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Spanish women's perceptions of empowerment during the reproductive process

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ABSTRACT

Dissatisfaction among women and health professionals regarding the health care provided during the perinatal period has led to the development of another style of care, oriented towards encouraging and respecting the autonomy of women during the reproductive process, what has called 'women's empowerment'. The aim of this paper is to describe women's perceptions of empowerment during the perinatal period and its relationship to the humanization of childbirth, individualized care, and a dignified treatment of their bodies. Study was carried with a descriptive qualitative exploratory methodology using six focus groups of between 5 and 8 participants (June 2020–June 2022). The groups were guided by a semi-structured questionnaire. Data analysis was performed according to the Taylor-Bodgan methodology. The number of participants was 39 (29 pregnant; the rest were less than 12 months postpartum). From the analysis of the data, nine categories arose: definition, benefits, harms, role of the midwife, relationship, essential aspects, knowledge, feelings, and improvements. As concluding remarks, participants perceive women's empowerment in the perinatal period as something beneficial, although this is a term with which they are unfamiliar. They consider that the role of the midwife and the information received are fundamental elements in this empowerment. Finally, a close relationship is established between this term and others such as individualized care and the humanization of childbirth.

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1. Introduction

In a broad sense, the health care provided to women during the perinatal period reflects the way in which societies understand female reproduction (Prosen & Krajnc, 2019). Even though it is a natural phenomenon, the reproductive process is often seen as an almost pathological event (Benyamini et al., 2017), in which health professionals (including nurses and midwives) perform numerous interventions on the bodies of women. This encourages these professionals to adopt a paternalistic attitude—well-intentioned but protective—that makes it difficult for each woman to be able to make autonomous decisions (Thompson et al., 2017). This paternalism is encouraged by the organization of the health system and the lack of knowledge that many women have of the reproductive process and their rights during it (Noge et al., 2020).

This situation generates dissatisfaction in both groups: professionals and women (and their families). Thus, a growing number of professionals opt for developing another style of (non-paternalistic) care with the aim of achieving a situation of real autonomy of women during their reproductive process—that is to say, in favour of women's empowerment during the perinatal period (Tunçalp et al., 2017). The aim is to achieve the effective participation of each woman in her own care during the reproductive process.

One of the main ways for this is to make it easier for each woman to be autonomous in recognizing her rights and expressing her preferences during the perinatal period (Giordano & Surita, 2019). This

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implies making medical terminology more accessible and providing information about the available care options, which involves women in informed and shared decision-making (Rayment-Jones et al., 2019).

However, it is not enough to offer more and better information. In the case of care provided by midwives, we see that other factors influence the empowerment process, such as the provision of quality care based on the scientific evidence (Cleary-Holdfoth et al., 2021) and focused on reducing unnecessary obstetric interventions, preventing the appearance of complications (Abdessalami et al., 2017), and increasing satisfaction among women, which encourages them to be self-confident (Nieuwenhujize & Leahy-Warren, 2019).

Other aspects are also relevant, such as personalized support by midwives (Sigurðardóttir et al., 2019), the understanding of rights and personal values (Kennedy et al., 2020), the cultural perspective on care (Altman et al., 2022), and the continuity of care (Neerland et al., 2022), which allows the establishment of relationships of confidence between women and their midwives (Lida, Horiuchi & Nagamori 2021).

This empowering care is very much related to what the literature describes as 'humanized care', a movement that seeks a balance between the medicalization and the physiology of the reproductive process (Clesse et al., 2018).

But it is not only health professionals who act to encourage women's empowerment. The women themselves have a key role to play in this matter, as their expectations, attitudes, and behaviours during the reproductive period influence the operational guidelines of the health system (Wadephul et al., 2020). Today, women demand more information about their reproductive process and that it is of better quality (McLeish et al., 2020). They also express the need for greater training of health professionals in humanized care, to avoid situations of disrespectful care (McLeish & Redshaw, 2019).

Humanized and empowering care during the reproductive process, centred on women's autonomy and dignity, has significant consequences: women relax and feel more comfortable (George et al., 2022); their preferences, experiences, and values are better understood and respected by the professionals who provide them with care (Akuamoah-Boateng & Spencer, 2018); midwives have a better self-perception of their work (Lukasse & Henriksen, 2019); and the use of unnecessary techniques is reduced (Roberts et al., 2020).

In the light of all the above, and in further recent studies in this area (O'Connell et al., 2021), it is of great interest to describe—in the specific case of Spain—the perceptions held by women on empowerment during the perinatal period as well as the relationship between this and the humanization of childbirth, individualized care, and the dignified treatment of their bodies.

2. Methodology

2.1. Design

Descriptive qualitative exploratory study using focus groups.

2.2. Study population

The women who participated in the study were pregnant (at any point of pregnancy) or postpartum (from the fourth week after delivery), and fluent in Spanish. Although other studies did not establish this limitation, we considered that the circumstances of adaptation to the care of the infant during the first four weeks of postpartum could affect the participation of the postpartum women in the focus group and the content of their participation. Participation was also offered to women who had gestated and/or given birth in the twelve months prior to the study.

2.3. Selection of participants

The strategy for recruiting participants was based on the dissemination of an open call for participation in the study via social networks (Facebook, Instagram, WhatsApp), in which the research team participated. Participation in the study was also offered to the participants of the I and II *Gender, health, and sexualities* conferences organized by the University of Huelva in 2020 and 2021. In addition, private centres that provide Pilates for pregnant women in the province of Huelva and two town halls in the province were contacted to develop face-to-face focus groups in their facilities.

2.4. Material and methods

Data collection was carried out through focus groups. In view of the past situation of the COVID-19 pandemic, some focus groups were carried out online by videoconference on the Zoom platform and others were face-to-face. In this respect, recent literature showed that there are no significant differences between the use of face-to-face and virtual focus groups in this type of study (Steward & Shamdasani, 2017) and that doing it online can even provide benefits, such as a greater geographical coverage and a greater guarantee of neutrality during the process (Salvador et al., 2020).

A semi-structured questionnaire was used to guide the development of the groups (Table 1). The groups were led by the first author who, as recommended by the literature (Nyumba et al., 2018), was specifically trained in conducting qualitative studies with the focus-group technique.

The study participants were recruited in June 2020 and in June 2022, when data saturation was reached. Data were gathered on sociodemographic variables such as gender, age, nationality, occupation, number of children, and others about prior knowledge of women's empowerment and at what point the women were in the perinatal period.

Six focus groups of between five and eight participants were created, with a total of 39 participants (Table 2). The assignation of the participants to the different focus groups, all of equal rank, was made randomly. All the focus groups had a duration of about 40 min and were conducted in Spanish, the native language of most of the participants. The criteria for the choice of the number of focus groups, their conduct, realisation, and duration were based on the recommendations from the literature (Hamui-Sutton & Varela-Ruiz, 2013).

All study participants were sent a survey created with Google Forms in which they were informed about the remit of the study, they were asked to provide their email addresses and the dates and time that would best suit them for holding the focus group if they wished to participate in the study. Later, an email was sent again requesting the disinterested, anonymous, and voluntary participation in the focus group and including the link for accessing the videoconference in the case of the online groups.

2.5. Data analysis

The information obtained from the video recording of the focus groups was transcribed (*verbatim)* to help the researchers in their analysis. They also took field notes and made reflections during the focus groups.

The final transcriptions were imported into the program *Excel*—as it was a small sample and so did not justify the use of software to assist in the analysis of qualitative data (Gil-García et al., 2002)—for the reduction, triangulation, and grouping of data, taking as a benchmark the data-analysis practice proposed by Taylor-Bogdan (1990).

2.6. Treatment of data

All the data derived from this study was treated in accordance with the provisions established in Organic Law 3/2018, of 5 December, on the protection of personal data and the guarantee of digital rights.

The initial questionnaire collected data of a personal nature such as information associated with the participants' attendance and occupation, but never related to their identity (forename, surnames, national

Table 1. Script followed during the carrying out of the focus group.

Question
1. Have you ever heard of women's empowerment? Where?
2. What for you is women's empowerment in the perinatal period?
3. Have you received training on women's empowerment in the perinatal period? What knowledge do you have of this topic?
4. What benefits or harm do you think that women's empowerment provides in the perinatal period?
5. What is the midwife's role in empowering women in the perinatal period?
6. Do you think that there is a relationship between women's empowerment in the perinatal period, the humanization of childbirth, individualized care, and the dignified treatment of women's bodies in this stage? In what way?
7. What aspects would you consider to be essential for the empowerment of women in the perinatal period?
8. Are you familiar with the Junta de Andalucía's childbirth plan? Have you used it? Do you think that it serves to empower?

Table 2. Focal groups information.

	Participant	Age	*N.* of children	Gestational situation	Prior Knowledge	Nationality	Educational Level
	(*n* = 39)	(*m* = 34)	0 (59%) 1(38.5%) 2(2.5%)	Pregnant (74.4%) Postpartum (25.6%)	No (79.5%) Yes (20.5%)	Spanish (95%) Other (5%)	Essential (10.3%) Medium (35.9%) Superior (53.8%)
FOCAL GROUP 1	E1P1	33	1	Pregnant	No	Spanish	Medium
	E1P2	38	2	Pregnant	No	Romanian	Superior
	E1P3	34	0	Pregnant	Yes	Spanish	Medium
	E1P4	29	0	Pregnant	No	Spanish	Medium
	E1P5	26	0	Pregnant	No	Spanish	Superior
	E1P6	31	0	Pregnant	No	Spanish	Essential
	E1P7	40	0	Pregnant	Yes	Spanish	Superior
	E1P8	34	0	Pregnant	Yes	Spanish	Superior
FOCAL GROUP 2	E2P1	38	1	Postpartum	No	Spanish	Medium
	E2P2	39	1	Postpartum	No	Spanish	Superior
	E2P3	37	0	Postpartum	Yes	Spanish	Superior
	E2P4	36	1	Pregnant	No	Spanish	Medium
	E2P5	40	0	Pregnant	No	Spanish	Essential
FOCAL GROUP 3	E3P1	30	0	Pregnant	No	Spanish	Medium
	E3P2	38	0	Pregnant	No	Spanish	Superior
	E3P3	25	0	Pregnant	No	Spanish	Essential
	E3P4	30	1	Pregnant	No	Spanish	Superior
	E3P5	33	1	Pregnant	No	Spanish	Superior
FOCAL GROUP 4	E4P1	31	1	Postpartum	No	Spanish	Medium
	E4P2	36	1	Pregnant	No	Spanish	Superior
	E4P3	41	1	Postpartum	No	Spanish	Essential
	E4P4	29	1	Postpartum	No	Spanish	Medium
	E4P5	32	0	Pregnant	No	Spanish	Superior
	E4P6	32	1	Pregnant	Yes	Spanish	Superior
FOCAL GROUP 5	E5P1	40	0	Pregnant	No	Spanish	Superior
	E5P2	35	0	Pregnant	No	Spanish	Superior
	E5P3	24	0	Pregnant	No	Spanish	Superior
	E5P4	40	0	Pregnant	No	Spanish	Superior
	E5P5	36	1	Pregnant	No	Spanish	Medium
	E5P6	40	0	Pregnant	Yes	Spanish	Medium
	E5P7	34	1	Pregnant	No	Spanish	Medium
FOCAL GROUP 6	E6P1	42	1	Pregnant	No	Spanish	Superior
	E6P2	35	0	Pregnant	No	Spanish	Superior
	E6P3	30	0	Postpartum	Yes	Spanish	Superior
	E6P4	26	0	Postpartum	No	Spanish	Superior
	E6P5	30	0	Postpartum	Yes	Lithuanian	Superior
	E6P6	31	0	Pregnant	No	Spanish	Medium
	E6P7	40	0	Pregnant	No	Spanish	Medium
	E6P8	32	1	Pregnant	No	Spanish	Essential

identity number [DNI], etc.) Data was also collected related to the following variables: gender, age, nationality, occupation, number of children, prior knowledge about women's empowerment, and at what point of the perinatal period they were.

For each participant, a personal identifying code (ID) was created through the assignation of a number to each focus group and each participant, in order of completion, linked to the letters G (focus group) and P (participant).

2.7. Ethical aspects

All the participants were informed orally and in writing about the objectives of the study when they were offered participation in the focus groups, in both the online and face-to-face formats. They were then asked to give written informed consent as well as consent to be video-recorded and for the processing of their data. Before starting each focus group, they were again given information about the study and about the possibility of abandoning it at any point.

The data were treated confidentially at all times, separating the information that could serve to identify the participants. The final data table for the analysis did not include the names of the participants, or their initials, as indicated in current legislation. On the other hand, it was guaranteed that none of the researchers had any type of relationship with any of the participants prior to the survey.

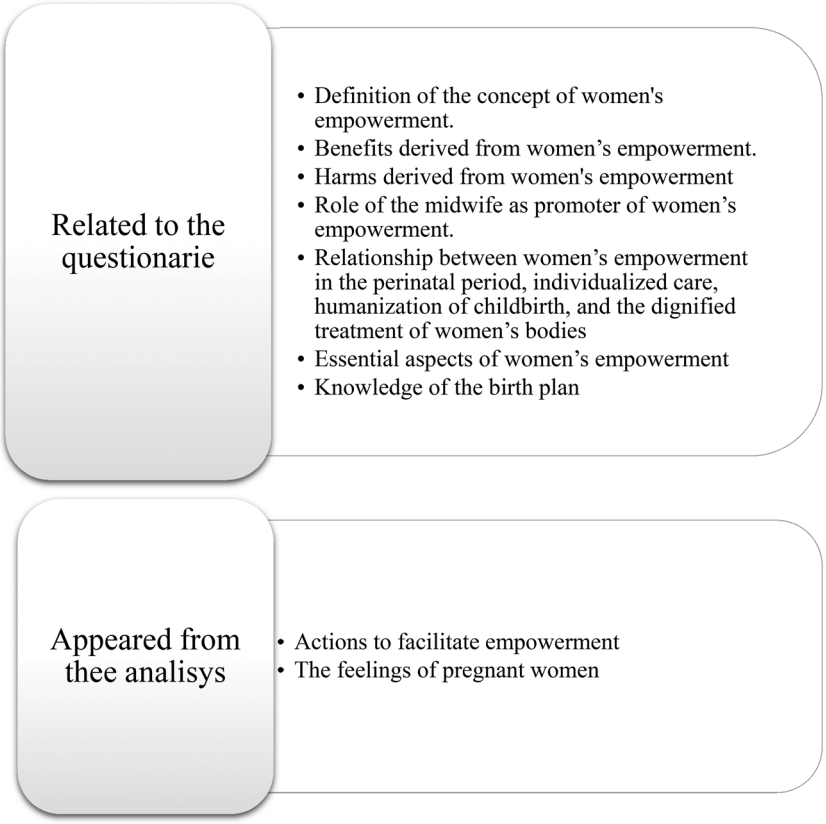

Figure 1. Relationship between the number of participants in the focus group according to age and reproductive status.

Ethical approval was requested from the regional government of Andalucía's ethical investigation committee, declaring that no biomedical aspects were studied in this investigation.

2.8. Viability/limitations

One of the limitations of this study can be found in a possible selection bias, in gathering only data from pregnant women, postpartum women after the fourth week of the postpartum period, and with children younger than 12 months. There could be other situations during the first four weeks of postpartum and after a year postpartum that are not included in the study.

3. Results

The total number of women who participated in the focus groups was 39, with ages ranging from 24 to 42. Of the sample total, 29 women were pregnant, and the remainder were in a postpartum of no longer than 12 months. Thirty-seven were of Spanish nationality, with one of Lithuanian nationality and one of Romanian nationality; all understood and spoke Spanish with a medium-high level. In terms of educational level, 13 had a university degree, 14 had knowledge of vocational training, and 4 had basic studies (Figure 1).

From the analysis of the data extracted from the focus groups, nine categories emerged: definition of the concept of women's empowerment; benefits and harms derived from women's empowerment; role of the midwife as promoter of women's empowerment; relationship between women's empowerment in the perinatal period, individualized care, humanization of childbirth, and the dignified treatment of women's bodies; essential aspects of women's empowerment; knowledge of the birth plan; the feelings of pregnant women; and actions to facilitate empowerment. The first seven of these were directly related

to the questionnaire that was used to guide the focus groups, while the last two appeared from the analysis of the participants' responses. Other data that were also considered important to collect and analyse were those that referred to training-information about women's empowerment and to knowledge of the existence of the birth plan.

3.1. Definition/concept of women's empowerment

Out of the total 39 participants, 31 were familiar with the term women's empowerment, while 8 had some type of knowledge. The majority of the participants define women's empowerment in the perinatal period as an attitude adopted by the pregnant women (with prior advice from health professionals and the acquisition of knowledge that they provide), which allows them to express their wishes during this period and that their decisions are respected by the professionals who treat them:

> Control, self-management, self-knowledge, a woman's capacity to manage herself in terms of emotions, in terms of working strategies. It is the confidence that you create for yourself through strategies and how I will deal with it in a positive way, how I can work with this to cope with childbirth, how it will be in the moments after the birth, and how I will cope with the new life. (G6P1)

3.2. Benefits and harms derived from women's empowerment

All the participants considered that women's empowerment in the perinatal period provides more benefits than harms and, furthermore, that the latter derive from the concept held by the health professional about empowerment. As benefits, the women indicated that empowerment provides awareness of the process, knowledge, security, peace of mind, and decision-making capacity.

> Information gives you the power of knowing what will happen during the pregnancy process, in the process of delivery. Having peace of mind, security, confidence and not being frightened is super important, because if you are frightened, the body responds in a way that will not help you in the process of childbirth. (G2P3)

The notable finding in terms of the negative aspects of women's empowerment in the perinatal period was the negative perception of some health professionals about health-service users who demonstrated that they had knowledge and information about their process and awareness of their rights. The women indicate that they believed that these professionals feel threatened, possibly for feeling insecure, out of date, or having little training.

> By speaking so confidently about what you want and what you don't want, they also criticize us for knowing everything. (G6P5)

Furthermore, they consider that when a woman is empowered it implies that she is more and more demanding about the care she is offered, which can prove negative, as if she does not receive the care, she can become disappointed and dissatisfied.

> We become more demanding; we want more. Or you go home saying that they are not giving me the solutions that I am looking for. (G1P5)

3.3. The role of the midwife as promotor of women's empowerment

Women consider that the figure of the midwife plays an essential role within women's empowerment in the perinatal period.

> Essential figure. (G3P4)

They indicate that the role of the midwife in women's empowerment consists mainly of providing information, giving reassurance, guiding, helping, giving confidence, advising, accompanying, providing emotional support, carrying out perinatal monitoring, giving women the capacity for self-care, and

respecting their decisions and wishes. In addition, they are also responsible for involving the partner-family in the process.

> Guiding her, helping her … like more confidence, as the midwife is supposed to know more about pregnancy, then you always have help for any question because you always have her there. (G2P4)

But, on the other hand, they also indicate that the midwife does not always perform the role indicated above or which they expect her to perform. Often, they were not up to date, did not offer an individualized care, were not empathetic, and did not have confidence in the decision-making capacities of the women. All this implies that they play an authoritarian role based on their knowledge or beliefs, and it is because of this that women demand to be able to take decisions as a team together with the midwife.

> First is informing you and explaining the different practices or at what point and in which circumstances each of them can be performed or whether it is desirable or undesirable – that's the first thing; and second, that they also assume – doctors, midwives, and nurses – that they have to give us a bit more of a say, so that it is not only they that carry out your delivery or your pregnancy. (G5P1)

3.4. Relationship between women's empowerment in the perinatal period, individualized care, humanization of childbirth, and the dignified treatment of women's bodies

When we ask participants about the relationship that may exist between these concepts, all believe that there is a relationship of dependency between them and that it is impossible to apply some of them without the others.

> I think they all go together a bit, don't they? It seems like that to me. Because the dignity of the woman's body is also in the empowerment that you put in yourself, the control you have over your own body… I think so. Which also go hand in hand to some extent. (G6P2)

3.5. Essential aspects for women's empowerment

Information is considered by the pregnant and postpartum women to be one of the key elements in empowerment, as it provides knowledge and thus awareness of the health process in which they find themselves.

> Having all the information for us to feel safe at this time and be in control of the situation. (G4P2)

Another aspect that was highlighted as important within women's empowerment is emotional support, both by the professional and by their partners, noting the need to inform the latter and involve them in the perinatal period.

> I think the support your partner gives you or the people at your side is very important, as well as your own strength, (G3P3)

They also consider the attitude and respect shown by the midwives during the pregnancy, delivery, and postpartum to be essential for having a satisfactory experience, as well as the fact that their wishes are considered.

> That they ask me my opinion and listen to me, that I can say 'I feel this, or I would like to do that', and then as a result of what I say that she guides me and says to me 'look, this can be done like this, or this can't be done like this', you know? But that they listen to me, not that they don't even do that. (G5P4)

3.6. Knowledge of the birth plan

Of the 39 participating women, 22 did not know the birth plan, despite being pregnant or having given birth within the previous year.

> Nothing, I had no information about this, no. I don't know how it goes, nor what information is provided, nothing. (G6P2)

The others who did know the plan or who had used it, considered that the birth plan is an instrument that is given to pregnant women on a compulsory basis, which sets down in writing the basic rights of women during labour. However, they say that in the majority of cases the professionals did not use it or take it into account.

> The truth is that I did not know what to put down nor did I feel qualified to do it and after I think they didn't use it much, because in the documentation they make you sign when you get to the hospital they make it clear they will try to follow your birth plan unless they consider that they do not have to follow it. So, it doesn't have much sense. (G2P2)

3.7. Feelings of pregnant women

One of the most widespread feelings among the pregnant women is the lack of knowledge about the process of pregnancy, labour, and postpartum.

> At least in my case, I don't know what benefits me most, if I need to have an epidural or not, if they cut me or not […] at least the midwife did not say anything to me, not the midwife or anyone else and this is something you miss so that you can then decide on the matter, knowing the pros and cons (G5P3)

This lack of knowledge combined with the lack of consideration by health professionals of their opinions and their wishes means that women feel unprotected and insecure, as well as little respected. And this means that, independently of their expectations, they submit themselves to what the health professional proposes to them.

> And they give you the feeling that, if you turn up with your birth plan and say that you want this, they are going to jump on you and say, 'look at this idiot'. The information that I have received from people, in a manner of speaking, is that they treat you like an object, and put you here and put you there, open your legs, they say that they don't talk about what they are doing to you or what you want at that time. (G5P2)

Furthermore, the fact of not always being looked after by the same healthcare professional (midwife or gynaecologist) also creates distrust, along with the feeling that the healthcare professionals do not give them all the time they require to attend to their needs.

> The appointments with your midwife at the health centre are very short, so it's true that in the end you go and between the questions and doubts you raise it's all a bit routine and although she is chatty and so on, it's all so short. (G6P3)

However, they feel valued when the midwife gets involved and takes their wishes and expectations into account.

> The young woman, come on, I remember that half the time I was pushing when standing up, as if I were someone shitting in a field, and the girl with a little mirror underneath lying on the floor. So, she could have told me to sit down there because my kidneys hurt. No. Even so, I respect her, at least the midwife that I had at that point, I respect her. (G6P3)

3.8. Actions to facilitate women's empowerment

From the answers above, we deduce that the participants in this study perceive that women's empowerment in the perinatal period is difficult to achieve at the present time. However, in their interventions the participants alluded to certain changes that they think could facilitate a more satisfactory experience for women during this period.

First, they consider that there needs to be a change in the organization of the public-health system, beginning with infrastructure, which at times makes it difficult for women to achieve their expectations and desires.

> Having private health – that's a hotel compared with the public. Because, for instance, with the Covid issue, I could be there in an individual room and in the public system they will make me share with someone. (G1P1)

But the central aspect, from their point of view, is that of the professionals. The participants say that they would like to have a specific person to whom they can direct themselves and who would always be looking after them to increase their security and confidence.

> You can have a super midwife during the pregnancy, and you say, wow, how wonderful, how good, she explains things to me so well; and when you turn up, you get a random midwife and in the end what you were told and what you have idealized is totally different from what you find later. (G5P6)

As well as their demand for continuity of care, they also allude to the lack of health professionals, which can be a triggering factor for much of the perceived inattentiveness.

> If only there had been more professionals, I would have loved it if the midwife didn't have to be shared between three cubicles, because in the end we all gave birth at the same time, and it was all a bit crazy at that point. (G6P3)

One feature mentioned is the training and attitude of the professionals, as the participants consider that the professionals need to be up to date and offer an egalitarian treatment, respecting the women's situation, wishes, and needs, as they perceive that there are variations in care between professionals with different levels of experience or who belong to different institutions.

> There really needs to be a common agreement among all the midwives in Spain, at state level, at regional level, or at the level of Andalusia. So, all of them have the same purpose and way of working. Not, they tell your one thing, others tell you something totally different, and this is crazy, there is no unification because everyone thinks in their own way, some are old-school, and others are of the modern school and now I am going to pray to see which one I get. There is no unification. (G5P6)

In terms of the role played by women as users of the health system during the perinatal period, the participants expressed the conviction that a lot of work still needs to be done to ensure that everyone is aware of their rights and that they can fight for their autonomy during the perinatal period.

> I think it is a bit about raising awareness, well, awareness, studying, researching, going a bit deeper into everything, a little bit too much because I think that a lot is needed, in that childbirth is a natural process and women can cope with it and it's a question of giving them time. (G6P3)

4. Discussion and conclusions

4.1. Discussion

Taking into account the nature of the study, it should be highlighted that what is expressed in the responses of our participants is related to their own experiences, beliefs, and knowledge, after being in contact with health professionals during the perinatal period.

In terms of the women's perceptions of women's empowerment during the perinatal period, our findings are backed by earlier studies which show that the participants see it as something beneficial (Pratley, 2016) and define it as an attitude that allows them to be autonomous and aware of their capacities and rights (Author). Similarly, as also occurred with the study by Palmquist et al. (2020), we find that they still see health care during the process of pregnancy, labour, and postpartum as being very medicalized.

In eliciting the perception of women of the factors that determine the degree of empowerment in this period, the participants in our study underline what was indicated by Tully and Ball (2013) in identifying information as the most enabling element for taking decisions together with the healthcare team. However, they suggest that today this information is scarce, as described in a similar way by Lázzaro and Arnao-Bergero (2021). The fact that the healthcare professionals informed them and provided them with knowledge gave them a positive emotional value for their own experience and that of their families, because they not only acquired awareness, knowledge, and capabilities, but also security and peace of

mind (Gómez-Fernández et al., 2020; Parang et al., 2023). Our participants underline the importance of the involvement of the partner of family in the perinatal period, as occurred in the study by Jeong et al. (2021). But, as suggested by Longworth et al. (2015), they continue to perceive that they bear the brunt of decision-making during this period.

In terms of the professionals, Martínez-García et al. (2018) also found that the participating women identify the midwives as a key agent in their empowerment, through such actions as providing information, enabling peace of mind, guiding, advising, respecting, giving confidence, and accompanying them during the process. We thus coincide with the work of Alfaro Blazquez et al. (2018) in the perception that our participants have of feeling valued by the midwives and consider them as their allies when the latter know their needs and those of their families and respect their wishes and expectations. This does not detract from the fact that the women also state that, in other cases, the midwives can complicate the process through their advice and the attitude they display, which can sometimes become a real lack of respect of their personal autonomy (Goberna-Tricas & Biurrun-Garrido, 2020).

When this lack of respect has occurred, tied to the limited consideration of their wishes and decisions by the midwives and other healthcare professionals, the participants in our study refer to having had a negative experience of the process of pregnancy, labour, and postpartum, considering that it has not responded to their needs, as Husein et al. (2018) also suggest. In these cases, coinciding with Kroll et al. (2022), our participants say that they had perceived that the healthcare professionals did not trust their capacities to make informed decisions during the perinatal period (specifically, in their written preferences in their birth plans, which they value as a tool that facilitates empowerment).

As well as their specific actions and their general attitudes, the participants in our study identify the time available for care as the third element to consider regarding professionals in their relationship with women's empowerment in the perinatal process (Lewis-Jones et al., 2022). They consider that, in general, the amount of time for care is limited and they attribute this to the lack of healthcare professionals.

This perception opens the field of analysis of the health system seen as an organic whole. Along these lines, the women who participated in our study demand a different organization that allows continuity of care by the same healthcare professionals, as has been argued by other studies (Tickle et al., 2021). They believe that this continuity—together with increased staffing levels and a greater application of the scientific evidence in the delivery of care—contributes significantly to improvements in the quality of health care (Pourette et al., 2018) and a greater degree of satisfaction (Gamedze-Mshayisa et al., 2018). As has been indicated in the study by Fernández-Castillo and Linares-Abad (2018), with the same organizational perspective, our participants say that the health centres are very limited in terms of resources and infrastructure and that this has repercussions in the quality of care. They thus suggest a change in the organization of healthcare given to women and their families during the reproductive process, so that they are the centre of care, in agreement with other findings (Liberati et al., 2019).

On the relationship between women's empowerment and other terms such as humanization of childbirth, individualized care, and dignified treatment towards their bodies, the women in our study established a clear connection. The available literature indicates that women consider that all these terms set out the same type of health care, which encourages their autonomy and respect for their wishes and preferences (Goberna-Tricas & Biurrun-Garrido, 2013).

4.2. Conclusions

Women perceive women's empowerment in the perinatal period as beneficial, as it gives them autonomy and awareness over their capacities and rights, although it is a concept with which they are little familiar.

As essential elements of women's empowerment in the perinatal period, the participants highlight information and the figure of the midwife. They consider that the information that is offered to them is limited and sometimes not up to date. In terms of the midwives, they highlight the importance of being respected and supported by them and consider that the time the midwives dedicate to the women is limited.

The participating women consider that women's empowerment in the perinatal period is intimately related to the humanization of childbirth, the dignified treatment of women's bodies, and individualized care. However, they claim that there is still much work to be done, both in the organization of the health system and in the attitude of pregnant women, women in labour, and postpartum women.

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Author contributions

GS-JD and MB-MC designed the study and conducted the analysis. MB-MC performed the data collection and draft the manuscript supervised by GS-JD. All authors contributed to revising the manuscript and approved the final version.

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