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Proactive behaviour in midwifery practice: A qualitative overview based on midwives' perspectives

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ABSTRACT

Background: Midwifery practice is in the process of continuing developments and contemporary working conditions asking for proactive behaviour, which could increase work-efficiency, job satisfaction, commitment and coping attitudes towards stress resistance. This study aims to provide an in depth exploration of midwives' perceptions of facilitators and/or barriers of proactive behaviour in midwifery practice.
Methods: A qualitative descriptive study, using individual semi-structured interviews, was undertaken within a sample of 102 Flemish and Dutch midwives who were interviewed from September to December 2017 using a four-item topic-list.
Results: Six influencing factors emerged from the data consisted of the causal, contextual and conditional factors faced by the midwives in order to show proactive behaviour in midwifery practice. Midwives elaborated the need for team consultations, a safe organizational culture, an appreciative midwifery leader and an attitude of lifelong learning. Furthermore, midwives are looking for a way to deal with both challenges in healthcare and the competitive societal system.
Conclusion: This inductive study confirmed, supported and expanded previous deductive research and provided additional insights of proactive behaviour in midwifery. Providing midwives with knowledge of the influencing factors, required to successfully effecting proactive behaviour in midwifery, this study has subsequently merit for future research in the transfer of recommendation in daily midwifery practice, education and policymaking.

Introduction

Midwifery practice has grown in complexity characterized by an overload of operational pressure and the need for cost-effective and continuous accessible healthcare [1,2]. The childbearing woman landscape also became more complex, for example, increased rates of obesity [3], more primi-multigravida women at an advanced age [4] and more women are living in very difficult social situations [5]. Midwives are expected to adapt quickly to keep up with the contemporary changes in the settings in which they provide midwifery care [6,7]. This ever-changing midwifery working field also seems to affect midwives' ability to fully exercise autonomy, and to advocate for women and normal birth. Jefford et al. [8] linked this changing context to where midwifery abdication is inevitable or at least very difficult to prevent. Job conditions could be influenced by organizational changes [9]. Both perceived and objective job conditions are important for the well-being of practicing midwives. An increased level of autonomy, by e.g. performing caseload midwifery, and awareness of emotional wellbeing of the midwife have been highlighted as important strategies in maintaining a healthy midwifery workforce [10–12]. Focus on wellbeing of families and midwives during the transition to motherhood in a busy society was also acknowledged by Fontein-Kuipers et al. [13] and Jespen et al. [14].

Researchers of this study draw attention to proactive behaviour to positively cope and act in times of change, stress and uncertainties [15]. The origin of the concept of proactive behaviour dates back to the 1960s–in which mainly motivational theories were examined and where the desirability of a certain outcome was mainly linked to the selection of a certain behaviour [16]. At this time, focus was mainly on intentions, motives and desires, and less on the relatively passive person

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subjected to organizational phenomena. Grant and Ashford [17] prioritized the active role of the persons in deploying influencing tactics, later on called forms of proactive behaviour, to improve social interactions, working structures and to expand knowledge and skills. The concept of proactive behaviour is a universal phenomenon generalizable to multiple professions. Also, in healthcare the term does occur, often in different meanings, like innovative or entrepreneurial behaviour. A concept analysis was performed using Walker & Avant's [18] eight steps method in order to understand and apply proactive behaviour in to the midwifery field [15,18]. By use of this method, the evolution of the concept of proactive behaviour in midwifery was exposed and a clear distinction between relevant and irrelevant features was made.

Midwives behaving proactively are always one step ahead, anticipate future possible barriers, see changes as an opportunity, work autonomously, adapt easily and in constant search for the most effective and qualitative state-of-the-art-care. This behaviour results in an increased work-efficiency, job satisfaction, commitment and coping attitudes towards stress [19,20]. Additionally, improved productivity and organizational success of the midwifery team may occur [21–23].

Proactive behaviour might add a significant value to the midwife's role to support the challenges of continuous adaption in midwifery care and their contribution to the quality of care of women and infants globally [24,25]. Therefore, this current study focused on the perceived experiences of midwives towards proactive behaviour.

Previous cross-sectional studies showed the association between midwifery students and midwives' individual and contextual antecedents, such as role-breadth self-efficacy and control appraisal, and proactive behaviour [26–28]. This qualitative study aimed to look for possible unknown or unexplored stimulators and barriers associated with proactive behaviour in midwifery practice. We aimed to contribute to the theoretical understanding regarding the influences on professional behaviour, without narrowing the researched concept to a single variable or descriptor, by means of qualitative research [29,30]. This study was guided by the research question "how do midwives experience proactive behaviour in their working field?".

Methods

Study design

A qualitative descriptive design was used to conceptualize patterns, processes and understanding how midwives, via their social interactions and reality, experience proactive behaviour in midwifery and theorize ways to support midwives in order to behave proactively. This design provides a comprehensive summary of perceptions in the everyday language of the participants and is the method of choice when seeking to obtain clear descriptions of phenomena [19]. Individual semi-structured interviews were conducted to explore Flemish and Dutch midwives' perspectives of midwifery situations in which they found themselves behaving more or less proactively.

Insuring the adherence to qualitative reporting standards, the 21-item consolidated criteria for reporting qualitative research (SQR) check-list was followed [31].

Sampling procedures and study participants

In Belgium and the Netherlands, midwives, licensed according the European directives (2013/55/EG), are able to take full medical responsibility for a woman experiencing normal pregnancy and birth independently. In Flanders approximately 5002 midwives are actively employed of which 82% (n = 4133) work in a hospital setting, 10% (n = 466) are self –employed and 8% (n = 403) combine both [32]. In Flanders, most childbearing women choose an obstetrician to be their primary care provider. Whenever they enter the hospital, they will be accompanied by a, mostly unknown, midwife who will take care of her during labour. Caseload midwifery is pursued by all midwives, but merely accomplished by the midwives who are self-employed. Although, midwives working in a Flemish hospital gain more and more opportunities to also be part of the prenatal care pathway. In the Netherlands, approximately 3221 midwives are actively employed of which 28.1% (n = 905) work in a hospital setting, 68.9% (n = 2219) are self –employed and 3% (n = 97) combine both [33]. Dutch midwives mostly perform caseload midwifery, but nowadays, tension rises between midwives and the obstetricians. The model of integrated-birth care creates a focus of attention and discussion in the midwifery field.

For this study, both Flemish and Dutch midwives who act as training placement for midwifery students of the faculty at the Artesis Plantijn University College in Antwerp, were deemed eligible (n = 139). These midwives already cooperated in an ongoing cross sectional study and were asked whether they were willing to take part in a follow-on personal interview concerning the topic of study. A large number of midwives (n = 102; 73%) positively responded to participate. Drawing on the principles of purposive sampling, employing the strategy of maximum variation in the selection of participants, an approximately equal percentage of Dutch (n = 46; 45%) compared to Flemish midwives (n = 56; 55%) were included for interviews. This method provided the opportunity to collect relevant, diverse and rich date related to the research question. A total of 102, all female, midwives and a mean age of 32 year, participated in this study. The type of work setting was subdivided in midwives working in a hospital (n = 64; 63%) and independent self-employed midwives (based in community service) (n = 38; 37%). More than half (n = 65; 63%) of the participants had less than 6 years of working experience. All characteristics of the participants are shown in Table 1.

Ethical considerations

Both the ethical advisory board of social and human sciences at the University of the GZA hospitals in Antwerp, Belgium (HD/ef/2017/11.23; approved 27th of September 2017) as well as the commission of medical ethics of Antwerp, Belgium (SHW_17_31_02; approved 17th of November 2017) gave their approval. An informed consent form, with information about the aim and design of the study was provided to the respondents. It was ensured that participation in this study was voluntarily, confidential and anonymous. Participants were reassured that they would not be identifiable in the transcripts, the audiotapes and any

Table 1
Midwives' characteristics.

Personal characteristics		n	%
Age	21–25	31	30
	26–30	28	27
	31–35	13	13
	36–40	4	4
	41–45	5	5
	46–50	10	10
	51–55	4	4
	56–60	2	2
	> 60	5	5
Nationality	Belgian	56	55
	Dutch	46	45
Work setting	Clinical/Hospital	64	63
	Self-employed/ Independent	38	37
Gender	Female	102	100
	Male	0	0
Number of years in work environment	< 1 year	29	28
	1–5 year	36	35
	6–10 year	12	12
	> 10 year	24	24
	Unknown	1	1

Table 2
Topic list.

First the concept of proactive behaviour in midwifery is elaborated and the understanding of the concept and of the difference with indicative concepts such as entrepreneurship, job crafting…is checked. Use the concept analysis of Mestdagh et al. (2016) as a guideline. Ask per topic:	
1.	The description of moments during their work in which they saw them self as a midwife/or a colleague (not) showing proactive behaviour?
2.	The indication of what they think are the pre-requisites to show proactive behaviour?
3.	The indication of what they think are possible barriers to show proactive behaviour?
4.	Thoughts on if proactive behaviour can be learned?

reports or published work.

Data collection

All face-to-face interviews were conducted between September 2017 and December 2017 by well-trained last year midwifery student research teams. All students participated in a 16h scientific training in conducting semi-structured interviews.

Ensuring consistency of terminology and understanding of the concept, the students explained the focus and design of the study based on the concept analysis of proactive behaviour in midwifery made by Mestdagh et al. [15]. Thereafter, a minimum of four open-ended questions, aiming to investigate the midwives' experiences, were asked, aided by validated topic list [34] (Table 2). This ensured that all interviews covered the same topic of interest and to maintain focus during the interview. During the interviews, field-notes were made.

A total of 102 interviews, with an average duration of 39 min, were performed one to one at the midwife's work place and audio-recorded. Audiotapes were stored in a password-secured place.

Analysis

All audiotaped interviews were transcribed verbatim, added with field-notes and anonymized. In a first phase, all interviews and field notes were read and re-read in order to familiarize with the data. In this stage, nine of the interviews were excluded from the study due to poor interviewing quality, thus 93 interviews remained. Based on the content of the transcripts, a code list was created without any pre-conceived framework (open coding). Afterwards tentative propositions about the relationships between codes were made and, those who captured similar concepts were, combined into categories (axial coding). Memo writing and mapping of concepts and ideas was used to further develop the logical chain of evidence for themes that emerged from the data. The final coding phase, known as "selective" coding, involved the identification of a theme that incorporates other categories or supersedes them in explanatory importance [35].

Finally, by re-revising the raw data again, further refining by merging, adding and removing redundant themes, six themes were identified. There was a clear and extended role of each researcher of this study in order to create a shared vision and conclusion, by means of constant comparison. There was no continuation in interviewing midwives until data saturation was perceived, but there was a clear and steady level of saturation after reading all 93 interviews. All analysis were performed in Excel©.

Findings

Six key themes were conceptualized from the midwives' perspective on proactive behaviour in midwifery (Fig. 1): The role of the team the midwife is working in, the organizational culture, leadership, education, challenges in care and the changing society. All themes are illustrated by quotes, which were translated and retranslated by two of the authors of this study. The ID number of the participant follows each quote. In addition, an indication was provided to clarify the nationality and employment of the midwife e.g.: DSEM for Dutch Self Employed Midwife, FCM for Flemish Clinical Midwife.

The midwife's team

First, the size, variety or shape of the team proved to be important predictors of the ability to show proactive behaviour. Participants indicated the advantage of working in a rather small team. This contributes discussing things in a small group rather than a big team *"where you are just one of many"* (FCM40). "*If you work in a larger team, you may take longer to come to an agreement" (*FCM44*)*.

The participants described the important benefit of discussing both daily and/or specific obstetric cases in team consultations on a regular basis, in order to create a sense of more shared-responsibility; *"we evaluate and adjust our practice if needed and possible" (*DSEM56*)*. One of the participants (DSEM59) also stated that these cases do not need to be super complicated. According to the participants, these consultations contribute to learn from each other's experiences and to improve quality; *"these meetings serve as a reference point to improve quality" (*DSEM39*)*.

The learning aspect of working in a team was also discussed by the participants as being something that can be achieved by clear and good communication; *"The only way to grow is when you communicate with your colleagues" (*FCM66*)*. In addition, feedback can be seen as an essential element in this process to allow midwives to reflect on their behaviour and to clarify opportunities to self-assess their skills and capabilities; *"Feedback is important to students, but I think we should do this as colleagues more often as well" (*FCM64*); "When you reflect and give feedback to each other as colleagues, you stay alert and not just be compliant to the standard protocols" (*FCM67*)*.

The level of proactive behaviour of midwives also seemed to be determined by collegiality; *"The team spirit has a positive effect" (*FSEM1*)*.

The statement, *"There can be a negative influence of colleagues in a team as well. When many of your co-workers are not punctual or lazy, you easily adopt to that behaviour and think when no one does it, why should I? (*FCM85*)"* reflects a negative potential of teamwork. When colleagues do not like to behave proactively, this could be a big hurdle for a midwife who does or intends to as described by one of the participants: *"you depend on the mentality of your co-workers (*FCM50*)"*.

Organizational culture of the midwives' working area

Many of the participants mentioned the importance of tolerance and of a safe organizational culture and open and transparent atmosphere as an impacting factor on the willingness and trust to behave proactively; *"With an open atmosphere everyone can express their opinion and everyone can learn from what the other one thinks" (*DCM17*); "The more confident you are within the group, the more you can show of yourself and dare to make suggestions" (*FCM47*)*. The explicit statement of FCM64 *"I think proactive behaviour is easily abolished when none of your suggestions are appreciated",* clearly indicates the need for a positive culture.

A part of the organizational culture is determined by the hierarchical status between midwives and obstetricians, which was very often addressed by the participants; *"The doctors' will is law" (*FCM5, FCM8, FCM12, FCM13, FCM29, FCM33, FCM51, FCM62, FCM85*)*. There is a certain authoritarian relationship, which could result in a system where midwives adopt a 'wait and see' attitude or do not dare to speak their mind to the doctor; *"A young novice midwife will not show*

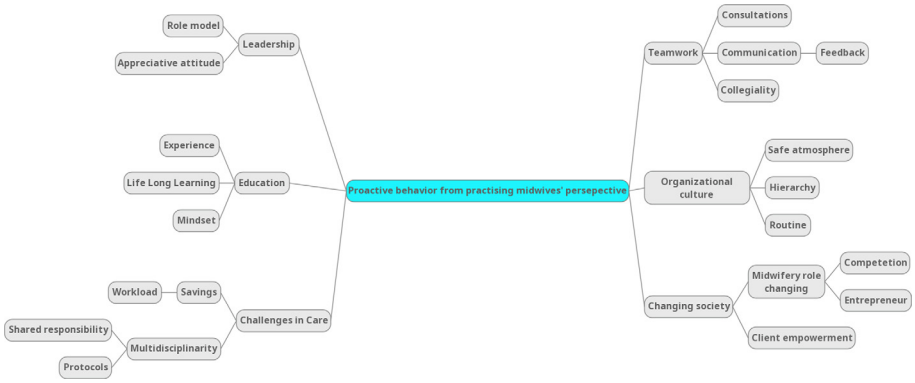

Fig. 1. Influencing factors that emerged from the transcripts.

*proactive behaviour to that extent, especially if that is a growling doctor" (*DSEM4*).*

Also part of the organizational culture that clearly stands out is that midwives consistently work according a fixed routine; *"We took it for granted because all midwives did this for years"* (DSEM6). They indicated that after graduation, it's easier to hold on to old habits and *"During our education we were extensively trained in critical thinking; but being in the clinical area, sometimes work is so for granted this could be a pitfall"* (DCM2 + FCM16).

The role of the midwifery leader

A good coach or mentor creates a safe feeling and thus is a great promotor of proactive behaviour; *"An involved leader who creates a sense of responsibility, could definitely stimulate proactive behaviour in the team" (*FCM5*).* Proactive behaviour is more likely fuelled when the supervising/managing midwife has an appreciative attitude towards the members of her team; *"When you feel that your work is appreciated, you get stimulated to move on" (*DCM2, FCM46, FCM68*).* Many of the participants mentioned the importance of their midwifery manager, whom should be a role model in showing proactive behaviour. Midwives will be much more inclined to follow their manager, stating that it's much more difficult to start this bottom-up; "*Whenever your leading midwife is open minded, the rest will follow"* (FCM91).

Education

A large number of the participants highlighted the 'nature' aspect of proactive behaviour by stating that it is a necessary intrinsic attitude to be a good midwife; *"It's an essential attitude as a midwife"* (DSEM28). Although, there was also a frequent reference to the role of the midwifery education and the importance of clinical placements, as the 'nurture' part of proactive behaviour; *"It's an important prerequisite in the educational program to become a midwife"* (FSEM7, DSEM59).

The learning aspect of proactive behaviour is clearly stated by participants discussing the need for experience in order to gain more knowledge and insight of proactive behaviour and to be able to be proactive to a certain extent; *"I've noticed that in the beginning of my career as a midwife, I tend to follow procedures without thinking. After some years of experience, I do question myself more regularly about the rationale of the procedures I perform"* (FSEM71). Expertise can help to avoid future problems; *"I've learned from experience that I need to reconsider everything calmly and don't make hasty decisions, but that took me some years"* (DCM21).

At the same time, this statement *"Some older, experienced midwives tend to rely on their 'old' knowledge at all times"* (FCM24) shows some midwives are just stuck to their habits because they feel some uncertainty by making changes or do not see or feel the need to step forward in order to change.

The lifelong learning-sharing-culture was a frequent comment as noted by one of the participants: *"As a midwife you can never say that you are experienced enough to stop learning"* (FCM44). Important to mention is that the participants also indicated "*Even small things can be proactive"* (FSEM53) and that it should not always be about world changing matters; *"Start small, you don't necessarily need to invent new protocols"* (FCM65).

Challenges in care

All participants mentioned the concept of time as a barrier of proactive behaviour in this study. Due to the constant evolving and changing maternity healthcare system, the midwife's workload had grown immensely and economical savings are inevitable. Therefore, midwives tend to 'stick to the old', revert to fixed routines and existing protocols. The midwives indicated that one needs to think in order to act and that the thinking process takes time when there is not always time available; *"As a fulltime midwife, you are just too busy to even think about new guidelines"* (DSEM28).

A major challenge within healthcare lies into the multidisciplinary cooperation of all health workers*; "The collaboration between all stakeholders in maternity healthcare could use some serious fine tuning"* (FCM47). Midwives indicated the need for a shared responsibility and autonomy concerning maternity health care and putting the right caregiver at the right place at the right time; *"In my opinion it is very important to create a co-working atmosphere, instead of a conservative, between the midwife, the obstetrician and the paediatrician. This contact should be on an equal level. Proactive behaviour of the midwife will be affected and/or stimulated whenever this has been established"* (FCM65).

Changing society

Clients nowadays increasingly want to have control. They become more independent, which for a large part has to do with new digital developments in health care; *"Nowadays women have searched for all information on the internet and have more and more complex questions and/or demands. We spent a lot of time in reassuring woman compared to 10 years ago"* (FSEM1). The challenge for midwives in this process of 'client empowerment' is to provide quick and easy access to relevant and direct information, custom made for all women so they can manage their own chosen care-path.

Two statements indicated the need for vigilance for a good balance between the different roles of the midwife; *"Because we are afraid of losing our clients, we sometime just act like the midwives in other practices do"* (DSEM39); *"Women need to be kept satisfied"* (FSEM34).

As an enthusiastic independent midwife in a competitive societal system, it is important to pay attention to your entrepreneurial skills, but at the same time, honest care for both mother and child must come first.

Discussion

The research question for this study focused on exploring Flemish and Dutch midwives' experiences of proactive behaviour in midwifery practice. This study described and explained midwives' experiences with proactive behaviour in midwifery practice, the impact of six influencing factors and their efforts to perform proactive behaviour.

First, underexposed in previous studies, but highlighted in this research was the emphasis on education. Midwifery education and practice primarily focuses upon the physical and mental care for women. Additional advanced professional skills, such as proactive behaviour, have not been sufficiently delineated [36]. The more midwives dare to take responsibility and the less assumptions there are made, the more proactive behaviour will get a chance to develop. Also, consistent with Parker et al. [37], paying attention to self-esteem, during the educational period and in practice, is needed to enhance midwives' mental health and success, which are both needed in order to be able to show proactive behaviour [38].

Second, rising from the influencing factor 'challenges in care', hierarchical burdens, should be discussed. Predominantly clinical working midwives reported this, however, also self-employed midwives sometimes clashed with the hierarchy. There is a clear need to shift towards a more open-discussion culture with all partners in the team the midwife is working in [39]. The safety and supportive nature of the organizational culture of the midwife could increase the level of willingness to behave proactively [40]. As Edmondson et al. [41] stated that psychological safety, being the shared belief that safety is guaranteed for interpersonal risk taking, stimulates team learning and/or innovation, and therefore stimulates proactive behaviour.

Third, also highlighted from the influencing factor 'challenges in care', a clear need for shifting reproductive health care to midwives has emerged. Midwives feel the need for an eligible job autonomy and link this as a stimulator to behave proactively. Notable is that self-employed midwives experience more autonomy compared to clinical working midwives. Practicing autonomously provides midwives with more job satisfaction and positively contributes to a good work-life balance [42]. The caseload midwifery model indirectly embraces this autonomy, and could effect a long-lasting connecting relationship between the childbearing woman and her midwife [14].

Fourth, the importance of an appreciative leader is also confirmed by Bailey et al. [43], stating that supportive supervision of a midwifery leader increases job satisfaction and motivation, and therefore the tendency of showing proactive behaviour. And Yin et al. [44] confirming that empowering leadership broadens the scope of the employees and therefore work more efficiently and tend to be proactive.

Fifth, the cross sectional study of Mestdagh t al. [28], linking individual and contextual factors to proactive behaviour in nearly the same group of midwives in this study, showed that midwives' level of proactive behaviour already diminishes after one year of working experience. To a certain extent, the participants in the study described this, but it was also elaborated that a certain level of working experience is required in order to be able to behave proactively. The challenge will lay in finding a sustainable balance.

Sixth, also in the cross sectional study of Mestdagh et al. [28], it has been revealed that midwives who work independently or are community-based, are more likely to show proactive behaviour in relation to midwives working in a hospital setting. This is consistent with the findings of this study where the shape, size and form of the midwife's team influences the level of proactive behaviour. According to Timmermans et al. [1], the way a team is composed has minor influence on the prevalence of team-learning activities, however the organizational context wherein the teams act had major effect on the prevalence of team learning activities which, in turn, is a prerequisite to perform production-oriented and innovation-oriented tasks such as behaving proactively.

By means of this inductive study-investigation, we can state that the results from previous deductive research can largely be confirmed, supported and expanded with six influencing factors. The challenges for future research lay in the transfer of recommendations in daily midwifery practice, education and how to mentor student and midwives in proactively dealing with these challenges.

A first limitation of this study is that purposive sampling was used whereby possibly only motivated midwives were reached by the student research teams to participate in this study. Ideally, a qualitative descriptive study employs theoretical sampling [35] although much effort has been made to achieve an equal distribution of the personal characteristics of the midwives, the majority of the studied group had only a maximum of six years of working experience. Since experience is designated as a prerequisite of proactive behaviour, further research is recommended in order to confirm and purify these findings and look for possible more stratification in working experience. To exclude possible bias by social desirable answers, the interviews were performed by students whom might be perceived as less threatening and therefore make more self-disclosure and/or honest answers.

Second, the already extensive in-depth knowledge of the research team concerning proactive behaviour in midwifery was a helpful strength in the substantive sensitivity necessary to generate categories and properties. The responsibility of the research team was to remain open and free to what is actually happened in the data.

Third, generated data was not given back to the midwives for member checking. This would have ensured the themes generated were an accurate representation of their experiences. However, credibility of the findings was strengthened by: (1) direct quotations while presenting the data; (2) data-triangulation from the interviews and field-notes, (3) thick descriptions, both in depth and contextually based, of the data by use of many quotes and (4) peer debriefing, discussing and interpretation of the findings from a professional and well experienced midwifery background between the midwifery students and the research team [45].

Fourth, many of the findings and challenges from this research are transferrable to other international midwifery practices, nevertheless some outcomes, might by typical for a Flemish or Dutch midwifery work setting. Sharing these experiences and results with other international midwives, could be the next step in the ongoing search for understanding proactive behaviour in midwifery practice.

Fifth, although an intense interview training was provided to the midwifery students to perform semi-structured interviews and interviews were checked and provided with feedback on their technique, yet nine of the interviews were of poor quality. Still a numerous number of transcripts (n = 93) provided very rich data and therefore trustworthiness of the data increased [46].

Conclusion

This study has produced a unique understanding of the way midwives perceive proactive behaviour in their daily practice and revealed the influence of six components. A first possible prerequisite is the midwifery team, in specific sizes and shapes, in which good communication and mutual feedback is a standard, in order to regularly organize team consultations. A second key role displayed the regulating power of the organizational culture of the team the midwife is working in. It is therefore important to create a safe atmosphere and exclude fear and uncertainty in a realistic hierarchical working level. The role of the midwifery leader with an appreciative and inspiring working attitude was detected as a third determining factor. The education component refers to the combination of a certain mind-set and innate attitude a midwife must possess as well as the learnability of this kind of behaviour both in midwifery-education as in their working years. Important conditions in order to stimulate this are a good communication and the constant attitude of lifelong learning. Midwives reported the constant pressure of challenges in the ever-changing healthcare system. Economical savings and growing workload might reduce the possible

time for midwives in order to behave proactively. Midwives indicate the need for shifting towards shared responsibility and autonomy concerning reproductive health care and a healthy multidisciplinary cooperation of all health workers. Extending caseload midwifery in Flanders could strongly contribute to this. A last important key role was dedicated to the competitive societal system in which a midwife needs to balance between entrepreneurial and empowering skills for both mother and child. The examination for the presence of proactive behaviour is essential in order to understand the barriers, enhancers and possible future consequences. Understanding midwives' experiences and perspectives of proactive behaviour is important to the future development of the midwifery profession and for the service of women and their families. By providing midwives, other health workers and policy makers with knowledge of the key factors needed to successfully emerge proactive behaviour in midwifery this study could cause positive implications for future midwifery policy and practice.

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Appendix A. Supplementary material

Supplementary data to this article can be found online at https://doi.org/10.1016/j.srhc.2019.04.002.

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