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“We should be experts, but we’re not”

Sexual counselling at the antenatal care clinic

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Abstract

**Objective:** Several studies show that nurses don’t meet patients’ needs in addressing issues around sexuality and sexual health. However, little attention has been paid to midwives’ views on sexual counselling. This study explores midwives’ views and experiences on sexual counselling during antenatal care.

**Study design:** Semi-structured interviews were conducted with nine midwives at seven different antenatal care clinics in southern Sweden. The interviews were analysed with qualitative content analysis, and script theory was used as a theoretical perspective.

**Results:** The result showed that the midwives considered sexuality important but hard to address. Lack of time, knowledge, and encouragement from the managerial level and/or lack of counselling tools were given as reasons for not bringing it up. In addition, midwives’ insecurity turned out to be even greater with patients that deviated from the heterosexual norm or had another cultural background.

**Conclusion:** There are cultural and interpersonal scripts in the workplace in which sexuality is not expected to be addressed. As long as these are in place, only education will not help to change issues in addressing patients’ sexuality. Organizational and managerial support along with education and opportunities for reflection and dialogue regarding sexual issues might help midwives to approach sexuality and change the cultural and interpersonal scripts.

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**Keywords:** communication, counselling, midwifery care, antenatal care, sexual health, sexuality.
Introduction

Sexual health has been recognized as an important health concern and has been the focus of considerable global attention for many years [1]. Negative sexual experiences can contribute to both physical and mental health problems as well as to complicated relationships [2].

Despite the need to raise sexual issues with patients in health care, only a minority of physicians, midwives and nurses have vocational training in sexology. Questions regarding sexuality may be regarded as problematic as they are sensitive and complex, and demand time and expertise [3, 4]. Research shows that most health professionals believe that they have insufficient education, feel poorly prepared or are unwilling to discuss sexual issues with their patients [5]. Other obstacles mentioned are differences between health professionals and patients concerning age, ethnicity, race, gender and sexual identity [3, 6-7]. Most studies concerning communication on sexual matters have been done in a nursing context [5, 8-12], while other health professionals, such as midwives, are virtually unexplored when it comes to this issue.

Midwives, by their close relationship with patients, are in a unique position to promote sexual health and provide sexual health advice to individuals in their care. Many women have sexual problems [2, 13-14] and studies have shown that sexual health problems and distress are common after childbirth, suggesting potentially high levels of unmet need [15-16]. A recent study [17], showed that sexual distress is also common during pregnancy, and the authors emphasizes the importance of identifying sexual distress in women during pregnancy in order to reduce sexual and relational problems after childbirth. When women attend antenatal care clinics there are opportunities to create a dialogue aimed at promoting their sexual health [5]. Women, however, seldom raise questions regarding sexual problems [2, 6], and midwives and physicians fail to raise questions regarding sexuality [3, 5]. To promote women’s sexual health, there is a need for improved dialogue between patients and health professionals. Midwives and physicians have the main responsibility to initiate this dialogue [13].

Antenatal healthcare in Sweden

Antenatal care was introduced in the 1940s in Sweden, and fully developed within a period of twenty years. The main goals of antenatal care are to provide health check-ups, information about pregnancy, labour, birth and the forthcoming parenthood as well as to prepare parents for birth. The maternity care system in Sweden is funded by taxes and is generally free of charge, and the antenatal care clinics are staffed by midwives. The Swedish midwives have an independent role when caring for woman with normal pregnancies and childbirth and are expected to tailor their support and care to all women [18]. Women make frequent visits to the antenatal clinic during pregnancy. Besides providing health check-ups to detect pregnancy complications, midwives also offer antenatal education classes, prescribe contraceptives and perform screening for detecting cervical cancer. A pregnant woman is usually cared for by the same midwife during the whole pregnancy [19].

According to Health Authority and the National Board of Health and Welfare in Sweden, the midwife should demonstrate knowledge in the areas of reproductive, perinatal and sexual health [20], and all midwifery education is based on national law. However, sexology is not included as a subject in all midwifery education, and the extent of sexology education varies depending on interest in the topic and local conditions [21].

Theoretical framework

The present study is qualitative. To obtain a deep understanding of the findings, Gagnon & Simon’s Sexual Script Theory has been used [22]. The idea of sexual scripts brings a metaphor and imagery for understanding human sexual encounters as social and learned interactions.
According to social scripting theory, information from the society and personal experience is stored in mind, and provide directions which helps individuals to interpret how to think, and behave [23-24]. When it comes to sexuality, people are guided through internalized sexual scripts based on own experiences and cultural norms.

The sexual scripts answer questions such as when, with whom, or what, where, how and why individuals express their sexuality and have sexual activities. The scripts change with the situation, time, people, place, and cultural context. The theory highlights three levels of scripting: the cultural/historical, social/interpersonal and intrapsychic levels [25], and can easily be applied on midwives work at the antenatal care. At the cultural level, the sexual scripts can provide standards for the encounters at antenatal care. The woman or the couple may have their own thoughts and patterns that she/they consider; the so-called intrapsychic and interpersonal scripts. The midwife has additional ideas based on her intrapsychic scripts and the intrapersonal scripts between her colleagues, and the workplace provides cultural scripts. Each individual creates their own scripts based on experiences and social learning [23]. Mismatching can occur when people following different scripts, such as the midwives in the clinical setting with scripts based on workplace structure, and patient´s scripts with the expectation of receiving information from a clinic that handles issues related to sexuality. Sometimes the scripts overlap in time, but that is far from obvious. The scripts interact and affect the meeting and the way in which sexuality is addressed.

Limited research has been undertaken on midwives’ perceptions of counselling and assessment of women’s needs and well-being in sexual life. Therefore, the present study aims to explore midwives’ views on and experiences of sexual counselling at antenatal care.

Within the framework of this purpose we have focused in particular on the following areas of inquiry: How do the midwives value the importance of and responsibility for addressing sexuality? When, with whom and how is sexuality communicated during antenatal care? Which factors can promote or inhibit communication about sexuality based on the midwives’ perspective?

**Methods**

A qualitative approach was chosen as it is person-centred and holistic, and refers in the broadest sense to research that produces descriptive data [26].

**Sample**

The sample consisted of nine midwives employed at antenatal care clinics (private and public) located in small and large cities in southern Sweden. They were chosen as a purposive sample to include as many different experiences as possible. The participants were women aged 44-66 years with professional experience ranging from five years to more than 33 years. All midwives had worked for at least one year with antenatal care. Four participants had taken courses that included sexology, one had just started a master’s program in sexology, and four midwives had no education in sexology.

**Data collection**

The participants were invited by email. The email consisted of the aim and information about the study, and stated that participation was voluntary and that they could withdraw at any time without giving a reason. Midwives who agreed to participate decided when and where to be interviewed. During a period of a month, semi-structured interviews were conducted “face-to-face”, and were recorded. The interviews lasted between 38 minutes and 65 minutes (mean 48 minutes).
**Data Analysis**

All interview data were transcribed verbatim and pseudonyms were used to protect identity. Data were managed manually to become familiarized with the material and increase the validity. The material was analysed using the qualitative content analysis method described by Graneheim and Lundman [27]. In the first step, the interviews were read through several times to gain a sense of the whole and to find “meaning units” corresponding to the aim of the study. In the second step, the meaning units were shortened to condense meaning while still preserving its core, and in step three, the condensed meaning units were coded. The codes were then abstracted, compared for differences and similarities, and sorted into subcategories and categories. The tentative categories were discussed by the researchers and revised. A process of discussion and reflection resulted in an agreement about how to sort the codes. Finally, the underlying meaning, the latent content, of the categories, was formulated into sub-themes and finally a main theme. An example of the analytical scheme is presented in Table 1.

**Table 1. Example of the procedure in the content analysis**

| Meaning-bearing unit | “It is perhaps midwives’ responsibility? Well, in fact I think we as midwives would be able to address sexuality in our encounters [...] but we do not have time for it. We should be experts at it but we’re not”.
| Condensed meaning unit | Midwives should be responsible for addressing sexuality in the encounters. But there is no time.
| Category | Midwives want to take responsibility for sexuality
| Sub-theme | Timing and Responsibility
| Main theme | Sexuality is an important aspect – but easy to overlook

The manifest content is about what the text says, such as what topics are covered during the meeting, while the latent content describes what the text is about, in other words, the midwives’ professional approach [27].

The study was approved by the ethical review board, Malmö University, Faculty of Health and Society, Sweden.
Results and Discussion

Five central subthemes were identified: Timing and responsibility, Being a perfect midwife, Normative thinking as an obstacle, Lack of skills and management support, and Views on sexuality are changing. Finally, one main theme emerged: Sexuality is an important aspect – but easy to overlook.

Timing and responsibility

The midwives in this study believed that women expect issues related to sexuality to be addressed at the antenatal clinic. Several factors played a role for a successful meeting to take place. The midwives expressed the importance of taking a genuine interest in people’s sexuality. But there was a fear of embarrassing patients, a fear often stronger than the desire to communicate about sexuality. They described being guided by their professional instinct in each situation, letting chemistry decide when and what to ask.

Timing was a very important factor, but not clear-cut. Midwives identified the need for time to develop the midwife–patient relationship and trust before raising issues of sexuality. When women came for contraception it was often described by the midwives as a good opportunity to bring up sexuality. But it was also evident in the interviews that if the patient did not express a wish to address issues related to sexuality, and the midwife’s impression was that “everything looked okay”, the topic was easily neglected. In the following quote the midwife waited for the initiative to be taken by the patient.

“If a young, confident woman comes to the antenatal clinic for contraception and she has a boyfriend… I mean I don’t ask her actively ‘How’s your sexual life?’.” (Leja)

The midwife’s intrapsychic scripts [22] seem to be directing the conversation. According to the midwife, sexuality was something very private only to be talked about when there were obvious problems that need to be solved. This script coincides with the medical script on the interpersonal level that sexuality is about functionality, so sexuality is only included in the medical context when something needs to be addressed or investigated. Gagnon & Simon [22] state that scripts are to be regarded as cognitive frameworks that facilitate external expectations and inner perceptions of how, when, with whom and why sexuality is expressed and organized.

The midwives in the study expressed that sexual distress was quite common during pregnancy. Despite an awareness, there was seldom time to raise the issue at the encounters. Thoughts about when it was the right time to raise sexuality concerns recurred frequently. Addressing sexuality was most likely in encounters when contraception was discussed and at postpartum check-ups (check-up 6-12 weeks after childbirth). Some midwives saw a natural entrance to the subject during postpartum check-ups, however, lack of time and knowledge restricted midwives when counselling sexuality issues after childbirth. Male partners’ attendance was described as a circumstance that sometimes complicated addressing sexuality even more. The midwives felt they had neither experience nor skills to talk about men’s sexuality. In practice, it becomes a way of invisible-making the sexuality of the partner even though it could be important for the couple as a whole.

At the antenatal clinic, many scripts compete simultaneously. The interpersonal script at the clinic does not say that sexuality shall be addressed at every appointment, even though midwives should communicate sexuality due to the law [20] which is a cultural script. Midwives’ intrapsychic scripts often seemed to involve a fear of embarrassing themselves or the patient which was greater than their determination and sense of responsibility to address
issues of sexuality. Such intrapsychic scripts coincide with and are consolidated by the medical cultural scripts that say that sexuality should only be addressed when there is a sexual health problem to solve, when medical knowledge is required. The midwives in the study stated lack of time for communicating sexuality but that seems like an excuse to cover for the inconvenience they felt. “To tune in” or find “the right timing” can be seen as an excuse for not initiating the issue. Sexuality was relevant and something that was part of midwives’ responsibilities.

“It is perhaps midwives’ responsibility? Well, in fact I think we as midwives would be able to address sexuality in our encounters [...] but we do not have time for it. We should be experts at it but we’re not.” (Görel)

Being a perfect midwife

The midwives saw themselves as professionals that at all costs had to do the right thing and shouldn’t risk saying or doing anything wrong. Uncertainty about what was right and wrong around sexuality occurred frequently in the material.

“I think it’s fear, that you would say things the wrong way at the wrong time. When I think of my colleagues and all other midwives, I know, you want to be so perfect, we must sort out so many things, and it should be perfect, and then you are afraid it will be wrong.” (Sara)

The midwives expressed the interpersonal script of being the “perfect and omniscient midwife”. The interpersonal script spills over into the intrapsychic one about not being good enough and unable to live up to the “perfect midwife” ideal. By not addressing sexuality nothing was risked. There are no clear guidelines at antenatal care for how sexuality should be addressed. Therefore, there are no interpersonal scripts at work that say they are doing wrong when they do not relate to sexuality. The risk of error was experienced much less if they were not pushing the issue of sexuality.

In the interpersonal script at the clinics, there was no clear prioritization of the issue. The midwives wanted to address the issue, but the fear of making mistakes or revealing prejudices were stronger than the will to bring it up. The fear of making mistakes was further increased when the midwives met people who deviated from the norm.

Normative thinking as an obstacle

Heteronormativity affects the work at the antenatal clinic. Midwives expressed a fear of making mistakes when they were confronted with the non-heterosexual norm. This was even though the midwives thought it was important that assumptions about sexual orientation were not made. All midwives agreed it was not their role to label or judge behaviour, but opinions like the following were common:

“It is because you are not so used to it [homosexuality], the most common is still heterosexuality and that you are afraid of not grasping it [homosexuality], and perhaps afraid that one might tread on someone’s toes?” (Lena)

Although caring for lesbian couples was unproblematic for some of the midwives, they described experiences of ambivalence or anxiety in the encounter and they had noticed and heard of some couples who had negative experiences with maternity care. The couples were sometimes looked upon as “different” or vulnerable.
Gagnon & Simon [22] believe that individuals relate to what society or the environment considers to be “common”. The findings give the impression that feelings of uncertainty come up around homosexuality.

Communication about sexuality was more difficult when the patient had a different cultural background than Swedish. This is in line with previous research on ethnicity and language difficulties when addressing sexuality [3, 6]. Questions concerning sexuality were rarely discussed when patients had a different ethnic background than Swedish. The motivation midwives provide was linguistic confusion and that one did not believe there was a need.

“But in those situations [when the woman doesn’t speak Swedish] it’s hard when it comes to addressing issues relating to sexuality, when using an interpreter, then there will be no sex talk.” (Berit)

The use of interpreters was a barrier to addressing the issue. People with immigrant backgrounds were seen as different with other needs. It was easy to stereotype people and in the worst case that limits the clinical understanding. The results coincide with previous research that has shown that ignorance and uncertainty among health professionals on issues that address gender, cultural and sexual orientation hinder conversation about sexuality [3, 6-7, 28].

Lack of skills and management support

Inadequate training in sexology was seen by the midwives as a major contributing factor in not addressing sexuality at the antenatal clinic. A difficulty frequently mentioned was the lack of skills on how to start a conversation on a topic as intimate and private as sexuality. The midwives feared offending the person or stepping over the boundary of what was considered the professional midwife–patient relationship.

“No, I do not think I’m prepared for counselling on sexuality, from my midwifery educational point of view I do not think that at all.” (Fatima)

The same findings have been observed in previous research [5-6, 13]. The midwives in the current study suggest that education in sexology contributes to confidence and courage to address sexuality. When lacking education, they had to base their knowledge on their own sexuality and experiences as women, therefore they stress it was easier to talk to women than men. One interpretation is that midwives use themselves (their own sexuality) as instruments/tools when they lack training and knowledge.

“But the woman’s anatomy is familiar to us. We know what it feels like to be pregnant, give birth and take contraception. We know how women’s sexual desire works.” (Lena)

There is an obvious risk that the information and advice given to the patient is limited by the midwife’s vision and experience when not based on evidence and knowledge.

The midwives explained sexual problems they encounter based on social factors: the image of how sexuality was conveyed by the media, appearance ideals and how to perform sexually. The cultural script demanding that everyone should have a wonderful and enjoyable sex life, is ever present in the community, in advertising, movies, music and so on. The midwives found it hard not to be affected by those messages. The consistent cultural script that sex is important, becomes difficult to manage on the interpersonal and individual level. In addition, the cultural script of the employer and the interpersonal script of the workplace signal that sexuality is not important.
Clearer mission and guidelines from management and the organization were requested from the midwives. A common opinion among the midwives was that the management’s disinterest influenced how they worked with sexuality counselling. The midwives expressed that as long as the sexological competence was not valued by and promoted from management, issues on sexuality would not be addressed. In a study by Wendt et al. [13], support from the organization and the use of personal skills and assets were found to be promoting factors for dialogue. Lack of organizational support or communication skills and difficult emotions complicated the situation, which might, in turn, inhibit midwives and clinicians from raising sexual issues [13].

Views on sexuality are changing

Midwives pointed out that sexuality was surrounded by many taboos but that the issue was not completely foreign to them. The midwives emphasized that this taboo was changing. That change was seen among younger women who are so much more open on issues of sexuality. A renegotiation of the sexual scripts takes place over time [23, 25]. To alter what is habitual may feel threatening and insecure, but in this case, it was welcomed by the midwives.

The midwives gave various reasons and thoughts on why sexuality could be sensitive and difficult to talk about. Their reflections revolved around social, cultural, generational differences and changes.

“Several generations have grown up with that; one should not talk about sexuality, we should not expose ourselves. Hopefully, more and more young girls are more outspoken.... The young women today talk about sexuality in a completely different way and are not ashamed, like we were when we were young.... Especially those born in the 1980s, late ’80s, early ’90s...” (Leja)

This clearly describes how a change in sexual scripts is occurring over time. The intrapsychic script, containing embarrassment and shame for women speaking openly about their sexuality, is changing in certain groups. Older midwives place their hope in that problems around talking about sex would resolve themselves naturally, when the younger generations take over.

The midwife quoted above saw signs that women got more affirmed in their autonomy around their sexuality. More and more women were not ashamed for their sexuality. This cultural script of women’s emancipation goes hand in hand with the intrapsychic in this regard.

Sexuality is an important aspect – but easy to overlook

Through midwives' narratives runs a thread that shows that sexuality is considered important for human well-being but that the topic was easy to lose in the encounters at the antenatal clinic. This emerged as the main theme in the material: *Sexuality is an important aspect - but easy to overlook.*

“I think we’ve forgotten about sexuality, we don’t have it consciously in our encounters.”
(Berit)

Sexuality was regarded as a sensitive subject that was more or less “forgotten”. All midwives stressed the need for further specialized training not only in physiology issues related to sexuality, but most importantly also in communication skills. Not having either knowledge support or organizational support to address issues around sexuality with patients at the antenatal care clinic, makes sexuality easy to overlook.
Study limitation

Some methodological considerations need to be discussed. Social desirability, according to Kvale [26], is a general tendency to exaggerate the positive attitudes and values in interviews and questionnaires. As stated earlier, sexuality can be a sensitive subject, and therefore give rise to social desirability. There is also a risk that midwives in this study answered the questions based on their beliefs about how society or patients view the midwife’s role and felt they should respond in a certain way. Midwives may have been influenced by disciplines or codes contained within the profession, or by the fact that the interviewer was a colleague to whom they want to show their competence as midwives. In this way, the workplaces’ current sexual scripts or social norms will affect the indirect answers to the questions. Five of the midwives had some form of training in sexology, which also may have affected the result. However, it is still within the scope of their view of counselling on sexuality that is the subject of this study. With a larger selection/more interviews or another method, such as an anonymous questionnaire, and in a different context, the result could possibly be different. Although the number of participants was limited to nine midwives, the narratives described a wide range of experiences and repetition of themes, ensuring saturation of data.

Implications

Today there is no clear expectation or thoughtful approach to how conversations about sexuality should be included in the work at the antenatal clinic. Clear guidelines on how the work on sexuality and sexual health will be conducted needs to be formulated. The focus should be on empowering midwives to dare to meet and strengthen patients they meet at the antenatal clinic to communicate issues on sexuality. According to Gagnon & Simon [22] scripts are changing and the process goes on all the time in the community, in the workplace and in individuals. The change may seem slow, but a normalization on sexual health and issues is evidently taking place. Although knowledge is available and offered there is no change if it is not included in the cultural and interpersonal scripts to communicate sexuality.

The different stages of the P-LI-SS-IT model (Permission, Limited Information, Specific Suggestions and Intensive Therapy) [29] when it comes to sexual counselling can usefully be adapted by the inclusion of the techniques discussed, such as: legitimizing sexuality as an aspect of care, listening and responding to cues, exploring feelings and expectations, giving information and acknowledging limitations. The PLISSIT model developed by Annon [29] have been used for addressing sexual health concerns in different clinical settings. Permission (P) is the base where the midwife can normalise discussions concerning sexual health in a non-judgmental way at the antenatal clinic. Including questions regarding sexual history into the assessment of the general health makes sexuality a natural part of the health history. Limited Information (LI), is the next level where the midwife can give simple information about sexual anatomy, physiology, and discuss normal life issues, challenges and attitudes and norms/ideal connected to sexuality. The third level, Specific Suggestions (SS), requires more knowledge, where the midwife can give some suggestions to help the individual with different sexual concerns, e.g. pain associated with sexual situations and/or sexual distress. The fourth level Intensive Therapy (IT) is required when specific suggestions are not sufficient and the patient is in need of more in depth treatment. As Annon points out [29], most people are helped by the first three levels. The levels in the PLISSIT model might give midwives a stronger framework within which to assist patients to increase enjoyment of their sexuality, which is an integral part of the human experience and a basic right of all.
Although timing is important in terms of the patient willingness to respond, it is not a luxury that midwives often have, given the increased turnover of patients in today’s health-care environment. By raising the issue, even if the person chooses not to respond, midwives are telling the patient they are open and willing to discuss sexual issues. An individual might not be ready to respond immediately but might feel more confident to return to discuss issues later. To provide holistic care, addressing all the patient’s needs, including their sexuality needs, must be addressed.

Summary and Conclusions

This study indicates that patients’ sexuality was considered an important issue by the midwives at the antenatal care clinic, but at the same time were sexuality questions easy to overlook. The reasons for not taking an active part in sexual counselling were embarrassment, lack of knowledge or skill, lack of encouragement from the managerial level and/or lack of counselling tools. In addition, even more uncertainty arises when the patient deviates from the heterosexual norm or has a different cultural background. Research studying conversation concerning sexuality issues in health care contexts have shown difficulties among health professionals in addressing sexuality with patients [4, 8, 15], and obstacles have also been seen to be greater when patients differ from the cultural and/or heterosexual norm [7]. However, the findings in the current study illustrate that the midwives' way to communicate sexuality was not something they thought they had mastered; they openly state how difficult the area was. Does this mean that midwives see this area as unimportant? Probably not, on the contrary, the result shows that all midwives believed sexuality issues were important and noted that they should be experts in this area, but they were not. This admission may seem negative but it can also allow for a more deliberate approach. The ability to show their uncertainty but still have confidence in their own skills could create opportunities. The result shows that there must be an explicit expectation at the workplace to communicate sexuality. “Guilt” or bad conscience that emerges in the interviews illustrates how midwives blame themselves for lack of conversation about sexuality, and this should be directed upward to the management and organization.

Conclusions

Sexual counselling at antenatal care clinics seems to be an important part of midwives’ work, but at the same time hard to address. There are cultural and interpersonal scripts in the workplace in which sexuality is not expected to take place. The findings illustrate that there must be an explicit expectation at the workplace, but as long as the cultural and interpersonal scripts are there, only education will not help to change addressing patients’ sexuality. It seems that the midwives either have knowledge support or organizational support to address issues around sexuality, which makes sexuality issues easy to overlook. Education in sexology can be seen as one part in the process for changing existing scripts. However, organizational and managerial support, and in addition education and opportunities for reflection concerning conversations regarding sexual issues might help the midwives to approach sexuality and change the cultural and interpersonal scripts.

Declaration of Conflicting Interests

There are no financial or other relationships that might lead to conflict of interest. The authors alone are responsible for the contents and writing of the paper.
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Contributions

AP coordinated the project, conceived the study, participated in its design, coordinated the data collection, analysed the data and drafted the manuscript.
EE participated in designing the study, assisted in the data analysis process and with the drafting of the manuscript. Both authors read and approved the final manuscript.

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