

WOMEN'S EXPERIENCES OF A VAGINAL DELIVERY CONDUCTED BY A PRIVATE MIDWIFE

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ABSTRACT

During the last decade the process of childbirth has undergone many changes in South Africa. Most women currently give birth in the hospital under the supervision of a medical practitioner because they belong to a medical aid scheme which enables them to consult an obstetrician for their delivery. Due to this fact, a large number of deliveries take place in a hospital setting, be it private or provincial. Research undertaken in South Africa (Du Plessis, 1991:58) with regard to women's experience of childbirth in a hospital while under the care of a medical practitioner; found that they were dissatisfied with their birthing experience and felt disempowered. They felt a loss of control during the labour process, experienced a sense of abandonment and lack of involvement. Different modern approaches to childbirth have developed all over the world, essentially in response to the progressive medicalisation of birth with an increase in the number of home deliveries by a midwife (Robertson, 1988:2). In South Africa, there seems to be an increase in the demand by mothers for a less technological medicalised birthing experience. There is furthermore an increase in the number of women who are beginning to express a preference for deliveries with a private midwife. In South Africa the trend back towards delivering with a private midwife is relatively recent and the field of private practising (independent) midwives a growing one. Research pertaining to this topic has been carried out in the United States of America, the United Kingdom and the Netherlands which concluded that the mother's experience of the birthing process with a midwife was a superior one. The experiences of the mother who delivered with a private midwife is an area in South Africa where very little documented research has been carried out. Due to this fact minimal documented research is available. Statistics with regard to the number of babies delivered by private midwives are unknown and no register exists of the names and numbers of private midwives available. The purpose of this research study was to explore and describe the experiences of women related to their exposure of birthing with a private midwife. This allows recommendations to be made with regard to the practice of private midwifery in South Africa. The private midwives can use these guidelines to improve their practice and contribute to a better birthing experience. A qualitative, descriptive, explorative and contextual research design was utilised to conduct this research. The focus was to obtain information that would facilitate understanding of the women's experiences of labor while under the care of a private midwife in a midwife obstetric unit. A qualitative design was used where the phenomenological method was employed. Purposeful, convenient sampling was done where the researcher consciously selected certain subjects from a midwife obstetric unit in Gauteng. The collection and analysis of data involved exploring and describing the women's birthing experiences by means of analysis of naïve sketches collected prior to discharge; unstructured in-depth interviews and a focus group. These interviews were transcribed verbatim to add depth to the findings. Tesch's descriptive method was used to analyse data. Data were clustered into relevant themes. A thorough literature study was performed in order to try and describe the phenomena as seen by others. Books relating to the research topic, relevant research material and newspaper articles were utilised. Guidelines were discussed and formulated. Lincoln and Guba's measures to ensure trustworthiness were applied. Two main themes were extracted. They were that a therapeutic relationship developed with the midwife, but at the same time they had unrealistic expectations with regard to the birthing process. These two themes were further divided into subthemes which will be discussed with regards to the research findings and will be verified by means of a literature control. All information will be supported by direct quotes obtained from the data collected during the interviews. The researcher found that women who delivered with a private midwife found it to be a hugely

positive experience. They felt that they were in control of their birth and the midwife remained unobtrusive, they felt safe and secure which enabled them to relax and enjoy the birthing process, they felt that they were not rushed because a therapeutic relationship had developed between the mother and midwife, and the midwife took time to concentrate on the mother as an individual. The bonding within the family unit was enhanced.

OPSOMMING

Kindergeboorte in Suid-Afrika het die afgelope dekade baie veranderinge ondergaan. Die meeste vroue skenk geboorte in die hospitaal onder die toesig van die geneesheer omdat hulle aan 'n mediese fonds behoort wat hulle in staat stel om 'n ginekoloog vir die bevalling te raadpleeg. Vanweë hiervan vind 'n groot aantal geboortes plaas in die hospitaal, ongeag of dit 'n privaat of provinsiale hospitaal is. Navorsing onderneem in Suid-Afrika (Du Plessis, 1991:58) met betrekking tot vroue se belewenis van kindergeboorte in 'n hospitaal onder toesig van die geneesheer het bevind dat hulle ontevrede was omdat hulle gevoel het dat hulle nie bemagtig was nie. Hulle het 'n gebrek aan beheer gedurende die geboorteproses beleef en verwerping asook 'n gebrek aan betrokkenheid ervaar. Verskeie moderne benaderings tot kindergeboorte het oor die wêreld ontwikkel in respons tot die toenemende medikalisering van geboorte, met 'n gevolglike toename in die aantal tuisbevallings onder toesig van die vroedvrou (Robertson, 1988:2). Dit wil voorkom of daar 'n toename in die aanvraag van moeders na 'n minder tegnologiese en gemedikaliseerde geboorte in Suid-Afrika is. Daar is verder ook 'n toename in die aantal vroue wat verkies dat hulle bevallings onder die toesig van 'n privaat vroedvrou plaasvind. 'n Betreklik nuwe neiging in Suid-Afrika is om weer soos in die verlede van die dienste van privaat vroedvroue gebruik te maak. Hierdie vroedvroue tree in 'n toesighoudende hoedanigheid tydens die geboorte op. Die dienste van privaat praktiserende (onafhanklike) vroedvroue word al hoe meer gebruik. Navorsing oor hierdie onderwerp is in die Verenigde State van Amerika, die Verenigde Koninkryk en Nederland uitgevoer. Daar is bevind dat die moeder die geboorte baie positief beleef indien sy geboorte geskenk het onder toesig van 'n vroedvrou. Daar het min navorsing in Suid-Afrika oor die belewing van hierdie tipe geboorte plaasgevind. Statistieke oor die aantal babas wat deur privaat vroedvroue verlos is, is onbekend en geen rekords bestaan waarin die name en getalle van privaat vroedvroue opgeteken is nie. Die doel van hierdie navorsing was om die belewenisse van vroue wat onder toesig van privaat vroedvroue gekraam het, te ondersoek en te beskryf. Aanbevelings om die privaat vroedvroue se praktykvoering te verbeter is gemaak om die geboortebelewenisse van vroue te verbeter. 'n Kwalitatiewe, beskrywende, ondersoekende en kontekstuele navorsingsontwerp wat die fenomenologiese metode ingesluit het is in hierdie navorsing gebruik. Die doel van hierdie navorsingstudie was om die belewenisse van vroue met betrekking tot die dienste van 'n vroedvrou tydens geboorte te eksploreer en te beskryf. Doelgerigte, gerieflikheidsteekproefneming is gedoen waartydens die navorser sekere subjekte van 'n vroedvrou-obstetriesse-eenheid in Gauteng geselekteer het. Die insameling en analise van die data sluit in die beskrywing van vroue se geboortebelewenisse deur middel van 'n analise van naïewe sketse wat voor ontslag ingesamel is; ongestruktureerde in-diepte onderhoude en fokusgroepe. Die onderhoude en fokusgroepe is verbatim getranskribeer om diepte tot die bevindinge te verleen. Tesch se beskrywende metode is gebruik om die data te analiseer. Data is in relevante temas gegroepeer. 'n Deeglike literatuurstudie is uitgevoer om die verskynsel, soos deur ander persone gesien, te beskryf. Boeke oor die navorsingsonderwerp, relevant tot die tema en relevante navorsingsmateriaal en artikels is gebruik. Riglyne is bespreek en geformuleer. Lincoln en Guba se maatreëls om vertrouenswaardigheid te verseker is gebruik. Twee hooftemas is geïdentifiseer, naamlik dat 'n terapeutiese verhouding met die vroedvrou ontwikkel het en dat die vrou onrealistiese verwagtinge rondom die geboorteproses gekoester het. Hierdie twee temas is verder onderverdeel in sub-temas wat bespreek word in terme van die navorsingsbevindinge. Hierdie bevindinge is met 'n literatuurkontrole geverifieer. Alle inligting is ondersteun met direkte aanhalings wat gedurende die onderhoude verkry is. Die navorser het bevind dat die vroue wat onder toesig van 'n privaat vroedvrou gekraam het, 'n baie positiewe belewenis gehad het. Hulle het gevoel dat hulle in beheer van die geboorteproses was, dat die vroedvrou in die agtergrond gebly het en dat hulle veilig gevoel het. Dit het hulle in staat gestel om te ontpaan en die geboorteproses te geniet. Hulle het geen gejaagdheid ervaar nie aangesien 'n terapeutiese verhouding tussen die moeder en die vroedvrou ontwikkel het. Die vroedvrou het op die vrou as 'n individu gefokus en het binding met die gesin as 'n eenheid bevorder.

INTRODUCTION, BACKGROUND AND PROBLEM STATEMENT

During the last decade the process of childbirth has undergone many changes in South Africa. Most women currently give birth in the hospital under the supervision of a medical practitioner (Nolte, 1998:9) because they belong to a medical aid scheme which enables them to consult an obstetrician for their delivery. Due to this fact, a large number of deliveries take place in a hospital setting, be it private or provincial. Similarly, the majority of women in the United States of America (USA) deliver in the hospital with a physician attendant (Howell-White, 1999:61). When a woman is asked about her birth experience, two commonly asked questions are: Who was your doctor? and What hospital did you deliver in? The underlying presumption is that women give birth in the hospital with an obstetrician. Factors contributing to this phenomenon include statistics showing that hospital deliveries are safer, public demand for hospital deliveries due to cultural norms and family influences (Nolte, 1998:9; Howell-White, 1999:61) and the fact that for many women the choice of provider or setting does not really exist. In a research study conducted by Chalmers (1990) it was found that *none* of the mothers in the sample group requested the assistance of a *private midwife* during their delivery. The sample group expressed an overwhelming preference towards a delivery in a *hospital*, which was conducted by *either* a doctor or midwife. It would thus seem that women take it for granted that their babies will be born in a hospital with an obstetrician because he offered them a “safe” and “painless” birth experience (Howell-White, 1999:61).

Research undertaken in South Africa (Du Plessis, 1991) with regard to women's experience of childbirth in a hospital while under the care of a medical practitioner found that they were dissatisfied with their birthing experience and felt disempowered. They felt a loss of control during the labour process, experienced a sense of abandonment and lack of involvement. The atmosphere was sterile, cold, impersonal and hostile, with a lack of privacy (Du Plessis, 1991:27; Kritzinger, 1996:315). During the labour, contact with the medical practitioner was predictable: the mothers felt that the physician related to them more on a professional level rather than a personal one. These findings are echoed by Kirkham (2000:39-42). These researchers found that

mothers experienced a loss of identity when they became part of a system rather than being treated as an individual and were excluded from the decision-making process.

The above-mentioned factors resulted in the mothers feeling angry, resentful and bitter with regard to their birthing experience. They were left feeling that the birth was not *their* achievement but rather that of the doctor (Wesson, 1998:1). Because most births are medically managed, women often feel that they are given very little choice over where, with whom and how to give birth. They are led to believe that they need to be rescued and cannot cope with natural birth (Hanrahan, 2004:22). Michael Odent (1994:2005) found that many women who came to his active birth unit had experienced trouble with previous labours and births. Some were extremely upset and worried and others had been considered “special” or difficult cases. The routine use of technology during deliveries shifts the power from the mother to those in control of the technology. This results in the mother feeling that she is being medically managed (England & Horowitz, 1998:110). The end result being, that the labour and delivery are regarded as a pathological condition, where the birth is treated as an abnormal process or illness. Mothers expressed their dissatisfaction with the rigidity of hospital births and the degree of medical interventions.

Different modern approaches to childbirth have developed all over the world, essentially in response to the progressive medicalisation of birth with an increase in the number of home deliveries by a midwife (Robertson, 1988:2).

In contrast to South Africa, extensive research has been conducted in the USA, the United Kingdom (UK) and the Netherlands with regard to deliveries conducted by private midwives. These studies have indicated a positive experience by the labouring mother. However, studies of women's *preferences* are primarily composed of small and retrospective studies focusing on only a limited number of *potential* influences on the woman's birthing experience (Annandale, 1988 *in* Howell-White, 1999:61).

In South Africa the trend back towards delivering with a private midwife is relatively recent, and the field of private practicing (independent) midwives is a growing one

(Nolte, 1998:9). Due to this fact minimal documented research is available. Statistics with regard to the number of babies delivered by private midwives are unknown and no register exists, of the names and numbers of private midwives available. According to the Expectant Mothers Guide (2005) only 17 names of midwives who perform deliveries are listed. It is furthermore not known if the labouring mother did indeed have a positive birth experience. The question therefore needs to be asked, *“What is the labouring mother’s experience of a vaginal delivery conducted by a private midwife in a midwife obstetric unit?”*

DEFINITION OF KEY CONCEPTS

The birthing process: Refers to the process of birth, from the onset of the contractions until the birth of the newborn baby.

The private midwife: In the context of the study, the midwife refers to a registered member of the South African Nursing Council. They work under the regulations that govern the nursing profession namely R2598 and R387 and specifically those that govern the practice of midwifery (R2488). The private midwife cares for the patient throughout the pregnancy, labour, birth and immediate postpartum period at home or in a midwife obstetric unit.

Midwife Obstetric Unit: This refers to a homely environment within a medical facility which also offers operating room facilities when in need of a Caesarean section. “The birth units are relaxed, intimate places which encourage partners, siblings and grandparents: thus family centered maternity care” (Hanrahan, 2004:18).

Midwife care: This refers to the responsibilities of the midwife during the labour process.

PURPOSE OF THE STUDY

The purpose of this research study was to explore and describe the experiences of women related to their exposure of birthing with a private midwife. This allows recommendations to be made with regard to the practice of private midwifery in South Africa. The private midwives can use these guidelines to improve their practice and contribute to a better birthing experience.

RESEARCH DESIGN AND METHOD

A qualitative, descriptive, explorative and contextual research design was utilised to conduct this research (Creswell, 1994:162; Mouton & Marais, 1996:103-169). The focus was to obtain information that would facilitate understanding of the women’s experiences of labour while under the care of a private midwife in a midwife obstetric unit. A qualitative design was used where the phenomenological method was employed.

POPULATION

The population consisted of all women who delivered with a private midwife in a midwife obstetric unit, regardless of parity or gravity. The participants in *Phase 1* delivered in four (4) different midwife obstetric units whilst the participants in *Phase 2* delivered with four (4) midwives in a group-practice. The labouring women were supported by either the husband or partner.

SAMPLING

Purposeful, convenient sampling (Burns & Grove, 1999:475) was done where the researcher consciously selected certain subjects from a midwife obstetric unit in Gauteng.

In *Phase 1* of the study the sample consisted of analyses of 47 naïve sketches written by mothers who delivered under the care of a private midwife. Eight (8) mothers participated in the unstructured interviews after the naïve sketches were analysed.

The naïve sketches and participants were obtained from seven (7) midwives in Gauteng who were willing to participate in the study. They were all registered midwives who have worked in a private practice for more than two years, and were qualified in advanced midwifery.

In *Phase 2* of the study 73 naïve sketches were analysed. Five (5) mothers participated in a focus group after conclusion of *Phase 2*. In this phase, four (4) midwives from a group-practice acted as the private midwives.

DATA COLLECTION

The collection and analysis of data was implemented

and divided into two phases:

Phase 1 involved exploring and describing the women's birthing experiences by means of analysis of 47 naïve sketches (Giorgi, 1985:1, 8) written by the mothers. The naïve sketches were written anonymously and it was hoped that the mothers would use their freedom of speech to be open and honest about their positive experiences. The naïve sketches were collected *prior* to discharge because the experience was still fresh in the mothers' memory; it was easy for them to recall what happened and could easily be put in writing.

Phase 2 involved analysis of 73 naïve sketches from participants who delivered with midwives in a group practice (group of four midwives). Five (5) mothers participated in a focus group after conclusion of Phase 2.

One central question was asked in both phases: "*How did you experience your delivery with the private midwife?*"

To validate the findings obtained from analysis of the naïve sketches, eight (8) unstructured, in-depth interviews were conducted by an experienced researcher, where the purpose of the study as well as the reason for using a tape recorder were explained to the mothers. These interviews were transcribed verbatim to add depth to the findings (Burns & Grove, 1999: 578-581).

The interviewer made use of bracketing (putting pre-conceived ideas aside) and intuiting (focusing on the lived experience of the participants to their delivery by a private midwife). Field notes were taken in order to document the non-verbal communication, the ease with which the interview was done, as well as the subjective interpretations of the interviewer.

During Phase 2 the focus group interviews took place in a private childbirth educator's clinic in a relaxed and calm atmosphere. The interviewer was an experienced childbirth educator and researcher who did not practice as an independent midwife. The interviewer created a context where the participants could speak freely and openly by using communication techniques such as clarification, paraphrasing, summarising, probing and minimal verbal and non-verbal response.

Interviews (both in-depth and focus groups interviews)

were conducted until data saturation had been reached as demonstrated by repeating themes.

Throughout the duration of the interviews field notes were made. The researcher made use of various communication skills, took note of non-verbal behavioural/communication skills, and made use of clarification, probing and silences to add to depth to the transcriptions.

DATA ANALYSIS

Tesch's descriptive method (Creswell, 1994:154-156) was used to analyse the data. All data collected were analysed by the researcher. This included reading through the transcripts and naïve sketches to get an idea of what was being said. The information was then analysed to identify meanings/themes. Data were clustered into relevant themes.

An independent coder experienced in the field of qualitative research analysed the data separately from the researcher. The researcher and coder engaged in a consensus discussion where the central themes were identified and discussed.

A thorough literature study was preformed according to Morse and Field (1996:106) in order to try and describe the phenomena as seen by others. Books relating to the research topic, relevant research material and newspaper articles were utilised. Guidelines were discussed and formulated.

TRUSTWORTHINESS

Lincoln and Guba's measures to ensure trustworthiness were applied (Lincoln & Guba, 1985:290-327). The strategies that were followed are:

Credibility - this was achieved by extended exposure in this particular field, keeping field notes, triangulation of the data and by conducting a literature control and using findings from similar studies

Transferability - this was achieved by conducting a literature control, the use of purposive sampling and through a dense description of the methodology used to conduct this study.

Dependability - this was achieved through a dense description of the data and the use of a coder when extracting themes and subthemes.

Confirmability - this was achieved by ensuring an audit of the entire research process.

During the interviews no pre-determined list of questions were used, so as to prevent prompting of the participant. The participant determined the content as well as the direction of the interview. All interviews were conducted by the researcher.

ETHICAL MEASURES

Ethical measures were adhered to throughout the duration of the research. This included obtaining informed consent from all participants, voluntary participation and freedom to withdraw from the research at any time, ensuring confidentiality and anonymity through not mentioning any names obtained during the collection of the data, protection from harm and providing feedback on the project to the participants (DENOSA, 1998:1-8).

RESULTS AND DISCUSSION THEREOF

Table 1 presents a brief summary of the themes and sub-themes that surfaced during the study into women's experiences of a vaginal delivery conducted by a private midwife.

Two main themes were extracted. They were that a therapeutic relationship developed with the midwife, but at the same time they had unrealistic expectations with regard to the birthing process.

These two themes were further divided into subthemes which will be discussed with regards to the research findings and will be verified by means of a literature control. All information will be supported by direct quotes obtained from the data collected during the interviews

Theme 1: The development of a therapeutic relationship with her midwife

A therapeutic relationship developed between the mother and the midwife, there was more time to bond with her newborn and the mother experienced greater involvement of the father in the birthing processes. The mother's experience of her birth when conducted by a private midwife was a far superior one. She felt that she could listen to her own body, she was more relaxed and less inhibited, she was surrounded by people she knew and trusted and the father could play a more active role in the birth. These confirm the findings of Kirkham (2000:39-42) and Wesson (1998:2). "People who are with you at your birth should be people with whom you feel connected and who have trust in you ... you feel less self-conscious, relaxed and secure" (England & Horowitz, 1998:200). "Birthing in privacy, on their own turf, reduces mothers' inhibitions and increases their sense of autonomy" (England & Horowitz, 1998:204).

Subtheme 1: The midwife became part of the birthing experience

This was a golden thread that ran through all of the data. The mothers developed a special connection with

Table 1: An overview of the major themes and subthemes of the woman's experience of a vaginal delivery conducted by a private midwife

Major themes	Subthemes
The development of a therapeutic relationship with her midwife	The midwife became part of the birthing experience The mother felt that she is in control of the birthing process and part of the decision-making process She felt safe and secure because the midwife concentrated on the mother as an individual The midwife enhanced the bonding between the family as unit
Unrealistic expectations with regard to the birthing process	Unrealistic expectations of the pain associated with the birthing process Experiencing birth guilt

their midwives: a sense of intimacy or feeling that the midwife was accessible. One mother said that it was like having second “*mommies*” around. Another said that it was like having her sister in the room. The midwife almost became a member of the family for the duration of the pregnancy. This is echoed by the following quotation: “*As a foreigner I had nobody with me... But they made it as if my family was around me*”.

The participants felt loved, supported and experienced a sense of closeness to the midwife. The mothers felt that the midwife took time to get to know them as people. They shared a very intimate and personal event in the lives of the mother and father and many felt that a lasting friendship had developed. The midwife was the first person that they would turn to if there was a problem. England and Horowitz (1998:205) support this when they state the following: “The personality and attitude of the nurse attending you in birth can be a surprisingly critical factor in your birth outcome. Her views on birth, pain, parents’ involvement in decision-making, and her capacity to provide encouragement, all will have a huge impact on your birth experience”. Odent (2004:21) the Founder of the Primal Health Research centre, supports this by stating: “The midwife was originally the mother figure ... The prototype of the person with whom one feels secure, without feeling observed and judged.” “... first person I phoned was midwife C. I desperately wanted her to be involved and tell me what was going on”. “The midwife visited us in our own home and that made the contact more intimate and personal”.

Pairman (2000) and Kirkham (2000:39-42) support this by stating that the relationship between the mother and midwife is one of equal sharing, involving trust, shared control, respect and understanding.

It was important to them that they had someone they trusted and knew to be with them throughout the birthing process. “*And I wanted a personal experience where the person delivering the baby would be actively involved from beginning to end*”.

This observation is supported by Fraser and Cooper (2003:34) and Kirkham (2000:41). Kirkham states that the mother is looking for an emotionally supportive as well as personal relationship with her midwife.

This research found that the relationship that developed

between the midwife and the mother was enhanced by the fact that the midwife had time from her; she was patient and took an interest in her as an individual. The mothers also felt free to ask questions without feeling stupid or humiliated: “... *she answered questions that I felt may be a bit silly to ask the doctors... Little questions, major questions, she answered everything very nicely*”. One of the major contributing factors was the fact that when the labour drew near, the midwife would phone the mother and enquire as to her condition and how she was feeling.

All the women who participated in this study were of the opinion that the birth was not rushed in any sense but allowed to follow its natural course. This made the mother feel safe and secure. The following statements echoed this sentiment: “*in all of that time she wasn’t in a rush to get home...*”, “... *she wasn’t rushed to go anywhere, you know*”.

The midwife was accessible to the mothers and this added to their peace of mind concerning their birth and pregnancy. They could phone the midwife at any time should they have concern or worries. “*I mean you can phone them anytime of the night and they will give you advice ...*”. “*What was nice was that I could phone them at anytime, if I had questions, or was concerned about something and they were always available*”.

Subtheme 2: The mothers felt that they were in control of their birthing process in relation to the decision-making process

Mothers described the relationship between them and their midwives in terms of friendship or a partnership. This type of relationship is used intentionally to shift power towards the woman. The mothers expressed that they felt in control of their labour and that they played an active part in the decision-making process. “*I felt I was on control of the birth although I was being guided and told that would be better or let me help you with that..., I felt like an active participant*”.

The power or control that the mother experienced with regard to the birthing process was based on the external or environmental factors she could control: she could change and choose her birthing position and she had the final say in the use of pain mediation. The mother felt empowered, because she was consulted with regard to any decisions that had to be made and felt that

she had the relevant information to make informed decisions. "... we were consulted on every decision and never once felt that the health of the either X or Y was compromised ... This was very empowering". "... and decisions to be made was communicated to us and our input actually counted!"

An active birth frees a woman to express her in a relaxed environment. If left to her own devices, she will spontaneously choose various body positions to improve comfort, to minimise pain and to enhance the descent and delivery of her baby. She thus assumes a dominant and responsible role and participates actively in the birth of her baby (Robertson, 1988 in Robertson, 2005:2). "It is recognized that the most powerful help for a woman may come from doing as little as possible" (Fraser & Cooper, 2003:34).

When the time came for decisions to be made, they were given all the relevant information and they could then make an informed decision. The midwife did not force her opinion or decision onto them. No intervention was embarked upon without the mother being consulted and the procedure being explained step-by-step: "... they explained exactly what they were doing whilst they were doing it ...".

They acknowledged that they needed the expertise and knowledge of the midwife, but that she was unobtrusive, gave them their space and allowed the mother to rely on her own abilities and confidence. "... she sort of respected my space as well, to do as I wanted to do". "She saw where she could intervene and help, but didn't force it". Kirkham (2000:104) states that it is important for the midwife to know when to stand back and let the mother focus.

To ensure that the mother has a positive birthing experience, it is essential that the midwife relinquishes control to the mother, and only intervenes when the situation requires her to. "So the control came in when I was pushing and I knew what I was doing, and I could feel actively that baby coming and I know what to expect. But there was a degree of more control (from the midwife) there". England and Horowitz (1998:204) state that the mother who feels in control of the birth reaches deep inside for whatever it will take to meet the challenge of the contractions.

Fraser and Cooper (2003:34-36) report that the relationship between women and their midwives is seen by women as important in itself as it forms the basis of the ability to give the woman choice and control. According to Hunt and Symonds (Clement 1998:89) the underlying issue with regard to the mother's perception of control and choice during the childbirth is that of open communication. It is therefore the responsibility of the midwife to empower the mother by supplying her with accurate, unbiased information and to include information from a number of sources (Clement 1998:86; Wilkins 2000:28-52). Women in labour look for respect, trust, warmth, care, understanding and encouragement from their midwives and not only physical support (McCrea, Wright & Murphy-Black, 1998:175).

Subtheme 3: She felt safe and secure because the midwife concentrated on the mother as an individual

This was a theme that was echoed in all of the interviews as well as the naïve sketches. The mothers all felt safe and secure. They all trusted the ability and competency of the midwives implicitly and looked to them for inner strength and support. They found that the continuity of care made them value the caregivers as professionals. Excerpts from the interviews to support the finding are: "This time around I felt that same sense of security when they were around me ...". "Oh, very, very professional, um also still very safe and secure with them the whole time. Their support was really really good".

"Midwife C is hugely competent ... don't remember looking to my husband for strength at all, midwife C was like everything at that point in time". England and Horowitz (1998:200), state that the mother feels less self-conscious relaxed and secure: all of which help her to cope with pain.

Due to the fact that the mothers felt safe and secure in the presence of the midwife, they could relax and be calm and enjoy the birthing process. This was reiterated in all the interviews. The mothers stated that they took their cues from the midwives: the midwives were calm and relaxed and this enhanced their feeling that the birth was a natural process. "Very relaxed, very calm nothing you know, no rushed ... nothing ... She stayed very calm and X was totally calm as well because midwife C was so calm...". England and Horowitz (1998:202)

confirm that a woman's intolerance of labour pain may not be to the pain itself, but to other people's response to it.

Research conducted by Kirkham (2000:46) found that a mother needs a midwife who enables the mother to focus on the birth as a natural process, to decrease fear and promote confidence and trust.

During the interviews, the mother's stated that they felt that the baby wasn't the sole importance of the delivery. They felt that they were seen and treated as individuals in the birth process and that focus was on them as much as it was on the baby. The feeling of being treated like an individual was not only during the birth, but was experienced during the antenatal visits to the midwife as well. The women expressed that the midwife was patient with them and treated them as special, unique people. The midwife used subtle methods of infusion of confidence and the mother could count on her undivided attention during the birth (England & Horowitz, 1998:204).

This aspect is highlighted by the following direct quotations: "... *it wasn't like a booked case scenario. It was very individual; she handled me like an individual*". "And after all, what I liked was how much attention she paid to me, I mean baby went with daddy and I became the centre of her attention".

In a study by McCourt, Hirst and Page (2000:268-287) women who received one-on-one care described the importance of the availability of the midwife as central to the trust they developed. Fraser and Cooper (2003:34) are of the opinion that midwives will find it easier to respond to individual needs, to comfort and to guide the mother through rough and difficult terrain if they knew and understood the women they were caring for. This can only be achieved if the care for the mother is individualised and personal.

Subtheme 4: The midwife enhanced the bonding between the families as unit

Birth is a very intimate yet social experience, and the inclusion of the family/husband promotes the bonding process of the family. The partners/fathers had a more active role. If needed, the midwife would communicate his spouse's needs or would interpret her needs for him. The women felt less anxious and distressed be-

cause they were not parted from their husbands or partners right at the start of their life as a new family. This sentiment was echoed with all of the women who participated in this study. One mother stressed this point in particular, when she said that the midwife encouraged the father's involvement in the antenatal visits. "... *She encouraged my husband's participation also in the whole process*". When interviewed the mother said that this enhanced the bond between them.

The new family was given time alone together after the birth, where the mother, the father and the newborn could reflect and adjust to what had just happened. They expressed gratitude for the midwife's respectful retreat: they needed the comfort of their partner's company and needed to share and discuss their feelings. One of the mothers said that the bonding between her and her newborn was an incredible experience due to the fact that the baby started to suckle immediately when she was born. This profoundly enhanced the bonding between mother and baby. With the support of a skilled birth attendant, couples experience emotional success in birth, and feel mothered while learning to nurse and care for their new baby (Hofmeyr, 1991:756-764).

All of the above factors prompted and enhanced the bonding process. The mothers verbalised that they felt a strong bond developed between the newborn and father as well as between husband and wife because of his inclusion and respectful attitudes by the midwife. "Also this time around, my husband participated more actively opposed to the other times ... he has bonded so much more with this baby than he did with the other two".

A mother quoted a well-known childbirth educator, saying that parenthood is a joint venture and it became the most enriching experience for all. Including her husband in the antenatal classes and the birthing process, made them "*feel less than a spare part in an unfamiliar ritual*".

Two fathers added their own quotes to the naïve sketches illustrating their experiences as a family unit. They both stated that it was a profound experience to listen to the fetal heartbeat, feel the fetal movement and then touching and holding this newborn infant. They felt new respect for the woman. One father wrote "I

spent a lot of time with my baby directly after birth ... I feel more sensitive to his needs and am able to interpret his signals". This confirms the statement of Finnbogadottir, Svalenius and Persson (2003:96-105) that the father's participation in all aspects of pregnancy, labour and care of the baby is a satisfying experience for the couple. Robbie Davis-Floyd (2005), a well-known anthropologist, says: "... birth rituals should affirm and reaffirm the unity and integrity of the family and the individuals that comprise it".

Theme 2: Unrealistic expectations with regard to the birthing process

Subtheme 1: Unrealistic expectations of the pain associated with the birthing process

Pain in labour and birth is significantly different from pain in other areas of our lives. It serves as an indicator that labour is progressing. It can be made manageable with comfort measures and education and allowing the body's endorphins to rise to the appropriate level to match the pain (Bobak & Jenson, 1990). Yet, "The intensity of labour pain is such that no technique can fulfill a promise of pain-free labour" (England & Horowitz, 1998:191). Women who choose to deliver with a midwife are a self-selected group with a clear commitment to labouring drug-free. They envision themselves coping with pain in other ways and understand that they do not have a "drug net" to fall into when labour becomes difficult.

Throughout the duration of the study, the researcher observed that the mothers were often surprised or shocked by the actual extent and intensity of the pain. This led to a naivety with regard to the birth and the birthing process. This is illustrated by the following quotations: "*The intensity of the contractions really scared me*"; "*It's absolutely impossible – it (the pain) created some kind of chaos to me*"; "*From the beginning it (the pain) was very unreal*".

Not all of the women attended the same childbirth educator and the mothers stated that some childbirth educators and health professionals re-enforced the hope that pain could be avoided. This narrowed the mother's vision of how she should manage labour pain. Mothers felt inadequate and experienced guilt when they found it difficult to cope with the pain of the contractions: "*It*

was so enormous ... I started to cry ... And I just could not cope". One woman admitted during the interview that she was over-confident because she believed from the brief discussions on pain relieving techniques in the childbirth education classes, that she would be able to cope. England and Horowitz (1998:191) state to this regard: "it takes practice to master these techniques ... There are no guarantees how well any of these techniques will work for you in labor".

When the mother felt well supported and guided by her midwife in methods to manage the pain of labour, she seemed to understand the purpose of feeling pain and accepted it. The mothers acknowledged that the pain of labour guided them to change positions to deal with the intensity of the contractions. "Pain in labour is universal and because it is regarded as a common experience it could be seen as comforting, a bond among women, a fundamental truth that confirms our special biological role and affirms the importance of our contribution to society" (Robertson, 2005:1).

Many mothers felt that the calm, serene environment of the midwifery unit contributed to her personal birth experience. All the mothers used the water bath either for pain relief or for birthing, and remarked of the benefits for them. "*The response to pain is partially determined by its physical and social environment. Your birth place and the people in it, play a vital role in your relationship with pain*" (England & Horowitz, 1998:199).

Subtheme 2: Experiencing birth guilt **Inability to cope with the contractions**

During the interviews, almost all women remarked on feelings of *guilt*: either from their inability to cope with the contractions, or from vocalising their discomfort during childbirth. The women who opted for pain relief felt ashamed of using drugs in labour. They mentioned that the fathers found it unbearable to see them in pain: "*I could see on his face the compassion he felt ... I felt worse for not being able to bear with it*". The mothers were experiencing guilt when they were vocal, even though it helped to cope with pain. "*When I started moaning and crying, I felt I was failing*". "*Why couldn't I cope with the pain? I was really suffering at one stage*". One of the mothers went so far as to say that she acknowledged that she was naïve with regard to the birth and her plans of what the birth was going to be like for her.

Inability to deliver without assistance

Women expressed feelings of guilt when they needed assistance, in the form of forceps, a vacuum or an episiotomy, during the birth. They hated the insertion of the apparatus and the marks it left on the baby's face or head. *"I hated the rubbery feeling when it (the forceps) was inserted ... I felt guilty because I just could not push him out myself"*.

One of the women felt offended when the midwife allowed the husband to watch the suturing of the episiotomy: *"I really hated that – I felt exposed ... I felt guilty because I wondered about how that would influence our sex life"*. This woman never confided her feelings to her midwife. Robertson (2005:2) states the following "If birth was not so sexual perhaps it would have been easier for women to express their needs and for others to recognize the importance of preserving the natural physiological flow of the process: keeping the sexual nature of birth 'out of sight' makes it easy to avoid confronting the issues". England and Horowitz (1998:169) feel that the father should be the *guardian* of the birth place who needs to be sensitive, calm and assertive to handle some of the situations that can happen. He needs to protect her privacy: "It is disheartening for the mother when her emotional anchor suddenly cuts loose". Odent (2004:21) states that the feeling of being observed is a type of neocortical stimulation, slowing the labour down and changing the way the mothers feel and act. For the mother participating in the study there was a difference between the midwife staying in front of the mother while suturing, and the father observing and watching the procedure.

CONCLUSION

The aim of this study was to better understand and explore the experiences of women who delivered with a private midwife.

The researcher found that women who delivered with a private midwife found it to be a hugely positive experience. They felt that they were in control of their birth and the midwife remained unobtrusive, they felt safe and secure which enabled them to relax and enjoy the birthing process, they felt that they were not rushed because a therapeutic relationship had developed between the mother and midwife, the midwife took time to concentrate on the mother as an individual. The bond-

ing within the family unit was enhanced.

The active birth approach utilised by the midwives seeks to humanise and feminise birth and raises questions about the effects of increasing obstetric intervention at a time when perinatal and maternal mortality statistics have stabilised in the western world (Hofmeyr & Sonnendecker, 1985:473). The active birth approach carries significant implications for the management of labour, which should statistically-speaking, be an uncomplicated event for the majority of women.

"If the basic needs of labouring women had been recognized half a century ago – the history of childbirth would undoubtedly have taken another direction ... The midwives would not have disappeared" (Odent, 2004:22).

RECOMMENDATIONS

The practising midwife/nursing practitioner needs to be made aware of the themes and subthemes that surfaced as a result of this research into women experience of a vaginal delivery conducted by a midwife. The recommendations will be discussed under three headings. They will be the nature and practice of the nurse practitioner/midwife, education with regard to the midwife/nurse practitioner and suggested areas for additional research.

The practice and nature of the midwife/nurse practitioner

- The curriculum content of the antenatal classes needs to address the concept of pain and the experience of pain during labour realistically. The experience of pain is an individual, intimate and subjective area and the midwife cannot generalise that all women will be able to cope/experience pain in the same manner.
- Alternative methods of pain control need to be made accessible to the practicing midwife/nurse practitioner. This is necessary to enable the mother as well as the midwife to control the pain during labour better. The use of a TENS machine as an alternative to pain control/relief needs to be addressed as well as the compassionate use of drugs and epidural anaesthesia.
- Due to the fact that the mother needs to feel

that she is in control of her labour and delivery, the midwife needs to ensure that the mother has sufficient knowledge. It is therefore the responsibility of the midwife to strive towards empowering the women, especially in antenatal classes, through equipping them with the relevant information, so that the mother can exercise control. This will result in a positive birthing experience by the mother.

- A bill of rights for the pregnant woman will ensure that the mother's control and authority over her own body is not undermined at any stage during her labour and delivery.

Education with regard to the midwife/nurse practitioner

- The mothers stated that they felt safe and secure in the care of the midwife because they fully trusted her abilities and level of competence. It is therefore essential that the midwife participates in continuing education. This will also ensure that the practising midwife keeps up to date with current development in the field of midwifery/obstetrics.
- The mothers were able to foster a warm relationship with the midwife because of good communication skills and mutual respect. Interpersonal and communication skills should be emphasised in the midwifery curriculum.
- The inclusion of the father in all aspects of pregnancy and labour should be paramount. The content/information in antenatal classes needs to be designed so that it offers support as well as information to the expecting father.

Suggested fields of additional research

Very little information is available with regard to the fathers and midwife's experience of the labour. It is therefore recommended that further research be conducted into these fields.

LIMITATIONS OF THE STUDY

Birthing is a very personal and individual experience, and some information may have been repressed/omitted with regard to the mother's own personal feeling as a result of the sensitive nature of the birthing experience.

This could have occurred due to the fact that the researcher was unknown to the participants and no long-term relationship could be established. Therefore the experiences of the women who participated in the study cannot be generalised to all women's experience of birth with a private midwife.

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