; being overwhelmed; being unable to participate in decision making; and being abandoned and alone. Multiparous women echoed these causes and added two more potential causes for FOC: fear of interventions; and fear of prolonged labour [8,9]. A *meta*-synthesis based on 14 qualitative studies shows that women suffering from FOC require support that can alleviate their existential issues, allowing them to express and integrate their feelings, experiences and expectations during pregnancy, childbirth, and postpartum [10].

Previous studies have shown the need for treatment options to be available for women with FOC during pregnancy and birth [11,12]. Among these is a study demanding the incorporation of theory-based concepts of care and effective interventions in the health care system to enhance midwiveś qualifications in supporting women with high or severe FOC [12]. There are various ways to recognise FOC, the most validated tool used worldwide being W-DEQ, a questionnaire that recognises FOC and evaluates its level as mild, moderate, severe, and phobic fear [1,13]. One study from Finland shows that psychoeducational group therapy has positive effects, in terms of fewer caesarean sections and more satisfactory delivery, for primiparous women with severe FOC [14]. According to a Swedish study, having a known midwife present during birth is another factor that has positive impact on women with FOC related to birth experiences, although it does not affect delivery outcome [15].

According to midwives in a Swedish study, it was emotionally demanding and time-consuming to take care of women with FOC during antenatal care, during the birth and postpartum [16]. Furthermore, a study from Norway shows that to provide optimal support, several factors that the midwives could not control had an influence, such as lack of continuity and individualised care [17]. In addition, another study shows that midwives need more education about severe FOC to identify and cope with these women in general [18].

In summary, while there is some research about midwives' experiences of FOC, we have not found any that focuses on how to encounter and support women with FOC during birth. Therefore, the aim of this study is to describe midwives' experiences of encountering and supporting women with FOC during birth.

Method

Design

A qualitative approach was used, which is useful when exploring the meaning of a specific phenomenon that has not been described previously, such as midwiveś experiences of encountering and supporting women with FOC during birth [19]. Malterud́s systematic text condensation (STC) was used to analyse the material thematically [19].

Settings

The study was carried out in Norway. Midwives working with hospital births and postnatal care can work at three different levels in this country: Birth clinics, maternity wards, and small midwife-led units. In addition, midwives can work in antenatal care, which is a part of primary health care. Midwives in Norway have professional responsibility for normal pregnancy and birth. Continuity of care from pregnancy to birth is rare, as midwives either work in primary health with antenatal care, or at hospitals with birth although they may sometimes have a combined position. Women will therefore usually meet different midwives who take care of their antenatal care and during the birth [20]. It is recommended that women with FOC receive extra counselling during pregnancy from midwives or obstetricians [21].

Participants and data collection

10 midwives who worked in birth clinics or on maternity wards were interviewed individually. Seven of the midwives worked in birth clinics, and three of them had previous experience of working in antenatal care. The remaining three midwives worked on maternity wards. The experience of the midwives varied between 2 and 32 years, see Table 1. The midwives in the study represented several counties and cities in Norway. Inclusion criteria was midwives working actively in birth clinics, on maternity wards or in small midwife-led units with intrapartum care, and having more than two years' experience. Midwives were recruited through a Facebook group for midwives in Norway, and through personal contact by two of the authors (XX, XXX) when they practiced as midwifery students. Interested midwives also informed other midwives in line with snowball sampling. The midwives received written information about the study and, if they were interested, they contacted the authors for more information.

A semi structured-interview guide with open questions was used for the interviews (Fig. 1). During the interviews, one of the authors (XX or XXX) was responsible for audio recording and asking follow-up questions, while the other author (XX or XXX) asked the questions from the interview guide. The interviews lasted between 25 and 55 min. Four of the interviews were carried out in person, while six were conducted by video conference due to the Covid pandemic. The interviews were audio recorded and securely stored.

Ethical considerations

The Norwegian Centre for Research Data (NSD) approved the project according to ethical standards for research. Participants were midwives who voluntarily participated and gave informed oral consent before each interview after being given both written and oral information. The participants chose the place and time for the interviews. They were informed about their right to withdraw from participation at any time without consequences, and that the information was confidential.

Data analysis

Audio recordings of the interviews were directly transcribed and STC was used for data analysis, involving four steps [19]. All authors were involved in the analysis. The first step was to get an overview of the material by reading the transcription, and to identify preliminary themes. In the next step, "meaning units" and code groups were identified by reading the material sentence for sentence. Unnecessary material was excluded, while "meaning units" that shed light on the phenomenon were placed into code groups. In the third step the "meaning units" were organised into sub-themes, and thereafter condensates were developed to describe each sub-theme. The final step of the analysis consisted of a re-contextualisation, where the condensates

Table 1
Participants.

Participant number	Work experience	Workplace
1	15 years	Birth clinic
2	8 years	Birth clinic/experience from antenatal care
3	2 years	Birth clinic
4	2 years	Maternity ward
5	32 years	Birth clinic/experience from antenatal care
6	4,5 years	Birth clinic
7	7 years	Maternity ward
8	18 years	Birth clinic
9	11 years	Birth clinic/experience from antenatal care
10	6 years	Maternity ward

Interview guide

- How do you define fear of childbirth?
- What is your most significant role as a midwife when you meet a woman with FOC?
- What challenges do you experience as a midwife during childbirth when meeting these women?
- Describe the collaboration between you as a midwife, and women with FOC at birth.
- What kind of support do you give women with FOC?
- Do you have any further thoughts regarding your experience of working with women with FOC during birth?

Fig. 1. Interview guide.

were converted into an analytic text that shed light on the phenomenon, which were the findings of the study. Throughout the data analysis, the authors strived to be aware of their own preunderstanding, be open-minded, and put aside theoretical frames of reference, allowing the data material to arise [19].

Results

The findings are presented in three main themes; *taking on a professional role as a midwife to take care of women; time matters for safety and trust*; and *to encounter and see women without prejudice.*

Taking on a professional role as a midwife to take care of women

For the midwives to appear professional was extra important for promoting birth as being safe for women with FOC, due to their vulnerability and fear. To reduce womeńs FOC, the midwives thought it was important to appear professional by portraying self-confidence. This was developed through work experience, which made the midwives more confident in their ability to handle women suffering from FOC. Self-confidence could then increase their professionalism in order to ease the tension and anxiety women would experience and allow them to trust that they would be safe no matter which midwife was present. Part of having self-confidence involved having control. Having control also gave midwives a feeling of professionalism, which was developed through their competence and experience. The midwives' considered competence to be about being proficient by having professional knowledge relating to FOC, while also emphasising the importance of independence and practical skills to handle the women in a professional manner. Independence was such an important factor that the midwives emphasised that it would help prevent unnecessary interventions and the involvement of other professionals, which could lead to a reduction in a woman's FOC. Even though the midwives were independent, they were aware that asking for help was not seen as a defeat. Moreover, being able to admit when they needed extra assistance increased the midwives' professionalism. Lack of guidelines as to how to handle women suffering from FOC could occasionally lead them to be insecure, but the midwives took all these concepts in order to handle women suffering from FOC in a professional way.

"Even though I haveńt worked that long as a midwife, I feel professional enough to stay focused and have control, even if FOC can complicate it a bit. Sometimes only a severe FOC can make me lose control and affect my self-confidence." (Participant 10).

A part of being a professional midwife was also to make women with FOC understand and maintain birth as a normal physiological process. The midwives appeared professional by informing and illustrating physiological and mental changes during the birth, to reduce womeńs FOC. Midwives thought this made women more confident and prepared for changes that seemed abnormal, but which are part of the physiological process of birth. FOC was not primarily seen as a risk factor by the midwives, but could sometimes develop complications in birth. Therefore, the midwives took care of the women by not relating FOC to a medical complication. Although pain is a reason for FOC, according to the midwives, they used their professional knowledge to explain how pain was necessary to expand cervix for the birth, and not dangerous. They thereby normalised the process of birth.

> "*I want to be the best midwife possible, and I try to give professional support, especially for women with FOC, and I do that by giving information early about the physiological process and being clear. I think it's better to be safe than sorry"*(Participant 9).

Being a professional midwife also involved motivating women suffering from FOC during birth, and the midwives expressed that the women often lacked confidence in giving birth. Motivation from the midwives could strengthen womeńs power to master birth and increase their confidence. The midwives could motivate them by being encouraging, passionate, and involved in the process. To help alleviate FOC, the midwives considered participation during the birth a major priority for these women. The midwives tried to motivate women to participate by having a constant dialogue with them. This included asking questions, giving options, and listening to womeńs views before making decisions. The midwives believed this could motivate the women to feel appreciated and acknowledged. They also thought this could motivate women throughout the birth and promote a normal physiological process – even though the midwives had been in various situations where FOC had suddenly occurred during birth and made the women incapable of speaking up for themselves. Consequently, the midwives sometimes had to make decisions based on professional recommendations, which they thought were the best for the women.

> *"As a professional midwife, I give them a lot of choices and options. I try to meet them in a slightly different way than others … I give them an opportunity to be more involved in their own birth and I want them to be a part of this journey with me."* (Participant 4).

Time matters for safety and trust

The midwives emphasised that time was essential to achieve continuity and create safety and trust for women with FOC during the birth. Due to capacity conflicts in the ward, the midwives saw it as challenging

to maintain continuity of care. In many cases, the midwives tried to promote continuity by helping each other have less responsibilities outside the birth room. This allowed them to follow up and focus on women with FOC, who they thought required more continuity. There was consensus among the midwives that this practice had a positive impact and was a necessity for women with FOC in order to maintain safety and trust, which ultimately led the midwives to feel they did a better job. Women with FOC had often birth plans with certain wishes and needs, and the midwives did their best to fulfil these, to create safety and trust. However, time restrictions sometimes made this impossible. This led the midwives to feel they were giving less support and could create mistrust, which they felt was unfortunate for women with FOC at a time when they most needed their support.

> *"Even though I find women with FOC as more time-consuming, there is no more time away from the ward arranged to promote more continuity in midwifery care, which can be frustrating."* (Participant 5).

The means of establishing safety and trust for women with FOC varied from individual to individual, and the midwives considered their presence essential to establishing these conditions for the women. According to the midwives, they tried to consider women's needs by being both mentally and physically present, as they thought this contributed to safety and trust. The physical presence of the midwives was - according to them - even more important when caring for women with FOC, since by being physically present they felt more secure in understanding and discovering what the women needed. When the midwives could not be present, they considered the womańs partner important for providing safety. Being both mentally and physically present helped the midwives to get to know the woman and her partner and create a trusting relationship. Even though this was more time-consuming, it was of extra importance when encountering women with FOC. All these aspects could create safety and trust according to the midwives.

> *"Presence is not just about being constantly in the birth room, but being available as soon as they call for you and showing them trust by turning up on time. Moreover, when I cań t manage to be present, I make agreements with her. In that way we negotiate through the birth."* (Participant 1).

In demanding situations where midwives did not have any contact due to a womańs FOC, they thought a calm approach was important to establish safety and trust. To have a calm approach, the midwives took their time and tried to present themselves as not in a hurry. They took their time to sit quietly by the womańs bed and have a relaxed discourse with a sensitive touch to create safety and trust. In many cases, the act of a sensitive touch would have a greater significance than words and could assist in creating a calm mind-set in women with FOC, as long as time would allow it. At the same time, the midwives had to be cautious in their approach when they were touching the woman, because they thought women could develop FOC through previous physical contact. Genuineness in the actions and behaviours of the midwives was necessary, because they thought women with FOC could easily pick up on expressions from them, which could create mistrust. A calm approach was also necessary for the midwives so they could use their senses to evaluate women and create a safe birthing atmosphere by lowering the lights, removing unnecessary equipment, and keeping the room tidy. This approach was even more vital for women with FOC.

> *"As midwives we are intimate…We must not forget that we have few boundaries and are closer to people than most. We need time to give a calm approach when we encounter women with FOC, and sometimes having two ears and one mouth could be enough."* (Participant 6).

To encountering and see women without prejudice

To encounter and see women with FOC without prejudices was important to the midwives because FOC was a term that was unclear and could therefore lead to misunderstandings for them. These misunderstandings could lead to comparing the term FOC with normal concerns and distress. Using the term wrongly could make the midwives not take the women seriously, making them feel dismissed, which they thought could increase their FOC and affect the care given in a negative way. The midwives also lacked guidelines on how to recognise, handle, and separate levels of FOC, which created uncertainty among the midwives. Because of the unclear definitions and lack of guidelines, the midwives experienced different attitudes towards FOC in both themselves and from the ward. These attitudes could cause prejudices, which the midwives thought could affect co-workers, and influence midwives' motivation when encounter women with FOC during birth.

> *"I have heard comments at work such as: suddenly it́s extremely popular to have FOC and: FOC has become a trend… These attitudes make me sad and create a negative work environment."* (Participant 3).

To avoid prejudices, the midwives encountered women with respect and acknowledged their FOC, as it was essential to encounter women in a neutral way and with an open mind. They were therefore open to adapt to womeńs needs, give women individualised care, and encounter them without prejudice. The women with FOC were sometimes more difficult to handle and required more attention, so many midwives felt they were giving more of themselves to satisfy the needs of the women. The midwives were conscious of treating women equally during birth to avoid prejudices and discrimination. They did this by giving the same care to all women during birth, even those with FOC. Avoiding prejudices like this requires a self-awareness that was developed through work experience and made it important to evaluate the relationship with a woman. Sometimes when the relationship with women with FOC was not right, the midwives were open for a change of midwife if necessary. They also thought it was important to reset their minds and attitudes before encounter the women.

> *"Sometimes I think it's difficult to communicate with these women, and I have actually backed out when the chemistry is not right, because communication is alpha omega."* (Participant 2).

Discussion

The findings from this study show that professional midwives who take care of women, that time matters for safety and trust, and that encountering and seeing women without prejudice is of importance when caring for women with FOC during birth.

Taking on a professional role as a midwife to take care of women

According to this study, a professional midwife who takes care of women is central for midwives when encounter and supporting women with FOC. This finding is supported by the International Confederation of Midwives (ICM), who state that professionalism in midwifery means working in partnership with women and giving adequate support, care and advice during pregnancy, birth, and the postpartum period [22]. One aspect of professional midwifery, according to our study, is having self-confidence in taking care of women with FOC. Self-confidence is also described in other studies as important for professional support of women during birth [17,23–27]. Due to their professionalism, the midwives in our study had self-confidence when they convinced women with FOC that they were safe during birth. This finding is supported by studies on womeńs experiences, which show that they need midwives to take care of them in a professional way by being self-confident [25,26].

Another aspect of being a professional midwife that emerged in our study was being independent. The midwives tried not to involve more people or interventions than necessary when caring for women with FOC during birth. Studies highlight interventions as one of the main reasons for developing FOC, which often requires obstetricians and other health professionals to be involved in the birth [8–10,16,28].

According to the midwives in our study, preventing interventions could reduce women's FOC, while bearing in mind that asking for help was not seen as a defeat. Moreover, this increased midwives' sense of professionalism when taking care of women with FOC. According to a study, midwives are responsible for seeking professional assistance when the care of the women so requires [23]. Studies confirm the importance of collegial support in midwifery care. At the same time, a lack of collaboration can affect midwives' ability to give women proper help, so creating a team around women during birth is clarified as high-quality care [17,23,24]. Moreover, there are few studies on how independent midwifery and collegial collaboration affects women with FOC during delivery. Further research is therefore needed.

Another aspect of being a professional midwife, according to our study, was promoting motivation for women with FOC during birth. Motivation during birth is highlighted as important in several studies in preventing medical interventions and having a positive impact on womeńs birth experiences [26–30]. According to our study, the midwives meant motivation gave women with FOC the power to master birth and gave them more self-confidence. This is confirmed by previous studies stating that midwives who strengthen womeńs self-confidence positively impact on women's feelings of being capable of giving birth [25,27,29,31]. At the same time, some studies indicate that women with FOC can lack motivation, which can challenge the midwives to achieve the right motivation for them [16,17,28,29]. One study also showed that less support from a midwife can lead to a lack of motivation [29]. The midwives in our study motivated women with FOC by being encouraging, passionate, and involved in the process. There are also other studies adding knowledge on how to motivate women by affirmation, empowerment, and recognition [17,20,23,25,27,29]. These additional aspects are not described in our study.

Time matters for safety and trust

To create safety and trust during birth, the midwives from our study emphasised that time was needed in order to be calm and have a calm approach to women with FOC. The importance of having this approach during birth is confirmed in other studies, and is essential for providing safety [17,25–27,30,31]. There are few studies on how a calm approach can affect women with FOC during birth. Moreover, the midwives in our study mentioned several aspects of how a calm approach can create safety and trust in the women. One aspect of a calm approach was a sensitive touch towards the women which often had greater significance than words. Studies confirm that massage and sensitive touch by a midwife has a positive impact for women, especially during the progression during birth [23,26–28]. Findings from our study highlight that the midwives were cautious in their approach when they were touching the women because the midwives' thought some women had developed FOC through previous physical contact. For example, some studies have indicated that physical abuse can be a factor for developing FOC [5,7,16]. Some studies indicates that midwives should maintain an appropriate distance from women, without being too close [23,31]. The midwives in our study tried to be genuine in their actions and behaviour, and one Swedish study confirms that women with FOC are more aware of midwives being genuine when taking care of them [28].

Another aspect of a calm approach was to use their senses to evaluate the women and create a safe birthing atmosphere. Using senses in midwifery is confirmed by earlier research to get a sense of what the women are feeling, and to encounter them during birth [27,29,31]. The midwives in our study created a safe atmosphere to reduce womeńs FOC. Being in a room without a safe and calm atmosphere can influence the women to not follow their birth process [27]. Therefore, a safe and calm atmosphere is highlighted as important to satisfy women giving birth [20,23,29,30]. This could be seen by the midwives in our study, who attempted to maintain a safe birthing atmosphere by lowering the lights, removing unnecessary equipment, and keeping the room tidy. According to previous studies, a calm and safe atmosphere can be affected by a medicalised room with lots of medical equipment [20,27,28,31]. Our study adds knowledge about how to create a safe and calm atmosphere, which is even more important for women with FOC, according to the midwives.

To encounter and see women without prejudice

One finding from this study was that the term FOC was unclear, which could create misunderstandings. Using the term wrongly could make the midwives not take women with FOC seriously and increase their fear, according to the midwives. Previous studies indicate that FOC is difficult to define, due to different cultures, measurements, and definitions [1,5,7]. The midwives in our study meant this could be unfortunate and could affect the care given in a negative way. Studies describe midwives being concerned about their ability to recognise and support women with FOC [5,16,17]. Another study emphasizes that midwives should have special training to encounter and support these women [18]. Furthermore, the midwives in our study wanted clear guidelines for handling and separating women's FOC from other concerns and distress. Lack of guidelines could also affect attitudes towards FOC in both themselves and others, which could create prejudice. There are few studies on how midwives' attitudes effect women with FOC, and further research is needed.

Another central aspect of encounter women with FOC without prejudices was to show them respect and acknowledge their FOC. According to the ICM, midwives are obligated to respect each individual woman and their circumstances [21], and studies also highlight the importance of respecting all women during birth to promote good midwifery care [17,23,26,27,29,31]. The midwives in our study provided individualised care to women with FOC and adapted to their needs, encountering them without prejudice. According to previous studies, individualised care is highlighted as essential in midwifery to respect all women's wishes and needs [16,23,25–27,30]. Besides giving women with FOC individualised care and treating them differently from others, the midwives in our study also described that it was important to treat the women with equality, to avoid prejudices and discrimination. One question to consider is what having individualised and at the same time equalised care means. The question of how to encounter and support women with FOC in the best way needs further research that should focus on both midwives and women with FOC.

Methodological considerations

The strength of a qualitative study is the ability to get a deep understanding of a phenomenon [19] – in this case, midwives' experiences of FOC during birth. Terms used by Malterud for scientific quality are 'reflexivity', 'validity', and 'trustworthiness' [19], which guided our research. We tried to reflect on our preunderstanding, both before and during the study, to be as open as possible to the studied phenomenon [19]. Internal validity determined how the study design related to the aim. We consider the method used relevant as it gave us an opportunity to describe the challenges midwives encounter in relation to women with FOC during birth. The interview guide was pilot tested, which is a strength [19]. We also tried to show the various steps in the research process and follow the interview guide for trustworthiness [19]. However, one limitation we can identify is that this was the first study for the interviewers. Another limitation is that some of the interviews were conducted by video conference due to Covid restrictions. Furthermore, participants may have had a special interest in the topic, which may influence the findings. Transferability (called external validity by Malterud) must be related to the fact that qualitive studies are contextual [19]. In our study, the contexts are the participants, their workplaces, their experience, and the high-income maternity care system. This does not mean that the findings are not relevant or transferable to other maternity care contexts. The relevance and transferability of the findings to something useful in other contexts will be judged when the study

is published [19].

Conclusion

This study indicates that the midwives needed to be professionals by using their competence and experience to create safety and trust, when encounter and supporting women with FOC. Organisational factors can impact the care given by the midwives to these women (such as lack of time). Lack of clarity concerning the concept of FOC can negatively influence the care, as can stereotyping the women. Therefore, there is a need for guidelines for FOC. These findings can be of importance to strengthening midwives' knowledge when encounter and supporting women with FOC during birth.

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Author contribution

XXX: Conducted the interviews, data-analysis, and writing the original draft. XX: Conducted the interviews, data-analysis, and writing the original draft. XX: Supervising the data-analysis, reviewing, and editing the manuscript.

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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References

[1] Nilsson C, Hessman E, Sjöblom H, Dencker A, Jangsten E, Mollberg M, et al. Definitions, measurements and prevalence of fear of childbirth: a systematic review. BMC Pregnancy Childbirth 2018;18(1):28. https://doi.org/10.1186/s12884-018-1659-7.
[2] Areskog B, Uddenberg N, Kjessler B. Fear of childbirth in late pregnancy. Gynecol Obst Invest 1981;12(5):262–6. https://doi.org/10.1159/000299611.
[3] Saisto T, Halmesmäki E. Fear of childbirth: a neglected dilemma. Acta Obstet Gynecol Scand 2003;82(3):201–8. https://doi.org/10.1034/j.1600-0412.2003.00114.x.
[4] Möller L. In: Health, obstetric outcomes and reproduction in women with vulvar pain or primary fear of childbirth. Linköping: Linköping University; 2019. https://doi.org/10.3384/diss.diva-156622.
[5] ÓConnell M, Leahy-Warren P, Khashan A, Kenny L, ÓNeill S, Sinéad M. Worldwide prevalence of tokophobia in pregnant women: systematic review and meta-analysis. Acta Obstet Gynecol Scand 2017;96(8):907–20. https://doi.org/10.1111/aogs.13138.
[6] Zhou X, Liu H, Li X, Zhang S. Fear of childbirth and associated risk factors in healthy pregnant women in Northwest of China: A cross-sectional study. Psychol Res Behav Manag 2021;14:731–41. https://doi.org/10.2147/PRBM.S309889.
[7] Lukasse M, Schei B, Ryding E. Prevalence and associated factors of fear of childbirth in six European countries. Sex Reprod Healthc 2014;5(3):99–106. https://doi.org/10.1016/j.srhc.2014.06.007.
[8] Slade P, Balling K, Sheen K, Houghton G. Establishing a valid construct of fear of childbirth: findings from in-depth interviews with women and midwives. BMC Pregnancy Childbirth 2019;19(1):96. https://doi.org/10.1186/s12884-019-2241-7.
[9] Kayleigh S, Slade P. Examining the content and moderators of womeńs fears for giving birth: A meta-synthesis. J Clin Nurs 2018;27(13–14):2523–35. https://doi.org/10.1111/jocn.14219.
[10] Wigert H, Nilsson C, Dencker A, Begley C, Jangsten E, Sparud-Lundin C, et al. Womeńs experiences of fear of childbirth: a metasynthesis of qualitative studies. Int J Qual Stud Health Well Being 2020;15(1):1704484. https://doi.org/10.1080/17482631.2019.1704484.
[11] Larsson B, Karlström A, Rubertsson C, Hildingsson I. The effects of counseling on fear of childbirth. Acta Obstet Gynecol Scand 2015;94(6):629–36. https://doi.org/10.1111/aogs.12634.
[12] Striebich S, Mattern E, Ayerle G. Support for pregnant women identified with fear of childbirth (FOC)/tokophobia – A systematic review of approaches and interventions. Midwifery 2018;61:97–115. https://doi.org/10.1016/j.midw.2018.02.013.
[13] Haines H, Pallant J, Fenwick J, Gamble J, Creedy D, Toohill J, et al. Identifying women who are afraid of giving birth: A comparison of the fear of birth scale with WDEQ – A in large Australian cohort. Sex Reprod Healthc 2015;6(4):204–10. https://doi.org/10.1016/j.srhc.2015.05.002.
[14] Rouhe H, Salmela-Aro K, Toivanen R, Tokola M, Halmesmäki E, Saisto T. Obstetric outcomes after intervention for severe fear of childbirth in nulliparous women – randomised trial. In J Obst Gynecol 2012;120(1):75–84. https://doi.org/10.1111/1471-0528.12011.
[15] Hildingsson I, Rubertsson C, Karlström A, Haines H. A known midwife can make a difference for women with fear of childbirth – birth outcome and womeńs experiences of intrapartum care. Sex Reprod Healthc 2019;21:33–8. https://doi.org/10.1016/j.srhc.2019.06.004.
[16] Salomonsson B, Wijma K, Alehagen S. Swedish midwiveś perceptions of fear of childbirth. Midwifery 2010;26(3):327–37. https://doi.org/10.1016/j.midw.2008.07.003.
[17] Tobiasson M, Lyberg A. Fear of childbirth from the perspective of midwives working in hospitals in Norway: A qualitative study. Nurs Open 2019;6(3):1180–8. https://doi.org/10.1002/nop2.304.
[18] Salomonsson B, Alehagen S, Wijma K. Swedish midwiveś views on severe fear of childbirth. Sex Reprod Healthc 2011;2(4):153–9. https://doi.org/10.1016/j.srhc.2011.07.002.
[19] Malterud K. Kvalitative forskningsmetoder for medisin og helsefag (Qualitative research methods for medicine and health science). 4th ed. Oslo: Universitetsforlaget; 2017.
[20] Aune I, Holsether O, Kristensen A. Midwifery care based on a precautionary approach: Promoting normal births in maternity wards: The thoughts and experiences of midwives. Sex Reprod Healthc 2018;16:132–7. https://doi.org/10.1016/j.srhc.2018.03.005.
[21] Steen T, Eberhard-Gran M, Nordeng H, Nerum H, Lyng S. Mental helse i svangerskapet (Mental health during pregnancy). *Veileder i fødselshjelp (Guidelines for maternity care)* https://www.legeforeningen.no/foreningsledd/fagmed/norsk-gynekologisk-forening/veiledere/veileder-i-fodselshjelp/mental-helse-i-svangerskapet; 2020.
[22] International Confederation of Midwives (ICM), ICM definitions. https://www.internationalmidwives.org/our-work/policy-and-practice/icm-definitions.html ; 2018.
[23] Halldorsdottir S, Karlsdottir S. The primacy of the good midwife in midwifery services: an evolving theory of professionalism in midwifery. Scand J Caring Sci 2011;25(4):806–17. https://doi.org/10.1111/j.1471-6712.2011.00886.x.
[24] Hansson M, Lundgren I, Hensing G, Dencker A, Eriksson M, Carlsson I-M. Professional courage to create a pathway within midwiveś fields of work: a grounded theory study. BMC Health Service Research 2021;21(1):312. https://doi.org/10.1186/s12913-021-06311-9.
[25] Brady S, Lee N, Gibbons K, Bogossian F. Women-centred care: An integrative review of the empirical literature. Int J Nurs Stud 2019;94:107–19. https://doi.org/10.1016/j.ijnurstu.2019.01.001.
[26] Aannestad M, Herstad M, Severinsson E. A meta-ethnographic synthesis of qualitative research on womeńs experience in midwifery care. Nurs Health Sci 2020;22(2):171–83. https://doi.org/10.1111/nhs.12714.
[27] Berg M, Òlafsdóttir Ò, Lundgren I. A midwifery model of woman-centred childbirth care – In Swedish and Icelandic settings. Sex Reprod Healthc 2012;3(2):79–87. https://doi.org/10.1016/j.srhc.2012.03.001.
[28] Nilsson C, Bondas T, Lundgren I. Previous birth experience in women with intense fear of childbirth. JOGNN 2010;39(3):298–309. https://doi.org/10.1111/j.1552-6909.2010.01139.x.
[29] Ménage D, Bailey E, Lees S, Coad J. A concept analysis of compassionate midwifery. J Adv Nurs 2017;73(3):558–73. https://doi.org/10.1111/jan.13214.
[30] Dahlberg U, Persen J, Skogås A, Selboe S, Torvik H, Aune I. How can midwives promote a normal birth and a positive birth experience? The experience of first-time Norwegian mothers. Sex Reprod Healthc 2016;7:2–7. https://doi.org/10.1016/j.srhc.2015.08.001.
[31] Blaaka G, Schauer ET. Doing midwifery between different belief systems. Midwifery 2008;24(3):344–52. https://doi.org/10.1016/j.midw.2006.10.005.