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DOI: [10.31965/infokes.Vol21Iss4.1401](https://doi.org/10.31965/infokes.Vol21Iss4.1401)Journal homepage: <http://jurnal.poltekkeskupang.ac.id/index.php/infokes>**RESEARCH****Open Access****What Makes Woman Afraid of Their Childbirth?: A Qualitative Study****Siti Nurhidayati^{1a*}, Revi Gama Hatta Novika^{1b}, Nurul Jannatul Wahidah^{1c}, Atriany Nilam Sari^{1d}, Luluk Fajria Maulida^{1e}, Rufidah Maulina^{1f}, Chusna Habiba^{1g}, Ramadhani Anggi^{1h}**¹ Department of Midwifery, Faculty of Medical, Universitas Sebelas Maret, Surakarta, West Java, Indonesia^a Email address: sitinurhidayati@staff.uns.ac.id^b Email address: revi.gama@staff.uns.ac.id^c Email address: njwahidah@staff.uns.ac.id^d Email address: atriany.ns@staff.uns.ac.id^e Email address: lulukfajria@staff.uns.ac.id^f Email address: maulinarufidah@staff.uns.ac.id^g Email address: chusnahabiba14@student.uns.ac.id^h Email address: anggiwn7@student.uns.ac.id

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Abstract

Fear generally fills the minds of pregnant women as they enter the third trimester of gestation. The older the gestational age, the more attention and thoughts of pregnant women are drawn to the approaching climax of childbirth, intensifying their anxiety and fear. This study aimed to assess the knowledge of birth preparedness and fear of childbirth. A qualitative facility-based descriptive study design and client exit interview questionnaire were utilized, conducted in Primary Health Care Mondokan, Sragen, from April until June 2023 with 33 pregnant women. Study participants were selected through purposive sampling. Three categories highlighted the preparedness for childbirth, including finding primary sources of information, the importance of birth companions, and reminding about the natural process of childbirth. The fear of childbirth was associated with fear of the childbirth process, fear of the tools used during childbirth, and the condition of the unborn baby. The findings suggest that pregnant women should prepare for childbirth and increase their knowledge of delivery by participating in antenatal classes to reduce fear about the childbirth process. Therefore, family healthcare providers, health facilities, other partners, program-level managers, and policymakers must take responsibility for improving health education and increasing preparedness and complication readiness through easily accessible health education strategies.

Keywords: Birth Preparedness, Fear of Childbirth, Knowledge, Health Facilities.***Corresponding Author:**

Siti Nurhidayati

Department of Midwifery, Faculty of Medical, Universitas Sebelas Maret, Surakarta, West Java, Indonesia

Email: sitinurhidayati@staff.uns.ac.id

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1. INTRODUCTION

The process of pregnancy induces various changes in a woman, encompassing both physiological and psychological transformations. This process is characterized by the natural occurrence of fertilization, resulting in the development of a fetus within the mother's womb, commencing from conception, and persisting until childbirth (Kementerian Kesehatan Republik Indonesia, 2019). Each woman envisions the childbirth and motherhood journey, and this perception significantly shapes her response to pregnancy. In the period leading up to delivery, numerous concerns occupy the mother's thoughts, such as the fear of surgical procedures, bleeding, potential complications, congenital disabilities, pain during childbirth, and the fear of post-childbirth challenges like intense straining or vaginal tearing, possibly requiring suturing. There may even be a fear of mortality, leading to apprehension about adequately caring for and raising the child (Munkhondya et al., 2020).

Typically, fear becomes more prominent in the minds of pregnant women as they enter the third trimester (28-40 weeks). As gestational age increases, attention and thoughts are increasingly drawn to the impending climax, intensifying anxiety and fear as childbirth approaches (Hidayat & Sumarni, 2016). From a psychological standpoint, fear can result in heightened pain, decreased uterine contractions, and prolonged labor (Dwiarini et al., 2022). This fear triggers muscle tension, particularly in the birth canal, making the labor process less smooth (Syada & Ramaida, 2017).

One significant factor contributing to the high incidence of Maternal Mortality Rate is the unpreparedness of mothers for childbirth. Lack of understanding about necessary preparations leads to obstetric complications, preventing timely and appropriate services and resulting in delays in referral (Kementerian Kesehatan Republik Indonesia, 2019). Essential preparations for pregnant women include developing delivery plans, making emergency decisions, understanding transportation systems, adopting saving patterns, and ensuring readiness with the necessary equipment (Naha & Handayani, 2020); moreover, engaging in positive affirmations, seeking expert consultation, and garnering support from loved ones play pivotal roles in easing the impending challenges of childbirth.

Analyzing the fear of childbirth stands as an early prevention measure, guiding the topics covered during prenatal education. Fear before childbirth correlates with emotional well-being, stress symptoms, depression risks, reduced confidence during childbirth, diminished ability to care for the child, and decreased maternal involvement in meeting fetal development requirements (Wigert et al., 2020). Emotional and psychological well-being are intertwined with perceptions and experiences of prenatal and childbirth, influencing decisions about the childbirth method. For instance, traumatic previous childbirth experiences can lead women to opt for a cesarean section, a global concern due to its potential impact on physical and psychological morbidity, uterus scarring, and associated costs (Fenwick et al., 2015).

However, a previous study investigating decision-making and respectful maternity care in Indonesia found that pregnant women received a moderate level of autonomy in decision-making and low levels of respectful maternal health care (Maulina et al., 2023). This finding highlights the importance of improved quality prenatal care and education, which can enhance midwives' awareness about related risks that are caused by low respect and decision-making, such as fear of childbirth. A previous study in Indonesia also found that fear of childbirth was a predicting factor of longer duration during the first stage and second stages of childbirth (Dwiarini et al., 2022).

Factors such as satisfaction with husband support, education level, number of ultrasound examinations, and participation in prenatal yoga classes can reduce fear of childbirth (Astuti & Kao, 2019; Marcelina et al., 2019). Exploring what mothers afraid of during childbirth and how they already prepare for childbirth can deepen and broaden our understanding of women's feeling during pregnancy and childbirth. However, Indonesian mothers' fear of childbirth is

essential to understand since cultural and social contexts may influence mothers' experience of fear of childbirth. Therefore, Indonesian-based and exploratory studies need to be conducted to enhance our understanding and determine the topic in prenatal education that would be taught to overcome their fear.

2. RESEARCH METHOD

A qualitative descriptive approach was used to explore how women have prepared for childbirth comprehensively and their perspective on their fear during childbirth. Qualitative methodology and a descriptive study design were used to obtain participant group interviews. This design was appropriate for the study because it allowed the researchers to explore the experience and expectations of the participants about preparation and childbirth fear.

Midwives contacted potential participants over the phone to provide information about the focus group discussions (FGDs) and invite them to participate. Thirty-eight pregnant women agreed to participate in the FGDs, and 33 attended.

The study was conducted at an antenatal class in a village in Sragen. The FGDs were conducted in a single session, with the principal researcher as the moderator. Research assistants carried out recording and documentation. The leading researcher guided the FGD until the end of the session. The FGDs occurred in a private room, specifically in the local community meeting room.

The participants consisted of 33 pregnant women who were purposely selected. To be recruited in the study, a pregnant woman had to meet the following criteria: i) their pregnancy from 28 to 40 weeks in the gestation period, ii) a singleton pregnancy without obstetric complication, iii) to be fluent in the Indonesian language. The sample was carried out by purposive sampling by inviting specific mothers for this study. The size of the sample was determined by saturation theoretical.

To gather the data, focus group discussions (FGD) for birth preparation and semi-structured interviews for childbirth fear. The researcher guided the FGD by paying attention to the flow of the discussion according to the interview guide, while a research assistant assisted with note-taking. The selected research assistants were midwives and final-year student midwives who had been given a briefing before the FGD was conducted. The data were collected during pregnancy class.

The FGD concluded when data collected from the informants reached data saturation. Data saturation occurs when researchers continue to collect data until nothing new is added to their arguments or conclusions based on the interview guide. The audio recordings were stored and lasted approximately 1 hour and 18 minutes in the local language. There was no prior relationship between the participants and the researcher.

The results of the FGDs were transcribed and translated into English. Following the steps outlined by Braun and Clarke in 2006, an inductive thematic analysis was employed to identify patterned meanings across the FGDs (Braun & Clarke, 2006). The objective of the FGDs was to gain insights into mothers' perspectives regarding preparedness and fear of childbirth about societal opinions, either directly or indirectly.

To conduct the thematic analysis, the researchers followed the steps proposed by Braun and Clarke, which included familiarizing themselves with the data by reading and re-reading the transcripts and noting down initial thoughts.

The script contained six questions, which were used flexibly depending on how the dialogue developed. The questions were divided into two themes: three questions about preparations for birth and three about childbirth fear. The questions are shown below;

Table 1. Questions guideline for Focus Group Discussion (FGD).

Theme	Subtheme	Questions
Preparedness	Information source acquired	Where did you obtain the information related to childbirth preparation
	Accompanied person during childbirth	What is the mother's opinion regarding the presence of a birthing companion?
	Mother preparation	What is the most dominant preparation that a mother undertakes to face the childbirth process?
Fear of Childbirth	Fear before childbirth	What fears does the mother experience before the childbirth process
	Fear during the childbirth process	What fears does the mother experience during the childbirth process
	Fear of baby's condition	What other fears does the mother experience related to the mother and baby?

The data was processed involving four phases: transcription, reduction, codification, and categorization, and the theme was to be a final data analysis. This study's rigor was triangulation data with FGD and provider interviews; three researchers did the coding. To ensure the participants' answers, researchers repeated the questions for consistency. The research team discussed the differences in time to reach the final code to ensure the dependability and consistency of the findings. This study was approved by the Health Research Ethics Committee of Dr Moewardi General Hospital in Surakarta (No. 409/III/ HREC/2023) on April 10, 2023. All methods were performed following the relevant guidelines and regulations.

3. RESULTS AND DISCUSSION

The researchers assessed 33 women during the third trimester of pregnancy to explore their preparedness and fear of childbirth regarding this pregnancy. The semi-structured questionnaire used in this study was about childbirth preparedness and fear of childbirth made by the researchers.

Table 1. Maternal socio-demographic variables, theory knowledge on birth preparedness, and fear of delivery.

Variables	Frequency (n)	Percentage (%)
Age		
<17	8	25
17-35	19	57,6
>35	6	17,4
Educational status		
Primary	10	30,3
Secondary and above	23	69,7
Occupation		
Housewife	8	24,2
Gov employed	13	39,4
Private employed	9	27,3
Private Business	3	9,1
Husband Educational Status		
Primary	4	12,1
Secondary and above	28	84,8
Not having husband	1	3,1

Family Size		
1-2	14	42,4
3-4	11	33,3
>4	8	24,3
Total	33	100

Table 1 shows that most respondents were during their 17-35th years old, 57,6% (n=33). The highest level of education was secondary and above 69,7 %, and the number of government employees was 39,4 %. Besides, their husband's level of education was mainly secondary and above 84,8 %, and 42,4 % of women had 1-2 family members.

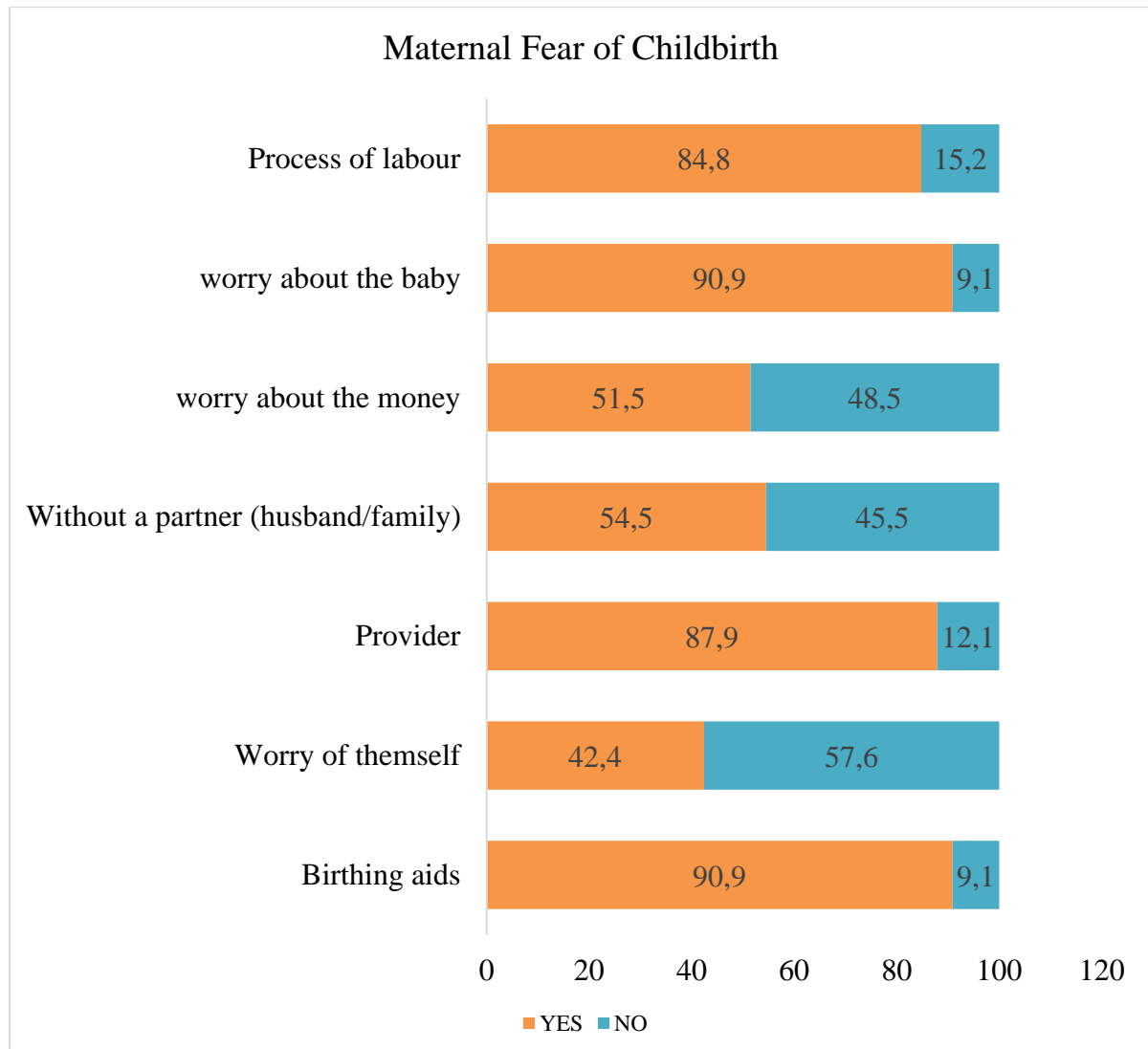


Chart 1. Maternal Fear of Childbirth

Chart 1 shows that regarding fear of childbirth, the majority express fear of the labor process (n=28, 84.8%), worry about the baby (n=30, 90.9%), concern about money (n=17, 51.5%), fear of childbirth process accompanied by their husband or family (n=18, 54.5%), worry about the provider (n=29, 87.9%), and fear of birthing aids (n=30, 90.9%).

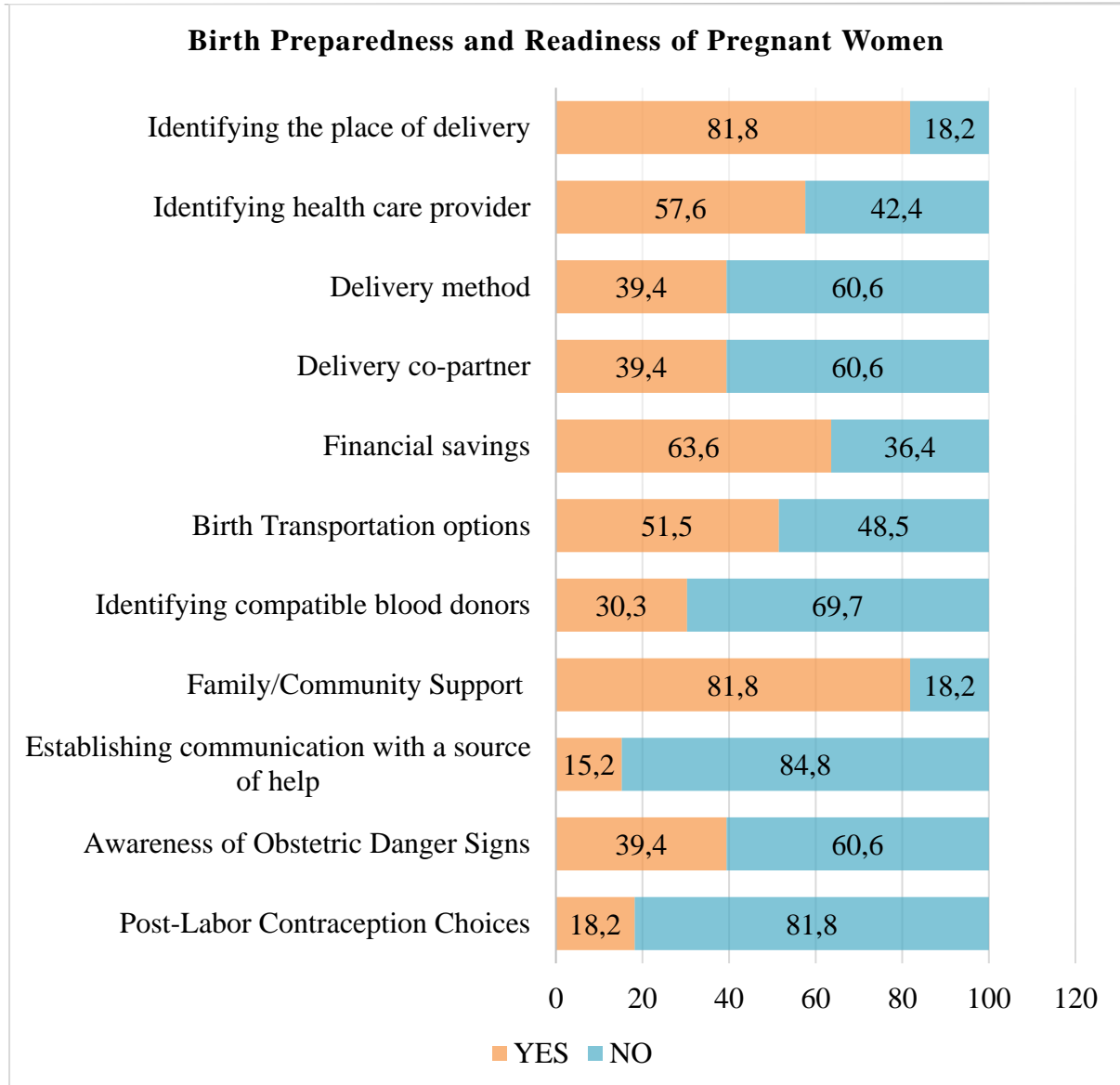


Chart 2. Birth Preparedness and Readiness among Pregnant Women.

Chart 2 shows that most respondents had already identified the place of delivery (81.8%, n=27) and the healthcare provider (57.6%, n=19). The pregnant women were also aware of having a co-partner during delivery (75.7%, n=25), saving money to prepare for childbirth (63.6%, n=21), identifying transportation options for childbirth (51.5%, n=17), having support from family (81.8%, n=27). However, they did not know the method of delivery (60.6%, n=20), did not identify compatible blood donors (69.7%), did not arrange a way to communicate with a source of help (84.8%, n=28), did not understand awareness of danger signs of obstetrics (60.6%, n=20), and did not know contraception to use after labor (81.8%, n=27).

A focus group discussion involving 33 pregnant women and two healthcare workers was performed with the results as follows;

1. Childbirth fear

1.1 Worried about Process

The labor process is a source of worry and fear for the mother before facing labor, such as worrying about not being able to push, the pain that arises, prolonged labor, running out of energy, and the baby not being born. Some informants said as follows:

"If you hear from some stories, it seems like straining is very difficult, especially when I imagine a 3kg baby coming out of our vagina. How can I do that?"

"Some brothers told me that when they are sick and want to give birth, it is like their backbones are broken, the pain in the stomach is unbearable, even if I am underweight, even though I am only underweight, I am already in pain, I am afraid if the pain occurs later, what should I do."

"I know that childbirth will be painful; I am just worried that the process will take a long time and I will run out of energy, then I will be weak, and my child will not be able to be born, worried that my baby will not be safe and I will be stigmatized as a bad mother."

1.2 Afraid of the Medical Tools Used.

Another fear that mothers feel is the tools used during childbirth. Fear of having an episiotomy, being sutured, fear of the tools available, and fear of the operation. Some informant statements are as follows:

"I am terrified that if my baby grows up, I will have to cut it, I imagine it is going to be very painful."

"what if the tear later has to be sewn up? Imagining being sewn up scares me. The thing I fear the most is being sewn up."

"If I am born later, I imagine the tools, scissors, needles, all the things used, ma'am. I am afraid; I imagine the tools there will be used for all of me."

1.3 Condition of the born baby.

The fear that arises in the mother can also come from a sense of worry about the baby being born. Worried about his imperfect shape and body parts that are unlike others. The informant's statement is as follows;

"I am afraid that my child will have missing parts of his body; I am worried about how he will be after birth."

"If the shape does not suit other children, I am afraid of being seen and ridiculed by my relatives and neighbors that I have a bad history of women."

2. Preparedness

2.1 Social media as their primary source to get their information

Information regarding birth preparedness for mother and baby was obtained by internet searching, especially from mothers who experienced a birth process. One participant said:

"Preparation for my baby and me, I am searching from social media about the birth story from the mother's experience, then I make a list for my preparation."

"I am searching through my phone, from my friends upload and browsing result in social media then I added (the list)"

2.2 Birth companion is important.

Some mothers feel comfortable and safe when they are accompanied during the childbirth process. Participants acknowledge the presence of birth companions such as their husband, mother, mother-in-law, and whoever they already knew.

"I feel that I need my husband to accompany me during my childbirth, whether I will do it normally (pervaginam) or Cesarean Section. I hope my husband still accompanies me so he knows the process."

"Whoever will accompany me be, the importance is presence, whether it will be my husband, mother, or mother-in-law."

"Yes, when being asked, (I prefer) husband and mother, but whoever they are, (they need to be) present because I do not know anybody in Primary Health Care."

2.3 Childbirth is a natural process.

Most participants believe that childbirth preparedness is to control worry about childbirth. They believe that childbirth can pass and many women can pass, too. Participants stated that:

"The fear is always there, but I am sure I can get through it. Many mothers have succeeded safely, and I definitely can."

"I am actually scared, but I am more impatient to meet my son, so I am sure I can."

"Very scared, but I was always reminded by my mother that it is natural for women to be given the same strength as above (God) "

This study explored childbirth preparation, birth plans, and childbirth fear from the perspectives of pregnant women, birth companions, and healthcare providers in a rural setting in Sragen. According to the results, women received their first information during the second trimester, with the majority being primigravida. Childbirth fear experienced by first-time mothers extends beyond the birthing process. It includes concerns about the process of labor, health providers, birthing tools, the baby's condition, financial issues, and lack of companionship. Interestingly, mothers mainly were not worried about themselves when they faced childbirth.

The intense process of labor and birthing equipment, cesarean section, and episiotomy were reported to be the source of fear of childbirth (Johnson et al., 2019). They were being affected by care providers such as care providers' disagreement with medical professionals regarding the intervention, disrespect, neglect, and lack of communication and support, leading to not feeling safe during their safe (Viirman et al., 2023).

A study from Finland revealed that disrespectful care and obstetric violence lead to negative childbirth experiences and be a ground for childbirth fear (Larsson et al., 2023). Furthermore, negative childbirth experience has been linked to problems in breastfeeding, post-traumatic stress disorder, and postpartum depression that may delay further pregnancy (Dencker et al., 2019; Viirman et al., 2023). In Indonesia, women experienced a low level of respect for maternity services during the COVID-19 pandemic, which may be caused by high workloads and adaptation to new protocols (Maulina et al., 2023). This study identifies women afraid of the labor process, health care providers, and birthing aids. To reduce this fear, women should suggest participating in antenatal education classes focused on childbirth preparedness, including handling themselves during childbirth labor, such as relaxation techniques, birthing position, and mental health support during labour. Studies showed that antenatal education reduces fear of childbirth and increases maternal self-efficacy (Pinar et al., 2018; Kızıllırmak & Başer, 2016). On the other hand, midwives should also be encouraged to work with more respect toward women and give them more autonomy regarding their decisions (Maulina et al., 2023).

Regarding worry about the unborn baby, mothers can be facilitated to have an ultrasound examination during the first and third trimesters (Wiraswati, 2022). In the latest ANC guideline, it was issued that mothers should have at least six times antenatal care, including two times to do ultrasound checks. Prenatal identification of congenital anomalies during a prenatal ultrasound can reduce women's anxiety about the fetal condition; hence, prenatal consultation can lower it (Simó et al., 2019; Yang et al., 2023).

In Indonesia, national health insurance, or *Jaminan Kesehatan Nasional*, covers maternal healthcare services, including pregnancy, childbirth, and postpartum. However, problems arise when women still need to pay for extra payments such as drugs, medication, or baby and mother essentials that need to be covered by JKN (Nugraheni et al., 2020). Another issue, only 15% of mothers who are in low economic status use JKN optimally (Nugraheni et al., 2020), putting them at a higher risk of failing into poverty because of a lack of maternal health care utilization services (Nugraheni et al., 2020). Women who experienced financial strains would lead to stunting and their children and adverse mental health outcomes (Marcil et al., 2020; Sari et al., 2020). These issues will be tackled if midwives and other healthcare providers could identify families experiencing financial problems and join advocacy to address women with financial issues (Marcil et al., 2020), at least during prenatal education.

A meta-synthesis of a qualitative study revealed that mothers mostly face childbirth as 'being at a point' with no return, a lack of control over themselves, and a lack of support in understanding their fear (Wigert et al., 2020). This study highlighted that societal ideas can exacerbate the fear of childbirth. Societal notions, such as infidelity by the husband, contribute significantly to childbirth fear. Fear of not being accompanied by a spouse or family member is a prevalent reason for mothers fearing childbirth. Educating husbands or spouses during childbirth or prenatal education increased their skill in childbirth support and maternal-neonatal outcomes (Sulistianingsih et al., 2023). Culturally specific treatments should be developed to support vulnerable pregnant women facing these issues, including inviting their husbands to prenatal education.

The study revealed that primigravid mothers get information from social media. Some mothers made preparations based on internet sources and midwives. In fact, according to Sanders et al. (2018), birth information significantly influences a pregnant woman's response to the birthing process (Sanders & Crozier, 2018). A previous study investigated that prenatal education delivered by social media did not differ significantly from those who receive an education from in-person education intervention (Mousavi et al., 2022). Even social media-based prenatal education can also lead women to give birth vaginally (Mousavi et al., 2022). This can be a new approach for healthcare providers to develop prenatal education programs that can reach women in many areas.

Birth preparedness and readiness of pregnant women relate to all the preparations made by mothers and infants during childbirth. Elements directly related to maternal preparations, which mothers can independently undertake and seek through social media sources (identifying the place of delivery, healthcare providers, financial savings, birth transportation options, and family and community support), have values trending above 50%. However, some aspects related to information that healthcare professionals should provide, particularly in obstetrics, require clarification (delivery method, delivery co-partner, identifying compatible blood donors, establishing communication with a source of help, awareness of obstetric danger signs, and post-labor contraception choices) and are less than 50% among pregnant women who have undertaken birth preparedness and readiness. This result also has been found in previous study that blood donors and complication readiness were less understood and prepared by mothers (Orwa et al., 2020)

Not all information related to these preparations can be determined by seeking information on social media only, which is needed from professionals with the capability. Based on the findings of the study by Kovala et al., (2016), some pregnant women and families consider expanding their knowledge through prenatal education to access reliable health information that can support decision-making during the childbirth process (Kovala et al., 2016). Consequently, some pregnant women who have not yet determined the components of preparedness and readiness for childbirth may not have been exposed to comprehensive health information about themselves and their infants

Childbirth preparedness is crucial, and it must be ensured that mothers are comprehensively prepared. However, some aspects of childbirth preparation, such as donor availability, awareness of danger signs, and post-labor contraception, needed to be given adequate attention by mothers in this study. Despite midwives conveying this information during ANC and pregnancy classes, some mothers still lacked understanding. One reason behind this may be associated with inadequate counseling during ANC and no actual birth plan-making during ANC. A previous study found that lack of childbirth preparedness and complication readiness was associated with lack of counseling during ANC (Orwa et al., 2020)

Therefore, more preparation is essential to mothers and neonatal well-being (JHPIEGO, 2009). Understanding warning signals of obstetric difficulties during pregnancy, labor, the postoperative period, and the neonatal period is a crucial aspect of birth preparation, contributing to appropriate and early referrals (Kaso & Addisse, 2014). A smooth delivery

necessitates pregnant women's knowledge and preparation for welcoming their child, and adequate preparations reduce confusion and fear during delivery, increasing the likelihood of receiving appropriate and timely care (Pantiawati, 2016). While attending regular childbirth education classes is crucial, providing flexibility in the format, such as offering two or eight short sessions and incorporating technology-based instruction, may better cater to women's needs, especially those relying on public health services (Meedya et al., 2021). In addition, more comprehensive counseling during ANC and making an actual birth plan that respects the mother's choice and decision is recommended as long as it still follows the guidelines of ANC. Moreover, in this setting, midwives can create an educational program based on the internet or social media, which also can promote respectful maternity care to make women less fearful about midwives and birthing aids.

This study, the first to explore childbirth fear during late pregnancy in a low-resource community, included perspectives from birth companions and healthcare providers to ensure robust findings. However, limitations include the study's relatively small geographical area, limiting generalizability, and potential bias due to the recruitment of pregnant women within the community. Future studies should verify why women need more understanding of complication readiness and how midwives perform during ANC sessions. Also, midwives need to make innovative interventions to minimize childbirth fear in a sociocultural context, utilizing antenatal classes to increase knowledge and awareness and investigating the effectiveness of practicing the delivery process. Screening for childbirth fear during pregnancy is also recommended, providing appropriate information from health workers tailored to individual needs. This approach can create positive first experiences of giving birth, reducing childbirth fear in subsequent pregnancies and increasing satisfaction with maternal healthcare services.

4. CONCLUSION

This study has revealed findings about preparedness for childbirth and childbirth fear. Fear of childbirth which were fear about baby's condition, labour process, without companion during childbirth, afraid of healthcare providers and birthing tools. Moreover, women already identify place of delivery, healthcare providers, financial saving, transportation modes, and companionship during labour. The findings suggest that pregnant women should prepare for childbirth and enhance their knowledge of delivery by participating in antenatal classes to reduce the fear of childbirth. Recommending the creation of a birth plan can provide pregnant women with a broader overview of what they should prepare for and enhance their understanding of complications readiness.

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