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Nature works best when allowed to run its course. The experience of midwives promoting normal births in a home birth setting

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ABSTRACT

Objective: to gain a deeper understanding of how midwives promote a normal birth in a home birth setting in Norway.
Design/setting: a qualitative approach was chosen for data collection. In-depth interviews were conducted with nine midwives working in a home birth setting in different areas in Norway. The transcribed interviews were analysed with the help of systematic text condensation.
Findings: the analysis generated two main themes: «The midwife's fundamental beliefs» and «Working in line with one's ideology». The midwives had a fundamental belief that childbirth is a normal event that women are able to manage. It is important that this attitude is transferred to the woman in order for her to believe in her own ability to give birth. The midwives in the study were able to work according to their ideology when promoting a normal birth at home. To avoid disturbing the natural birth process was described as an important factor. Also crucial was to approach the work in a patient manner. Staying at home in a safe environment and establishing a close relationship with the midwife also contributed positively to a normal birth.
Key conclusions: the midwife's attitude is important when trying to promote a normal birth. Patience was seen as essential to avoid interventions. Being in a safe environment with a familiar midwife provides a good foundation for a normal birth. The attitude of the midwives towards normal childbirth ought to be more emphasised, also in the context of maternity wards.

Introduction

Most pregnancies among healthy women are normal, and most births can proceed without unnecessary medical interventions (Olsen and Claussen, 2012). According to the World Health Organization (WHO, 1996), 70–80% of all pregnant women are considered low-risk cases at the beginning of birth. Some women still experience complications during pregnancy, and there is broad consensus that births with high risk involved must be confined to large birth clinics (Directorate of Health, 2010). However, there are different attitudes regarding what is safe for the mother and the baby. These must be seen in light of how birth is understood as a phenomenon. There are two theoretical perspectives which Rooks (1999) describes as The medical model and The midwifery model, respectively. The medical model is characterised by the idea that the hospital provides safety for pregnant women, as you can quickly intervene if complications occur. Childbirth is seen as a risk and can only be defined as normal in retrospect. The midwifery model focuses on normality during pregnancy and childbirth. Berg et al. (2012), Olsen & Claussen (2012) and Shaw (2013) emphasise that the possibility of complications should not undermine the value associated with a woman's experience of being pregnant and giving birth. The midwifery model has much in common with what the International Confederation of Midwives (ICM, 2014) describes as an important strategy; to protect normal birth.

ICM (2014) defines a normal birth as a unique, dynamic process based on physiological and psychological interaction between the mother and the fetus. A normal birth takes place when the woman commences, continues and completes labour with the infant being born spontaneously at term, in the vertex position, without any surgical, medical or pharmaceutical intervention. ICM wishes to support normal childbirth, as pregnancy and childbirth are physiological life events for the majority of women. The promotion of a normal childbirth is included in the ICM Scope of Practice and midwives should have the competence to support the physiology of childbirth. Women should be

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able to access midwifery-led care and one-to-one care, including the choice of a home birth. A normal birth is health promoting, not only for the woman but also for families and society in general (WHO, 1996; ICM, 2011). Downe and Mc.Court (2008) stress that midwives with a health promoting perspective will meet the woman with a salutogenic focus rather than concentrating on factors that could prevent a normal birth. They also emphasise that health care in the future should have a more salutogenic focus, where health represents a contrast to disease and risk thinking. Salutogenesis offers a new framework for understanding how women experience labour. It enables us to understand how maternity care and research in this area can be based on the promotion of positive well-being.

WHO (1996) has developed guidelines for care in connection with the promotion of normal birth. These emphasise that the woman should give birth at a place where she feels safe and is able to access appropriate care. In Norway, maternity care is organised at two bureaucratic levels; antenatal care is part of the primary health services, which are organised at the municipal level, whilst the special health services are responsible for intrapartum and postnatal care. This may lead to fragmented services, causing pregnant women to encounter several professionals, instead of care based on relational continuity. In a fragmented model of care, there are fewer opportunities for individualised care. For this reason, the White Paper 12 (Ministry of Health and Care Services, 2009) highlights the importance of limiting the number of professionals with whom a woman interacts during her maternity care. In the special health services, maternity care is organised at three different levels that vary according to the expertise available; small midwifery-led units, maternity wards and birth clinics. Birth clinics have the highest competency and emergency preparedness level (Directorate of Health and Social Affairs, 2005). Low-risk pregnant women may also choose to give birth at home. Home birth is not part of the public services in Norway and is only offered by private practice midwives. It has to be financed by the women themselves and depends on the availability of a midwife who offers services near their residence. Because of this, home birth is not an option for everyone (Directorate of Health, 2012), and there are only a few other alternative models of midwifery-led care in Norway.

The increasing use of interventions in hospitals in general, and a financially pressured healthcare system, have resulted in a need for change in the organization of maternity care (Coxon et al., 2014). The National Institute for Health and Care Excellence (NICE, 2014) published guidelines recommending that low risk pregnant women give birth at home or in midwifery-led units, as this has been shown to reduce the risk of unnecessary interventions. This is based on research indicating that it is safe to give birth at home, in cases where the woman meets the specific selection criteria (NICE, 2014). The Birthplace in England Collaborative Group (2011) supports a policy of offering healthy women with low risk pregnancies a choice of birth setting. In spite of this, more than 70% of all women in Norway plan to give birth at high-technology birth clinics. Planned home births are related to a lower risk of intervention during birth, a lower rate of episiotomy and instrumental deliveries, as well as fewer anal sphincter tears (Johnson and Daviss, 2005; Lindgren et al., 2008; Janssen et al., 2009; Blix et al., 2012) and postpartum haemorrhage (Hutton et al., 2009; Janssen et al., 2009).

On the basis of research underpinning the benefits of giving birth at home, the aim of this study is to gain a deeper understanding of how midwives promote a normal birth in a home birth setting in Norway.

Methods

Data collection

A qualitative approach was chosen for data collection, and the data presented are based on in-depth interviews. In-depth interviews are suitable for reflections on a specific topic, enabling us to gain knowledge and a deeper understanding of how midwives work to promote a normal birth at home (Malterud, 2013). The midwives spoke freely about their experiences, which made it possible to discern the knowledge and attitudes underpinning their work.

Participants

A Norwegian union of midwives provided an overview of midwives facilitating home births in Norway. There are about 20 independent midwives assisting home births on a regular basis in the country (Lindgren et al., 2014).The participants were recruited via e-mail and telephone. The inclusion criterion was that the midwife had at least five years of professional experience with home births. A total of 12 midwives from different regions in Norway were requested to participate, and nine were eventually included in the study. Two midwives did not want to participate and one was excluded due to insufficient experience with home births. The number of years of experience of home birth amongst the midwives ranged from between 5 to 26 years. It was desirable to include midwives who predominantly provided labour care at home, however two of the midwives interviewed also worked in a birth clinic. The sample consisted exclusively of women. The midwives were given written and oral information about the aim of the study as well as the terms of confidentiality. They subsequently signed a written consent form. The Norwegian Social Sciences Data Services approved the study (no. 51421). An interview guide with 5 open-ended questions was prepared in advance (Table 1). The guide was tested and revised after a pilot interview. The questions were derived from a literature review on the topic and based on professional knowledge and experience. The guide was used to direct the conversation to the chosen subject, rather than for asking specific questions (Malterud, 2013). Follow-up questions were asked when it was required to clarify opinions and statements. Eight of the interviews were conducted at the informants' home or workplace, and one was carried out via Skype. Each interview lasted about 40–60 minutes. After nine interviews, data saturation was achieved. The data assembled were rich in content, as all the midwives spoke freely about the topics, providing detailed accounts of their experiences with home births.

Data analysis

The interviews were recorded and transcribed verbatim. The transcribed interviews were analysed carefully using systematic text condensation, which is a descriptive and explorative method for analysis of different types of qualitative data, such as interview studies, observational studies, and analysis of written texts (Malterud, 2013). This method was therefore suitable for the study in question. Systematic text condensation, developed by Malterud (1993), is a modified version of Giorgi's (1985) phenomenological analysis. The purpose of the phenomenological descriptive approach is to generate knowledge about the informants' experiences within a particular field. The researchers try to identify the essence or themes that emerge from the data. The method of analysis followed a four-step analytical procedure (Malterud, 2013). First, all the interviews were read through in order to obtain a general impression, the wholeness of the text being more important than the details. The researchers looked for themes

Table 1
Interview guide.

1. Why did you start working with home births?
2. Can you describe how you work during a home birth?
3. How do you promote a normal birth at home?
4. What does working with home births give you as a midwife?
5. Are there any challenges with working as a home birth midwife? If so, can you describe some of them?