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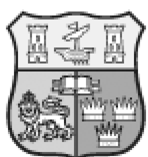

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WOMEN'S EMPOWERMENT IN PREGNANCY AND CHILDBIRTH: A CONCEPT ANALYSIS

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Highlights

- The defining attributes of empowerment of women in pregnancy and childbirth are external and internal to the woman.
- External attributes include gender equality, access and control over resources, meaningful interconnectedness and facilitation of a woman's choices and decisions.
- Internal attributes include a woman's belief in her own ability to achieve meaningful goals and have control over her situational context and behaviours of herself and those around her.
- Empowerment needs to be understood within the socio-cultural-economic-political landscape of the individual woman whose internal belief in herself is key.

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WOMEN'S EMPOWERMENT IN PREGNANCY AND CHILDBIRTH: A CONCEPT ANALYSIS

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ABSTRACT

Background: Empowerment is expected to have a beneficial effect on a woman's well-being during the perinatal period and her readiness to face the challenges of motherhood. In the literature on pregnancy and childbirth, empowerment is used widely in different contexts, with different connotations and often without a definition, thus indicating a lack of clarity of what is actually meant by the concept.

Objective: To report an analysis of the concept of women's empowerment in the context of the perinatal period.

Methods: We used the concept analysis framework of Walker and Avant to analyse the concept of women's empowerment during pregnancy and childbirth. In July 2018, we did a systematic search in EBSCOhost, including the database MEDLINE, CINAHL, PsycINFO, PsycARTICLES and SocINDEX, using keywords: empower, women, childbirth and their synonyms. All selected papers were analysed for definitions of empowerment, defining attributes, antecedents and consequences.

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Results: Ninety-seven scientific papers from all continents were included in the analysis. Defining attributes, antecedents, consequences and empirical referents are discussed, and a model case as well as related and contrary cases are presented.

Conclusion: Attributes, external and internal to the woman, were identified. Both types of attributes need to be considered within the broader socio-cultural-economic-political landscape of the individual woman, in conjunction with a woman's belief in herself and her meaningful interconnectedness with carers.

Relevance: This study resulted in an understanding of empowerment in the context of pregnancy and childbirth that can be used in research and for the development of interventions preparing women for childbirth and their subsequent transition to motherhood.

Keywords: childbirth, empowerment, concept analysis, perinatal period, women.

Word count: 3702

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Introduction

Women's health during pregnancy and childbirth is recognised internationally as the cornerstone to a populations' health (WHO, 2015). Worldwide, an estimated 139 million births take place per year with a maternal mortality of 216 maternal deaths per 100,000 live births in 2015 and a greater percentage of women will experience the death of her child through perinatal or neonatal death (UNFPA, 2015). These figures demonstrate the serious health issues for women and infants during this period, further underlined by the devastation of acute and chronic physical and psychological morbidity.

It is commonly believed that greater empowerment of women will lead to improvements in their health, including pregnancy and childbirth (WHO, 2015; ICM, 2014). Women's empowerment is generally positively associated with maternal and child outcomes in developing counties as concluded by a systematic review of 67 studies of varying quality (Pratley et al., 2016) and thus must be considered as a viable strategy in attaining positive childbirth outcomes for women and infants. Empowering women is expected to have a beneficial effect on a woman's psychological well-being during the childbearing period and her readiness to face the challenges after birth, where she needs to adapt to a new role as mother responsible for raising a child (Garcia and Yim, 2017; Raymond et al., 2014; Nilsson et al., 2013). Additionally, a positive birth experience also seems to have an empowering affect (Olza et al., 2018; Lewis et al., 2018).

The global strategy for Women's, Children's and Adolescent's health (WHO, 2015) commits to translating health care, including maternity care services, that facilitates empowerment of women and positive childbirth outcomes, both physically and psychologically for women, infants and families. Design and provision of good quality maternity services for women and their families need to go beyond survival during childbirth and should entitle women to be active participants in their own care as this is closely connected to their empowerment (ICM, 2017). A meta-synthesis of 35 studies from 19 countries (Downe et al., 2018), concluded that what matters to women is a positive experience of childbirth. This positive experience is facilitated by women being the centre of care; involved in decisions of care; in a safe empathetic environment with competent healthcare professionals. A core component of this care, particularly where intervention is deemed necessary, is the sense of control and personal achievement of the birth outcome. Women's empowerment needs to be considered at the macro and micro levels in order for it to be realistic and sustainable within the broader health and social care arena. Empowerment for women is influenced by the collective, social, economic, legal and political as well as the individual psychological aspect (Salazar et al., 2012).

Empowerment is considered an important part of good maternity care, but as a concept, it is poorly understood. The concept of empowerment has been previously explored, but limited to the midwifery context in Sweden (Hermansson and Mårtensson, 2011). Undertaking a concept analysis of empowerment as a broader concept focused on women in the perinatal period, can provide a more basic and deeper understanding of the concept and its underlying attributes. Therefore, given the significance of this concept for maternity care providers in supporting women to have a fulfilling childbirth experience and positive adaptation to her role as mother, it is necessary to undertake a concept analysis.

Our aim is to report an analysis of the concept of women's empowerment in the context of the perinatal period.

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Methods

We explored the concept of a woman's empowerment in pregnancy, childbirth and the postnatal period ~~from the perspective of women and care providers~~.

Concept analysis

We used Walker and Avant's framework for concept analysis (2011, chapter 10) following their eight steps: (1) concept selection, (2) determination of aims, (3) identification of uses of context, (4) determination of defining attributes of context, (5) identification/construction of a model case of context, (6) identification/construction of additional cases of context, (7) identification/construction of antecedents and consequences of context and (8) definition of empirical referents of context.

Walker and Avant's framework is frequently used to clarify the meaning of concepts that are used as basic building blocks in theory construction. A well-defined concept is crucial for research and policy-making. Identifying the defining attributes of a concept makes clear what characterizes the concept (step 4). Construction of a model case (step 5) makes clear how the concept presents itself as a pure example from real-life and construction of additional cases (step 6) present what related or contrary examples of the concept may look like (Walker and Avant, 2011).

Although other methods of concept analyses are available (Rodgers and Knafl, 2000), we chose Walker and Avant as a classical systematic approach frequently used to clarify ambiguous or overused concepts that are prevalent in nursing and midwifery.

Search strategy

In July 2018, we conducted a systematic search in EBSCOhost, including the database MEDLINE, CINAHL, PsycINFO, PsycARTICLES and SocINDEX, using the key concepts 'empowerment' and 'woman' and 'childbirth', and there synonyms (table 1). Limitations were set to publications in the last ten years. Both authors independently read the abstracts and selected papers, and discussed differences until we reached consensus over the papers included.

The inclusion criteria were: (1) publications in peer reviewed scientific journals, including original research, reviews and opinion papers, (2) exploring the concept of empowerment of (3) women in the perinatal period~~, from (4) women's or care providers' perspectives~~. We excluded papers that (1) focused on empowerment of fathers or care providers, or (2) explored empowerment in the context of contraception or abortion care.

No quality assessment of the individual papers took place as we are not analysing the 'findings' from the studies as such, but the way empowerment is described, defined and used.

[Table 1. approx. here]

Data extraction and analysis

Data were extracted from the selected papers and entered into a purpose-built datasheet under the headings: author(s), year, country of data collection, aim, research design, definition of empowerment, defining attributes, antecedents and consequences. Subsequently, we separately analysed the extracted data going back and forth to the original papers, and discussed our findings until defining attributes, antecedents and consequences emerged from the data as interpreted by the authors. We analysed the data in its entirety, acknowledging the context of the country of origin of data. We used the definition of the World Bank for the identification of low/middle and high-income countries (World Bank, 2017).

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RESULTS

Included papers

The search gave 1,924 hits in EBSCOhost, resulting in 1,867 unique hits after removing 57 duplicates. Figure 1 demonstrates the selection process that resulted in 97 included scientific papers (see Appendix 1 for reference details.)

[Figure 1 approx. here]

Based on title and abstract, we excluded 1,702 papers that clearly did not meet our inclusion criteria. Subsequently, full papers (n=158) were reviewed and 61 papers excluded because (1) they did not explore the concept of empowerment, but only mentioned it once or twice in the discussion (n=54), (2) the context was not the perinatal period (n=1), (3) they were in languages we could not handle (n=2) or (4) they were published in journals that did not use peer review (n=2).

Characteristics of the papers

The papers mainly reported on research (n=86) with 46 studies having a qualitative design, 36 studies using a quantitative design and three mixed methods studies. Additionally, there were eight literature reviews and four opinion papers. (Appendix 2)

The studies in the included papers collected data from many different countries in Europe (n=24), North America (n=18), Middle America (n=2), Africa (n=17), Asia (n=18) and Australia (n=5). Additionally, two studies collected data from multiple low-income countries in Asia and Africa. (Appendix 2)

The main areas where potential empowerment was studied in the analysed papers were birth experience (n=22); health outcomes of mother and baby (n=14); use of maternity services (n=13); participation in care (n=12) and satisfaction with care (n=10). Other areas were health behaviour (n=5); mistreatment in maternity services (n=3) and domestic violence (n=3). Only nine papers had empowerment as the key concept under study and explored its meaning in a broader sense.

There was a distinction between papers from low/middle-income countries (n=40) and high-income countries (n=57) with regard to the dimensions of empowerment explored. Almost two-thirds of the papers from low/middle-income countries (26 out of 40 = 65%) focused on at least three empowerment dimensions (psychological, social, economic, legal or political), and frequently considered both the individual and collective aspects of empowerment. Whereas, papers from high-income countries focused on the psychological dimension only, with only a quarter (15 out of 57 = 26%) combining this with the social dimension. Most of these papers concentrated on the individual aspect of empowerment.

Definition

From the 97 papers, 28 indicated a definition of empowerment (Appendix 2). Of these papers, 12 used a definition based on Kabeer's work (1999) who conceptualises empowerment of women as the ability to make strategic life choices. This includes three dimensions: socio-cultural, economic and psychological. The socio-cultural dimension refers to gender equality and includes education

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and the ability to make decisions. The economic dimension refers to access and control over means on making a living and may also include resources, such as ownership of land. The psychological dimension refers to self-esteem, self-efficacy and having choice. Commonalities across the other definitions were: autonomy/control; ability to make choices; self-efficacy; access to and control over resources.

Defining attributes

Based on the information from all the included papers, we identified defining attributes of empowerment of women in pregnancy and childbirth as external and internal to the woman. The external environment includes both political, legal, cultural and economic attributes, and the internal are attributed to the individual's sense of control (box 1).

The first external attribute is gender equality where women have equal authority regarding their choices of models of pregnancy and childbirth care. The second external attribute is access to and control over resources such as social resources, antenatal care and reliable knowledge and information. Within this is the need for meaningful interconnectedness between the woman and significant others. Another external attribute is the facilitation of a woman's choices and self-determining decisions in terms of her labour and birth.

The internal attributes are those inherent to the woman. The first is a woman's belief in her own ability to achieve meaningful goals and the second is to have control over her situational context and behaviours of herself and those around her. These are self-efficacy and power-over-self, to be in control of herself and decisions that affect her.

Box 1: Defining attributes of empowerment

External attributes

- Gender equality
- Access and control of resources
- Facilitation of women's choice and decisions

Internal attributes

- Women's belief in own abilities
- Control over situation, self and others

Cases: model, related and contrary

As recommended by Walker and Avant (2011), we constructed model, related and contrary cases to demonstrate and clarify the defining attributes of the concept empowerment in pregnancy and childbirth as we identified them in the included papers (Table 2). These are hypothetical cases based on the authors' experience in clinical practice. The model case includes all the above mentioned critical attributes. One related case (1) demonstrates that the woman is socially and economically empowered, but lacks self-confidence in her ability to birth and also to keep a sense of control in her new situation; the other related case (2) depicts the woman who is psychologically empowered, but experiences little power over her situation. The contrary case describes a woman's birth experience where all the attributes of empowerment are absent.

[Table 2. approx. here]

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Antecedents

Antecedents are the prerequisites for the realisation of empowerment. From the literature reviewed, five antecedents were identified: emancipated environment, supportive alliances, education, birth choices and reverence. An *emancipated* climate is one that is free of violence, recognises a woman's civil rights, facilitates a woman's access to resources and promotes gender-equity and her political participation. *Supportive alliances* refer to a social network of members who have expertise or similar experiences, as well as family and friends that engage with the woman and support her needs during the perinatal period. The emphasis is on partnerships, shared experiences and woman-centred care. *Education,* which can be formal or informal, is the intention to enhance knowledge and understanding of pregnancy and childbirth, as well as developing capacities to deal with new situations and challenges as they relate to the perinatal period. An example of formal education can be antenatal classes, and informal education can be finding information on the internet or role modelling from other pregnant women or mothers. The opportunities for a woman to make her own *birth choices* also need to be present, explicitly mentioned in some papers were access to home birth, physiological childbirth and midwifery care. Acknowledging a woman's participation and control over her care can facilitate her empowerment in pregnancy and childbirth. A philosophy of *reverence,* which includes trust, listening and respect for a woman's autonomy also contributes to her empowerment.

Consequences

Four consequences of a woman's empowerment in pregnancy and childbirth were identified. Satisfaction with the *birth experience* is deemed positive and exudes a sense of accomplishment. Such an experience offers a woman the opportunity to heal from a previous traumatic birth. In addition, empowerment contributes to a woman's *overall health* and the health of her baby and family. It enhances her self-confidence and emotional well-being. Her capacities for *self-advocacy* are strengthened, making it possible for her to interact more assertively and as an equal to care providers, increasing her sense of control over choice and decision-making. Empowerment of women can also contribute to *healthcare services*, in terms of improving maternity care services and the woman's use of such services, such as (timely) antenatal care and skilled birth attendants.

Empirical referents

The final step in the Walker and Avant (2011) method of concept analysis is to identify the empirical referents or indicators that can be used to measure the concept or validate its existence in reality. These referents are indicators or items that further verify the concept. A measurement tool of empowerment in the perinatal period should incorporate the defining attributes as identified in step 4, as well as the different dimensions of empowerment. From the papers reviewed, a variety of instruments were used to measure empowerment. All were questionnaires, including a range of 5 – 54 items. Some measures included only one dimension of empowerment in the perinatal period, e.g. the psychological or economic dimension; others included psychological, social, economic, legal and political dimensions. The attributes that came up in the questionnaires were related to a woman's self-image (esteem/confidence/efficacy), her access to social resources, her decision-making power over self, children and economic resources, and gender equality. However, only two instruments

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measuring empowerment specific to the perinatal period were found. The Self-Structured Pregnancy Empowerment Questionnaire (SSPEQ) was based on a literature review of studies measuring empowerment among Iranian women (Borghei et al., 2016). It measures social relationships, financial ability, political activity and prenatal training covering the socio-political, autonomical and educational dimensions of pregnant women's empowerment. It has been validated among a mix of women in Iran. The Pregnancy-Related Empowerment Scale (PRES) builds upon the concept of health-related empowerment and integrates social theory, feminist theory, and Bandura's theory of self-efficacy (Patil et al., 2017; Klima et al., 2015). It evaluates some empowerment attributes such as: a woman's connectedness to her care providers and peers; participation in decision-making; and capacity to recognize and engage in pregnancy-related healthy behaviours. The PRES was validated among low-income pregnant African American and Hispanic women in the U.S.

DISCUSSION

In this paper, the concept of women's empowerment in pregnancy and childbirth was reviewed. At the outset, it is important to acknowledge the distinction between low/middle-income and high-income countries with regards to the dimensions attributed to the concept. Low/middle-income countries focused on both individual and collective aspects of empowerment and at least three out of the five dimensions. Whereas high-income countries focused on the individual and predominantly on the psychological with some also including the social dimension. Therefore, this has implications in reaching a consensus for a definition. The most commonly used definition was that proposed by Kabeer (1999) which includes three dimensions: socio-cultural, economic and psychological. This definition considers a broad context of the concept at both the collective and individual level. The challenge in providing a clear definition is perpetuated by the lack of consensus throughout the literature on examining and understanding the concept at an individual level only, rather than also considering the woman's broader socio-cultural-economic-political context. The defining attribute of the external environment is as critical a consideration as the internal individualised attributes to women. Women need to be free of domination in its broadest sense before they can be facilitated to be empowered internally, also in high-income countries. To suggest that women as individuals can somehow be empowered in pregnancy and childbirth while they continue to be collectively dominated politically, economically, and culturally is unreasonable. Where women have equality of gender in all aspects of their environment are in a position to be better facilitated to be empowered as individuals in pregnancy and childbirth.

A woman's power to make her own decision is an important part of empowerment, which is reflected in both the external and internal attributes. In it broadest sense, women's decision-making power over self needs to be grounded in her socio-political environmental context. It requires an environment that recognizes her equality, autonomy and creates space for her choices and decisions. Furthermore, having power of decision-making at the macro level will facilitate and enable power at the micro level while she builds her strength and belief in her own self-efficacy to take control over the decisions she faces in the perinatal period. However, having a child is a life-changing event with unpredicted incidents where women may encounter vulnerable situations when facing decision with far-reaching consequences. Decisions can challenge a woman's sense of power and raise a need to seek support and advice from her care provider (Noseworthy et al., 2012). A respectful relationship between a pregnant woman and her care provider based on trust and understanding is essential for maternity care. This relationship enables a woman to be actively involvement in her care, promotes her self-care and supports her to make her own informed

decisions (Seefat et al., 2011, Renfrew et al., 2014). Shared decision-making is part of building this relationship. It is an essential component of the ethical provision of *good* maternity care. Offering woman-centred care and enhancing women's empowerment are not possible without giving a woman an active say in what happens to her and her child, in an environment without domination and with meaningful interconnectedness. This includes providing a woman with honest information tailored to their characteristics and circumstances, supporting her to make and achieve her own choices, while safeguarding that she does not feel abandoned with the burden and responsibility of choices (Nieuwenhuijze and Kane Low, 2013).

In terms of measuring empowerment in the perinatal period, two instruments were identified, however, both are limited and neither covers the full scope of attributes. The socio-political, autonomical and educational dimensions of the SSPEQ cover a number of the external and internal attributes of empowerment, such as meaningful interconnectedness with the community and control over social resources. However, it lacks items around equality and self-determining decisions. Most items of the SSPEQ measure the contribution prenatal training has to women's empowerment, well-being and preparedness for childbirth and the baby, they are not measuring empowerment in itself (Borghei et al., 2016). The PRES evaluates psychological and social dimensions, and covers external and internal attributes of empowerment, such as equality, meaningful interconnectedness, a woman's choices and control of herself and decisions that affect her. It lacks attributes such as control over resources (Patil et al., 2017; Klima et al., 2015).

Given these findings, further development of a measurement instrument that includes all the identified attributes is necessary. The different aspects of control come up as a significant attribute of empowerment and should be included in the measurement. Control is multidimensional with external and internal dimensions (Green and Baston, 2003; Ford et al., 2009). External control is described as involvement in the birth process (Waldenström, 1999), understanding what health-care providers are doing (Green, 1999) including women's influence over procedures, decisions and information (Ford et al., 2009).Women's internal control include a sense of control over self, such as thoughts, emotions, behaviours and dealing with labour pain (Green and Baston, 2003; Ford et al., 2009).

A strength of our study is the systematic search and extensive use of studies on empowerment in the context of maternity care. However, to keep the search results manageable, we did not include resources such as grey and popular literature, as suggested by Walker and Avant. This limits the scope of the concept empowerment as we presented it. Another strength is the inclusion of studies from all over the world, which clearly outlined the need for empowerment of women to be considered in its broadest context, before making recommendations at an individual level in a specific context of pregnancy or birth. We do believe the consequences of lack of empowerment are far reaching for women and their children. However, a systematic review to synthesize the evidence on maternal (psychological and physical) and infant (mode of birth, bonding) outcomes for empowered women is necessary to establish the full impact of women's empowerment.

A limitation of the cases we presented is that they do not included an example from low-income countries, even though much of the literature for the concept analysis is from these countries. However, the authors felt that their experience did not allow for construction of such as cases. Especially, as a case construction is already a reductionist view of reality in itself, as women's experience of the perinatal period is hugely complex.

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CONCLUSION

This study has systematically searched relevant databases, retrieved and reviewed papers using Walker and Avant (2011) framework to report an analysis of empowerment for women in pregnancy and childbirth. It is clear that empowerment needs to be understood within the socio-cultural-economic-political landscape of the individual woman whose internal belief in herself is the key to open up for the empowering experience. Further research is necessary to establish the contribution of women's empowerment throughout the perinatal period in preparing women for childbirth and their subsequent transition to motherhood.

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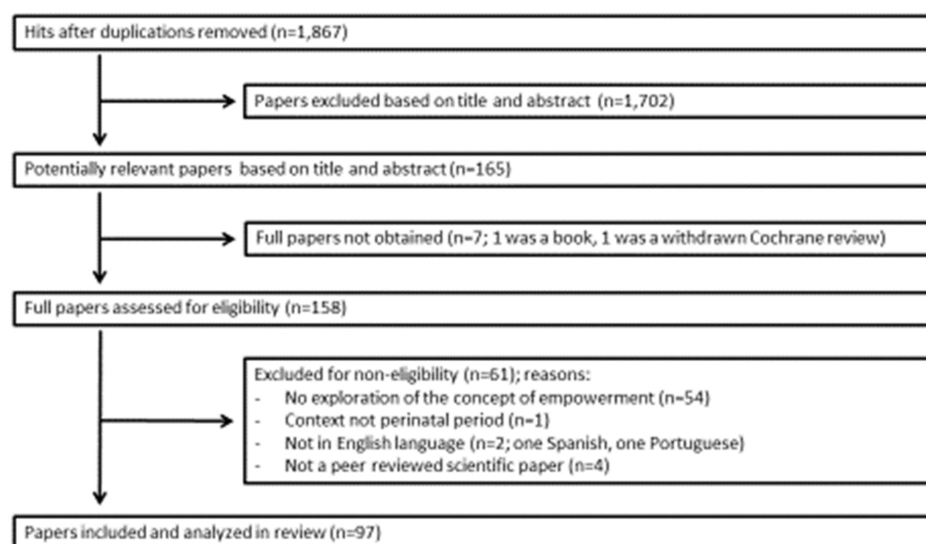

Figure 1: Flowchart of the systematic search

Table 1. Search terms used for EBSCO host

Key concepts	**Empowerment**		**Woman**		**Childbirth**
Search terms	TX empower*	AND	AB wom* OR mother* OR maternal* OR primip* OR multip* OR paturient* OR female*	AND	AB childbirth OR "child birth" OR child-birth OR birth* OR labour OR labor OR delivery OR intrapartum OR perinatal OR pregnan* OR antenatal OR antepartum OR ante-partum OR postnatal OR postpartu* OR post-partu*

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Table 2. A model and two related cases on empowerment in the context of the perinatal period

Model case	Related case (1)	Related case (2)	Contrary case
Marie is 20 years old, and has given birth to her son four weeks ago. Her pregnancy was unplanned, but after the first shock, she and her partner adjusted quickly to the idea of welcoming the baby. She is convinced that they can cope with this together. In addition, her mother and older sister, who recently had a baby, give her lots of support, practically and emotionally. Marie recently left school and found a job just before she got pregnant. Her new employer perceived the pregnancy positively: "this is part of life", and allowed her to adjust her tasks while her tummy grew bigger. She is looking forward to going back to work in a couple of months. Her job gives her financial independence and this is something she values. During pregnancy, part of her check-ups were through group antenatal care. This was a positive experience, sharing emotions, ideas and advices with women in similar situations. She felt prepared for her birth and wrote in her birth plan that she wanted a natural birth. The start of the birth was great, she felt so excited. However, by the time she got to 8 cm and began to lose hope of not needing an epidural. The midwife stayed with her and helped	Kate is 40 years old, and 39 weeks pregnant with her first child. Getting pregnant was quite a surprise for her and her husband, as they had been trying for years. They had gone through the whole infertility process. All this, has made her feel insecure about her body and she now wonders how it will cope with the pregnancy and birth. Everybody in her surrounding is supportive; they help her and mean well, but the help does not always fit with her needs, talking about the risks of pregnancy for an older mum. She has a great job as a lawyer. Her employer very much appreciate her; however, her urge to do the job well takes up a lot of her time and she feels there is not enough time left to connect with the baby and prepare for the birth. Her midwife is really nice and patient in answering all her questions and involving her in the decision-making. Still, she feels the pressure of the many decisions, making	Aicha is 26 years old, and expecting her third child in a month. She already has two sons. One year ago, she moved from Syria to the UK. She has a university degree and taught mathematics at a secondary school in Aleppo. She was politically active and had to flee her country, together with her family. She became pregnant because her contraception failed and she has mixed feelings about having another child in their present circumstances. Still, she is sure she wants to keep the baby. Her husband says he is happy with the pregnancy, but he is depressed and does not help a lot with the chores in the house. They live in a small apartment together with her husband's parents. She feels the pressure to adapt to their needs all the time and they clearly don't like it, if she goes out of the house on her own. Moreover, they have to rely on welfare for their money. She would really like to get a job again. During her	Anna is 25 years old, she just gave birth to her 3rd child. Although she wants a larger family, this pregnancy came a bit too early. Her other two children are just 18 months and 3 years old. Her husband is away for work a lot and her mother and relatives live hours away. Except for a niece, who wants to help but is always interfering with the upbringing of the children. She had a part-time job, which she enjoyed, but got sacked just before her maternity leave. She would like to find a new job, but lacks the energy to organise it. She hates being financially dependent on her husband, even though he says it doesn't matter. As a consequence, they cannot afford childcare anymore. Her pregnancy wasn't easy, lots of Braxton-Hicks contractions that made it necessary for her to slow down. Her birth was induced at 41 weeks, because she could no longer cope. It all went

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her breath through the final contractions, while her partner rubbed her back. In the end, pushing was a relief and she felt so proud of herself when she held her son skin-to-skin. The first weeks were chaotic with people coming round to see the baby, but she was able to concentrate on the breastfeeding and bonding with her child. She very much feels empowered to face the challenges ahead.	sure she makes the right choices. She feels she is lacking a sense of control within herself and the power to stand up for what she needs. She really hopes the birth will go well and that she can avoid an epidural. However, everybody is telling her that she can always have one if she needs it.	pregnancy check-ups, she was not offered choices. Is this because she does not understand the language very well? She knows what she wants for the birth: to walk around; that really helped her the last time. She will tell them the next time she is at the clinic for her check-up.	well, but she felt very little in control. The midwives were very busy and she did not want to take up their time, after all, it was her third birth. Her mother came down for a week and just left. She feels exhausted.

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