Creating a safe haven - Women's experiences of the midwife's professional skills during planned home birth in four Nordic countries

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Abstract

Objective: The midwife assisting a birth has a considerable impact on the woman's experience of the birth. The aim of this study was to investigate the experience of the midwife's professional skills among women in Norway, Denmark, Iceland and Sweden who chose a planned homebirth.

Design and setting: All known homebirth midwives were asked to inform the mothers about the project and invited them to complete a questionnaire regarding different aspects of their homebirth experience.

Method: The women were asked to assess ten different aspects of the midwives' professional skills on a four-graded scale below the main question: What was your experience of the midwife who assisted the labor? Furthermore, the mothers' experiences with the attending midwives were identified in the free text birth stories. The chosen method was a mixed method design.

Findings: The experience of the home birth midwives' professional skills was generally high scored. No statistically significant differences were found regarding the assessment of the midwife. The content analyses yielded one overarching theme: The competence and presence of the midwife creates a safe haven, and three categories, Midwife's safe hand, Midwife's caring approach and Midwife's peaceful presence.

Conclusion: Women choosing a home birth in the four Nordic countries experienced that their midwives were highly skilled and they found the presence of the midwives significant in helping them to feel safe and confident during birth. Despite differences in organization and guidelines for home births, the women's experience of the midwife's professional skills didn't differ between the four countries.

Keywords: Midwife, professional skills, home birth, women's experience, mixed method

Introduction

In four of the Nordic countries, Norway, Denmark, Iceland and Sweden the culture and linguistic context, public health conditions and the health care system with tax-paid equal access for all habitants are rather similar. Furthermore, maternity care is free of charge and midwives are the primary care givers in normal pregnancy and childbirth. Close to all births are documented in national birth registers. The number of births in Sweden in 2010 was about 113.000 (1), in Norway 60.000 (2) in Denmark 61.000 (3) and in Island 5000 (4). The vast majority of births occur in obstetric hospital settings and alternatives are few. In both Norway and Iceland there are eight units each led by midwives and in Sweden there is one unit led by a midwife that is located at a hospital. Denmark has no units led by midwives.

The prevalence of home births for Sweden and Norway is about one per thousand and for Denmark and Iceland 1-2 percent (5, 6). The Nordic countries differ regarding the regulations governing the choices available to women who consider opting for a home birth. In Denmark all women have the right to be attended by a midwife during a homebirth, and there are different kinds of home birth organizations; you can, for example, have prenatal care with the midwife who will attend the homebirth and you can call the hospital for a midwife when labor starts. National guidelines are available and the homebirth service is funded by taxes (7). In Norway and Iceland the service is fully or partly funded by taxes and national guidelines are available (8, 9), but access to a midwife attending the birth varies geographically. In the Stockholm County Council guidelines have been developed for publicly funding of planned home births; for the rest of Sweden (25 councils) no guidelines have been formulated, and the woman who wishes to give birth at home must pay for what is purely a private service (10).

Planned home births are associated with a high incidence of spontaneous vaginal birth with few interventions (5, 11, 12) and a high degree of satisfaction (13, 14, 15). The nature of the relationship with the midwife and the support from the midwife during childbirth in general are fundamental in determining the degree of satisfaction with the experience of childbirth and the medical outcome as well (16-21). Having a negative experience of the midwife increases the risk for the overall birth experiences to be negative (22, 23). For women who choose to give birth at home the contact with the midwife is usually established during the pregnancy. Knowing the midwife is mentioned as one of the reasons for choosing a home birth (14, 24). Other reasons are the increased autonomy, considering the birth as a natural process with no needs for intervention and a mistrust of medicine establishment, previous negative birth experience in the hospital, and to be able to have the family around them in the home environment (14, 15, 24).

As the role of the midwife is important for a positive birth experience and the degree of satisfaction with homebirth is high, it could be presumed that the midwife in attendance in the home birth setting possesses certain qualities and skills. Up to the present time, little has been known about how mothers view the midwives who assist home births in the four Nordic countries; we also lack knowledge about how the perception of the midwife is influenced by the organization of home births. The aim of this study was to investigate the experience of the midwife's professional skills among women in Norway, Denmark, Iceland and Sweden who chose a planned homebirth.

Method

This population-based, multinational study is inspired by a mixed method design, used when a question can be answered from both quantitative and qualitative data, and the results can

give convergence to each other (25). In this study, a concurrent triangulation approach is used, the quantitative and qualitative data collection is concurrent and there is no predominance of the qualitative or quantitative data. The questions used are taken from a questionnaire using assessment scales and open-ended questions. The results are presented side-by-side, which means that the results will be integrated with the answers from both types of analysis (25). The study was approved by the Regional Research Ethics Committee of Karolinska Institutet in Stockholm, Sweden, nr 2009/147-31.

Setting, sample, data collection

A collaborative research project among Sweden, Denmark, Iceland and Norway was established in 2009 with the aim of enhancing the knowledge about planned home births by aggregating data from the four countries. A study-specific questionnaire was developed based on a previously used questionnaire from a similar project (13, 26). Midwives fluent in Swedish and the one of the other languages translated the Swedish questionnaire into each of the other Nordic languages. All known home birth midwives were asked to inform the homebirth mothers about the project and ask them to fill out the questionnaire. The data collection was introduced consecutively between November 2009 and March 2010. The data analyzed in this study were drawn from the register the 1st of September 2011. The questionnaires were available at the website; www.nordichomebirth.com

The women were asked to assess the midwives' professional skills on a four-graded Likert-scale. Ten different aspects of the midwives' qualities were estimated below the main question: What was your experience of the midwife who assisted the birth? Statements about medical skills as well as emotional and caring skills were assessed using the four options: Not agree at all, disagree partly, agree partly, and agree completely. (Table 2)

Data analysis

The questions were analyzed separate with a statistical model and a qualitative content analysis as described below.

Statistical analysis

The software program SPSS 20.0 was used for the descriptive analysis and Pearson's chi-square test was performed in order to detect potential differences between reports from the different countries. As the responses tended to be extreme towards either the negative or positive end of the scale the cutoff point was set between agree completely and the other three alternatives (i.e. 1-3 and 4).

Content analysis

A qualitative approach was used in order to further explore the women's experience with the midwife. The women responded to one open question where no limit was placed on the length of the response. The question was: "Could you please describe the birth in your own words?" A qualitative content analysis was used to analyze the birth stories in order to find descriptions of the midwife assisting their home birth. Units of analysis in this study were all units containing any information about the midwife.

All the birth stories were read through in a naïve reading. Then, in a second reading, meaning units containing any information about the midwife were identified. All units were read through several times to get a sense of the content in each statement. The meaning units of analysis were then condensed and subcategories were created on the basis of differences and similarities. Finally categories were created that were related to the content of the stories regarding experience of the midwives. The two authors (IS and HL) discussed the meaning units, subcategories and categories. In a final step reflection within the research group resulted in one overarching theme describing the women's experience of the midwife. During

the whole analysis process the intention was to stay as close to the written texts as possible by moving frequently from the whole to the parts and from the parts to the whole (27, 28).

Findings

A total of 939 women answered the questionnaire. The distribution among the countries is shown in figure 1. The age of the women ranged from 19 to 42 years with an average of 34 years. More than 90 percent of the women were cohabitants with the partner who attended the planned home birth. There were no statistically significant differences between the countries regarding socio-demographic factors. In Sweden a lower percentage of women were giving birth to their first child compared with the other countries, but the differences were not statistically significant.

The result shows a high level of satisfaction regarding the different aspects of the midwife's skills in general (Table 2). For the majority of the questions around 90 percent of the women responded that they fully agreed with the statements describing the midwife as competent. Concerning the midwives' attention to the partners' needs about three out of four women fully agreed that the midwife met the partners' needs. No statistically significant difference between the countries was identified. Overall three percent of the women responded that they did disagree to statements describing the midwife as competent, but no statistically significant differences were detected between the countries.

Altogether 603 women had written down their birth stories in response to the open question. A total of 355 (59 %) of the birth stories included statements about the midwife. The greatest number of responses was from Denmark (n=293), and then in descending order Sweden (n=58), Iceland (n=16) and Norway (n=16). The extent of the birth stories varied from a few

words to detailed descriptions from onset of labor until some hours after the birth. The total number of words in the material that was analyzed, stories containing statements about the midwives, was 14400.

The content analysis resulted in one general theme: The competence and presence of the midwife create a safe haven, strengthened by the woman-midwife relationship created during the pregnancy. The theme illustrates the interpreted meaning of the women's experience of the midwife as being physically, emotionally and mentally present to fullest extent. The midwife's presence strengthened the women's feelings of safety and comfort and allowed them to give birth on their own terms following the birth process in their own rhythm. Knowing the midwife was an important part of feeling safe, as the mother didn't have to explain or express her feelings and wishes, though they were known in forehand. Some women not knowing her mentioned it as something they missed, while other said it did not matter, as she easily made a good relationship to the parents. Three categories; midwife's safe hand; midwife's caring approach and midwife's peaceful presence, with subcategories, were identified and will be presented below integrated with the results from the statistical analysis concerning midwives' competence (Table 3).

Midwife's safe hand

The women reported that the midwife had an overview over the birth process. The perception of the midwife as being able to grasp the situation made them feel safe and they could go on with the labor process without any worries. The midwife watched over the labor progress and monitored the wellbeing of the baby and thus made the women feel safe. The results correspond well with assessments of medical skills where overall 95 percent of the respondents completely agreed that the midwife was medically skilled (range 93-98 %), 91

percent fully agreed that she was technically skilled (range 89-94 %) and 93percent (range 91-100 %) fully agreed that the midwife was confident,

Having control over the course

This subcategory described midwives' way of having a watching eye over the process, to ensure normality. The midwife checked the woman's blood pressure, the heartbeat of the baby; she did vaginal examinations and confirmed that the birth was proceeding normally. She examined the newborn baby, checked that everything was fine and if necessary supported the baby and the mother after birth.

She (midwife) listened to the fetal heart sounds and they were just fine. She said that I was completely dilated, something I had not realized (No)

The midwife picked up my daughter from the water and observed that she was pale (Dk)

Having a sense of when and how action is needed

The women often described the midwife as non-active, but when needed, she was more active. She could recommend amniotomy, acupuncture or a bath when time was right for that. When the women felt like she was losing control the midwife took a more assertive role. The midwife in some cases used reboozo in order to help the baby down the birth canal. Some of the women were advised to go to the hospital due to slow progress of labor or having a retained placenta and then the midwife ensured a safe transfer. The women described the measures as significant

The delivery itself was a good experience but our daughter had to be suctioned, given oxygen, and stimulated (Dk)

The midwife managed to break the water and was also able to dilate fully the cervix: We felt really well taken care of (No)

Midwife's caring approach

The midwife cared for the women in a way that they said helped them through labor. It was a feeling of loving, caring hands and to be in the total center of the attention that the women described. The women described the care as strengthening their self-confidence and their ability to handle the contractions and go on with the birth. This is in line with the finding from the statistical analysis showing that 95 percent of the women completely agreed with the statement that the midwife was supportive (range 89-100%), 90 percent meant that she was encouraging (range 86-94%) and 91 percent fully agreed that she was emotionally skilled (range 89-92%) (Table 2)

Provides support and encouragement

Many of the women carefully described the support they experienced from the midwife. The support was perceived not only as professional but also as loving and encouraging attendance. The support could be specific like focus on breathing, or pressing on aching back. It was described in terms of cooperation, good teamwork between the woman, the partner and the midwife. The women also said it was encouraging to receive information and explanations regarding the labor progress.

She was a very calm but supportive voice in the room, telling me to trust myself and breathe through the pain. That helped me to get through (Dk)

With the help of the midwife I took the baby who was screaming right away. The midwives supported me without at all taking over (from me (Sw)

She encouraged me and said all the right things. She helped me to experience childbirth as a natural event, and the pain as well (Ic)

Two of the women experienced lack of support, because the midwives arrived just before the birth and there was no time to establish contact, something they missed.

I did not really manage to establish any real contact with the midwife, so things just were very practical during a period that was really difficult...I felt a bit alone during the final hours (Dk)

Guidance

Guidance from the midwife referred to being there with ensuring and supportive words in certain situations. In some stories guidance was not named specifically but was mentioned in phrases such as “with good guidance from the midwife...”. More specific guidance could be helping the woman to find a good position, breathing, and cooperation during the pushing phase; telling her to take it easy, don’t press too hard to avoid ruptures, and follow the sensations of the body. The women were in some cases guided to protect their perineum by themselves and feel the head of the baby, and sometimes even to catch the baby themselves. Lack of guidance was described as being missed if the midwife did not come in time for the birth, or if not enough guidance was provided.

So nice with her safeguard presence and soft voice who guided me when the labour was most intense... like a light in the dark (Sw)

She gave me guidance and encouraged me to listen to my own body and told me that I was doing well (No)

The only thing that was missing was a bit more guidance from the midwife during that phase. I did not get to know if I was doing right or how long a time was left
(Dk)

Midwife's peaceful presence

The peaceful presence of the midwife was understood as an important component for the woman's feeling of safety. The women reported that it was crucial for them to know that someone with professional skills was sitting guard, keeping the process in mind and watching without intervening. This is also mirrored by the results from the statistical analysis; 93 percent of the women fully agreed that the midwife was calm (range 90-100%), 95 percent (range 90-100 %) that she was worshipful and 92 percent agreed to the statement that she was attentive to the woman's needs (range 88-100%). (Table 2)

Showing respect by staying in the background

For some women it was important to stay in control of the situation, and to do this on their own terms. They didn't want anybody to take over and tell them what to do and how to do it, but rather they wanted to listen to their own bodies and follow the process. With the midwife in the background they felt free to do this. The midwife was perceived as a guest in the woman's home and it was significant that she also acted like one, with respect for the parents as hosts. To be treated with respect was described by the women as being taken seriously when they were expressing their wishes concerning the birth process.

The midwife had complete confidence in me and was there keeping her distance in the background (Sw)

It all turned out to be on our premises. Really great midwife who was good at listening to our wishes and thoughts (Dk)

A midwife who displayed her ability to keep calm and to show respect and who was really fantastic!!!(Dk)

Four women reported that the midwife did not fully respect their wishes and needs, which made their birth experience being not what they had expected

But I had also requested a natural third stage so with the cord intact...., but she repeatedly asked if she could cut the cord, despite my wishes (Sw)

Everything went according to plan until the midwife refused saying that I was in the transition stage, what I felt I was---, but I was in the transition stage (Dk)

Create peace and security

The midwife was perceived as tranquil and peaceful, allowing the women to feel secure. The midwife's presence, more than her action, was described as creating a space of peace and security where the women felt they are in good hands. The midwife also took her time; there were nothing else to disturb her concentration of the birthing woman. Some women mentioned that they were better cared for at home than in the hospital because at home the midwife could be by the woman's side all the time.

The midwife was fantastic, my heart get warm when I think of her...supportive, warm and e incredibly safe to have her (Sw)

She was there when I needed her, her calmness made that I didn't feel insecure over the situation at any time (Dk)

Discussion

Women with planned home births in the Norway, Denmark, Iceland and Sweden experienced that the midwives in general were highly skilled regarding medical aspects as well as

emotional aspects. The women's experiences could be understood as resulting from the midwives creating a safe haven, an environment where the women felt safe and could focus on the birth process.

Despite differences regarding organization and guidelines between the countries, no statistically significant differences were found between the countries regarding the factors related to the midwife's competence. Women choosing a homebirth seem to be more satisfied with their birth experience as a whole than women giving birth in the hospital (29, 30). Morison et al (31) and Dahlen et al (32) described similar findings and concluded that women who planned for a homebirth had clear expectations for the birth and made some efforts to get them realized. This included having a close contact to a known midwife, who during pregnancy, labor and birth provided support and enhanced their confidence in their abilities to achieve a normal birth (32). In this study we do not know how many of the women who knew their midwife ahead of labor and this was not the object for our analysis. However, according to the results, organization and guidelines may be of less importance when the home birth actually takes place; the midwife comes as a guest to the woman and provides woman-centered care.

The midwives' presence, rather than their actions, was emphasized by the women in this study. The midwives were described as competent, calm and empathetic and their presence seemed to create a safe environment for the women giving birth. The midwives' being present and fully able to observe, assess and act when needed is highly valued characteristics that have been described previously (14, 15, 33, 34). The presence, the "being there", and the silent support, that is characterized by being seen, understood and listened to was more important than what was said and done (13, 34, 35) and the midwife was not expected to fulfill other tasks as might be expected in a delivery ward where the midwife has responsibility for more than one woman in labor (31). The concept of "being with woman"

described by Hunter (17) is defined as presence and support, psychological, emotional and physical, given by the midwife in accordance with the wishes of the woman giving birth, and this seems to be better fulfilled where the psychosocial midwifery model is current. The psychosocial model of midwifery care is related to the model of woman-centered childbirth care described by Berg et al (36). Three central components are described: the reciprocal relationship, the birthing atmosphere of calm, trust and safety and the grounded knowledge of the midwife, which is described as embodied knowledge. Presence and continuous support are shown to have considerable impact on women's ability to give birth on their own terms (35, 37, 38). The midwives' psychosocial approach, described by the women, and the women's experience of the concept of "being with woman" as described in this study, might explain the high estimates of midwifery skills and competence.

Methodological considerations

The large number of respondents in this study strengthens the results, and we have reason to believe that a large percentage of all women who gave birth at home during the study period responded to the question. However, due to uncertainty in national birth registers, we do not know the total number of home births during the study period. We do not know how many of the midwives informed how many women, and how many informed women answered the questionnaire, but the number of respondents corresponds well with the number of births registered by the midwives in the same research project. Women who were dissatisfied may not have responded to the questionnaire, but on the other hand one could assume that those who were really dissatisfied would take the opportunity to report their experiences. Since home birth rates differ between the four countries; the uneven distribution of responses from the different countries mirrors the reality.

The midwives in the four countries were successively informed about the project. This explains the small number of participants from Norway where information about the project was given later and more participants had replied after the final date for this study.

The women were asked to write down their birth stories in their own words; they were not specifically asked to express their experiences of the midwife's skills. This may result in lack of information, but we can assume that if the midwife was important to the birth experiences, she would be mentioned in the birth stories, as previously reported by Wilde et al and Janssen et al and (21, 39).

Different strategies may be applied in using mixed method approach depending on the relative importance given to either the qualitative or quantitative data, in the collection phase as well as in the analysis and reporting phase. This model generally uses separate qualitative and quantitative analysis methods and the results can be integrated or connected, or used side by side to reinforce each other, often in the discussion section. The use of mixed method approach applied in this study proved a strength as the qualitative data helped validate the quantitative ones, in order to amplify and give a more personal insight into the women's experience of the home birth midwife. All data were collected in the same study population during the same period of time (22).

Conclusion

Women choosing a home birth in Norway, Denmark, Iceland and Sweden are highly satisfied with the competence of their midwives. Despite the differences in organization and guidelines for home births, the women's experience of the midwife's professional skills does not differ between the four countries. The strength of the woman – midwife relationship, seemed to be similar from country to country irrespective of the nature of the health care

system within the four Nordic countries. Further research regarding the experience of the midwives attending home birth would contribute the body of knowledge in this field.

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