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Managing Risk or Facilitating Safety?

“In any intelligent fool can make things bigger, more complex, and more violent. It takes a touch of genius, and a lot of courage, to move in the opposite direction.”

—Albert Einstein

In 2012, conservationists, fishers, and community members united across Australia to protect marine life from the threat of super trawlers. This action led to banning the giant boats from our waters. Super trawlers, measuring up to 144 meters long, use nets up to 600 meters long and can catch up to 250 tons of fish a day. The problem with this method of fishing is it is indiscriminate and the “bypatch” (unintended capture of other marine life) includes endangered turtles, giant rays, and dolphins (Greenpeace, 2014). Those who manage super trawlers cannot of course see what is wrong with this approach because they efficiently process the largest catches of fish in the world. Tasmanian Tapp (2014) wrote a beautiful song to protest the introduction of super trawlers into Australian waters and asked poignantly, “How will we explain to them (future generations) the damage we have done?” (Tapp, 2014).

You may be wondering why I am writing about super trawlers in the International Journal of Childbirth (IJC). The questions I am asking in this editorial are, has modern maternity care morphed into a super trawler of risk, scooping up with its well-meaning “net” the bycatch (healthy, young, childbearing women). I will argue that our increasing focus on managing risk is not the same as facilitating safety, and it is time for a safety approach to replace the current risk management approach.

Modern maternity care is not immune to the risk-averse paradigm pervading the world. However, when we become risk-averse, we invite other risks that we are often blind to. This is described as “earnestly filtering the bath water whilst the baby is left to drown” (Ballat & Campling, 2011). The giant super trawlers of maternity care throw their ever-widening risk assessment, risk screening, and risk avoidance nets out, pulling more and more women into them along with the inevitable bycatch. When only 15% of low-risk primiparous women give birth without medical intervention in some of our models of care, then we have to admit we have a problem (Dahlen et al., 2012). We know this is less about women and more about our care; as in other models with a strong social focus, these same low-risk women have normal birth rates of more than 85%—the complete opposite (Birthplace in England Collaborative Group, 2011).

The risk management approach seeks to obviate measurable risk and ignores the impact of perceived risk and risk that is difficult to measure. Under this paradigm, psychological, social, cultural, and spiritual factors that may enhance safety, and are what make us human, are hard to quantify and so are ignored. It is hardly surprising then that ignoring these important aspects of safety is leading increasingly to traumatized women and dehumanized care, and this creates other risks (Jackson, Dahlen, & Schmied, 2012).

Under the risk management paradigm, if you can’t count it, then it appears not to count and every risk can be reduced or eliminated. In Australia, for example, a young aboriginal woman flown out of her remote community at 36 weeks of pregnancy to wait for birth in a big city boarding house away from family and friends, unable to birth “on country,” which she believes connects the spirit of the child to the land, may seem like a good way to manage the physical risk associated with remote birthing (physical). Is this approach, however, facilitating safety—emotional, spiritual, cultural (Dietsch et al., 2011), and are there better...
ways to approach the issue (Van Wagner, Osepchook, Harney, Crosbie, & Tulugak, 2012)? The risk management approach has redefined birth from being a social experience to a medical one that needs to be quantified and managed (Hacking, 1990). Deviations from normal are labeled outliers (e.g., women with longer labors), and normality is progressively redefined until complexity becomes the new normal.

Transferring women during planned homebirths has bought our institutions into sharp relief for me. Fox, Sheehan, and Homer (2014) publish a metasynthesis of the experience of homebirth transfer in this edition of IJC. Navigating locked doors, intercoms, birth rooms designed for surgery not birth; passing the beautifully framed hospital mission statements; espousing women-centered care and promises of respect, dignity, and evidence-based care, I am struck by how these contrast with the inevitable fight to get a mat and a beanbag so the woman does not have to be on the bed, the reaction to requests for delayed cord clamping, the struggle to scrounge up some form of acceptable sustenance from sparse hospital kitchens, and the battle to use the pristine clean bath for pain relief. I am struck by the fact that our institutions are geared toward managing risk and not about facilitating normality, and healthy women are the bycatch of this all-pervading risk approach.

Managing risk is not the same as facilitating safety, and it is time we woke up to this fact. If we banned the word risk and embraced the word safety, could we transform maternity care?

Odent (2014) describes the emergence of water immersion after the historic student revolt in France where an “audacious creativity” resulted, and the watchword was “it is forbidden to forbid.” He describes taking advantage of this “transient cultural folly to do what would have been impossible ten years before or ten years after,” introducing water to help replace drugs in labor (Odent, 2014). Perhaps it is time for a revolution in maternity care (a bloodless one I hope) that unites us to move the super trawlers of risk off our maternity service shores. We could all do with some audacious creativity in our large, highly streamlined, and over-regulated maternity care environments. Continuity of midwifery care is one very effective way to facilitate safety through relationship-based care (Sandall, Soltani, Gates, Shennan, & Devane, 2013) and could be argued to not only be audaciously creative but also vulnerable in our complex, procedural-driven organizations. If we unite, disparate as we may be, with a common aim to facilitate safety in maternity care, we may be able to stop the current bycatch resulting from the super trawlers of risk. If we focused on safety and not risk, on relationship-based care, not system-based care, we could make maternity care safer for everyone (women, health professionals, and organizations).

I want to end with Tapp’s (2014) words from his song about super trawlers and encourage the same passion and unity in our profession—“Hold on tight! Get ready to fight.”

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REFERENCES


A Situational Analysis of the Status of Midwifery in North Africa and the Middle East

Atf Ghérissi and Judith Marie Brown

Midwives from the Middle East and North African (MENA) region convened in Dubai, United Arab Emirates in 2012 to engage for the first time ever in a discussion concerning regional strategic interventions to strengthen midwifery and the work of midwives in the Arab countries. The workshop was an opportunity to establish a culture of positive and balanced collaboration and mutual understanding among midwives and between midwives and other maternity care professionals including nurses and obstetricians. Key challenges and opportunities in midwifery in the MENA region were identified. Participants agreed on strategic goals to strengthening midwifery education, regulation, and associations in the MENA region.

**KEYWORDS:** midwifery; MENA; education; regulation; association

### INTRODUCTION AND BACKGROUND

The State of the World’s Midwifery Report (United Nations Population Fund [UNFPA], 2011), the Millennium Development Goals (MDGs): 2012 Progress Chart (United Nations, 2012), and the Countdown to 2015 (World Health Organization [WHO], United Nations Children’s Fund, 2012) documents offer evidence of the international acknowledgment that progress toward achievement of MDG5 (improve maternal health) has been slow in most countries. Global action has been accelerated to improve reproductive health and to reduce both maternal and child mortality (MDG4). The “Global Strategy for Women’s and Children’s Health” (Partnership for Maternal, Newborn and Child Health, 2010) has underpinned these efforts in several countries in the Middle East and North African (MENA) region, such as notably Djibouti, Morocco, Somalia, Sudan, and Yemen. Many of the countries in the MENA region have included midwives among their health human resource personnel, but even where midwifery services exist, the midwives face many issues and challenges related to education, regulation, lack of distinct professional associations, leadership development, and support.

The 22 Arab states can be divided into three groups based on the percentage of deliveries attended by skilled health personnel and the maternal mortality ratio (Table 1). The first group, where both indicators are balanced, contains small, mostly rich Gulf countries as well as middle-income countries such as Lebanon. In the second group, maternal mortality is between 50 and 100 deaths for 10,000 live births when the percentage of assisted deliveries is at least at 80%, and this suggests geographic, social, cultural, and economic barriers, including the weak quality of maternal health services, as in Djibouti for example. The third group has countries where the percentage of births attended by skilled health personnel is at an average of 48% and the maternal mortality ratio range is more than 100 and reaches 1,000, as in Somalia. In addition to other factors, the situation in most countries in this group can be linked to the lack of availability, accessibility, and affordability of maternal services in remote and rural areas (Ghérissi, 2012; Ghérissi, Brown, & Eladawy, 2011).

Regardless of the indicators, midwives face similar challenges such as low status of women, gender issues, and workplace domination. In many of these countries, childbearing women and their midwives are currently experiencing unimaginable stress and hardships because of the turmoil and trauma of revolution and war.

The impetus for the conduct of a situational analysis of midwifery in the MENA region was the realization...
by the authors and others (midwives and donors) that the “collective force” of midwives and their respective and supportive delegations from Arab states could be unleashed to develop a sustainable and dynamic regional strategic plan for the strengthening of midwives and midwifery services. This article presents the process and outcome of that strategic planning meeting.

MATERIAL AND METHODS

The situation analysis was conducted as a qualitative assessment and not as a formal research project. Accordingly, although formal human subjects’ approval was not required, the assessment was nevertheless conducted, in accord with all principles of ethical conduct of research that respected total anonymity of respondents.

The specific objective of the analysis was to conduct a situational analysis on current midwifery education, regulation, and association service provision within countries in the MENA region. The delineation of regional strategic goals and interventions used a consensus model and evolved through a progressive process that involved participants in identifying and discussing current gaps and challenges according to their own respective experience, in agreeing to priority issues to be addressed and then, in translating them into strategic goals and interventions.

Sample

There were 39 delegates from the MENA midwifery region, representing 10 countries (Djibouti, Iraq, Morocco, Oman, Palestine, Qatar, Somaliland, Sudan, United Arab Emirates [UAE], and Yemen), who were gathered in Dubai for that purpose. Participants included midwife educators, midwife regulators, representatives of midwives and nursing associations, representatives of ministries of health, and supportive delegations from Arab states could be unleashed to develop a sustainable and dynamic regional strategic plan for the strengthening of midwives and midwifery services. This article presents the process and outcome of that strategic planning meeting.

**TABLE 1** Maternal Mortality Ratio and Deliveries Attended by Skilled Personnel in the Arab States

<table>
<thead>
<tr>
<th>COUNTRIES</th>
<th>DELIVERIES ATTENDED BY SKILLED HEALTH PERSONNEL</th>
<th>MATERNAL MORTALITY RATIO (DEATHS/100,000 LIVE BIRTHS)</th>
<th>NEONATAL MORTALITY RATE (PER 1,000 LIVE BIRTHS) 2008–2012</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Group of countries where the proportion of deliveries attended by skilled health personnel is high and the maternal mortality ratio is low</strong></td>
<td>Qatar 100%</td>
<td>7</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>United Arab Emirates 100%</td>
<td>12</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Kuwait 99%</td>
<td>14</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Bahrain 97%</td>
<td>20</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Saudi Arabia 100%</td>
<td>24</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Oman Sultanate 99%</td>
<td>32</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Lebanon 97%</td>
<td>25</td>
<td>5</td>
</tr>
<tr>
<td><strong>Group of countries where the proportion of deliveries by skilled personnel and the maternal mortality ratio are both high</strong></td>
<td>Tunisia 95%</td>
<td>56</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>Libya 100%</td>
<td>58</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>Jordan 99%</td>
<td>63</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>Iraq 80%</td>
<td>63</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td>Palestine —</td>
<td>64</td>
<td>13 (West Bank and Gaza)</td>
</tr>
<tr>
<td></td>
<td>Egypt 79%</td>
<td>66</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>Syria 96%</td>
<td>70</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>Algeria 95%</td>
<td>97</td>
<td>17</td>
</tr>
<tr>
<td><strong>Group of countries where the proportion of deliveries by skilled personnel is low and the maternal mortality ratio is high</strong></td>
<td>Morocco 74%</td>
<td>100</td>
<td>19</td>
</tr>
<tr>
<td></td>
<td>Yemen 36%</td>
<td>200</td>
<td>32</td>
</tr>
<tr>
<td></td>
<td>Djibouti 78%</td>
<td>200</td>
<td>33</td>
</tr>
<tr>
<td></td>
<td>Comoros 62%</td>
<td>400</td>
<td>32</td>
</tr>
<tr>
<td></td>
<td>Mauritania 57%</td>
<td>510</td>
<td>40</td>
</tr>
<tr>
<td></td>
<td>Sudan 23%</td>
<td>730</td>
<td>31</td>
</tr>
<tr>
<td></td>
<td>Somalia 9%</td>
<td>1,000</td>
<td>50</td>
</tr>
<tr>
<td><strong>MENA region</strong></td>
<td>95.9%</td>
<td>179</td>
<td>16.68</td>
</tr>
</tbody>
</table>

and student midwives. The International Confederation of Midwives (ICM) provided technical support, and the WHO participated through personal presence and financial support of 3 delegates.

Procedures

The workshop process consisted of plenary sessions as well as subregional common language working group sessions where participants introduced their respective situations, raised common issues and challenges, and identified ways to resolve them. Groups were asked to report on major strengths, challenges, and opportunities and to make key strategic suggestions for the way forward.

Data Analysis

The comments and suggestions have been treated using the directed content analysis approach (Hsieh & Shannon, 2005; Mayer & Deslauriers, 2000).

RESULTS

The findings of the situation analysis highlighted key characteristics of midwifery in the countries of the MENA region that illustrate not only the major strengths and challenges faced but also the awareness of existing opportunities that enable midwifery in the region to move forward.

Landscape of Midwifery in the MENA Region

It appears obvious that in the MENA region, the fundamental issue faced by midwives is their unclear identity buried among a multitude of cadres trained, employed, and empowered as midwives despite the lack of qualifications according to the “ICM International Definition of the Midwife” (ICM, 2011). Several categories of health workers are identified as midwives in the region, including registered midwives, enrolled midwives, community midwives, clinical officers, community health nurses, community health extension workers, and often, traditional birth attendants. This situation is worsened by donor demands for training programs for even more new cadres to provide midwifery services. In most of the countries, midwives do not have a formal specific job description. That makes their definition even weaker and does not allow a distinction between the roles of midwives and nurses.

The medical rather than a midwifery model of care, the doctors’ domination partly because of the emerging private sector, the medicalization of the profession, and the frustrated feeling of a subordinate relationship toward the doctor and/or the nurse are other challenges faced by the midwives in the region, who suffer from being led by other professions. The midwives are often perceived as serving in the role of obstetric assistant. As a consequence, midwives are characterized by a lack of self-confidence, a lack of autonomy, and low status.

Additional challenges to role progression include the absence of both career planning and promotional prospects and by poor conditions of service (salaries, educational benefits). The work of the midwife carries stigma in some countries. Midwives are often exposed to burnout through working in a precarious and at times unsafe working environment, where service quality is often poor, not based on evidence and compounded by the lack of support services such as a sound referral system.

In some countries, war and political unrest have led to the destruction of infrastructure and instability. Midwives are geographically isolated in several practice settings, given the size of the country.

There is often little community support for midwifery services, justified by dissatisfaction with the quality of midwifery services. All of this is demotivating and demoralizing and contributes highly to midwives’ migration mostly to accept positions with high salaries and privileges offered by some countries within and outside the region.

The global advocacy targeting the MDGs 4 and 5 created a global awareness of midwifery services followed by global mandates and advocacy on behalf of the profession. The ICM has gained recognition as a referent and credible international professional organization not only among midwives but also among other professional organizations such as International Federation of Gynecology and Obstetrics and donor agencies. The tools developed by ICM are considered a standardized framework for midwifery education such as the education, and regulation standards, the essential competencies, and the definition of the midwife regularly updated (ICM, 2011).

Such a historical global voice for world midwifery inspired midwives in the MENA region to become organized and work toward autonomy in practice. It was also perceived as an opportunity by midwives for more unity
Midwifery Education

Midwifery education in the region is challenged by lack of resources often because of the absence of a specific budget line. At the same time, education fees for midwifery students are very high in some countries (e.g., Palestine). For some countries, the education programs are donor-dependent and the donors themselves have tended in the past to sponsor “band-aid” solutions to problems such as starting new cadres without much reflection.

In the countries of the MENA region, as in many regions worldwide, midwifery education programs suffer from a lack of sufficient qualified and experienced teachers within the specialty of midwifery, from different standards of teaching, from lack of adequate training in clinical teaching, from poor preceptorship, and generally, from a lack of a clear and standard profile of midwifery teachers. Midwives and midwifery teachers have little opportunities to access education and training according to standards, or continuing assurance systems for quality of teaching. They have low salaries and work with inadequate training resources (human and material), poor administrative arrangements, and lack of flexibility in decision making. Moreover, there is a general need for education materials in the Arabic language.

In all countries, midwifery education programs are led by doctors or by nurses but rarely by midwives. The emergence of private midwifery schools and private medical practice, where the same doctors are very often leaders, managers, supervisors, teachers, and employers, contribute to strengthen medical domination and confuse and undermine midwifery education.

Those schools have courses that fall short of recognized standards, have been set up outside of public government systems and universities, and, in fact, are some owned and operated by medical doctors. Yemen and Tunisia are among the countries very concerned by this important issue.

Major strengths of midwifery education in many of the countries include the fact that most public education is free of cost and that countries have a common entry level, which is secondary education. In some countries, scholarships or incentives are provided to midwifery students (such as transportation fees and opportunities for learning experiences in countries located within the region). Preceptorship has been newly introduced in the learning approach in a few countries.

Incentives for teachers and graduates include the elective experiences in other countries. A few countries, such as the Oman Sultanate, have set very high qualifications for the teachers and have ensured a good supply of resource and simulation materials.

Midwifery Regulation

Participants had very little to say about midwifery regulation in the MENA region not least because of the absence of regulatory systems, of relicensing procedures, and of regulatory bodies or enforcement. In a few countries, when they do exist, they are fragmented and very weak.

This lack of understanding by governments and policy makers of the importance to public health and safety of a regulatory framework for midwifery is evidenced by the inconsistent commitment and support to midwifery regulation implementation within the region.

In the few countries in which some form of regulation has been reported, the body has various titles and may have responsibility for regulation of other cadres, although they may all be identified and assigned as midwives in the workplace. The international definition of the midwife, as developed by ICM, is acknowledged and followed in some countries, such as in Morocco, in Oman, in the UAE, and more recently, in Iraq.

Midwifery Associations

There are midwives associations, nurse-midwives associations, or even a midwifery committee in most of
the countries (Algeria, Djibouti, Iraq, Libya, Morocco, Oman, Palestine, Somaliland, Sudan, Tunisia, and UAE). All are legally recognized and all have a board, excluding Palestine. Most of them have developed a vision and a mission statement, except for Iraq and Palestine. Most are managed by employed staff and volunteers (Yemen, UAE, and Somaliland), others only by volunteers (Palestine, Djibouti). The associations are mainly financed by member fees (Yemen, Djibouti), by member fees and donors (Yemen, Somaliland), by member fees and fund raising (UAE), by donors (Sudan), or by a nongovernmental association (NGO; Palestine).

All of the associations depend in part on the work of volunteers and often work without sufficient material or financial resources to manage administration and secretarial demands. Membership fees from midwives are a constant challenge because of low salaries and economic conditions within countries.

Many associations report lack of cohesion amongst midwives, lack of advocacy and social marketing skills, and lack of confidence and autonomy, which block initiatives. Partnership relations are very limited, and the existing associations face difficulties in recruitment, in finding legal support, and sometimes in having too few midwives to form and maintain an association. All these difficulties threat the sustainability of those associations and weaken their visibility and credibility.

Good links with other professional organizations as well as a feeling of power have been reported by the associations represented in the workshop. The existing professional associations, the new achievements for some of them such as for Morocco and Iraq, and the network and support provided to midwives on the field in Gaza such as by the midwifery committee in Palestine offer the opportunity to form internal networks with other associations to expand and exchange programs.

DISCUSSION

The workshop provided a forum of exchange and discussion to develop regional strategic interventions to strengthen midwifery and the work of midwives in the Arab countries and to establish a culture of a positive and balanced collaboration and mutual understanding between the midwives themselves and between midwives and other maternity care professional including nurses and obstetricians.

The commitment to a midwifery reform in the region is strong because of current political will and because of the obvious and visible global support extended at country level from donor agencies such as UNFPA, WHO, and the Spanish Agency for International Development Cooperation described as partners at global, regional, and national levels.

At country level, there is a general willingness to invest in midwives, and in some countries, the government is beginning to recognize and support them within the system and the community. The engagement of the ministries of health is also a determinant of support to any midwifery education reform.

The adoption of ICM-linked competency-based curricula for midwifery education has provided a better understanding of the concept of competence. The integration of midwifery programs of study within degree-granting pathways, such as the licence-master-and doctorate level has been perceived in some countries as a reform that offers midwives the opportunity of academic advancement and career progression.

CONCLUSION

Based on the gaps highlighted and prioritized, workshop participants developed 14 regional strategic goals and 34 strategic interventions to enhance and upscale midwifery in the MENA region (Table 2). They also generated the Dubai declaration (ICM, 2012) using their collective voice to call on the governments, donors, and fellow midwives to commit to strengthening and scaling up of the midwifery profession in their respective countries.

Midwives from the MENA region demonstrated an awareness and determination to defend and place value on their image and status. If such determination can be recognized and supported by governments and within the health systems and communities where they work, there is every chance that midwives can and will realize their vision and mission. The existing national plans for maternal and newborn health services in most of the countries are opportunities for midwives to exploit.

The Dubai workshop was the beginning of a strong commitment by midwives and others for a better future for the profession, for the quality of midwifery services, for a better health system, and by extension, for a better woman’s health in the region.
TABLE 2  Midwifery Regional Strategic Goals

<table>
<thead>
<tr>
<th>REGIONAL STRATEGIC GOALS</th>
<th>STRATEGIES</th>
</tr>
</thead>
</table>
| **Midwifery Regulation** | • Develop the concept of supervision of midwifery practice through the government and MOH and midwifery and nursing council pathways.  
• Establish legislation/policy to monitor accountability, role and responsibility, midwives rules, and code of practice and ethics.  
• All midwives to maintain professional portfolio and demonstrate evidence of continuing professional development  
• Establish quality assurance mechanisms that are transparent and include risk management and reflective practice.  
• Scope of midwifery practice to be adapted from the ICM to ensure definition of the midwife defines the role and responsibility of the midwife |
| 1. To ensure countries of the MENA region have in place a statutory body for midwives to ensure safe midwifery practice | • Develop and get a midwifery act approved by parliament.  
• Advocate for independent and autonomous midwifery practice.  
• Strengthen and implement midwifery scope of practice and ethics code, licensing, and relicensing requirements and procedures. |
| 2. Well-established regulatory systems in countries | • Establish a special regional committee  
– to develop the deontological code for midwives  
– to review by stakeholders  
– for distribution  
– for monitoring and evaluation |
| 3. Set/stand a midwives code of ethics for MENA region | • Establish and strengthen midwifery professional associations to meet application requirements.  
• Undertake fundraising for the association.  
• Lobby for membership of the association amongst midwives.  
• Availing human and financial resources for midwifery association  
• Use technical assistance from the ICM headquarters.  
• Identify potential MENA region leaders.  
• Develop regional leadership programs.  
• Develop regional partnership initiatives.  
• Encourage those in charge of midwifery education programmes to include professional and management skills development.  
• Organize a MENA forum to focus on midwifery leadership and management. |
| 4. Accelerate the reviewed regulatory status of midwives—Morocco. | • Undertake assessment of country needs.  
• Comparison of needs with existing cadres  
• Prioritization of needs and cadres  
• Gradual elimination of redundant cadres and focus on strengthening of skill and competencies of the priority cadres |
| **Midwifery Professional Associations** | • Establish committee for accreditation system from representatives from higher education, MOH, and midwifery association with support from the ICM.  
• Advocacy for midwifery profession in the community  
• Develop an approved curriculum based on international standards.  
• Establish standards for accreditation.  
• Train committee members in accreditation system.  
• Enhance the number of midwifery teachers.  
• Homogenize the instruction of teachers. |
| 1. Establishment of independent midwifery associations within MENA countries based on ICM definition of the midwife | • Establish and strengthen midwifery professional associations to meet application requirements.  
• Undertake fundraising for the association.  
• Lobby for membership of the association amongst midwives.  
• Availing human and financial resources for midwifery association  
• Use technical assistance from the ICM headquarters.  
• Identify potential MENA region leaders.  
• Develop regional leadership programs.  
• Develop regional partnership initiatives.  
• Encourage those in charge of midwifery education programmes to include professional and management skills development.  
• Organize a MENA forum to focus on midwifery leadership and management. |
| 2. Deploy resources from UNFPA and WHO. | • Establish committee for accreditation system from representatives from higher education, MOH, and midwifery association with support from the ICM.  
• Advocacy for midwifery profession in the community  
• Develop an approved curriculum based on international standards.  
• Establish standards for accreditation.  
• Train committee members in accreditation system.  
• Enhance the number of midwifery teachers.  
• Homogenize the instruction of teachers. |
| 3. Register country associations with the ICM. | • Establish and strengthen midwifery professional associations to meet application requirements.  
• Undertake fundraising for the association.  
• Lobby for membership of the association amongst midwives.  
• Availing human and financial resources for midwifery association  
• Use technical assistance from the ICM headquarters.  
• Identify potential MENA region leaders.  
• Develop regional leadership programs.  
• Develop regional partnership initiatives.  
• Encourage those in charge of midwifery education programmes to include professional and management skills development.  
• Organize a MENA forum to focus on midwifery leadership and management. |
| 4. Develop midwifery leaders to ensure midwives are the lead professionals influencing positive outcomes for women and their families. | • Establish and strengthen midwifery professional associations to meet application requirements.  
• Undertake fundraising for the association.  
• Lobby for membership of the association amongst midwives.  
• Availing human and financial resources for midwifery association  
• Use technical assistance from the ICM headquarters.  
• Identify potential MENA region leaders.  
• Develop regional leadership programs.  
• Develop regional partnership initiatives.  
• Encourage those in charge of midwifery education programmes to include professional and management skills development.  
• Organize a MENA forum to focus on midwifery leadership and management. |
| **Midwifery Education** | • Establish committee for accreditation system from representatives from higher education, MOH, and midwifery association with support from the ICM.  
• Advocacy for midwifery profession in the community  
• Develop an approved curriculum based on international standards.  
• Establish standards for accreditation.  
• Train committee members in accreditation system.  
• Enhance the number of midwifery teachers.  
• Homogenize the instruction of teachers. |
| 1. Rationalize midwifery education. | • Establish committee for accreditation system from representatives from higher education, MOH, and midwifery association with support from the ICM.  
• Advocacy for midwifery profession in the community  
• Develop an approved curriculum based on international standards.  
• Establish standards for accreditation.  
• Train committee members in accreditation system.  
• Enhance the number of midwifery teachers.  
• Homogenize the instruction of teachers. |
| 2. Enhance midwifery education and practice by developing an accreditation system for education. | • Establish committee for accreditation system from representatives from higher education, MOH, and midwifery association with support from the ICM.  
• Advocacy for midwifery profession in the community  
• Develop an approved curriculum based on international standards.  
• Establish standards for accreditation.  
• Train committee members in accreditation system.  
• Enhance the number of midwifery teachers.  
• Homogenize the instruction of teachers. |
| 3. Prepare and improve midwifery faculties based on the ICM standards and according to country needs. | • Establish committee for accreditation system from representatives from higher education, MOH, and midwifery association with support from the ICM.  
• Advocacy for midwifery profession in the community  
• Develop an approved curriculum based on international standards.  
• Establish standards for accreditation.  
• Train committee members in accreditation system.  
• Enhance the number of midwifery teachers.  
• Homogenize the instruction of teachers. |
**Table 2: Midwifery Regional Strategic Goals (cont.)**

<table>
<thead>
<tr>
<th>REGIONAL STRATEGIC GOALS</th>
<th>STRATEGIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Midwifery Education</td>
<td></td>
</tr>
<tr>
<td>4. Attract more students to midwifery education so as to retain midwives in the profession.</td>
<td>• Coach young midwives affected to the rural areas.</td>
</tr>
<tr>
<td>5. Establish a bridging program to unify the midwifery profile and achieve a better quality of care.</td>
<td>• Establish and develop a bridging programme.</td>
</tr>
<tr>
<td>6. Establish a functional regional resource center for midwives.</td>
<td>• Undertake coordination between the policy and decision makers to develop and implement the programme.</td>
</tr>
<tr>
<td></td>
<td>• Undertake human resources planning for gradual transition.</td>
</tr>
<tr>
<td></td>
<td>• Use the center for regional training, e-library, workshop and conferences, skills building, and improvement of networking and strengthening of partnerships through periodic conferences.</td>
</tr>
</tbody>
</table>

Note. MENA = Middle East and North Africa; MOH = ministry of health; ICM = International Confederation of Midwives; UNFPA = United Nations Population Fund; WHO = World Health Organization.

**References**


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Safe Arrivals: Responding to the Local Context in a Training Program for Birth Attendants in Cambodia

Lois V. McKellar and Kevin Taylor

The World Health Organization (WHO) recommends that every woman should have a skilled birth attendant (SBA) attend her birth; however, until this ideal is met, traditional birth attendants (TBA) continue to provide care to women, particularly in rural areas of countries such as Cambodia. The lack of congruence between an ideal and reality has caused difficulty for policy makers and governments. In 2007, The 2h Project, an Australian-based, nongovernment organization in partnership with a local Cambodian organization, “Smile of World,” commenced the “Safe Arrivals” project, providing annual training for SBAs and TBAs in the rural provinces of Cambodia. Following implementation of this project, feedback was collected through a questionnaire undertaken by interviews with participants. This was part of a quality assurance process to further develop training in line with WHO recommendations and to consider the cultural context and respond to local knowledge. Over a 2-year period, 240 birth attendants were interviewed regarding their role and practice. Specifically, through the responses to the questionnaires, several cultural practices were identified that have informed training focus and resource development. More broadly, it was evident that TBAs remain a valuable resource for women, acknowledging their social and cultural role in childbirth.

KEYWORDS: midwifery; health promotion; maternal health; Millennium Development Goals

INTRODUCTION

Each year across the world, more than 536,000 women die because of complications developed during pregnancy and childbirth, and 10 million more suffer debilitating illnesses and lifelong disabilities. Pregnancy and childbirth are the leading cause of death and disability for women in developing countries (Kurjak & Bekavac, 2001; United Nations [UN], 2008). Despite substantial commitment by world leaders, there has been minimal progress in reducing maternal and infant mortality. The UN (2008) Millennium Development Goal (MDG) 5 that aims to reduce maternal mortality by 75% and to achieve universal access to reproductive health services by 2015 has made the least progress of all MDGs. At the global level, maternal mortality decreased by 1% per year between 1990 and 2005—far less than the 5.5% annual improvement needed to reach the target (United Nations, 2008, p. 25). At this rate, MDG 5 will not be met in Asia until 2076 and years later in Africa (Ugal, 2010, p. 4).

In Cambodia, the maternal mortality ratio (MMR) is officially 540 for every 100,000 live births (World Health Organization [WHO], United Nations Children’s Fund, 2010). The unofficial MMR is around 700 per 100,000. This means that a pregnant woman in Cambodia has 83 more times the chance of dying than a pregnant woman in Australia. The “official” maternal death rate accounts for 18% of all deaths of Cambodian women aged 15–49 years; the reality would be much higher (WHO, United Nations Children’s Fund, 2010). In rural and remote Cambodia, where 85% of the
population live, only 28% of women have a skilled birth attendant (SBA) present during delivery (Yanagisawa, Oum, & Wakai, 2005). For most laboring women, the most common birth assistant is a traditional birth attendant (TBA). WHO provides a definition of the TBA as “a person who assists the mother during childbirth and who initially acquired her skills by delivering babies herself or through apprenticeship to other TBAs” (WHO, 1992). TBAs comprise a large proportion of accoucheurs throughout the world (Kruske & Barclay, 2004). Certainly, in Cambodia, following the civil uprising and subsequent devastation, TBAs have been the predominant maternity care provider for most women, with most of these women learning their trade from other TBAs or by trial and error.

During the 1970s and 1980s, providing training to TBAs was adapted as a strategy to reduce maternal and neonatal mortality. Many countries engaged in training programs with a focus on providing antenatal care and managing intrapartum and postpartum emergencies. Notably, many programs were implemented based on a strong Western medical ideology (Kruske & Barclay, 2004). During the 1990s, it became evident that maternal mortality worldwide was not decreasing, and in 1996, the WHO changed the focus from the need to provide women with a trained attendant to a skilled attendant. Most recently, according to the State of the World’s Midwifery Report (United Nations Population Fund, 2011), there has been a call for a focus on global efforts to ensure all women have access to a qualified midwife. However, until this ideal is met, TBAs continue to provide care to women, particularly in rural and remote areas of countries such as Cambodia. In a Cochrane review commentary regarding TBA training, MacArthur (2009) states

>> Although a skilled birth attendant for all women is obviously the ideal, in many developing countries, even if such workers were acceptable, there is insufficient availability and the poor rural areas do not offer attractive employment options. It may therefore be years before this is a feasible option.

It has been suggested that the apparent lack of success in training TBAs may be caused by the use of maternal mortality (MM) as one of the key determinants of success. Measuring MM is fraught with difficulty in many developing countries because of underreporting or the inability to use reliable tools to collect data. Furthermore, it has been recognized that many training programs have been based on a biomedical model, which is not responsive to cultural worldview or local context (Kruske & Barclay, 2004). In a review of the effect of shifting policies on TBA training, Kruske and Barclay (2004, p. 309) acknowledged that “rarely was local knowledge incorporated into education curricula” and that consultation with the training participants was limited. This article describes the findings of a questionnaire that sought to consider the cultural context and incorporate local knowledge into the development of training for birth attendants in Cambodia. The questionnaire was implemented through an Australian-based nongovernment organization (NGO), The 2h Project, working in partnership with the Cambodian government, Ministry of Health, and provincial health services to provide training through the Safe Arrivals program to both traditional and skilled birth attendants in rural provinces throughout Cambodia.

**PROGRAM**

The Safe Arrivals training program provides 3-day intensive residential workshops for TBAs and SBAs. A voluntary team of six to eight Australian midwives, including academic staff from tertiary institutions, provides interactive teaching sessions and practical demonstrations through a team of official Cambodian interpreters. The program covers a range of basic skills and evidence-based practices across topics such as contraception, sexually transmitted infections, nutrition, infection control, breastfeeding, immunization, as well as care during pregnancy and childbirth. In consultation with the Ministry of Health, all TBAs and SBAs in the province where workshops are conducted are required to attend, and in return, transportation, accommodation, meals, and wages are provided by The 2h Project.

To provide an understanding of the local context and embed a quality assurance process to inform further development of the program, a questionnaire was designed to gather information and describe the current practice of the birth attendants participating in this program. Both the Safe Arrivals training program and a proposal for the questionnaire were submitted to the Cambodian Ministry of Health. A memorandum of understanding (MOU) was provided for the training to be conducted in a specified number of provinces, and approval was given for the questionnaire to be undertaken concurrently. Working as “outsiders” in developing countries can be fraught with numerous challenges,
How much training have you had?
Why did you become a birth attendant?
Do you visit the mother before she has a baby? If yes, how many times?
Have you heard of mothers getting sick after the birth of their baby?
What would you do if they got sick?
Have you heard of mothers dying from this sickness?
Have you heard of babies getting sick in the first few weeks after being born?
What would you do to help these babies?
Have you heard of babies dying from this sickness?
What traditions/customs do mothers follow before and after the baby is born?

FIGURE 1 Example of questions used in the interview.

particularly when trying to follow strict ethical guidelines and processes. At the time of this project, only a small number of NGOs were being given approval to deliver birth attendant training, and being granted an MOU was seen as highly commended and was respectfully accepted.

Over a period of 2 years, 240 out of a possible 897 Cambodian birth attendants participating in the Safe Arrivals training program completed the questionnaire while attending the workshop. Because of a lack of written literacy, the questionnaire was conducted through face-to-face interviews. Attendants at the training were invited by the interpreters to participate in the interview. Women were provided verbal information about the questionnaire, and verbal consent was obtained; however, all data collected were documented anonymously. The questionnaire was purposely designed to provide birth attendants with an opportunity to describe their experiences. The questionnaire collected demographic and descriptive data through a range of closed- and open-ended questions. Examples of the questions are included in Figure 1. The questionnaire was initially developed in English and subsequently translated to Khmer to ensure that the questions would be appropriately understood by the Cambodian women. The interview was conducted by the midwives providing the training when they were not engaged in teaching. An interpreter was used to facilitate the interview between the midwife and the birth attendant and was provided a copy of the written questionnaire in both English and Khmer. Responses from the women to the questions were provided through the interpreter and documented in English by the midwife at the time of the interview. Interviews were not recorded because this may have been inhibited honest conversations. At times throughout the interview, the birth attendants were reluctant to answer some questions, and the interpreters explained that this was because of a fear of being held responsible. The birth attendants came from across four different provinces, Kampong Speu, Ta Keo, Pursat, and Prey Veng. Table 1 provides demographic data to describe each province.

<table>
<thead>
<tr>
<th>PROVINCE</th>
<th>KAMPONG SPEU</th>
<th>PREY VENG</th>
<th>TA KEO</th>
<th>PURSAT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total population</td>
<td>574,597</td>
<td>978,659</td>
<td>811,732</td>
<td>355,592</td>
</tr>
<tr>
<td>No. of health centers</td>
<td>50</td>
<td>90</td>
<td>70</td>
<td>30</td>
</tr>
<tr>
<td>No. of midwives</td>
<td>2–4</td>
<td>2–4</td>
<td>2–4</td>
<td>2–4</td>
</tr>
<tr>
<td>No. of TBAs</td>
<td>90%</td>
<td>90%</td>
<td>90%</td>
<td>90%</td>
</tr>
<tr>
<td>Maternal deaths per year</td>
<td>17–20</td>
<td>17–20</td>
<td>12–15</td>
<td>14–18</td>
</tr>
<tr>
<td>Targeted districts</td>
<td>Chbar Mon, Samrong Tong, Phnom Sruoch, Oudong</td>
<td>Kam Chay Mear, Prey Veng, Masang</td>
<td>Don Keo, Bati, Prey Kabass</td>
<td>Sampov Meas, Ba Kan, Kra Kor, Kan Dieng, Phnom Kra Vanh, Veal Veang</td>
</tr>
<tr>
<td>Total trainees</td>
<td>193</td>
<td>204</td>
<td>250</td>
<td>250</td>
</tr>
</tbody>
</table>

Note. TBAs = traditional birth attendants.
Data from the questionnaires were collated. Demographic data, and data regarding work practices of the TBA, such as number of antenatal visits conducted, were analyzed as simple statistics. Qualitative data from the interviews were analyzed for commonly occurring ideas and issues that appeared to be of particular significance. The purpose of this analysis was to inform the further development of the Safe Arrivals training program by providing insight into the experiences of the participating birth attendants.

**FINDINGS**

Out of the 240 birth attendants, 82 (34%) considered themselves SBAs, whereas 156 (65%) identified themselves as TBAs, and 2 (1%) women did not classify themselves. The age of the birth attendants varied, with the TBA being older on average than the SBA. The average age range for the SBA was between 35 and 54 years; the average age range for the TBA was between 45 and 64 years (Table 2). Regarding training, 40 (49%) SBAs had 12 months training, whereas 23 (28%) had less than 12 months; for TBAs, 94 (60%) TBAs had 3 days training or less, and half of these had no training (Table 2). Interestingly, 67 (43%) TBAs had practiced for greater than 30 years with only 7 (11%) having practiced for 9 years or less. This contrasted with 40 (49%) SBAs having practiced for less than 20 years (Table 2). This is consistent with the WHO change of emphasis during the 1990s to provide SBAs for women during birth.

Birth attendants were asked about the provision of antenatal care. There were 78 (95%) SBAs and 124 (80%) TBAs who visited the mothers during the ante-

<table>
<thead>
<tr>
<th>AGE RANGE IN YEARS</th>
<th>SBA</th>
<th>TBA</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;25 years</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>25–34 years</td>
<td>7</td>
<td>3</td>
</tr>
<tr>
<td>35–44 years</td>
<td>30</td>
<td>10</td>
</tr>
<tr>
<td>45–54 years</td>
<td>29</td>
<td>59</td>
</tr>
<tr>
<td>55–64 years</td>
<td>8</td>
<td>51</td>
</tr>
<tr>
<td>&gt;65 years</td>
<td>2</td>
<td>33</td>
</tr>
<tr>
<td>N/A</td>
<td>2</td>
<td>0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>LENGTH OF TRAINING</th>
<th>SBA</th>
<th>TBA</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>0</td>
<td>33</td>
</tr>
<tr>
<td>1–3 days</td>
<td>9</td>
<td>61</td>
</tr>
<tr>
<td>&lt;3 months</td>
<td>3</td>
<td>27</td>
</tr>
<tr>
<td>3–6 months</td>
<td>11</td>
<td>6</td>
</tr>
<tr>
<td>12 months</td>
<td>40</td>
<td>10</td>
</tr>
<tr>
<td>18 months</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>24 months</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>&gt;24 months</td>
<td>12</td>
<td>2</td>
</tr>
<tr>
<td>N/A</td>
<td>2</td>
<td>15</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>LENGTH OF PRACTICE</th>
<th>SBA</th>
<th>TBA</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;5 years</td>
<td>7</td>
<td>6</td>
</tr>
<tr>
<td>5–9 years</td>
<td>3</td>
<td>5</td>
</tr>
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<td>10–14 years</td>
<td>13</td>
<td>13</td>
</tr>
<tr>
<td>15–19 years</td>
<td>17</td>
<td>9</td>
</tr>
<tr>
<td>20–24 years</td>
<td>11</td>
<td>19</td>
</tr>
<tr>
<td>25–29 years</td>
<td>10</td>
<td>29</td>
</tr>
<tr>
<td>&gt;30 years</td>
<td>5</td>
<td>67</td>
</tr>
<tr>
<td>N/A</td>
<td>16</td>
<td>8</td>
</tr>
</tbody>
</table>

*Note: SBA = skilled birth attendant; TBA = traditional birth attendant.*
natai period. There were 61 (74%) SBAs who visited the women at least three times, with 27 (33%) visiting the women more than five times. There were 78 (50%) TBAs who visited the women at least three times, with only 16 (10%) visiting more than this during the antenatal period. They were asked to describe what they did during the visits. Predominantly, the TBA would feel the mother’s abdomen to determine the position of the baby and in particular, the baby’s head. They would also check that the baby was moving. Some of the TBAs indicated that they gave the women advice. The SBA also checked the women’s abdomen identifying that they would check the fundal height and position. They would also listen to the fetal heart rate and take a blood pressure reading.

During the interview, the midwife tried to gain an understanding regarding the type of problems that the birth attendants might encounter and how they had managed these. Initially, this question was met with a guarded response, and there was limited information provided. It was suggested by the interpreter that the birth attendants were reluctant to discuss problems or poor outcomes because they were fearful they would be held responsible. The question was reworded to ask if they had heard of any problems other birth attendants faced during pregnancy, birth, and following birth and what was done to manage these problems. The most common problems identified by both SBAs and TBAs were bleeding, high blood pressure, swelling and seizures, headaches, fever, long labor with obstruction, and retained placenta. Regarding the baby, the birth attendants described stillbirth or babies born unconscious because of long labors, babies born blue, breathing difficulties, weakness, fever, cough, yellow babies, and seizures.

Birth attendants were asked to describe how they managed these problems, and many responded with similar answers. TBAs stated that they would refer the women to the clinic or hospital, but this was usually done after the women had been in labor for several hours. Referral was not routinely used as an option during pregnancy or early in labor. The time to get to a clinic if referred ranged from 15 min to more than 8 hr, but most commonly, clinics or hospitals would be 2–3 hr away. This time was calculated based on using the most available form of transport, which is the “moto”—a carriage pulled by a motor cycle. Both TBAs and SBAs would use traditional practices, most commonly the use of a firestone (warmed rock) on the belly after birth to “stop the bleeding,” as well as ice to the head for fever or the administration of “bark” medicine. Sometimes, birth attendants would recommend rice wine “until the pain stopped.” They would also manually remove the placenta if it was retained. The SBAs used oxytocin, referred to as “oxy,” if the mother began to bleed. They were also keen to give paracetamol to the mother and/or baby if they were unwell.

The question was also asked if they had heard of mothers who had died during or after childbirth, although this question was not answered by 51 (33%) TBAs, 57 (54%) of those who responded stated they had heard of mothers dying. Although 62 (75%) SBAs provided an answer to this question, 26 (42%) of these stated they had heard of women’s death during or after childbirth. A similar question was asked regarding whether birth attendants had heard of babies dying during or after childbirth, and a similar response rate was gained, with 60 (57%) TBAs who responded stating that they had heard of babies dying, whereas 28 (47%) SBAs knew of babies’ deaths during or after birth.

The questionnaire tried to gain an understanding of common practices during labor. Care provided was usually supportive and caring. Most significantly, two practices were identified that were concerning. Birth attendants were asked if they assisted with delivering the placenta and how they did this. There were 149 (96%) of the TBAs who assisted with the delivery of the placenta, and most commonly, this was by actively massaging or rubbing the abdomen. There were 76 (93%) SBAs who also assisted delivering the placenta in the same manner but used controlled cord traction as well. They would only use a form of oxytocin if there was bleeding, but this was not used routinely. In addition, although the mothers were able to walk around during labor, birth attendants were reluctant to allow women to birth in any other position than lying down on their back. Many of the birth attendants described the position of the women during birth similarly to this response from a TBA, “[they] walk around with little pain, and with big pain they lie down, put knees up, and don’t move.” A few SBAs stated they would get the mothers to sit up, and very few acknowledged they would encourage women to squat for birth.

Birth attendants were asked about specific rituals that they employed through the care they provided; Table 3 provides a summary of these. Although many of these simply reflected cultural and religious traditions, there were some that could be potentially harmful such as minimizing food during pregnancy to reduce difficulty at birth, as well as the rice wine, which has high alcohol content and the unknown constituents of the Khmer tree bark medicine.
The questionnaire also sought to understand some of the psychosocial aspect of being a birth attendant in Cambodia with several questions seeking to understand what they thought made a "good" attendant at birth and why they became birth attendants (Table 4). Various responses were given to these questions with both SBAs and TBAs acknowledging that being caring and taking care of the mother and baby was their primary role. SBAs also made comments showing an awareness of the need for knowledge and training to be able to do this well.

There were some insightful comments gained regarding questioning the birth attendants about why they took on this role, and in many cases, this led to sometimes lengthy narratives. Commonly for the TBAs, there was a sense of expectation that they would take on this role. This may have been because their mother or grandmother was or because they were asked to assist at a birth: "My grandmother was and I followed. My neighbor asked me to help deliver the baby."

In many cases, they began their journey as a birth attendant because they were appointed by Khmer Rouge officials following the genocide in Cambodia in the 1970s. The TBAs stated that they were ordered to take on this role, some threatened with their life, and that they were often as young as 14–15 years of age, having no previous experience. "If I didn't become a midwife, I would die."

Some also identified that there "were not enough in their village," and another example was that a "fire had destroyed their hospital, so she just helped," or they were appointed by a commune leader: "No midwife in the commune—helped with births and now a birth attendant."

Some simply just wanted to become one; they "wanted to care for women and help their country," and they "wanted to save lives."

Most commonly for SBAs, there was a degree of choice evident in their decision to become a birth attendant: "I wanted to become one" and "it was my ambition." What was evident, however, was that for both, there was an evident concern and commitment to the women of their country and that despite the high rate of sickness and death they witnessed, they continued in their role.

**DISCUSSION**

The responses to this questionnaire have directly informed the Safe Arrivals training with further
development of training resources that consider the local context and a more diligent cultural preparation of midwives who implement the program. This supports the notion that it is important to consider the local cultural context in development of training needs and is appropriate to tailor the resources to address these needs and specific practices (Kruske & Barclay, 2004). Several examples are evident; firstly, gaining an understanding around the way in which birth attendants manage third stage directed our teaching to focus on appropriate practice when conducting physiological (expectant) third stage. Although there is still debate in practice regarding active versus physiological management of third stage where oxytocics are readily available, there are clear guidelines in managing the delivery of the placenta when active management cannot be implemented (Stables & Rankin, 2010). For example, a hands-off approach is advocated when no oxytocics drug is administered. Rubbing and handling of the uterus during third stage may contribute to hemorrhage or increase the retention of the placenta (Sinclair, 2004; Stables & Rankin, 2010; Thorpe & Anderson, 2010). Notably, hemorrhage and retained placenta were identified as problems birth attendants face during birth. The Safe Arrivals program is now more explicit and detailed in the teaching provided to the attendants about both active and physiological management of third stage.

Secondly, identifying that Cambodian women are encouraged by birth attendants to lie flat on their back for birth was significant. The training has purposefully incorporated resources, which explain the implications these might have on birth outcomes. Specifically, birth attendants are shown different birthing positions and how this may assist with birth. It is interesting to note that this practice is a difficult concept for the birth attendants to embrace and is not necessarily understood or supported by government health officials who suggest that maybe Cambodian women do not want to do this. Nevertheless, providing the birth attendants with evidence-based practice that can be implemented simply may influence the outcome of some births. In addition, resources focusing on nutrition have been adapted, incorporating teaching around safe foods, alcohol consumption, and healthy eating using local food sources. Also, the final day of the workshop now has time dedicated for the participants to work in groups and respond to scenarios, which provides an opportunity for the women to incorporate the knowledge they have gained. This enables the training midwives to reinforce several of the practices highlighted.

The findings also highlighted the difficulty for women to access emergency care when it is needed, and a substantial focus on early referral has been incorporated into the training program. The training specifically teaches birth attendants to encourage their women to attend their antenatal appointments at a local health clinic. Officially, the Cambodian Department of Health recommends that pregnant women attend at least four visits with an SBA or midwife during their pregnancy. Although this is encouraged, the training also focuses on providing TBAs with skills to identify possible complications during pregnancy and early labor and explicitly teaches about the importance of early referral to the local health clinic. TBAs are taught to organize an emergency transport plan within the local village to assist the woman to receive skilled and appropriate care. This specific component of the training has been further evaluated to ascertain if an increase in referral and attendance at health clinics has occurred in the provinces in which this redeveloped training has been implemented. The results of this evaluation are yet to be published.

Finally, the findings indicated that 80% of TBAs visit the women in their care during the antenatal period and as such, represent a means of access to women birthing in the rural and remote areas of Cambodia. Nevertheless, during 2010, the Cambodian government actively discouraged women from using TBAs for any of their care during pregnancy and birth. Anecdotally, it has been claimed by several provincial health officials that there was an increase in maternal and child deaths and that these were now occurring at health centers or outside health centers that were closed (personal communications). It was also noted that TBAs were reluctant to discuss poor outcomes unless they could distant themselves from being held responsible. This is certainly not only because of the political history and associated genocide many of these women lived through but also in response to recent attempts to outlaw TBAs as a means to manage the high mortality rates. Despite this, it must be considered, that while there are insufficient numbers, and a lack of accessibility, for all women to be attended by a midwife or SBA, it is important that TBAs are recognized as a valuable resource for women, acknowledging their social and cultural role in childbirth (de Bernis, Sherratt, Abou-Zhar, & Lerberghe, 2003; Dietsch & Mulimbalimba-Masururu, 2011).
CONCLUSION

As outlined in this article, the responses to the questionnaire provided a means to focus and improve the training provided by this NGO for birth attendants in Cambodia. A commitment by the NGO and Cambodian government to incorporate local understanding and evidence-based practice ensures ongoing quality improvements regarding training programs. The findings also identified that TBAs continue to provide care and support to women during the childbirth continuum. Acknowledging that TBAs are a vital link in providing access to women particularly in the remote provinces of Cambodia may be of significance in future projects. A specific focus on facilitating a partnership between midwives, SBAs, and TBAs to increase referral and access to care in early pregnancy might be a possible strategy. This is in line with the WHO report (2005, p. 25) that proposed that “where TBAs are well-integrated into the community and are well respected, efforts can be made to redefine their role to become support workers or health promoters.” Such an approach would use the accessibility of TBAs and provide a vital link in facilitating skilled care for every woman. It is also recommended that there is a need to provide ongoing professional development through evidence-based trainings to SBAs.

LIMITATIONS

This article reports the responses to a questionnaire developed primarily as a tool to facilitate ongoing quality rather than a research tool; nevertheless, the findings from the questionnaire provide valuable insight regarding the experiences of Cambodian women and TBAs and may provide an important foundation for future research.

REFERENCES


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Immigrant New Mothers in Finnish Maternity Care: An Ethnographic Study of Caring

Anita Wikberg, Katie Eriksson, and Terese Bondas

PURPOSE: To illuminate experiences and perceptions of caring in the maternity care culture of immigrant new mothers in Finland.

DESIGN: This is a descriptive interpretive ethnography.

PARTICIPANTS AND SETTING: Seventeen new mothers from different cultures on a maternity ward in a medium-sized hospital in Finland.

METHODS: Focused ethnographic analysis and interpretation of interviews, observations, and field notes were used.

FINDINGS: Caring was part of the positive experience of childbearing and beneficial for the health and well-being of the immigrant new mothers. Negative experiences of health care impaired their well-being. The resources of Finnish maternity care and cultural knowledge of the nurses facilitated the caring. The policy and attitude of Finnish society encouraged childbearing. The immigration regulations affected support during childbearing negatively and tended to caused loneliness. The Finnish maternity care was not fully adapted to the mothers’ wishes to understand the organization of Finnish maternity care, to communicate, to breastfeed, and to have family-centered care, a flexible length of stay in the hospital, and extended support after childbirth.

CONCLUSION: Caring improves the childbearing experience and the well-being and health of new immigrant mothers; therefore, caring needs to be emphasized in maternity care, health care administration, and nursing education.

KEYWORDS: intercultural caring; health; suffering; maternity; immigrant women; Finland

INTRODUCTION

In an increasingly multicultural world, more women from different cultures are entering maternity care. In this study, the perspective of immigrant women who come from different cultures, and give birth in a new culture, are studied. Caring has been described as the core of nursing (Eriksson, 2002; Leininger, 2006). These internationally known theorists describe caring as encompassing love, hope, listening, understanding, respect, presence, and comfort, among others. The presence of caring has been described as promoting health and well-being (Eriksson, 2002; Leininger, 2006). In nursing care for people of other cultures, the absence of caring or noncaring has been described as hurt dignity (Heikkilä & Ekman, 2000), insensitivity and prejudice (Davies & Bath, 2001), and racism and discrimination (Browne & Fiske, 2001; Johnstone & Kanitsaki, 2009; Tebid, Du Plessis, Beukes, van Niekerk, & Jooste, 2011). Noncaring leads to the avoidance of health care services and disrupted nursing care relationships, which indirectly can cause higher morbidity and mortality (Berggren, Bergström, & Edberg, 2006).
In Finland, young immigrant women between 15 and 29 years of age are the only immigrant group using more health care because of pregnancy and birth than the Finnish majority (Gissler, Malin, & Matveinen, 2006). However, perinatal mortality is considerably higher among babies born to mothers from Africa, including Somalia (Malin & Gissler, 2009). Similar findings are found in Sweden (Essén et al., 2000; Robertson, 2003) and Norway (Vangen, Stoltenberg, & Stray-Pedersen, 1999), showing that immigrant mothers receive suboptimal care and have more health problems compared to the majority population. According to O’Mahony and Donnelly (2010), immigrant mothers have a higher risk of postpartum depression. However, if following cultural traditions, for example, “doing the month,” the risk is lower. It has been suggested that European midwives and obstetricians should pay attention to the challenges of cultural, as well as medical, competence when caring for immigrant women (Elebro, Rööst, Moussa, Johnsdotter, & Essén, 2007).

Brämberg and Nyström (2010) claim that the whole life history of immigrants affects their situation, which influences their activity and participation in health care situations. They suggest that it would be essential to consider the life situation of immigrants instead of just their cultural background. Lack of knowledge and information about expectations during the childbearing of women with different cultural backgrounds might lead to the insensitive and ineffective cultural care of these women (Brathwaite & Williams, 2004).

Maternity care and the experiences of mothers in different cultures have been studied extensively. Lamp (1998) studied the meanings of generic and professional culture care and practices in Finnish childbirth, whereas Bondas (2000) studied the experience of Finnish women being pregnant and giving birth. The meaning of childbirth to Finnish women was studied by Callister, Vehviläinen-Julkunen, and Lauri (2001). Few qualitative studies on immigrant mothers’ experiences of caring in Finnish maternity care culture were found (cf. Adjekughele, 2003; Banjara, 2011; Wikberg, Eriksson, & Bondas, 2012). Common findings in these studies were language problems and insufficient information that sometimes influenced health negatively. The mothers thought that the maternity care was of high quality and accessible to everyone who had a health insurance card. The mothers, however, missed support from their extended family, and family-centered care was not emphasized enough, even though the fathers were allowed to take part. Differences in expectations and experiences of caring in Finnish maternity care have been described (Wikberg et al., 2012), as well as stereotypes and the ethnocentric views of nurses. Finnish maternity care traditions were sometimes imposed on the immigrant mothers. However, the professional nurses were seen as friends and conflicts were solved. The cultures of the mothers, as well as the Finnish maternity care culture, influenced the caring. Caring was related to the changing culture.

Malin and Gissler (2009) call for qualitative studies on the experiences of birth and care of ethnic minority mothers that could possibly explain higher perinatal mortality and morbidity among immigrants in Finland. They suggest that “non-Western women might be at risk of discrimination and deprivation based on gender, class and ethnicity” (Malin & Gissler, 2009, p. 12). Because caring seems to play an important role for a positive childbearing experience, it is essential to study how women from other cultures experience caring during childbirth in a country such as Finland with high-quality maternity care. Childbearing includes pregnancy, labor, and the postpartum period.

**PURPOSE**

The purpose is to illuminate the experiences and perceptions of caring in the maternity care culture of immigrant new mothers in Finland. This ethnography focuses on caring in maternity care during childbearing from the point of view of immigrant new mothers. This study is part of a project called Encountering the Unknown in Health Care.

**THEORETICAL PERSPECTIVE**

The theoretical perspective is the caritative caring theory and caring science tradition (Eriksson, 2002, 2006; Lindström, Lindholm, & Zetterlund, 2006). This means that the mother is seen as an entity of body, soul, and spirit. She is both unique and part of a community, where family and friends are important. Caring can take many forms and expressions. Respect for the dignity of the woman as a human being, genuine com-
munion with health care professionals, and an understanding of the human being is the ethos underlying caring. Caring is the core of nursing care, which alleviates suffering and promotes health and well-being. Not only the mother’s physical and mental health is considered but also her well-being. The caring science tradition not only describes what is experienced but also tries to find deeper understanding through interpretation. Health and suffering are two sides of human life. The mother’s health and well-being can be compatible with endurable suffering. The mother strives for health and well-being but might experience suffering. Health and suffering contain doing, being, and becoming. Suffering can be described as a drama with three acts, where the nurse confirms the suffering of the woman, allows the woman time and space to suffer, and allows the woman to reconcile with the situation. The suffering of an immigrant mother can be caused by illness, life, and violation or noncaring in health care. Life refers to the situation of immigration as well as becoming a mother.

The caring science tradition earlier is the foundation of intercultural caring (Wikberg & Eriksson, 2008; Wikberg & Bondas, 2010; Wikberg et al., 2012). Intercultural caring refers to a genuine relationship between the nurse and the patient from different cultures that are seen as equal. Caring is seen in four different dimensions: universal, cultural, contextual, and unique. Outer factors as well as the inner core of caring are important for the experience of caring. Caring strives to alleviate suffering and improve health and well-being. Culture refers to “a pattern of learned but dynamic values and beliefs that give meaning to experience and influences the thoughts and actions of individuals of an ethnic group” (Wikberg & Eriksson, 2008, p. 486).

SETTING

The setting is Finland, a Nordic country. During the past 20 years, immigration has increased more than six times in Finland (Statistics Finland, 2012). In 2010, there were 167,954 (3.1%) foreign nationals in Finland. In the same year, there were 224,388 (4.2%) persons speaking a language other than the national languages of Finnish (90.4%), Swedish (5.4%), and Sámi (0.03%) as their mother tongue. The most common foreign languages spoken were Russian, Estonian, English, Somali, and Arabic. Most foreign-born (64.6%) were from Europe, 19.8% were born in Asia, and 9% in Africa. The foreign population in Finland is younger and has higher fertility rates than the Finnish population (Malin & Gissler, 2009).

The Finnish health care system supports maternal and child health. The service is paid for by taxes and is free of charge for patients. The patient pays a nominal fee only for hospital and outpatient clinical visits. During pregnancy, practically all mothers, including immigrants, visit a public health nurse or midwife at an antenatal clinic regularly, on average, 15.6 visits in 2010 (National Institute for Health and Welfare, 2011a). Women also see a medical doctor three times during pregnancy. Mothers who live in Finland and are covered by the Finnish social security system are entitled to a maternity grant if they register with maternity care before the end of the fourth month of pregnancy (Kela—The Social Insurance Institution of Finland, 2011). Mothers are entitled to maternity and parental leave and an allowance of 105 plus 158 days. Either parent can use the latter. In addition, fathers can take paternity leave and an allowance of 1–18 days. Almost all babies are born in hospitals assisted by a midwife, but pediatricians and obstetricians are readily available if complications occur. After delivery, the mother and the baby stay in hospital on average for 3 days and are then referred back to the health center, where the public health nurse or midwife continues the care of the mother and baby. Home visits are also made. Refugees have the same rights as Finnish nationals, whereas asylum seekers have a more restricted access to health care. Both groups are offered maternity care and interpreters free of charge and have organizations that assist them. In 2010, maternal mortality (4.9 out of 100,000) and perinatal mortality (4.0 out of 1,000) in Finland (National Institute for Health and Welfare, 2011a, 2011b) were among the lowest in the world.

The maternity ward in Western Finland, where the study was conducted, has about 1,400 deliveries a year. The ward has a philosophy of care, including family-centered care, being baby-friendly, supporting breastfeeding, striving for a satisfied and safe family, encouraging self-care, individuality, and support of motherhood. Nurses in this study refer to public health nurses, midwives, and auxiliary pediatric nurses. Caring refers to the interpersonal relationship between a nurse or doctor and a mother, whereas care refers to the organization of the health system. Maternity care is part of health care, which refers to both medical and nursing care.


<table>
<thead>
<tr>
<th>COUNTRY OF BIRTH</th>
<th>REASON FOR IMMIGRATION</th>
<th>TIME IN FINLAND</th>
<th>RELIGION</th>
<th>AGE</th>
<th>NUMBER OF CHILDREN</th>
<th>INTERPRETER AT INTERVIEW</th>
<th>NUMBER OF OBSERVATIONS</th>
</tr>
</thead>
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<tr>
<td>Australia</td>
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<td>8–9 years</td>
<td>Christian</td>
<td>28</td>
<td>1</td>
<td>—</td>
<td>2</td>
</tr>
<tr>
<td>Bosnia</td>
<td>Work, family</td>
<td>2 years</td>
<td>Muslim</td>
<td>19</td>
<td>1</td>
<td>Husband</td>
<td>1</td>
</tr>
<tr>
<td>Bosnia</td>
<td>Work, family</td>
<td>5 years</td>
<td>Muslim</td>
<td>32</td>
<td>3</td>
<td>—</td>
<td>2</td>
</tr>
<tr>
<td>Bosnia</td>
<td>Work, family</td>
<td>2 years</td>
<td>Muslim</td>
<td>27</td>
<td>1, pregnant</td>
<td>Professional interpreter</td>
<td>—</td>
</tr>
<tr>
<td>Burma</td>
<td>Refugee</td>
<td>8 months</td>
<td>Christian</td>
<td>19</td>
<td>1</td>
<td>Professional interpreter</td>
<td>3</td>
</tr>
<tr>
<td>Colombia</td>
<td>Studies</td>
<td>3 years</td>
<td>Christian</td>
<td>36</td>
<td>2</td>
<td>—</td>
<td>1</td>
</tr>
<tr>
<td>Estonia</td>
<td>Family</td>
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<td>—</td>
<td>20</td>
<td>1</td>
<td>—</td>
<td>2</td>
</tr>
<tr>
<td>Estonia</td>
<td>Marriage, work</td>
<td>8 years</td>
<td>—</td>
<td>32</td>
<td>3</td>
<td>—</td>
<td>2</td>
</tr>
<tr>
<td>Estonia</td>
<td>Work</td>
<td>3 years</td>
<td>—</td>
<td>32</td>
<td>2</td>
<td>—</td>
<td>1</td>
</tr>
<tr>
<td>Hungary</td>
<td>Work</td>
<td>2 years, 5 months</td>
<td>Christian</td>
<td>25</td>
<td>1</td>
<td>Professional interpreter</td>
<td>2</td>
</tr>
<tr>
<td>India</td>
<td>Work, family</td>
<td>5 years</td>
<td>Hindu</td>
<td>31</td>
<td>2</td>
<td>—</td>
<td>3</td>
</tr>
<tr>
<td>Iraq</td>
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<td>10 years</td>
<td>Muslim</td>
<td>28</td>
<td>3</td>
<td>—</td>
<td>3</td>
</tr>
<tr>
<td>Iraq, Kurdish</td>
<td>Asylum seeker, family reunification</td>
<td>2 years</td>
<td>Muslim</td>
<td>22</td>
<td>2</td>
<td>Professional interpreter</td>
<td>3</td>
</tr>
<tr>
<td>Russia</td>
<td>Work</td>
<td>4 years</td>
<td>—</td>
<td>33</td>
<td>1</td>
<td>—</td>
<td>1</td>
</tr>
<tr>
<td>Thailand</td>
<td>Marriage</td>
<td>1.5 years</td>
<td>Buddhist</td>
<td>28</td>
<td>4</td>
<td>Husband</td>
<td>—</td>
</tr>
<tr>
<td>Uganda</td>
<td>Marriage</td>
<td>2 months</td>
<td>Christian</td>
<td>34</td>
<td>1</td>
<td>—</td>
<td>3</td>
</tr>
<tr>
<td>Vietnam</td>
<td>Marriage</td>
<td>1.5 years</td>
<td>—</td>
<td>23</td>
<td>1</td>
<td>Husband</td>
<td>1</td>
</tr>
</tbody>
</table>

**PARTICIPANTS**

There were 17 first-generation, immigrant new mothers who participated in the study (see Table 1). One mother was pregnant. The other mothers had given birth 1–3 days ago. There are 3 mothers with previous children who delivered in Finland for the first time. The educational level, occupation, and employment of the mothers varied. An additional 3 mothers declined to participate, and 6 were not included because no interpreter was available, one mother was too young to participate, and in one case, the nurses forgot to inform the researcher. However, 12 Finnish female nurses and pediatricians took part in the care situations that were observed, and 7 fathers took part in the interviews or care situations observed.

**METHODS**

This ethnographic study is focused on caring from the inside perspective of immigrant new mothers. A thematic guide based on previous studies on intercultural caring (Wikberg & Bondas, 2010; Wikberg & Eriksson, 2008) was used. The thematic guide included questions about caring, health and well-being, and external circumstances. Questions were both general and specific. The mothers were asked to tell about their experience of the care and the caring they had received during childbearing and to explain what they meant by or to give an example of what they said. The interviews were conducted in Finnish, Swedish, or English by the first author (AW) with the help of four professional interpreters and three fathers (see Table 1). All the mothers were interviewed once and 15 were observed. Unstructured observations (Mulhall, 2003) were conducted during the nursing encounters. Field notes and other documents, except medical files, were also used. The interviews were recorded and transcribed verbatim in the language of the interview; the observations were written down as soon as possible, and field notes were written and documents collected alongside the study. The analysis and interpretation were inspired by Nikkonen, Janhonen, and Juntunen (2001), Roper and Shapira (2000), Spradley (1979), and Geertz (1973). The transcribed data were read and reread and categorized to form themes. First, the data of each mother and then the data of all the mothers were analyzed and interpreted together. Finally,
the themes were examined to find patterns (Roper & Shapira, 2000) that explained and illuminated the mothers’ experiences of caring in the Finnish maternity care culture. Quotations were used as examples of patterns. Finnish and Swedish quotations were translated into English and back-translated by a different person so as not to lose any meaning.

**Ethical Considerations**

The Finnish National Advisory Board on Research Ethics (2002, 2009) has been followed. Permission to conduct the study was granted from the ethical committee of the hospital. All the participants were given verbal and/or written information about the study. They were informed about voluntary participation, confidentiality, and the possibility to withdraw without any explanation or influence on their care. Written consent was received from all the participants. A small gift was given to all the mothers after the interview.

**FINDINGS**

The findings presented are six patterns interpreted from the data to illuminate the immigrant new mothers’ experiences and perceptions of caring.

**Caring Was Beneficial for Health and Well-Being**

The mothers said that the care they had received had been good for them and their baby’s health and well-being. The mothers described how regular and thorough checkups, examinations, and tests were good for them and their baby’s physical health. A mother of three said,

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Really good, really good . . . always at antenatal clinic, time to check baby’s heartbeat and blood pressure and everything . . . this weight, the . . . of the belly [shows how to measure] . . . This always comes . . . and the mother can be calm . . . and know everything is going well.
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Nothing was missed in the antenatal clinics, and special health concerns such as premature uterine contractions, thyroidal problems, or high blood sugar were attended to.

The mothers said that it felt good to meet the nurse at the antenatal clinic or at the hospital. This was described as having a psychological effect on the health of the mother, even though the mothers thought their basic health was the same as before, or it had improved during the pregnancy or stay in Finland. They mentioned relevant information and advice they had received from the nurses. Friendly nurses who had time for them made the mothers want to attend the antenatal clinic. When the nurses really wanted to help them and their babies, it also affected their well-being positively and made life easier. The mothers said that the care they had received was good for their health, but the pregnancy and delivery itself affected their health negatively, for example, weight gain or pain during the delivery or from perineal sutures after the labor.

The mothers talked about their baby’s health during pregnancy, delivery, and afterward. During pregnancy, the mothers were worried that it would end in a miscarriage, that the baby would be born too early or die, or that the baby would be damaged at birth. The tests and examinations usually reassured and calmed them. If the nurse or doctor doing the ultrasound did not say anything, they became alarmed that something was wrong. Another mother of three said,

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Now it was good when here is ultra [sound]; it was really nice . . . when you could see everything yourself and she explained really well what it is—hands, brain, heart, and everything . . . there [other place] you just lay down, and I remember there was a man, he just examined me, but he did not say anything; I always had a panic that “is everything alright?” and you could not see anything; he gave a few pictures and said “everything is ok,” but now I had a real good feeling . . .
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After delivery, the mothers were worried that they would not get help if they needed it. They were worried that they would not be able to take care of the baby and that their milk would not be enough, and they had no one to ask. The mothers felt the hospital was safe, and the nurses and doctors would know what to do if something went wrong. These mothers had visited delivery wards during pregnancy or emergency rooms with their newborn when they panicked about the health of their baby, and they got help. The mothers who had delivered children in Finland before felt more comfort in knowing that they could call the nurses, who were there for them.
Negative Experiences of Health Care or Traumatic Memories Made the Mothers Suffer

Those mothers who did not get the information or support that they needed because of language problems or the attitudes of the nurses did not like to go to the antenatal clinic in the beginning. This made them frustrated. A mother of two felt that she had received misleading advice and the wrong recommendations about diet at the antenatal clinic, which resulted in health problems later on. Mothers who were not given information in a language they could understand or felt that their dignity was not respected in the beginning did not enjoy the relationship with the nurse. A first-time mother said,

I had disagreements with the nurse at the antenatal clinic during the pregnancy... In the end, I got all the answers... In the beginning, the problem was that I did not understand why the nurse did not want to understand that I had fear, even if it was the same nurse, already then, when I had those [earlier complications]...

A mother of two had a traumatic memory of her first delivery in Finland, where both she and her baby had health problems. When complications occurred during delivery, the nurse did not listen to her; the mother received no information and had to guess from the little language she understood. Facial expressions and the body language of the nurses and doctors made her understand that there was something seriously wrong.

... and suddenly, there were a lot of people around... eight or nine people, doctors and nurses, and their faces were like horror... and they told my husband, "you have to go out."... but they never told me anything.

After delivery, the mother had more complications. Because of this, she was unable to take care of the baby, who also needed special care. She could not see her baby often and felt that she was treated badly. This was experienced as having a negative influence on her health and well-being. She did not receive any explanation as to why things went wrong and why procedures were done the way they were. This affected her mentally so much so that she became very scared of childbirth. During the next pregnancy, this was, however, corrected, and the most recent delivery was a good experience.

A first-time mother said she was afraid of hospitals because of previous experiences of losing someone in her native country.

... I personally have a phobia for hospitals; it just scares me... [sighs deeply] yeah, [the voice almost cracks]. Probably, ... ok, back home, maybe the fact that you go to a hospital and you probably lose somebody there. You just have this feeling; it's just not a good feeling, so you keep kind of remembering it.

The mothers mentioned that they did not want to or could not speak about everything with the nurses but saw it as their own responsibility to tell. A mother of three said, "for example, they [the nurses] don't know that something has happened, and others [mothers] can tell that the nurses have not helped them, but if you do not tell, so it is your responsibility."

The Economic Resources and Education of the Nurses Facilitated Caring for Immigrant New Mothers

The mothers mentioned the economy. A first-time mother feared becoming pregnant when there was an economic recession in Europe. She said,

... perhaps the recession... because it affects psychologically... If you discuss it and problems, might come, it is not connected to care, but it affects this... my own nerves, sometimes. I am pregnant and now this strikes... How it affects, that is, can I support my own child?... and I think it is for everybody...
shortage of resources or materials. A mother of three said,

... and you do not need to have a lot of things because here are [showing her nightdress] ... nightdress and gown ... and there [in country of origin], there is nothing, but you have to [searching for words] ... bring your own.

The mothers mentioned maternity, paternity, and parental leave and allowance and the maternity grant, a package with baby clothes or cash benefit, from the Social Insurance Institution of Finland as positive things. A first-time mother said that the good education of the nurses also affected the nursing care and caring positively. Others talked about maternity care professionals as experts. The mothers mentioned and it was also observed that the nurses knew some of the culturally specific needs of the immigrant new mothers.

The Policy and Attitude of Finnish Society Encouraged Childbearing

The mothers were really grateful for being able to live in Finland. They hoped to learn the language and get an education in the future. The society felt safe, and this encouraged their decision to have a baby. A first-time mother said, “It feels much safer here in Finland and calmer than in [country of origin] ...” Maternity care is available equally for everybody. A mother of three mentioned the Act on the Status and Rights of Patients (Finlex, 1992), which states that everybody is entitled to good quality health care. The mothers also mentioned that there is a positive attitude toward children in the country. Another first-time mother said, “You cannot lose your job because you get pregnant.” Day care is available and children are welcome everywhere. She continued,

I think ... that people want to have children in Finland. In some way, they are not welcome any more in [country of origin], in restaurants. [Here] there is day care everywhere and you don't have to book day care already before they are born ... to get a place.

She continued that maternity leave promotes breastfeeding.

... but you do not have time to breastfeed [in country of origin] if you have to go back to work then ... It is actually quite few that breastfeed. ... but here, it is like clear that everybody should breastfeed. I think it is good. ...

The mothers also said that fathers are allowed to take part in the maternity care. A mother of three said, “In my country you cannot get a support person; like the husband cannot be with you, and no (grand)mother.” Fathers usually took part in both antenatal clinics and delivery and visited after delivery. Some fathers were unable to be at the antenatal clinics because of their work. However, fathers were sometimes rejected and excluded by the nonverbal body language of nurses in the hospital. According to an observation, the nurse turned her back on the father when talking to and assisting the mother with breastfeeding. The father took his jacket and left the room. Other fathers were asked to interpret, make the bed, or heat the bottle or make sure the baby was bottle-fed. The father's experiences of childbirth or becoming a father were not discussed.

A first-time mother also thought that the government controls the people by paying for the health care and especially by using social security numbers. On the other hand, she liked the fact that nobody can cheat or disappear in the health care system.

Immigration Regulations Negatively Influenced the Loneliness of the Mother and Her Support During Childbearing

The mothers missed their family members, especially their mothers and sisters. Some accompanied them in maternity care. In both interviews and observations, it became clear that if the mothers or mothers-in-law were living in Finland, they assisted and advised and sometimes made decisions for the new mothers. A (grand) mother wanted to visit her daughter during childbearing but was not granted a visa. A mother of two said,

... everything is nice, but one thing is ... my mum, she did not come here, so I am a little bit [laughs but looks unhappy]. Researcher: Are you sad because of that? Mother: Yes, my dad, he came here, but my mum [sounds sad and longing, almost crying]. Father: She could not come because some paperwork [visa] was not ok.
Immigrant New Mothers in Finnish Maternity Care

The mothers said that the grandparents helped them with child care in their country, but here, they had no one. Some had family, or countrymen, but some were alone with their husband. One first-time mother’s husband was still in a refugee camp without a permit to enter the country. She said, “I am here alone giving birth to the first child, so . . . ” However, another first-time mother also mentioned that the advice from relatives was not appropriate in Finland, and therefore, she became more worried when listening to them.

Finnish Maternity Care Was Not Adapted to the Immigrant New Mothers

Maternity care was organized differently in different countries. Some of the mothers had difficulties in knowing where to go and whom to talk to when becoming pregnant in Finland. All the mothers were not used to nurses being responsible for normal pregnancies and deliveries. The mothers felt disappointed in the beginning because they did not meet a doctor at each appointment, but in the end, they appreciated the good quality of nurse-led antenatal clinics. A first-time mother said, “. . . caring was good or excellent, but the system was not clear.”

The amount and timing of, for example, maternity leave and tests were different. The mothers would have liked to have more ultrasound examinations. They thought it was good for the baby’s health to check the baby more often, and it made them happy to see the baby each time. A first-time mother said,

> Each time I would go to the hospital like for the monthly periodic checks, I would have antenatal, and they would do my . . . ultrasound. Yes, so they would check the baby’s state and everything, but I noticed that when I came here, it’s not, not a regular thing to do ultrasounds, which I thought was not good, ’cause sometimes you can’t know what is happening to your baby and yet . . . probably . . . a problem going on in there . . .

Information from the antenatal clinic to the hospital and vice versa was not always transmitted smoothly, according to the mothers. The mothers said that they sent text messages as soon as they had delivered to the nurse in the antenatal clinic because this was faster than to wait for a letter from the hospital. The mothers thought they went more often to antenatal clinics than they would have done in their own country because the next appointment was automatically given or they had knowledge from previous pregnancies.

The mothers enjoyed having their own delivery room safeguarding their privacy. A mother of three said,

> . . . I have to say, the nursing care is really good here in Finland. . . . from where I come from, it is a big difference that I can say . . . for example in [country of origin] when you come to the hospital to deliver, then many young women [deliver] in one room so . . . I can watch another woman deliver and here . . . Everybody has their own room.

However, mothers would have liked to have their husbands or other family members with them all the time after the delivery in the hospital. This was not possible because there were no family rooms in the maternity ward. Some of the mothers also wished to stay longer in the hospital to become used to caring for the baby, in particular, to manage breastfeeding as well as to rest and recover. These mothers were worried about going home because they had no relatives to ask questions from.

According to interviews and observations, the rules seemed to be flexible or not fixed. Sometimes, for example, information about the sex of the baby at ultrasounds was received, visiting hours were extended, family rooms were arranged, and sometimes not. During the summer, the mothers complained of a disruption of continuity with inexperienced temporary nurses at the antenatal clinics. A mother of two had met a doctor at the antenatal clinic who was disorganized, could not find equipment, and told her that there was no time to answer her questions because of the workload that day. She thought the appointment could have been rescheduled instead of blaming her for the mess. Mothers who had no common language with the nurse thought it was difficult to communicate and get information because interpreters were not used or not available. However, several mothers were impressed by the ability of the nurses and the doctors to serve them in three languages (Finnish, Swedish, and English) in the hospital. A mother also had dif-
difficulty filling in forms because she did not know the Latin alphabet very well.

The six patterns presented in this study showed that the mothers were grateful for the high-quality maternity care they had received during pregnancy and childbirth. The mother's caring experiences had a positive influence on their health and well-being, whereas noncaring experiences, including a lack of cultural knowledge and traumatic memories, caused suffering. The accessibility to care and caring was influenced by external circumstances such as economy, education, policy, laws, and the organization of maternity care.

**DISCUSSION**

This ethnographic study illuminates the experiences and perceptions of caring by immigrant new mothers in the maternity care culture of Finland. This study did not examine mothers from a specific culture or compare different cultures but rather the perspective of immigrant new mothers giving birth in a new culture different from their own. Similar studies on the experiences of women of several African (Murray, Windsor, Parker, & Tewfik, 2010) and Asian (Hoang, Le, & Kilpatrick, 2009) cultures giving birth in Australia have been found.

From the descriptions of the mothers and the observations, it was clear that the physical health of the mothers and babies was emphasized most in the care. It seemed almost as if the baby's health was more important for the mothers than their own health. The mothers appreciated thorough checkups (cf. Bondas, 2002; Shafiei, Small, & McLachlan, 2012). However, the mothers said that the nurses cared for them and asked “how they felt and managed with the baby,” which made the mother feel well and enjoy going to the antenatal clinic (cf. Carolan & Cassar, 2010; Small, Liamputtong Rice, Yelland, & Lumley, 1999; Wikberg et al., 2012), as well as developing their identity as mothers (Ny, Plantin, Karlsson, & Dykes, 2007). Spiritual issues were not discussed according to the mothers in this study, but sometimes during observations, the admiration and discussion of the wonder of the birth of the child created a special moment.

Other mothers felt lonely and isolated because they had no relatives around or could not understand the nurses, which made them frustrated, insecure, or scared. If interpreters were not available or arranged, they did not get information and knowledge (cf. Banjara, 2011; Lyberg, Viken, Haruma, & Severinsson, 2012). Suffering occurred when they did not get the support they needed or their dignity was hurt when they were not listened to or they did not get answers to their questions. Not listening to the mother or not arranging interpreters as well as not understanding the culture of the mother or having prejudice toward the immigrant new mother or her partner can be compared to suffering caused by nursing care (cf. Eriksson, 2006) because of cultural incompetence or intolerance. The immigration situation itself can be seen as a suffering of life (cf. Eriksson, 2006). Even if the woman voluntarily leaves her country, she misses her family, friends, and culture. Resettlement might have priority over pregnancy (Carolan & Cassar, 2010). Although pregnancy and birth are not considered an illness, the ailment during pregnancy, pain during childbirth, and body changes after the birth can be compared to the suffering of an illness (cf. Eriksson, 2006).

In this study, some of the mothers revealed part of their painful past life histories, but several mothers from crisis areas declined to take part in the study, and some started to cry when kindly asked if they wanted to participate. Some of the mothers who did not want to or could not reveal everything to the nurse might also have had difficult memories. Traumatic experiences in the past might affect the mother's present childbearing experience (cf. Lyberg et al., 2012). The mothers might visualize “all sorts of horrible pictures” (Eliasson, Kainz, & von Post, 2008, p. 504) if they do not understand the language and only see the facial expressions of the nurses. Therefore, it is vital to use professional interpreters to give the mother the possibility to disclose traumatic memories, especially if she is coming from regions with war, catastrophe, or crisis, where rape, torture, and other forms of suffering might have occurred (Correa-Velez & Ryan, 2012).

The caring, which was expressed in the relationships with the nurse, had given the mothers a positive childbearing experience, which was described as being good for their health and well-being, whereas noncaring had brought about suffering and was experienced as decreasing their health and well-being. This is, however, not different from mothers giving birth in their own culture (cf. Callister, 2012; Eliasson et al., 2008; Hunter, Berg, Lundgren, Ólafsdóttir, & Kirkham, 2008). Caring and noncaring experiences during the childbearing period have lifelong significance for the woman (cf. Beck, 2006; Forssén, 2012; Hallgren,
Kihlgren, & Olsson, 2005; Lundgren, Karlsdottir, & Bondas, 2009).

External circumstances affect caring either positively or negatively. In this study, none of the mothers mentioned difficulties with transportation (Correa-Velez & Ryan, 2012; Hill, Hunt, & Hyrkäs, 2012); long waiting times and child care (Correa-Velez & Ryan, 2012) costs (Beine, Fullerton, Palinkas, & Anders, 1995); or lack of resources, including shortage of personnel to access maternity care (Shafiei et al., 2012). Instead, it was the availability of interpreters, organization of the maternity care, as well as immigration regulations that affected their possibility to receive good care, have a good childbirth experience, and achieve health and well-being. Private rooms during labor, the acceptance of husbands or support persons during labor, the availability of special diets and antenatal preparations courses, including visits to the hospitals, were all highly appreciated. The mothers found the maternity care to be of good quality and inexpensive.

The mothers were expected to adapt to the maternity care system (cf. Lyberg et al., 2012; Lyons, O’Keeffe, Clarke, & Staines, 2008). Research has shown that immigrant mothers in Finland use antenatal services similarly to Finnish mothers (Malin & Gissler, 2009), which is not the case in other countries (cf. Choté et al., 2011). The free access to maternity care and the requirement to visit the antenatal clinic before the end of the fourth month to be entitled to the maternity grant might encourage early registration. The maternity ward had only a limited number of beds, and the turnover was fast, which meant the mothers could rarely stay longer than 2–3 days after a normal delivery, even if they did not feel ready to go home. The nurses wanted to check and teach the mothers about recovery, breast feeding, and child care, although the mothers might not have been ready for the information (cf. Dykes, 2005). First-time immigrant mothers and mothers who delivered for the first time in Finland, and who had no relatives, needed assurance that the nurse would assist them if any problems occurred at home. Finnish first-time mothers have also been reported (Bondas, 2002; Bondas & Eriksson, 2001) to feel lonely or lose friends because of childbirth and need help from the nurse to form new networks.

With respect to the theory of being with child (Bondas, 2005), there seemed to be no interaction between immigrant new mothers and Finnish mothers. The caring communion between the new mother and the nurse, as well as the family communion between the new mother and her partner or grandmother, was incomplete.

Costs saved in maternity care when having a fast turnover in the hospital and not using interpreters might be lost when mothers have medical interventions or complications because of communication problems or the unnecessary use of emergency services. The complaints about poor information exchange between hospital and antenatal clinics could partly be caused by the laws and acts that safeguard the rights of the patients when exchanging information between different health organizations. A Health Care Act (Finlex, 2010) has since been implemented that should improve exchange of information.

In spite of the maternity ward’s philosophy that included family-centered care, no family rooms were available after delivery. During the study, a stricter rule about visiting was introduced—only the father and the siblings could visit—because of influenza epidemics. Grewal, Bhagat, and Balneaves (2008) have suggested that family-centered care should incorporate cultural traditions in a respectful way. Flexible time schedules at the antenatal clinics and information to fathers about their rights to attend might increase the immigrant fathers’ presence. Some nurses seemed to have a prejudice toward Finnish fathers marrying foreign women. A positive attitude toward fathers and their experience of childbirth and becoming a father might make them more willing to participate. According to Börjesson, Paperin, and Lindell (2004), the new mother receives the most support from the husband and her own mother. They are not always available and sometimes prevented from entering the country by immigration regulations (cf. Ny et al., 2007).

The immigrant new mothers’ initial disappointments (cf. Upvall, Mohammed, & Dodge, 2009) could have been avoided if they had received more information about the Finnish maternity care organization. Many of the mothers in this study wanted more ultrasound examinations than are offered in maternity care in Finland. According to Hofmann (2007), technology such as ultrasound has received new values and uses than it was originally intended for. Ultrasound in itself is wanted because it is a sign of progress and status, and instead of detecting the abnormal, it is used to calm worried parents that everything looks normal. The mothers in this study liked to see the baby and get a picture to keep and show others, but it also calmed them if they were worried about the health of the baby.
The immigrant new mothers’ feelings of loneliness and insecurity might be intensified by the Finnish cultural view of women as independent and the emphasis on self-care. Many collective cultures have an extended family concept, where family includes more than the Finnish core family of an individualistic society (cf. Banjara, 2011; Hanssen, 2004). Networks or doulas (Akhavan & Lundgren, 2010) for immigrant mothers, as well as the extended use of nurses in the antenatal clinic, who have caring relationships for an extended time with the immigrant new mothers, might decrease their vulnerability and loneliness and help the mothers build a network of friends.

In this study, it seemed as if the newly arrived mothers were more likely to follow the traditions of their original culture, whereas the mothers that had immigrated several years ago had adapted to or accepted many of the Finnish practices in maternity care. Opposite findings have been described by Brathwaite and Williams (2004), who studied Chinese immigrants in Canada, where the newest arrivals were less likely to follow traditional practices. Acculturation, among other things, has been used to explain “the healthy immigrant effect,” which refers to the fact that even though immigrants are usually healthy upon entering a country, within 10 years, they have similar health to the majority population in a country (Higginbottom et al., 2012). According to Samarasinghe, Fridlund, and Arvidsson (2010), nurses need to consider the importance of acculturation and the meaning of family for the health of the mother to avoid imposing an ethnocentric view of health, focusing on the physical health of the mother, which was also found in this study. However, the acculturation might be unique to the encountering cultures and the life situation of the individual immigrant mother.

In the model for intercultural caring (cf. Wikberg & Bondas, 2010; Wikberg & Eriksson, 2008; Wikberg et al., 2012), universal caring, the cultural background, maternity care context, and unique needs and wishes of the mothers, as well as the external circumstances in their life situation, are important for health and well-being. Caring takes place in the relationship between the nurse and the mother, and therefore, the relationship is of utmost importance for the experience and outcome of the childbirth (Hunter et al., 2008). The cultures of the nurse and the mother are seen as equal, meaning they are equally valuable and important in the encounter. Both cultures influence the caring encounter, which can empower the immigrant new mother.

External circumstances, such as the organization of maternity care, the availability of interpreters, and immigrant regulations, might hide some of the caring and disempower the immigrant new mother. The immigrant new mothers could be compared to the metaphor of Alice in Wonderland (Wikberg & Bondas, 2010), where they entered a strange land with confusing rules. The caring dimensions—universal, cultural, contextual, and unique—need to be seen from both the mother’s perspective and from the nurse’s maternity care culture perspective. On the one hand, there are nurses who really want and try to care for the mothers, but on the other hand, there are outer circumstances that make it difficult. If caring is not present, the encounter with the maternity care might cause suffering. The ethics of intercultural caring is to see suffering caused by cultural differences, cultural incompetence, disempowering relationships, and the prejudice of nurses. The Finnish maternity care culture influences the mother’s experience of caring at the same time as it changes with the encounter with immigrant new mothers. This study supported that caring promotes health and well-being and alleviates suffering and that the absence of caring might cause suffering. It also supported that external circumstances influence the experience of caring and therefore, the health and well-being of immigrant new mothers.

Credibility and Trustworthiness

The focus of the study was caring; however, the participants described both caring and noncaring. The ethnographic observations and field notes together with interviews brought about a deeper understanding of the perspectives of the mothers because what the participants said could also be seen or experienced and not only verbally expressed (cf. Zhao, Esposito, & Wang, 2010). Observations also showed cultural behavior and produced new data for the study.

The transcriptions were read in the interview languages so as not to lose any meaning but were analyzed in Swedish. The back-translation of the Finnish and Swedish quotations guaranteed that the original meaning was preserved. Only minor alterations of the language have been made to make the quotations more understandable. To ensure trustworthiness, the transparency of the study, the setting, participants, method, and the ethical issues have been emphasized.
Limitations and Further Research

The participants might have changed their behavior because an observer was present, which may have inhibited their answers because the interview was recorded or because the request for informed consent, including their signatures, was asked for. A follow-up interview could have given more data and deepened the study further. The availability of professional interpreters could have deepened some of the interviews and enabled additional mothers to participate. On the other hand, using interpreters involves several layers of interpretation (Brämberg & Dahlberg, 2012), which could blur understanding. Many non-Western cultures have an oral narrative tradition, whereas Finnish culture is heavily based on written and electronic information besides some practical demonstration. The participants’ understanding of the concepts of family, health, and suffering was not studied. Maternity care culture might be different in other regions of Finland, even if the national regulations are the same. Traditional minorities and illegal immigrants, who were not part of this study, might have a different view about caring in maternity care.

More extensive studies could be conducted to find out if a lack of consideration for language or culture or racism or external circumstances are experienced as affecting well-being and health from the immigrant new mothers’ perspectives. How will acculturation change the experiences of the mothers? Will the next generation of mothers with a different cultural background have similar experiences? The experiences of Finnish mothers who have foreign partners as well as experiences of Finnish women giving birth abroad could be studied. Would more caring relationships improve the health outcomes of immigrant mothers and their babies? More research on caring for immigrant mothers from the perspective of Finnish nurses and doctors is needed as well.

Implications

Some implications are suggested about the organization, education, laws, and attitudes of nurses (See Table 2). Patients should be able to expect a maternity organization that accommodates their need for support during pregnancy, labor, and the postpartum period, including professional interpreters, and genuine family-centered care. The immigrant mother should be able to expect nurse-initiated discussions about her cultural, maternity-related, and unique needs and expectations. Cultural competence, including caring, should be promoted, whereas ethnocentrism, incompetence, racism, and discrimination should be worked against. Flexibility and humanity in implementing and interpreting the laws are needed.

CONCLUSIONS

The mothers’ cultural and unique expectations or needs were not always recognized, which was perceived as cultural insensitivity; however, when the cultural background was recognized, it was perceived as being the expert knowledge of the nurse, and it empowered the mothers. The nurses’ natural way of caring in the Finnish maternity care culture was often unreflective toward the immigrant new mothers’ culture and life situation, which could be seen as ethnocentric or as an imposition of cultural pain or causing cultural suffering. General Finnish policy and politics influenced the desire to have children, access to and experience of maternity care, and the loneliness of immigrant new mothers. A vulnerable life situation increases suffering. Therefore, both previous (traumatic memories) and present life situations (insecurity of asylum seekers, resettlement, and acculturation) need to be considered in nursing care. The adjustment of maternity care organizations to the needs of mothers from other cultures might increase their feeling of well-being, possibly even improve health outcomes, and save costs in the long term. The prejudice of nurses as well as an extended understanding of the family should be considered to accommodate the family of immigrant new mothers to maternity care. Even though there is some universal caring, immigrant new mothers are very heterogenic, having different cultural backgrounds, maternity traditions, life situations, and different support organizations and need therefore to be encountered as unique individuals. To improve general awareness, nurses and researchers might need to take a more active role in informing health care politicians, policy makers, and administrators on the importance of caring, the life situations of immigrant mothers, and the influence of external circumstances to alleviate suffering and promote health and well-being for immigrant new mothers.
TABLE 2 Implications for Practice

| Organization | Flexible time schedules at antenatal clinics are needed to facilitate for the fathers’ participation. More beds are needed in the maternity wards so the mothers can stay longer if they do not feel secure with baby care and breastfeeding. Alternatively, more intense support through home visits by nurses and help to build networks are needed. Family rooms in postnatal wards support the participation of fathers and other family. Continued employment of auxiliary pediatric nurses might be a good and economic solution to assist mothers who want to stay longer in the hospital or who need more help at home. Placing mothers in the ward according to language skills instead of nationality or cultural background could improve the satisfaction of the mother, as well as network building. Continuity of maternity care during summer holidays needs to be improved. Caring could be included in maternity philosophy on all levels. Encouraging, educating, and employing doulas from the local ethnic communities, as well as allowing predelivery visits of immigrant new mothers to the delivery ward, and including discussions about the mother’s needs and cultural expectations could further improve the childbirthing experience. |
| Education | Intercultural caring should be included in the education of all nurses and doctors according to the recommendations of the Ministry of Education (2006). The education should contain information about the importance of caring, the connection between caring and the experience of health and well-being, the influence of previous traumatic experiences and external circumstances on the nursing care situation and health, as well as an understanding of the total life situation of the immigrant. Cultural, contextual, as well as unique caring needs should be considered. The education should additionally contain information about general theories and concepts as well as specific cultures and contexts. |
| Laws | Enable the presence of fathers and grandmothers during childbirth by allowing them to enter the country. Be flexible with the maternity grant if the mother has just arrived, and she has not been able to attend the antenatal clinic as required. Follow the Act of Patients’ Rights by arranging interpreters when needed to give information and good quality care. In addition, women without health insurance cards need to receive care and caring during pregnancy and birth. |
| Attitudes of nurses | Continue a friendly attitude toward children and immigrant mothers. Prepare for counteractions toward the intolerance of immigrants, which can change the positive attitudes the immigrant mothers have of Finnish society. Nurses need to become aware of their attitude toward fathers and involve them more in the care. Nurses need to take a more active role in informing politicians, policy makers, and administrators of the needs of caring and the life situation of immigrant mothers to safeguard maternity care resources and changes of restricting rules and policies. Continue the baby-friendly movement by genuinely supporting the positive attitude toward breastfeeding by immigrant mothers. |

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Immigrant New Mothers in Finnish Maternity Care  Wikberg et al.

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Experiences of Women Planning a Home Birth Who Require Intrapartum Transfer to Hospital: A Metasynthesis of the Qualitative Literature

Deborah Fox, Athena Sheehan, and Caroline Homer

Recent evidence supports the safety of planned home birth for low-risk women when professional midwifery care and adequate collaborative arrangements for referral and transfer are in place. The purpose of this article is to synthesize the qualitative literature on the experiences of women planning a home birth, who are subsequently transferred from home to hospital. A metasynthesis approach was selected because it aims to create a rich understanding of women’s experiences of transfer by synthesizing and interpreting qualitative data. Three categories were synthesized: “communication, connection, and continuity,” “making the transition,” and “making sense of events.” Quality and clarity of communication, feeling connected to the backup hospital, and continuity of midwifery care help make the transfer process as seamless as possible for women. Arriving at the hospital is a time of vulnerability and fear, and retaining the care of a known midwife is reassuring. New caregivers must also be sensitive to women’s need to be reassured and accepted. The reasons for transfer need to be clearly communicated both at the time of transfer and in more detail during the postpartum period. Women need to talk through their experience and to acknowledge their feelings of disappointment in order to move forward in the next phase of their lives. Continuity of carer enables this to be done by a known caregiver in a sensitive and individualized manner. Further qualitative research to examine home birth transfer issues, specifically in the Australian context, is currently being planned as part of the Birthplace in Australia project.

KEYWORDS: midwifery; home birth; transfer of care; women’s experiences; metasynthesis

INTRODUCTION

Recent evidence supports the safety of planned home birth for low-risk women when professional midwifery care and adequate collaborative arrangements for referral and transfer are in place (Brocklehurst et al., 2012; Catling-Paull, Coddington, Foureur, & Homer, 2013; de Jonge et al., 2013; de Jonge et al., 2009). Despite the low rates of home birth in many developed countries, there remains a demand for home birth services (Catling-Paull, Foureur, & Homer, 2012). The recent Birthplace in England study (Brocklehurst et al., 2012) demonstrated no difference in adverse perinatal outcomes for low-risk multiparous women who planned a birth at home, in birth centers, or in an obstetric unit. For primiparous women, there was again no difference when comparing adverse perinatal outcomes with birth centers or obstetric units; however, an elevated risk of poor perinatal outcomes was identified for those primiparous women who had planned a home birth. Brocklehurst et al. (2012) and other studies demonstrate a trend for larger proportions of primiparous women to be transferred than multiparous women (Blix, Huitfeldt, Øian,Straume, & Kumle, 2012; Brocklehurst et al., 2012; Johnson & Daviss, 2005; Tyson, 1991; Wiegers, van der Zee, & Keirse, 1998). Available data shows a four to five-fold increase in transfers for women having their first baby when compared with women who have given birth before (Table 1).
Table 1: Findings of Quantitative Papers Examining Transfer Rates

<table>
<thead>
<tr>
<th>Author, Date, Country</th>
<th>Total Transfer Rates</th>
<th>Primiparous Women Transferred</th>
<th>Multiparous Women Transferred</th>
<th>Urgent Transfers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amelink-Verburg et al., 2008, The Netherlands</td>
<td>29.3% transfer rate</td>
<td>—</td>
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<td>—</td>
</tr>
<tr>
<td>Anderson &amp; Murphy, 1995, United States</td>
<td>9.8% transfer rate (8% in labor, 0.8% postpartum, 1% neonatal)</td>
<td>—</td>
<td>—</td>
<td>1 in 1,000</td>
</tr>
<tr>
<td>Blix et al., 2012, Norway</td>
<td>12.1% transfer rate; transfers occurred during intrapartum period or within 5 days after birth.</td>
<td>31.7%</td>
<td>6.3%</td>
<td>Primiparous women: 1.4% of all planned home births; Multiparous women: 0.9% of all planned home births</td>
</tr>
<tr>
<td>Brocklehurst et al., 2012, England</td>
<td>21% transfer rate</td>
<td>45%</td>
<td>12%</td>
<td>—</td>
</tr>
<tr>
<td>Catling-Paull, Dahlen, &amp; Homer, 2011, Australia</td>
<td>Excluded; sample &lt; 20</td>
<td>—</td>
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<tr>
<td>Cheyney, 2011, United States</td>
<td>12% transfer rate</td>
<td>—</td>
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<tr>
<td>Creasy, 1997, England</td>
<td>Excluded; sample &lt; 20</td>
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<tr>
<td>Dahlen, Barclay, &amp; Homer, 2010, Australia</td>
<td>Excluded; sample &lt; 20</td>
<td>—</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Davies, 1997, England</td>
<td>14% uneventful transfers</td>
<td>—</td>
<td>—</td>
<td>None</td>
</tr>
<tr>
<td>Durand, 1992, United States</td>
<td>11.9% transfer rate</td>
<td>—</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Janssen et al., 2002, Canada</td>
<td>16.5% during labor (before birth)</td>
<td>—</td>
<td>—</td>
<td>3.6% of all planned home births</td>
</tr>
<tr>
<td>Janssen et al., 2003, Canada</td>
<td>23.1% transfer rate</td>
<td>—</td>
<td>—</td>
<td>3.4% of all planned home births</td>
</tr>
<tr>
<td>Johnson &amp; Daviss, 2005, United States and Canada</td>
<td>12.1% transfer rate</td>
<td>25.1%</td>
<td>6.3%</td>
<td>Primiparous women: 5.1% of all planned home births; Multiparous women: 2.6% of all planned home births</td>
</tr>
<tr>
<td>Lindgren et al., 2008, Sweden</td>
<td>12.5% transfer rate</td>
<td>—</td>
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<tr>
<td>Lindgren, Radestad, &amp; Hildingsson, 2011, Sweden</td>
<td>14.15% transfer rate</td>
<td>—</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Murphy &amp; Fullerton, 1998, United States</td>
<td>10.2% transfer rate: 8.3% in labor, 0.8% PN, 1.1% neonatal</td>
<td>27%</td>
<td>5.7%</td>
<td>—</td>
</tr>
<tr>
<td>Tyson, 1991, Canada</td>
<td>16.5% transfer rate (intrapartum or to 4 days postpartum)</td>
<td>—</td>
<td>—</td>
<td>40%</td>
</tr>
<tr>
<td>Wiegers et al., 1998, The Netherlands</td>
<td>—</td>
<td>40.1%</td>
<td>11.6%</td>
<td>—</td>
</tr>
</tbody>
</table>

Note. Empty cells denote no data available.

Women’s approaches to making decisions about where to give birth are complex, multifaceted, and derived from manifold formal and informal sources. It is clear from the literature, however, that choice and control is important to women in childbirth (Creasy, 1997; Janssen, Carty, & Reime, 2006; Vedam, Goff, & Marnin, 2007) and that social and familial reasons are significant in most women’s choices to give birth at home (Bailes & Jackson, 2000). Women choosing home birth may value alternative forms of knowledge and undergo a process of challenging hegemonic biomedical paradigms (Cheyney, 2008), which are widely accepted in society and commonly exploited in the media. Despite the fact that hospitals may provide the technological means to monitor and treat problems in childbirth, awareness of this is not reassuring to some women. Such women value the natural processes of their bodies more highly than scientific and technocratic approaches to birth, choosing to birth in what they perceive as the safety of their own homes (Davis-Floyd & Sargent, 1997).
Quantitative studies examining transfer rates for women planning home birth highlight several reasons for transfer. Most transfers are reported to occur for nonurgent indications, such as delayed progress in labor (Amelink-Verburg et al., 2008; Anderson & Murphy, 1995; Davies, Hey, Reid, & Young, 1996; Johnson & Daviss, 2005; Lindgren, Hildingsson, Christensson, & Rådestad, 2008; Murphy, 1998), the woman's request for pharmacological pain management (Amelink-Verburg et al., 2008; Johnson & Daviss, 2005), or the unavailability of her midwife (Lindgren et al., 2008). Small numbers of women (Amelink-Verburg et al., 2008; Anderson & Murphy, 1995; Johnson & Daviss, 2005) are transferred because of potentially life-threatening emergencies such as postpartum hemorrhage (Amelink-Verburg et al., 2008; Anderson & Murphy, 1995; Davies et al., 1996; Durand, 1992; Johnson & Daviss, 2005; Lindgren et al., 2008; Tyson, 1991) or neonatal respiratory distress (Amelink-Verburg et al., 2008; Anderson & Murphy, 1995; Durand, 1992).

Some women find transfer distressing, whereas others do not. For example, Wiegers et al. (1998) found that women who were transferred from planned home birth to hospital in The Netherlands were as positive as women who had planned a birth in hospital regarding their birth experience, their midwife, and the 10 days postnatal period. However, these findings are in contrast to those reported by others who have found that transferred women were less satisfied with their experience. Lindgren, Rådestad, and Hildingsson (2011) identified that women who were transferred from planned home birth to hospital in Sweden were less satisfied than those who gave birth at home. Similarly, Christiaens, Gouwy, and Bracke (2007) found that transferred women in Belgium and The Netherlands were less satisfied than those who had planned a hospital birth. This study included women who planned a home birth at or after 30 weeks’ gestation. No difference was found in satisfaction levels between the women transferred in pregnancy or women transferred during labor. Most of the transferred women felt they had made an appropriate choice about place of birth, but fewer were sure they would choose home birth again next time. Communication issues and organizational factors (such as the inability of the home birth midwife to remain as caregiver in hospital) were the main contributing reasons for their dissatisfaction.

In many western countries, women will continue to choose to plan a home birth despite the challenges involved. Some of them, and/or their babies, will require transfer to hospital during labor or soon after birth. Although guidelines exist for the processes of transfer, we do not fully understand how women experience this emotionally and psychologically. Therefore, the aim of this metasynthesis is to review and synthesize, from the current literature, the views and experiences of women in developed countries who have planned a home birth and subsequently been transferred to hospital during the intrapartum or early postnatal periods.

**METHODS**

**Design**

A metasynthesis approach to the qualitative literature on the views and experiences of women planning a home birth, who are subsequently transferred from home to hospital during labor or in the early postnatal period, was undertaken. This approach was selected because it aims to create a rich understanding of women’s experiences of transfer by analyzing and synthesizing qualitative data.

A metasynthesis attempts to explore phenomena related to a specific research question to illuminate and enrich understanding of the chosen phenomenon. More than a summary of available evidence, it seeks to analyze existing research in a way that enables new insights, synthesizing between the studies, determining comparisons and contrasts between them, and identifying relationships and refutations which may be either apparent or implied. This results in a holistic analysis (Thorne, Jensen, Kearney, Noblit, & Sandeclipseus, 2004; Walsh & Downe, 2005) that is derived from an interpretive paradigm (Noblit & Hare, 1988). The aim of a metasynthesis is to develop knowledge in and increase understanding of a phenomenon of interest (Thorne et al., 2004).

Various approaches to metasynthesis are seen in the literature (Thorne et al., 2004). Most are informed by the metaethnographic approach of Noblit and Hare (1988), considered a seminal work on the method (Thorne et al., 2004; Walsh & Downe, 2005). Noblit reminds us that qualitative research is the “. . . juxtaposition of the author’s perspective with the perspectives of those studied” (Thorne et al., 2004, p. 1347). The synthesis of qualitative research adds a further layer, that of the interpretation of the synthesizer, who seeks to relate ordinary concepts from the data to existing discourse (Thorne et al., 2004).

The structure of this metasynthesis has been influenced by the approaches of Schmied, Beake, Sheehan, McCourt, and Dykes (2011); Walsh and Downe (2005); and Noblit and Hare (1988). Beginning with
a focused literature search, it then combines findings from studies that have employed different methodologies. The original analyses and the authors’ interpretations contained within the studies, and the relationships between the studies are used to create new interpretations. These interpretations are further related to contemporary discourse, striving to make the result richer than the sum of its parts (Thorne et al., 2004; Walsh & Downe, 2005).

Definitions

For the purposes of this study, planned home birth is defined as when the planned place of birth at the onset of labor is the woman’s home, with care from a private or publicly funded registered midwife. It does not mean a birth at home unattended by a professional midwife or a birth before planned arrival to hospital. Transfer is defined as the transport of a woman who has planned a home birth, and/or her baby, from home for referral to an obstetric hospital. This may have occurred after the onset of labor or within several days after birth. The transfer may occur because of complications or risk factors emerging during the labor or immediate postpartum period, and/or the woman may have requested a transfer because of social reasons or the desire for pharmacological pain management. This study does not include women for whom consultation with a medical practitioner is sought on the telephone but subsequently remain at home for birth and the early postpartum period.

Inclusion and Exclusion Criteria

Qualitative studies or only the qualitative section of mixed method studies that explored the views and experiences of primiparous and multiparous women planning a home birth, who are subsequently transferred to hospital during labor or in the early postnatal period, were included. Literature on free birthing (Dahlen, Jackson, & Stevens, 2011) and home births in developing countries (Ghazi Tabatabaie, Moudi, & Vedadhir, 2012; Radoff, Levi, & Thompson, 2012) were excluded because these bring unique and complex issues that are beyond our primary aim. Also excluded was literature about women who, at the onset of labor, plan to give birth in a hospital but unexpectedly gave birth before reaching the hospital. In addition, search terms embryo, in vitro fertilization (IVF), and blastocyst were specific keyword exclusions. This was decided after an initial search which drew hundreds of hits related to assisted reproduction.

Search Strategy

For the purposes of a larger PhD study, a systematic search was undertaken for all literature pertaining to home birth transfer using the following databases: Academic Search Complete and CINAHL (Ebsco), Informit, Cochrane Library (Wiley), Intermed, Maternity and Infant Care, Medline (Ovid), Pubmed, Scopus, ScienceDirect (Elsevier), ANL Trove (theses), and ProQuest Dissertations and Theses. Search terms included homebirth OR home birth AND transfer. These broad search terms were used to encompass the wider scope of the aforementioned PhD project. Only research published since 1990 in English was sought because home birth practice has undergone many changes over the past 20 years in many countries because of political issues and midwives’ access to indemnity insurance. The search attracted 1,520 hits; 333 relevant titles were chosen for abstract review and following abstract review, 196 abstracts remained. The full texts of those papers were sought and reviewed for relevance. After full text review, 18 papers relating to intrapartum or early postpartum transfer remained. Of these 18 papers, 14 were quantitative and 4 were qualitative studies. All the qualitative studies specifically addressed women’s views and experiences of intrapartum or early postnatal transfer during a planned home birth (Catling-Paull et al., 2011; Creasy, 1997; Dahlen et al., 2010; Lindgren et al., 2011). A further paper was later added which was published just after the search, which included a section on the experiences of two transferred women (McCourt, Rayment, Rance, & Sandall, 2012). Quality appraisal of these five papers was undertaken using the Critical Appraisal Skills Programme (2010) “Qualitative Research checklist.” Five papers that included data from 89 women remained after quality appraisal (Figure 1).

Analysis

The seven-step process of metaethnography proposed by Noblit and Hare (1988) was used as a basis for this analysis. The seven steps are illustrated in Figure 2, and details of the steps as they applied in this study appear in the following text. Three categories were synthesized: “communication, connection, and continuity,” “making the transition,” and “making sense of events.” Each
Literature search was undertaken, using search terms *homebirth* OR *home birth* AND transfer NOT IVF NOT embryo NOT blastocyst. Articles sought are in English, published since 1990. Databases searched: Academic Search Complete, CINAHL, Informit, Cochrane Library, Intermed, Maternity and Infant Care, Medline (Ovid), Pubmed, Scopus, ScienceDirect, ANL Trove (theses), and ProQuest Dissertations and Theses.

There were 1,520 hits. There were 333 titles identified as relevant, abstracts of which were reviewed. Abstracts from studies on home birth in developing countries were excluded. Literature search was undertaken, and studies on free birth and unplanned home birth were excluded at this stage.

There were 196 papers that remained; full texts were reviewed. A filter was applied related to intrapartum or early postpartum transfer to hospital after planned home birth.

There were 18 papers that remained and were again reviewed. Of these 18 papers, 14 were quantitative and 4 were qualitative studies. All the qualitative studies specifically addressed women’s views and experiences of intrapartum or early postnatal transfer during a planned home birth. One additional paper was later added, which had a section on two women’s experiences of transfer.

There were five papers that remained. Quality appraisal was undertaken using the Critical Appraisal Skills Programme checklist for appraisal of qualitative research.

There were five papers that remained for inclusion in the metasynthesis. These five papers included data from 89 women.

**FIGURE 1** Selection process of papers for inclusion in metasynthesis.
As described in the search strategy, qualitative studies that specifically addressed women’s views and experiences of intrapartum or early postpartum transfer were drawn from the larger search. Mixed method studies that included a qualitative section were also useful.

3. Reading and repeated reading, noting themes and concepts inherent in the text

Ideas started to form about how the studies related by reading and rereading the studies. Copious pencilled notes were made on a hard copy of each paper, about the themes and concepts emerging from each individual paper.

4. Determining relationships between the studies; discerning similarities, connections, and contrasts

From notes on the themes and concepts of each study, ideas began to formulate about which studies were saying similar things (e.g., women felt they were met with negative attitudes upon arrival at hospital), which studies were saying things which were connected (e.g., the different ways in which the benefits of continuity of midwifery carer emerged from the data), and which studies found contrasting things (e.g., in some studies, the home birth midwife was not able to continue caring for the women in hospital, and in other studies, this was expected). A table was constructed to reflect the themes and concepts and the related quotations from women (raw data) representing this (Table 3). A table describing the main elements of each study was also formulated (Table 4).
### Synthesized Categories, Themes, and Related Quotations From the Data

<table>
<thead>
<tr>
<th>COMMUNICATION, CONNECTION, AND CONTINUITY</th>
<th>RELATED QUOTATIONS</th>
</tr>
</thead>
</table>
| Communication of information            | “Originally when I asked for a home delivery and talked to the GP about it, he was sort of fairly honest in explaining . . . because it was a first birth that there was a reasonable chance that I’d end up in hospital” (Creasy, 1997, p. 35).
|                                          | “I needed to know absolutely everything about how it [publicly funded home birth] worked” (Catling-Paull et al., 2011, p. 125).
|                                          | “I don’t like the polarization [sic]; being at home or at the hospital. More communication would have made it easier for everyone involved” (Lindgren et al., 2011, p. 103). |
| Connectedness with a hospital            | “. . . knowing that if I didn’t want to go ahead with it then I could always back out and still go to the hospital. I was fine, I was very relaxed about it” (Catling-Paull et al., 2011, p. 125).
|                                          | “Some of my family thought it was really nice and really good that I was already a patient there and transfer would be really smooth. If I had to transfer it would be ok” (Catling-Paull et al., 2011, p. 125). |
| Continuity                               | “I just like the idea of the backup there, the continuity. I just like the fact that I go to hospital for my appointments and the hospital is the one looking after me” (Catling-Paull et al., 2011, p. 125).
|                                          | “. . . I just wished that my homebirth midwife had been allowed to stay with me” (Lindgren et al., 2011, p. 103).
|                                          | “. . . [Midwife, C] always kept me very focused and in control of the situation, we were . . . worked very well together as a team” (McCourt et al., 2012, p. 8). |

### MAKING THE TRANSITION

| Hostile behaviors                        | “When we came to hospital we felt like aliens, the atmosphere was hostile and I was scared” (Lindgren et al., 2011, p. 103).
|                                          | “The doctor looked me in the eyes and said ‘What would have happened if you hadn’t had the option of coming here when things went wrong?’” (Lindgren et al., 2011, p. 103). |
| Negative attitudes                       | “It was hard to meet people at the hospital, and being confronted with their negative attitudes towards homebirths” (Lindgren et al., 2011, p. 103).
|                                          | “When we came to the hospital I was exhausted and needed to rest but everyone was so upset about my homebirth that I didn’t get a chance to sleep” (Lindgren et al., 2011, p. 103). |
|                                          | “In the postnatal ward we met a midwife who had given birth at home herself, and that was the first time at the hospital I felt that someone had understood me” (Lindgren et al., 2011, p. 103). |

### MAKING SENSE OF EVENTS

| Understanding why transfer occurred      | “The waters broke, and . . . she very calmly just said, ‘Right, the baby has poo-ed inside you, it’s not a big deal, it’s fine. All we have to do now is call an ambulance,’ So I said, ‘OK, that’s fine, not a problem’” (McCourt et al., 2012, p. 8).
|                                          | “The placenta was fixed to the womb, so it couldn’t have come away anyway . . . I did the important bit myself” (Creasy, 1997, p. 36). |
| Acknowledging feelings of disappointment | “I felt like I wasn’t good enough and I felt disappointed that my body didn’t do what it was supposed to do” (Lindgren et al., 2011, p. 103).
|                                          | “I think there’s disappointment or a sense of loss too. Part of me feeling disappointed in my body . . . Loss of not doing it as I thought I could do it” (Dahlen et al., 2010, p. 1982).
|                                          | “Giving birth at home was a dream for me. I thought of it as the best start for the baby, so it was disappointing having to finish the birth at the hospital” (Lindgren et al., 2011, p. 103). |
| Moving forward                          | “For eight weeks I did not embrace motherhood . . . I wouldn’t completely let go of my old life without a baby and not being a mother” (Dahlen et al., 2010 p. 1982).
|                                          | “I was just husting because I couldn’t talk enough about this . . . I got sick of talking about it too, but it was unresolved” (Dahlen et al., 2010, p. 1981).
|                                          | “They would say oh! You’ve got to get on with it. And it was like I don’t need to hear that. I’m going to get on with it but I’d like to also say it’s not that easy” (Dahlen et al., 2010, p. 1982).
|                                          | “This time I needed some help but next time I’ll do it at home all the way!” (Lindgren et al., 2011, p. 103).
<p>|                                          | “I still strongly think that home is the place to be, yes I still will definitely plan another homebirth” (Catling-Paull et al., 2011, p. 126). |</p>
<table>
<thead>
<tr>
<th>Author, Date, Country</th>
<th>Scope and Purpose</th>
<th>Design, Methods</th>
<th>Sampling, Participants</th>
<th>Analytic Strategy</th>
<th>Numbers of Women Providing Raw Data (89 in total)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dahlen et al., 2010, Australia</td>
<td>To explore first-time mothers’ birth experiences</td>
<td>Qualitative, grounded theory design; in-depth interviews 6–26 weeks after birth, lasting between 20 min and 3 hrs</td>
<td>Purposeful and theoretical sampling: 19 primiparous women, 7 planned home births, 1 transferred from planned home birth to a hospital, forceps birth</td>
<td>Grounded theory</td>
<td>There was one woman interviewed.</td>
</tr>
<tr>
<td>Catling-Paull et al., 2011, Australia</td>
<td>To explore multiparous women’s choices and experiences of publicly funded home birth</td>
<td>Interpretivist; semistructured interviews lasting 1 hr, using open-ended questions, in their homes, 6–26 weeks postpartum: Interviews were audio taped.</td>
<td>There were 10 multiparous women, all English speaking—3 were transferred to hospital during intrapartum period. Participants de-identified during transcription from audio tapes.</td>
<td>Thematic analysis, constant comparative method of analysis, categories formed</td>
<td>There were three women interviewed.</td>
</tr>
<tr>
<td>Creasy, 1997, England</td>
<td>To explore women’s experience of transfer from community care to consultant obstetric care in Sheffield, England</td>
<td>Mixed method; during a 6-month period, 122 women booked for community care (GP unit or home birth) were followed prospectively. Consent was obtained at 32 weeks from 112 women. Questionnaires were sent during antenatal and postnatal periods. Women who were transferred were invited for semistructured interviews lasting 30 min. The average timing of interview was 30 days postnatal.</td>
<td>The qualitative part of the study employed purposive sampling. There were 14 women who had been transferred to consultant care in late pregnancy or labor who were invited to participate in a semistructured interview lasting 30 min. There were 12 who agreed. There were 10 who had planned to birth in GP unit; 2 planned home births (1 was transferred in labor for failure to progress and had a ventouse, 1 was transferred postnatally for removal of retained placenta).</td>
<td>Thematic analysis, constant comparative method of analysis, categories formed</td>
<td>Taped interviews were transcribed and analyzed according to grounded theory.</td>
</tr>
<tr>
<td>Lindgren et al., 2011, Sweden</td>
<td>To compare the experiences of women planning a home birth who were transferred and those who completed birth at home</td>
<td>Positivist; quantitative data collection, mixed method analysis</td>
<td>There were 674 women planning a home birth between 1998 and 2005 who were invited to participate. Each of the 671 women who agreed received one questionnaire. There were 95 who were transferred. There were 81 women who responded to open-ended survey questions about their experience of transfer.</td>
<td>Mixed method analysis: quantitative SPSS and qualitative content analysis</td>
<td>There were 81 women who responded to open-ended survey questions.</td>
</tr>
<tr>
<td>McCourt et al., 2012, United Kingdom</td>
<td>To explore organizational and professional issues impacting on safety and quality of care in four different birth settings in the United Kingdom</td>
<td>Qualitative; ethnographic case studies</td>
<td>There were 156 interviews with women and partners, care providers, and stakeholders. There were 50 practice observations and review of 200 documents.</td>
<td>Case study method using interpretive systems approach: Thematic and framework analysis identified five areas. NVivo8 was used to catalogue data.</td>
<td>There were two women interviewed.</td>
</tr>
</tbody>
</table>

Note: GP = general practitioner; SPSS = Statistical Package for Social Sciences.
5. Translation of the studies into each other
This stage looked for more nuanced connections between the raw data from individual studies; what the authors’ interpretations of the data were offering; and how different authors’ interpretations were similar, connected, or contrasting. One example of this was consideration of the contexts of the five papers and the focus each author placed on their interpretation. Despite the studies possessing different foci, emanating from different countries and cultural contexts (United Kingdom, Sweden, Australia), and different groups of women (primiparous women, multiparous women, women in private and publicly funded models of care), it was possible to draw similarities and contrasts between the papers. The identification of these similarities and contrasts enabled connections to be made and draft categories to be developed. Each category identified emerged from in two or more of the papers examined, from quotations of the women (the raw data), and/or interpretations of the individual authors.

6. Synthesizing the translations
A more in-depth synthesis, this phase was a final fermentation process of “connecting the dots.” Consensus (or otherwise) with the authors’ interpretations of their data, adding further layers of interpretation from the data and adding further layers of synthesis to the authors’ interpretations of their data, was achieved. In addition, it was examined whether one author’s interpretation may have illuminated the interpretation of another. An example of this is that issues around continuity of care emanated from all the papers as a determinant of the quality of women’s experiences of transfer. This manifested in various ways, but it was possible to contemplate how the presence or absence of continuity of care could influence a woman’s experience during transfer.

7. Expressing the synthesis
Qualitative research may be expressed in a variety of ways for a range of audiences (Noblit & Hare, 1988). In this case, the expression of the synthesis is in a written form, specifically aimed at a professional journal audience.

FINDINGS

Of the papers, two used grounded theory (Creasy, 1997; Dahlen et al., 2010), two used thematic analysis (Catling-Paull et al., 2011; Lindgren et al., 2011), and one was an ethnographic case study (McCourt et al., 2012). Two papers were from Australia (Catling-Paull et al., 2011; Dahlen et al., 2010), one from Sweden (Lindgren et al., 2011), and two from the United Kingdom (Creasy, 1997; McCourt et al., 2012).

Communication, Connection, and Continuity

Women felt reassured during the antenatal period when they received information about the likelihood and processes of potential transfer. Feeling connected to a hospital during pregnancy helped women feel prepared because they had some knowledge of their destination if transfer were to occur. This category encompasses the themes “communication of information,” “connectedness with a hospital,” and “continuity.”

Communication of Information

Communication of information by caregivers during the antenatal period was an important component of feeling prepared for home birth. Women and families appreciated when caregivers encouraged them to remain open-minded and flexible in their approach to unexpected outcomes.

Originally when I asked for a home delivery and talked to the GP about it, he was sort of fairly honest in explaining... because it was a first birth that there was a reasonable chance that I’d end up in hospital (Creasy, 1997, p. 35).

Women wanted honest and open information on the reality and likelihood of transfer, the practical mechanisms of transfer, the role of the midwife after transfer, and the potential interventions which may occur in hospital. Women provided with such information were more understanding and accepting of events in hospital when transfer occurred. Data from the papers highlighted this, for example,

I needed to know absolutely everything about how it [publicly funded home birth] worked (Catling-Paull et al., 2011, p. 125).

Women also conveyed that the style of the care in hospital felt different from that received in their home. One woman felt that better communication may have ameliorated this by saying,
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I don’t like the polarization; being at home or at the hospital. More communication would have made it easier for everyone involved (Lindgren et al., 2011, p. 103).

Connectedness With a Hospital

Belonging to a publicly funded home birth program promoted feelings of connectedness with the hospital, although there was only one study exploring this specifically. Confidence in the hospital as backup was evident for one woman because she felt she already belonged at the hospital when she went there for antenatal appointments, as highlighted here:

I just like the idea of the backup there, the continuity. I just like the fact that I go to hospital for my appointments and the hospital is the one looking after me (Catling-Paull et al., 2011, p. 125).

Another woman in the publicly funded home birth program had expressed (during her antenatal period) that if she had to transfer, she felt she would be all right. Her family was also reassured by the connectedness with the hospital, as in this quote:

Some of my family thought it was really nice and really good that I was already a patient there and transfer would be really smooth. If I had to transfer it would be ok (Catling-Paull et al., 2011, p. 125).

Flexibility was provided by a sense of belonging to the hospital and the ability to change place of birth plans at any time if necessary or desired:

... knowing that if I didn’t want to go ahead with it then I could always back out and still go to the hospital. I was fine, I was very relaxed about it (Catling-Paull et al., 2011, p. 125).

Continuity

One of the reasons home birth was chosen by women in the studies was because of the continuity of caregiver that is integral to the model of care. Continuity or lack thereof remained an important determinant in coming to terms with being transferred. When the home birth midwife was not able to continue caring for the woman in hospital, this was seen as a negative (Lindgren et al., 2011):

... I just wished that my homebirth midwife had been allowed to stay with me (Lindgren et al., 2011, p. 103).

Known caregivers provided reassurance by being able to communicate in a way that was appropriate to the individual woman. Explanations which were tailored to a woman’s individual needs and to her state of mind and body at the time were more helpful. Women were more trusting of information given by a caregiver with whom they had a rapport:

... [Midwife, C] always kept me very focused and in control of the situation, we were ... worked very well together as a team (McCourt et al., 2012, p. 8).

Making the Transition

The phase of making the transition from home to hospital was often made more difficult for women because of hostile behaviors and negative attitudes displayed by hospital staff. These themes are reflected here.

Hostile Behaviors

Hostile behaviors displayed at the hospital added to women’s feelings of vulnerability and fear upon arrival. There were several quotes conveying this:

When we came to hospital we felt like aliens, the atmosphere was hostile and I was scared (Lindgren et al., 2011, p. 103).

The doctor looked me in the eyes and said “What would have happened if you hadn’t had the option of coming here when things went wrong?” (Lindgren et al., 2011, p. 103).

... I wish they had been more accommodating (Lindgren et al., 2011, p. 103).
Experiences of Women Planning a Home Birth Who Require Intrapartum Transfer to Hospital

Negative Attitudes

Negatives attitudes displayed by hospital staff about home birth caused one family to feel marginalized in the hospital setting, with two women saying,

*It was hard to meet people at the hospital, and being confronted with their negative attitudes towards homebirths (Lindgren et al., 2011, p. 103).*

*When we came to the hospital I was exhausted and needed to rest but everyone was so upset about my homebirth that I didn't get a chance to sleep (Lindgren et al., 2011, p. 103).*

On the other hand, one woman met a midwife on the hospital postnatal ward who had herself had a home birth. This appeared to reduce her feelings of alienation. She said,

*In the postnatal ward we met a midwife who had given birth at home herself, and that was the first time at the hospital I felt that someone had understood me (Lindgren et al., 2011, p. 103).*

Accepting and appreciating the care of the hospital staff was a positive coping strategy used by some women. The ability to adopt this attitude, however, was dependent on the woman's personality and the circumstances surrounding the transfer (Creasy, 1997).

Making Sense of Events

The category involves three themes: “understanding why transfer occurred,” “acknowledging feelings of disappointment,” and “moving forward.”

Understanding Why Transfer Occurred

Information and preparation provided by the midwife at the time of transfer enhanced the women’s sense of control (Creasy, 1997; Lindgren et al., 2011). Women found it important to understand clearly why the transfer needed to occur. Transfer to hospital was seen by some as a threat to their ability to listen to their body in labor, and this in turn threatened their sense of control over the situation (Lindgren et al., 2011). Women who understood that there were clear cut indications for transfer and interventions seemed to feel more easily ready to accept the situation (Creasy, 1997). They were more likely to believe that the clinical picture was beyond their control, for example,

*The placenta was fixed to the womb, so it couldn't have come away anyway . . . I did the important bit myself (Creasy, 1997, p. 36).*

*The waters broke, and . . . she very calmly just said, “Right, the baby has poo-ed inside you, it's not a big deal, it's fine. All we have to do now is call an ambulance.” So I said, “OK, that's fine, not a problem” (McCourt et al., 2012, p. 8).*

Acknowledging Feelings of Disappointment

A sense of loss of the plans to give birth at home and feelings of disappointment were common. Women described feeling that their bodies had not performed to their expectations. Some examples of this include the following:

*I felt like I wasn't good enough and I felt disappointed that my body didn't do what it was supposed to do (Lindgren et al., 2011, p. 103).*

*I think there's disappointment or a sense of loss too. Part of me feeling disappointed in my body . . . Loss of not doing it as I thought I could do it (Dahlen et al., 2010, p. 1982).*

Disappointment at not having the baby at home and disappointment in their bodies manifested feelings of lost dreams (Dahlen et al., 2010; Lindgren et al., 2011), which were often profound. These lost dreams seemed to create a sense of failure, that the woman's body was not good enough, and did not do what it was supposed to do (Lindgren et al., 2011). Women expressed this by saying,

*Giving birth at home was a dream for me. I thought of it as the best start for the baby, so it was disappointing having to finish the birth at the hospital (Lindgren et al., 2011, p. 103).*
Experiences of Women Planning a Home Birth Who Require Intrapartum Transfer to Hospital

Fox et al.

Preparation of women, through the provision of information during the antenatal period; optimal communication and professional behavior at the time of transfer; and the provision of postbirth counselling may significantly improve women's levels of coping with unexpected outcomes. Optimizing opportunities for the provision of continuity of midwifery care and building a sense of connection between women planning a home birth and their backup hospital are organizational aspects which may be addressed.

The findings show that receiving information during the antenatal period is important to women. The literature also demonstrates that antenatal education increases maternal satisfaction with the birth experience (Walsh, 2012), reduces anxiety levels for women, and increases partner involvement in labor and birth (Ferguson, Davis, & Browne, 2013). The potential for quality antenatal education to prepare couples emotionally for childbirth appears to be at the heart of this association. Both cognitive and affective aspects are equally important to the preparation of women and their support people (Ferguson et al., 2013), and this may logically be assumed to apply when assisting women to feel ready for the possibility of transfer during or after planned home birth.

Gaining familiarity, during the antenatal period, with the personnel, processes, and environment of the backup hospital seems to enhance confidence in women and reassure their families. When women planning a home birth were prepared during pregnancy for the possibility of transfer, and were familiar with the hospital processes and environment, it created a sense of safety and security for them and their families. This familiarity may have created more realistic expectations, which may be important for primiparous women who have a higher likelihood of transfer than do multiparous women. This sense of security was evident in the paper about publicly funded home birth (Catling-Paull et al., 2011). Although the Catling-Paull et al. (2011) study was limited to multiparous women, the women's comments displayed a strong sense of confidence in the hospital with which they felt connected.

The findings include quotes from several women who described meeting with negative attitudes toward home birth among hospital staff. This finding is of particular concern because the behavior described contravenes the International Confederation of Midwives (ICM) International Code of Ethics for Midwives (2008). According to the code, midwives must support the right of women and families to participate in decisions about

Moving Forward
This theme was about the women being able to process what had occurred, by talking it through as much as they felt was needed. One woman described feeling that she couldn't talk enough about it but simultaneously was sick of talking about it because she felt the issues remained unresolved. This process was a type of retrospective sense making, a justification for events.

DISCUSSION
This analysis identifies, from women's perspectives, several potential improvements in care during transfer to hospital from a planned home birth. Preparation of women, through the provision of information during the antenatal period; optimal communication and professional behavior at the time of transfer; and the provision of postbirth counselling may significantly improve women's levels of coping with unexpected outcomes. Optimizing opportunities for the provision of continuity of midwifery care and building a sense of connection between women planning a home birth and their backup hospital are organizational aspects which may be addressed.

For eight weeks I did not embrace motherhood . . . I wouldn't completely let go of my old life without a baby and not being a mother (Dahlen et al., 2010, p. 1982).

I was just busting because I couldn't talk enough about this . . . I got sick of talking about it too, but it was unresolved (Dahlen et al., 2010, p. 1981).

They would say oh! You've got to get on with it. And it was like I don't need to hear that. I'm going to get on with it but I'd like to also say it's not that easy (Dahlen et al., 2010, p. 1981).

This time I needed some help but next time I’ll do it at home all the way! (Lindgren et al., 2011, p. 103).

I still strongly think that home is the place to be, yes I still will definitely plan another homebirth (Catling-Paull et al., 2011, p. 126).
their care and must also respond to the psychological and emotional needs of women seeking care, whatever their circumstances.

As Dahlen et al. (2011) suggest, it may be more appropriate for maternity care providers to reflect on why women choose to birth outside mainstream hospital services, than to make negative judgements about their choices. Widely recognized is that opposing paradigms exist around perceptions of risk and safety in relation to maternity care (Anderson & Murphy, 1995; Ashley & Weaver, 2012; Bick, 2012; Blix, Oian, & Kumle, 2008; Cheyney & Everson, 2009; Foley & Faircloth, 2003; Homer, 2010; McMurtrie et al., 2009; Walsh, 2000).

Polarization of attitudes to the safety of home birth is a key concept in the literature (Catling-Paull et al., 2012; Chervenak, McCullough, Brent, Levene, & Arabin, 2013; Cheyney & Everson, 2009; Dahlen, 2012; Homer, 2010). Issues such as hostile behaviors displayed toward women after transfer from planned home birth are perhaps implicitly buried in this paradigmatic problem.

Women who have chosen home birth commonly face challenges in advocating for their decisions, the reasons for which are complex (Cheyney, 2008). The process of choosing and planning a home birth involves working outside accepted norms and navigating around obstacles in an established maternity care system (Cheyney, 2008). Communicating with relatives, friends, and/or health professionals about their choice of birthplace is often problematic because the decision to have a home birth challenges hegemonic biomedical beliefs (Cheyney, 2008; Jordan, 1997). A range of belief systems may exist concurrently in any particular sphere. Some views will dominate, either because they are more efficacious or because they carry a stronger structural power base, often both. When one view gains acceptance, alternative types of knowledge may become devalued. Individuals who subscribe to alternative, nonhegemonic belief systems are often seen as uninformed, naïve, or pestilent (Jordan, 1997). Cheyney (2011) describes choosing home birth is an act of resistance, demonstrating avoidance of a "doctor-up, mother-down hierarchy" (p. 531).

Cheyney (2008) applies the notion of a "systems-challenging praxis," a term derived from the critical medical anthropology work of Singer (1995). According to Cheyney (2008), cultivation of this praxis involves three stages. The first stage involves questioning accepted public narratives around childbirth, the second constructing counternarratives to become empowered and, finally, belonging to and becoming supportive of an alternative collective belief (Cheyney, 2008). This very process may play a role in the difficulty some women experience during a transfer to hospital and may even, in some cases, result in their reluctance to be transferred. The transfer, occurring during labor, a vulnerable time for most women, involves a fundamental paradigm shift to begin to accept the very systems and values they had previously resisted. Hostile behaviors by hospital staff are likely to exacerbate women's feelings of fear and vulnerability as they make the transition to being cared for in hospital.

Access to clear and accurate information at the time of transfer is beneficial, especially for those experiencing complications of a traumatic nature. Unexpected and dramatic events, which may disrupt a woman's belief systems and sense of control, are likely to be psychologically distressing (Gamble &Creedy, 2009). Women value the opportunity to talk about events, to accept feelings of disappointment and move on to the next phase of their lives. This next phase will include either transition to parenting or embarking on grief reactions, neither of which are insignificant experiences. Resolving issues around the birth itself is therefore imperative. In a study by Creedy, Shochet, and Horsfall (2000), one in three women reported a stressful birth, as well as demonstrating three or more symptoms of trauma within 6 weeks of birth. Of the women surveyed, 5.6% were also diagnosed with an acute posttraumatic stress disorder (PTSD). Midwives have the opportunity to provide emotional and psychological support for women experiencing such distress during the postpartum period. Postbirth counselling has been explored in the literature and found to be beneficial for many women (Fenwick et al., 2013).

For some women, transfer was largely a negative event that resulted in varying degrees of disappointment and loss. Questions emerge as to whether a more positive attitude to transfer could be constructed by negotiating women's expectations differently. Transfer in and of itself is not a poor clinical outcome. In some settings, early labor assessment is done at home, and no firm decisions need to be made regarding place of birth until labor has established (Brintworth & Sandall, 2013; McCourt et al., 2012). Conversely, the findings show that access to continuity of carer and the standard of care received in hospital has an important impact on the way women experience transfer (Creasy, 1997; Lindgren et al., 2011).

Finally, the concept of continuity of carer and its implications for women's experiences emanates from all three categories in various ways. One of the reasons home birth is chosen by women is because of the...
continuity of caregiver that is integral to the model of care (Longworth, Ratcliffe, & Boulton, 2001). The value of rapport, trust, and confidence that women develop with a known midwife is widely recognized as being associated with improved outcomes and higher maternal satisfaction. A Swedish quantitative study (Lindgren et al., 2008) found that women having their first baby and planning a home birth were four times more likely to be transferred to hospital if the midwife attending the home birth was different from the midwife they had seen during pregnancy. Although the provision of continuity of carer may not be possible in all transfer settings, all of the time, the findings suggest that optimizing opportunities for continuity of midwifery carer for women through the transfer process is beneficial. There is inherent value in personalized maternity care and this would inevitably add to the quality of support felt by women being transferred (Creasy, 1997). In the late 20th century, concern grew that maternity care in many settings was becoming increasingly fragmented (McCourt, Stevens, Sandall, & Brodie, 2006). A ground-swell of midwifery literature evidencing and discussing the value of midwifery continuity of care was published around the start of the new millennium (Hatem, Sandall, Devane, Soltani, & Gates, 2008).

A known midwife has the capacity to enhance communication and provide individualized information to women at all three of the crucial stages of childbearing (antenatal period, time of transfer, and postbirth). During transfer, providing continuity of carer provides the midwife, at the very least, the opportunity to enable a smooth handover to hospital staff. At best, women need not lose the care of their known midwife simply because they require transfer. One might argue that this is a vulnerable time when a woman needs support and advocacy from her known midwife more than ever. Follow up from a known midwife during the postnatal period facilitates an opportunity for women to talk about their experience with a trusted caregiver.

**FURTHER RESEARCH**

Further research is needed to explore how home birth midwives view and experience transfer and how hospital staff encounter receiving women who are transferred from planned home birth. Gaining understanding of health care providers’ views and experiences may clarify the challenges involved in transfer processes and illuminate how a more collaborative service may ameliorate some of the challenges faced.

Empirical research is needed in the Australian setting to explore the views and experiences of women and health professionals involved in home birth transfers. Publicly funded home births in the Australian setting will be examined specifically in relation to transfer to hospital, as part of the Birthplace in Australia project.

The reasons for a four- to fivefold increase in the likelihood of transfer for a primiparous woman in comparison to a multiparous woman needs further exploration to investigate any association with poorer outcomes for primiparous women and their babies.

**CONCLUSION**

This study will hopefully stimulate further discourse around home birth transfer processes. Women’s choices around place of birth are complex, involving social perspectives and personal definitions of emotional safety. Despite high transfer rates and perinatal mortality rates in some studies, many women will still choose home birth. Understanding the views and experiences of women who are transferred to hospital after planning a home birth is important because it may help to inform the development of woman centered care practices and help to improve the attitudes and behaviors of health professionals involved. Maximizing opportunities to provide women with continuity of midwifery carer, especially from home to hospital, may help to streamline the transfer process and improve safety and well-being for women and babies in such situations. Improving the quality of care during and after transfer and maintaining safety for women choosing home birth is paramount. Quality and clarity of communication, feeling connected to the backup hospital, and receiving continuity of midwifery care helps make the transfer process as seamless as possible for women. Arriving at the hospital is a time of vulnerability and fear for women and the presence of a known midwife will provide valuable support at this time. New caregivers must be sensitive to the woman’s need for reassurance and acceptance. The reasons for transfer need to be clearly communicated to women at the time of transfer and the circumstances fully understood in more detail during the postpartum recovery period. This can be done in a sensitive and individualized manner by a known caregiver. Women need to talk through their experience and to acknowledge their feelings of disappointment to move forward in the next phase of their lives. This synthesis aims to create a starting point toward understanding, from women’s perspectives, how home birth transfer processes may be improved.
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Maternal Obesity and the First Birth: A Case for Targeted Contemporary Maternity Care

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BACKGROUND: Obesity in childbearing women is associated with poorer pregnancy and birth outcomes, particularly caesarean section, compared with normal-weight women. The high caesarean section rate may reflect care and outcomes which occur at the time surrounding the first birth.

AIM: To describe the birth outcomes of extremely obese pregnant women (body mass index [BMI] of 40 or more) experiencing their first birth.

METHODS: Clinical audit was used to systematically review the care and birth outcomes of all extremely obese pregnant women experiencing their birth at one study site during a 2-year period in 2009 and 2010. Fifty participants birthed during the study period. Data were collected from booking to discharge from the maternity service and included variables such as model of care, number of appointments, and obstetric and neonatal outcomes. Descriptive statistics were used to describe and synthesize the data. Inferential statistics were used to draw inferences about the population.

RESULTS: Obese women rarely had contact with a midwife, except at booking, receiving a standard model of care provided by numerous caregivers, most often inexperienced medical staff. More than half of the obese women experienced a caesarean section (56%), 2.3 times that of normal-weight primiparous women who birthed at the study site during the same period (24.2%). This was despite 64% experiencing normal pregnancy free from any complication. For women who planned to labor, birth intervention including induction of labor, augmentation for slow labor, epidural, and continuous cardiotocography was high. Caesarean occurred most often for “failure to progress” and “failed induction.”

CONCLUSION: Clinical audit was useful in determining information, which suggests current maternity care provision is not meeting the needs of extremely obese women experiencing their first birth.

IMPLICATIONS FOR PRACTICE: The development of effective, targeted antenatal care designed to meet the needs of extremely obese women is recommended as are strategies to keep birth normal.

KEYWORDS: pregnancy; body mass index; morbid obesity; caesarean section; gestational diabetes; cardiovascular pregnancy complications

INTRODUCTION

The prevalence of maternal obesity is increasing exponentially with reports of it reaching epidemic proportions throughout the developed world, mirroring that of obesity in the general population (World Health Organization [WHO], 2012). This is concerning given that maternal obesity is now recognized as a key risk factor for adverse outcomes for both women and their babies (Centre for Maternal and Child Enquiries [CMACE], 2011) such as hypertensive disorders (Abenhaim, Kinch, Morin, Benjamin, & Usher, 2007; Dodd, Grivell, Nguyen, Chan, & Robinson, 2011; Knight, Kurinczuk, Spark, & Brocklehurst, 2010; Mbah et al., 2010), diabetes (Abenhaim et al., 2007; Athukorala, Rumbold, Willson, & Crowther, 2010; Dodd et al., 2011; Knight et al., 2010), thromboembolism (CMACE, 2011), and caesarean section (CS). The number of women experiencing
CS has been shown to increase in a dose-related fashion with increasing body mass index (BMI; Abenhaim et al., 2007; Bhattacharya, Campbell, Liston, & Bhattacharya, 2007; Chu et al., 2007; Khaskan & Kenny, 2009; Knight et al., 2010; Mantakas & Farrell, 2010; Mbah et al., 2010; Poobalan, Aucott, Gurung, Smith, & Bhattacharya, 2009; Sebire et al., 2001; Usha Kiran, Hemmadi, Bethel, & Evans, 2005). Work undertaken with Australian childbearing women has demonstrated comparable trends (Athukorala et al., 2010; Dodd et al., 2011). Similarly, health statistics data obtained for one hospital in South East Queensland revealed that in 2010, the CS rate for normal-weight women (BMI of 19–24) was 24.5%, increasing exponentially with BMI to 29.1% for BMI of 25–29, 32.9% for BMI of 30–34, 33.3% for BMI of 35–39, and 43.8% for BMI of 40 or more (Health Statistics Centre Queensland Health, 2012).

In addition, there is a growing body of evidence that identifies a strong association between primiparity and increased CS rates in obese women. A systematic review of 11 studies (N = 209,193) conducted by Poobalan et al. (2009) reported obese primiparous women (defined as BMI of 35 or more) were three times more likely to experience CS compared with their normal-weight counterparts (crude pooled odds ratio 3.38, 95% CI [2.49, 4.57]). Similar results are reported by others (Bhattacharya et al., 2007). Although there is no doubt that maternal ill health and subsequent concerns for the fetus are likely to play some part in the increased rates of CS, the sheer number of caesareans in this group of women suggests that there may be other contributing factors.

One of the most important strategies for reducing the overall CS rate is to reduce the number of primary CSs. Gaining a better understanding of all the factors associated with a primary caesarean in this group of women may assist health care professionals improve the quality of maternity care and ultimately, a woman’s reproductive health.

Although there is a lack of evidence pertaining to the care and outcomes of women with very severe obesity (defined as BMI of 40 more; WHO, 2000), there is also no agreed term to describe obesity subgroups beyond this BMI. Recent work describing the prevalence and outcomes of women with a BMI of 50 or greater have used various terms including super obese, morbid obese, or extremely obese (Australasian Maternity Outcomes Surveillance System, 2010; Knight et al., 2010; Mbah et al., 2010). Because there is currently no standard agreed terms, this article will define subgroups not currently described elsewhere as moderately obese (BMI of 40–44), extremely obese (BMI of 45–49), and super-extremely obese (BMI of 50 or more).

**AIM**

This article presents the birth outcomes of moderate to super-extremely obese pregnant women (BMI of 40 or more) experiencing their first birth. The results are part of a larger study exploring the health service usage and outcomes of extremely obese Australian women (Slavin, Fenwick, & Gamble, 2013).

**Ethical Approval**

Ethical approval to conduct the project was granted by the Hospital District Human Research Ethics Committee (HREC) and Griffith University HREC.

**METHOD**

This study used a retrospective, clinical observation research design.

**Setting**

The study was carried out at one maternity unit in South East Queensland, Australia. The unit manages low-, medium-, and selected high-risk pregnancies for approximately 3,500 women per year. Midwife antenatal care is offered to women with no medical or obstetric complications. Specialist care is provided to women who have identified risk factors and/or who develop complications during pregnancy including women with moderate to extreme obesity. Between 2009 and 2010, 6,995 women birthed at the study site. This included 3,082 (44.1%) women experiencing their first birth, which is only slightly higher than the national average of 41.6% (Li, McNally, Hilder, & Sullivan, 2011). A further 3,913 (55.9%) women experienced their second or subsequent births. The overall prevalence of moderate to super-extremely obese women (BMI of 40) was 21.9 per 1,000, (n = 153; Health Statistics Centre Queensland Health, 2010).

**Sample**

The primary target population was 50 pregnant women experiencing their first birth with a self-reported pre-pregnancy booking BMI of 40 who birthed at the study site between January 1, 2009 and December 31, 2010. This represents 32.7% of the larger group.
Data Collection

Using a specifically designed audit tool, clinical audit was used to identify several outcome variables including maternity service use and birth outcomes from booking to discharge from maternity care (Slavin, Fenwick, & Gamble, 2013).

Data Analysis

Data were entered into Statistical Package for the Social Sciences (SPSS) database version 19. Descriptive statistics were initially used to describe and synthesize the data. Inferential statistics were subsequently used to make inferences about the population. Relationships between categorical variables were examined using chi-square analyses, between continuous variables using Pearson’s product–moment correlation test and for relationship between continuous and categorical variables using one-way analysis of variance (ANOVA). An alpha level of 0.05 was used for all statistical tests. Outcome measures were defined according to the definitions within the literature.

RESULTS

Participant Characteristics

Fifty moderate to super-extremely obese women birthed their first baby during the study period. The average age of participants was 28 years (SD = 5), which is the same as the Australian national average for 2009 (Li et al., 2011). Most women were in the moderate obese group (BMI of 40–44; n = 37, 74%), with the remaining 26% of women being in the extreme to super-extreme obese groups.

Antenatal: Model of Care

Women generally booked for maternity care at 20 weeks’ gestation (range = 8–38 weeks) and attended 12 (range = 1–21) antenatal visits. Most women experienced shared care with their general practitioner attending the hospital at some point during their pregnancy. When women did attend the hospital antenatal clinic, they were seen by several different clinicians (n = 6, 1–16; see Table 1), most of whom were medical staff in various stages of their training program (residents and registrars). Most women only saw a midwife at their booking visit. In this group of first-time mothers, the nonattendance rate was 55.3%, five times the nonattendance rate of the general maternity population during the same period (10.8%; Decision Support Services Queensland Health, 2012). Just less than half the women attended some form of antenatal education classes (n = 24, 48%).

Although 32 women (64%) experienced normal, healthy pregnancies free from complications, 8 (16%) women developed or were treated for hypertension and 10 (20%) for diabetes. The development or treatment of both diabetes and hypertension was rare (n = 2, 4%).

Birth Outcomes

Labor

Only 17 (34%) women experienced spontaneous onset of labor, whereas 25 (50%) experienced an induction of labor (IOL). The most common reason for IOL was postdates pregnancy (n = 8, 32%). Hospital policy at the time of data collection was routine IOL at term plus 10 days regardless of cervical favorability. The other main reasons for induction were diabetes (n = 6, 24%), prelabour rupture of membranes (n = 5, 20%), and hypertensive disease (n = 3, 12%). One woman was induced following an intrauterine fetal death at 27 weeks’ gestation. Eight separate reasons were provided for IOL.

Four women who commenced the induction procedure with the administration of vaginal synthetic prostaglandin did not dilate sufficiently to allow artificial rupture of membranes (ARM). A further two

<table>
<thead>
<tr>
<th>TABLE 1</th>
<th>Overview: Antenatal Visits Experienced by Obese Women</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ANTENATAL (AN) APPOINTMENTS</strong></td>
<td><strong>N = 50</strong></td>
</tr>
<tr>
<td>Booking gestation (weeks)</td>
<td>20 (8–38)</td>
</tr>
<tr>
<td>Number of AN visits</td>
<td>12 (1–21)</td>
</tr>
<tr>
<td>Number of staff seen</td>
<td>6 (1–16)</td>
</tr>
<tr>
<td>Number of GP visits</td>
<td>43 86</td>
</tr>
<tr>
<td>Number of midwife visits</td>
<td>49 98</td>
</tr>
<tr>
<td>Number of junior doctor visitsa</td>
<td>43 86</td>
</tr>
<tr>
<td>Number of senior doctor visitsb</td>
<td>37 74</td>
</tr>
<tr>
<td>Number of obstetric consultant visits</td>
<td>7 14</td>
</tr>
<tr>
<td>Number of failure to attend visitsc</td>
<td>26 54</td>
</tr>
<tr>
<td>AN education classes</td>
<td>24 48</td>
</tr>
</tbody>
</table>

Note. GP = general practitioner.

aResident, intern, junior house officer. bRegistrar, primary health organization. cExcludes two stillbirths.
women did experience ARM and synthetic oxytocin infusion but did not establish in labor. All four women subsequently experienced a CS for “failed IOL.”

For women who experienced labor (n = 38), birth interventions were high. In addition to the high IOL rate, a further 13 (34.2%) women experienced augmentation with either ARM and/or synthetic oxytocin infusion following a diagnosis of dysfunctional labor.

Although 19 women (50%) had an epidural sited during labor, which subsequently lead to electronic fetal monitoring using continuous cardiotocography (CTG), almost all the women (95%) with a live fetus were monitored in this way. Most babies were monitored directly using a fetal scalp electrode (n = 25, 65.8%). Perhaps not surprisingly, less than 40% of the women were reported to be mobile in labor (15 out of 38, 39.5%).

**Birth Mode**

Twenty-two women birthed vaginally (spontaneously [n = 15, 30%], assisted [n = 7, 14%]; see Table 2). In total, 28 women (56%) birthed their baby by CS. This is almost 2.5 times that of normal-weight primiparous women at the study site during the same period. Of the 1,386 normal-weight (defined as BMI of 20–24) primiparous women, 335 (24.2%) experienced CS.

Seven women experienced planned elective CS, and a further 21 experienced emergency CS (see Table 3). One woman in the emergency group was booked for elective surgery for breech but experienced emergency CS following the onset of spontaneous labor.

**TABLE 2** Overview: Labor Onset and Mode of Birth for Women Experiencing Their First Birth

<table>
<thead>
<tr>
<th>Age (years)</th>
<th>N = 50</th>
<th>%</th>
<th>M (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Onset of labor</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spontaneous</td>
<td>17</td>
<td>34</td>
<td></td>
</tr>
<tr>
<td>Induction of labor</td>
<td>25</td>
<td>50</td>
<td></td>
</tr>
<tr>
<td>Elective caesarean</td>
<td>8</td>
<td>16</td>
<td></td>
</tr>
<tr>
<td>Mode of birth</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spontaneous vaginal</td>
<td>15</td>
<td>30</td>
<td></td>
</tr>
<tr>
<td>birth</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vaginal (vacuum)</td>
<td>4</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>Vaginal (forceps)</td>
<td>3</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Caesarean section</td>
<td>28</td>
<td>56</td>
<td></td>
</tr>
<tr>
<td>BMI group</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>40–44</td>
<td>37</td>
<td>74</td>
<td></td>
</tr>
<tr>
<td>45–49</td>
<td>6</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td>≥50</td>
<td>7</td>
<td>14</td>
<td></td>
</tr>
</tbody>
</table>

Note. BMI = body mass index.

**TABLE 3** Indication for Caesarean Section

(Elective and Emergency; N = 28)

<table>
<thead>
<tr>
<th></th>
<th>ELECTIVE (N = 7)</th>
<th>EMERGENCY (N = 21)</th>
</tr>
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<tbody>
<tr>
<td>n (%)</td>
<td></td>
<td>n (%)</td>
</tr>
<tr>
<td>Failure to progress</td>
<td>10 (35.7)</td>
<td>6 (21.4)</td>
</tr>
<tr>
<td>Failed IOL</td>
<td>6 (21.4)</td>
<td></td>
</tr>
<tr>
<td>Fetal distress</td>
<td>4 (14.3)</td>
<td></td>
</tr>
<tr>
<td>Breech</td>
<td>2 (7.1)</td>
<td>1* (3.6)</td>
</tr>
<tr>
<td>Maternal request</td>
<td>2 (7.1)</td>
<td></td>
</tr>
<tr>
<td>Vasa praevia</td>
<td>1 (3.6)</td>
<td></td>
</tr>
<tr>
<td>Macrosomia</td>
<td>1 (3.6)</td>
<td></td>
</tr>
<tr>
<td>High head</td>
<td>1 (3.6)</td>
<td></td>
</tr>
</tbody>
</table>

Note. IOL = induction of labor.

*Planned elective CS for breech; progressed to emergency CS following spontaneous labor.

For the 20 unplanned CS, there were eight different reasons documented. However, “failure to progress” and “failed induction” were the most common and accounted for more than half of the caesareans performed. Breech presentation and “maternal request” accounted for more than half of all elective procedures (see Table 3). No woman was documented as having a planned elective CS for the comorbidities associated with obesity.

When comparing women who birthed vaginally to women who birthed by CS following planned labor (excluding planned elective CS), the groups of women were similar in many respects. There was no significant difference in maternal age, infant birth weight, onset of labor, epidural, diabetes, or hypertension for women who birthed vaginally or by CS. Furthermore, there was no significant association between BMI group and mode of birth χ²(2, [n = 42] = .81, p = .67, Cramér’s V = .14).

**Neonatal Outcomes**

There were 50 babies born including 2 stillborn babies born at 22 and 27 weeks’ gestation. This is a concerning finding because the stillbirth rate of 40 per 1,000 births is more than five times that of the general Australian population (4% vs. 0.78%, retrospectively; Li et al., 2011). Live babies were generally born in good condition, with 5 out of 48 (10.4%) babies requiring neonatal resuscitation. Although 4 out of 48 (8.3%) required intermittent positive pressure ventilation via bag and mask, this is only slightly higher than the general population of 7.2% (Li et al., 2011). One baby (2.1%) required cardiac compressions, which is six times higher than the general population of 0.3% (Li et al., 2011).
Twenty-seven (56.3%) babies were admitted to or were cared for by the special care nursery. Main reasons were maternal diabetes \((n = 7)\), suspected infection \((n = 6)\), and macrosomia (birth weight more than 4,500 g; \(n = 5)\). Two live-born babies were premature at 35 and 36 weeks’ gestation. Average birth weight was 3,720 g \((SD = 519 g)\).

**DISCUSSION**

The results reported in this article demonstrate that moderate to super-extremely obese women having their first baby commonly experience quite different birth outcomes to those of normal-weight women and the general population. Although the overall CS rate for primiparous women in Australia is 32.8% (Li et al., 2011) and for the study site for the same period was 26.6%, the CS rate for the cohort of women in this study was more than double (56%). This was despite 64% of the women experiencing normal, healthy pregnancies free from complications other than obesity itself.

For women who planned to labor, birth interventions were high. For example, almost 60% of these women experienced an induction. Although the authors of two systematic reviews (Caughey et al., 2009; Gülmezoglu, Crowther, & Middleton, 2006) concluded that IOL does not increase the CS rate, a significant methodological critique of this work calls into question the appropriateness of routine IOL for well women and fetuses before 42 weeks’ gestation (King, Pilliod, & Little, 2010; Mozurkewich, Chilimigras, Koepke, Keeton, & King, 2009). There is also increasing evidence that primiparous women having an IOL are the largest group contributing to the CS rate (Brennan, Murphy, Robson, & O’Herlihy, 2011; Slavin & Fenwick, 2012). Certainly, one could argue that the risk of stillbirth in extremely obese pregnant women perhaps justifies IOL. Clinicians, however, need to assist women carefully weigh up the risks because surgical birth itself is associated with increased morbidity especially in this group of women (Belizán, Althabe, & Cafferata, 2007; Stivanello et al., 2010).

Similarly, rates of augmentation for dysfunctional labor were also high in this study with more than 90% of women experiencing either IOL or augmentation. With a strong association between the use of Syntocinon and increased perceptions of pain, it is not surprising that half the women used epidural for pain management (Hildingsson, Karlström, & Nystedt, 2011). Likewise, the use of continuous fetal monitoring (CTG) was high with all but two women being monitored in this way. Although there are often concerns with being able to accurately listen and record fetal heart rates in extremely obese women, the use of CTG is strongly associated with increased rates of CS (Alfirevic, Devane, & Gyte, 2006).

In light of the increasing CS rate, there is currently an international drive to “keep birth normal” particularly during the first birth (Commonwealth of Australia, 2011; NSW Department of Health, 2010; Maternity Care Working Party, Royal College of Midwives, Royal College of Obstetricians and Gynaecologists, National Childbirth Trust, 2007). The results of this study add to the existing literature and support the need to keep birth normal and avoid unnecessary interventions especially in obese women having their first baby. In this group of childbearing women, although some might argue that birth interventions should be considered “part and parcel” of care, the dilemma of whether such intervention acts as a paradox or panacea appears clear. Obese women experienced very high rates of birth intervention including IOL, augmentation, epidural, and CTG use. Although there is now increasing evidence to suggest IOL should be reserved only for those women with clear medical indications, the obese women in this study experienced IOL for a myriad of ambiguous reasons. Given the evidence, one could postulate that the high rate of medical intervention that occurred during labor may in fact be a mediating factor contributing to the high CS rate experienced by primiparous obese women who plan to labor. Consequently, there is a need to identify strategies aimed at reducing unnecessary interventions in labor especially for those women experiencing their first labor and birth.

**Antenatal Care—A Gift or Pandora’s Box?**

Although each woman’s pregnancy, labor, and birth process contribute to her birth outcomes, there is now a substantial body of evidence that suggests that how women are cared for during their pregnancy and labor can significantly affect their birth outcomes. For example, continuity of midwifery care is associated with reduced birth interventions (Hodnett, Gates, Hofmeyr, Sakala, & Weston, 2011; Jackson et al., 2003) as well as increased vaginal birth rates, reduced CS rates, and reduced special care nursery admissions (Hartz, Foureur, & Tracy, 2012; Hatem, Sandall, Devane, Soltani, & Gates, 2008; Henderson, Hornbuckle, & Doherty, 2007; Sandall, Soltani, Gates, Shennan, & Devane, 2013; Turnbull et al., 2009). The women in this study predominantly experienced fragmented medical care. When accessing
hospital care, these women were mainly seen by medical practitioners still in various stages of their training program with limited midwifery as well as consultant input. The care received by the women included in this study mirrors that of the general maternity population within the study site. Most women who currently attend hospital for pregnancy care receive limited continuity of care in busy clinics. Medical clinics are routinely overbooked with no midwifery support. Women who develop complex needs therefore often receive no midwifery care. The findings of this study may therefore be seen in other high-risk groups of women who receive routine hospital-based obstetric care.

The number of women not attending appointments was also significant. For example, more than half the women \( (n = 26, 55\%) \) had missed appointments with 13 women missing two or more appointments. This is five times the rate in the general pregnant population \( (10.8\%; \text{Decision Support Services Queensland Health, 2012}) \). There may have been a myriad of reasons for this outcome such as lack of transport and poor social circumstances. Given the high numbers, one could also postulate that perhaps nonattendance reflected dissatisfaction with service provision. Certainly, those challenging standard systems of medicalized maternity care would suggest this model of antenatal care to be somewhat dysfunctional with multiple care providers; time constraints; limited resources; and unclear aims, values, and philosophies influencing the care provided \( \text{(Dahlen, Barclay, \\& Homer, 2010b; Homer, Brodie, \\& Leap, 2008; Page, 2008)} \). Australian researchers Hartz et al. (2012) described standard care as “predominantly fragmented, organisation and/or practitioner-centric” \( (p. 40) \). The women in this study received medicalized, fragmented antenatal care. Midwifery care was all but nonexistent except for the booking visit. Within this context, it is likely that little attention was paid to their individual needs and preferences, quality preparation for birth, or women’s knowledge or understanding of the maternity care system.

**Implication for Practice**

To meet the needs of obese women experiencing their first pregnancy and birth, targeted maternity care may be the answer. Targeted maternity care has been shown to be an effective strategy in meeting the needs of several vulnerable groups of women \( \text{(Grady \\& Bloom, 2004; Ickovics et al., 2003)} \). Our work suggests that primiparous women with a BMI of 40 or more should be viewed as a vulnerable group for several reasons. First, maternal obesity is associated with a higher incidence of depression particularly in adolescent females \( \text{(Pickering, Grant, Chou, \\& Compton, 2007; Blaine, Rodman, \\& Newman, 2007)} \), cigarette smoking, \( \text{(Cupul-Uicab et al., 2012)} \), domestic violence \( \text{(Huang, Yang, \\& Omaye, 2011)} \), asthma \( \text{(Benninger \\& McCallister, 2010)} \), and obstructive sleep apnea \( \text{(Ursavas, Karadag, Nalci, Ercan, \\& Gozu, 2008)} \), all of which can have serious negative sequelae for the growing fetus. Second, compared to multiparous women and in fact regardless of BMI, primiparous women may require additional support during pregnancy as well as labor and birth. This is a view shared by others \( \text{(Dahlen, Barclay, \\& Homer, 2008; Miller \\& Skinner, 2012)} \). For example, Dahlen, Barclay, and Homer (2010a) found that first-time pregnant women reacted to the unknown of labor quite differently to those women experiencing a subsequent birth. The level of preparation, support, information, communication, choices, and sense of control all explained the diversity in the first-time experiences of birthing women. American authors Fair and Morrison (2012) similarly found that first-time pregnant women’s perception of being in control significantly predicted birth satisfaction with high levels of correlating satisfaction levels. The work of both Schempf and Strobino (2009) and Goler, Armstrong, Taillac, and Osejo (2008) takes this one step further, suggesting that women who develop a high internal loci of control during the antenatal period are also more likely to be receptive to positive health modifications and strategies which ultimately contribute to better birth outcomes and increased birth satisfaction.

Thus, maternal obesity together with primiparity represents a complex issue which requires a holistic approach to care. With this in mind, a contemporary approach to antenatal care provision for extremely obese pregnant women experiencing their first pregnancy may be the answer. This is not a new idea with specifically developed programs, such as centering in pregnancy focusing on other specific groups of women showing improved perinatal outcomes \( \text{(Grady \\& Bloom, 2004; Ickovics et al., 2007)} \). Whereas medically focused antenatal care aims to identify and manage potential complications, midwifery care focuses on providing woman-centered care using a holistic approach. A reconceptualization of antenatal care provision, drawing on the skill set of both professional groups, to better meet the needs of obese women may improve outcomes and be more acceptable to women, possibly resulting in positive experiences and improved birth outcomes.
Although the numbers included in this clinical observational study are small, the findings do support the need for further research, which should include the development and testing of appropriate interventions (such as models of care) to identify the most effective way to meet the needs of this client group.

LIMITATIONS

Potential limitations and biases included inconsistency in data presentation. Although the Queensland Perinatal Data form requests prepregnancy weight and height to calculate BMI, clinical audit consistently identified booking weight as being recorded rather than prepregnancy weight resulting in the more serious systematic error. This is, however, a consistent finding reported by others (CMACE, 2010). In addition, retrospective cohort data is primarily based on perinatal databases. A recent review of Australian maternity data collections identified significant gaps in available data, with models of maternity care and continuity of care often poorly reported (Australian Institute of Health and Welfare, 2011). A further limitation may be sample bias. Although data were collected over a 2-year period in an effort to increase numbers, the sample size remained small and the power may not have been sufficient to identify statistical differences within the groups. In addition, only collecting data from one study site limits the generalization of the findings.

CONCLUSION

This study has identified that current service provision to extremely obese women experiencing their first birth at the study site may be contributing to suboptimal outcomes. The high stillbirth rate is an alarming finding and warrants urgent further research in this area. To improve outcomes, and reduce the CS rate, maternity providers need to use a primary health care approach to identify possible strategies which will be acceptable to obese women. The development of targeted maternity care aimed at meeting the needs of obese women experiencing their first birth may well be the answer to improving both outcomes and satisfaction for obese women. To inform service development, research needs to focus on identifying what service provision would most likely be used by this group of women. Qualitative studies are therefore required to answer this question for local populations.

NOTE

1. Excludes two extremely premature stillborn babies born at 22 and 27 weeks’ gestation.

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MIDWIVES: CHANGING THE WORLD ONE FAMILY AT A TIME

This year, the International Day of the Midwife (IDM) once again highlighted the importance of midwives, their work on a local and global level, and the impact they have on families around the world. The 2014 sub-theme “Midwives: changing the world one family at a time” was accompanied by the overarching theme “The world needs midwives now more than ever” as part of an ongoing campaign to highlight the need for midwives in the run-up to the deadlines for the Millennium Development Goals (MDGs). The two themes, along with “Midwives save lives” and “Investing in midwives,” formed the basis of the key messages of the 2014 IDM campaign. These key messages were presented to midwives and member associations, governments, policy makers, and other stakeholders to reinforce the themes and provide further explanation and understanding.

An example of these messages was that midwives change the world by caring for mothers and babies. By caring for them, midwives help ensure that women are healthy, thus contributing to a strong community and economy. Moreover, midwives educate families on how to delay, space, or limit pregnancies and provide family planning services to achieve the healthiest outcomes for women, newborns, infants, and children. Another important message is that up to two-thirds of maternal deaths could be averted if there was universal access to a well-educated, regulated midwifery workforce in a health system with adequate supplies. Investing in midwives can save millions of lives every year, leading to healthy and wealthy nations around the world.

The IDM was an opportunity to yet again raise awareness for midwives and midwifery globally and to celebrate the truly lifesaving work midwives do. It was an opportunity to reach out to policy makers, governments, civil society, and other stakeholders and inform them about the benefits of quality midwifery care for women and their children. To guide them in this advocacy and organize events to showcase midwifery, International Confederation of Midwives (ICM)’s Member Associations were provided with a resource pack. This pack included key messages, facts and figures, tips on media engagement and writing a press release, a social media guide, and the IDM artwork for posters and use on social media. The virtual side of the IDM campaign included blog series and guest blogs with partner organizations, such as Healthy Newborn Network (an initiative of Save the Children’s Saving Newborn Lives), World Vision, Jhpiego (Maternal and Child Health Integrated Program), and African Medical and Research Foundation. In addition, ICM organized a global Twitter chat on May 5, in which partners were matched with member associations for a more interactive and enriching Twitter session.

MIDWIFERY DEVELOPMENT IN CHINA

To address the issue of midwifery development in China, ICM organized a workshop focused on gap analysis in Shijiazhuang, on March 25–27, 2014. The purpose of the workshop was to contribute to the development of midwifery in China; to learn about the situation of midwifery in China with specific attention to the three pillars—education, regulation, and association; and to discuss the impact of how well-resourced and regulated midwives can contribute toward the reduction of maternal and neonatal deaths. New gap analysis tools
were developed in 2012 to identify gaps and challenges in midwifery and therefore help strengthen member associations’ ability (in collaboration with local stakeholders) to address the gaps. The set of documents in ICM’s three official languages (English, French, and Spanish) includes Member Association Capacity Assessment Tool, Pre-Service Education Assessment Tool, and Regulation Assessment Tool. They can all be found on ICM’s website.\(^1\) The main objectives of the workshop were to share the results of the survey conducted in August 2013, to discuss how those results can contribute to the recognition of midwifery profession as an autonomous and distinct profession, and to strengthen the three pillars of midwifery to enable provision of quality care to mothers and newborns in China. The workshop provided in-depth understanding about the importance of midwifery care for policy makers and stakeholders in the country. To conclude the workshop and have participants and stakeholders commit to the agreements, a joint declaration was issued and closing remarks were made by ICM Board Member Sue Bree.

The ICM gap analysis workshop was the first of its kind in China. Midwifery, as an indispensable workforce for maternal and newborn health, has gained more support and understanding only over the past two decades, even though the profession has existed for centuries. Through United Nations Population Fund (UNFPA) and 29 other international organizations and institutions, United Nations (UN) recently appealed for global actions to scale up midwifery care. For these reasons, the workshop for midwifery development in China was both internationally and domestically significant. The development of midwifery care also provides an answer to the country’s health care reforms under its rapid economic, social, and technological development.

During the same week, ICM convened a 2-day “Helping Mothers Survive Bleeding After Birth” (HMS-BAB) workshop. This activity was part of a scientific conference on perinatal medicine organized by Shijiazhuang Maternal and Child Health Hospital. Since May 2013, ICM has been working with Laerdal Global Health and Jhpiego in disseminating the HMS-BAB initiative, an evidence-based training program to equip midwives with additional skills on how to manage and control postpartum hemorrhage (PPH). The approach uses an innovative birth simulator called Mama Natalie. Management of PPH is part of ICM’s Essential Competencies for Basic Midwifery Practice\(^2\) because PPH remains one of the leading causes of death for women and their newborns. The HMS-BAB workshop was attended by 18 participants, who were awarded certificates for their achievements. In a second step, these participants could become master trainers, who in turn can train midwives in management of PPH with HMS-BAB.

**SECOND MIDDLE EAST AND NORTH AFRICA REGIONAL MIDWIFERY CONFERENCE, MIDWIFERY EDUCATION: CHALLENGES AND OPPORTUNITIES**

Representatives from ICM attended the second Middle East and North Africa (MENA) Regional Midwifery Conference, which took place in Riyadh, Saudi Arabia, on April 1–2, 2014. In partnership with the Ministry of Health, Kingdom of Saudi Arabia, the UNFPA Arab States Regional Office committed to sustain the momentum from the first MENA Midwifery conference in Dubai, in November 2012, by organizing this second symposium. Midwifery education was the focus of this 2-day conference, which explored the different components of midwifery education, including successful experiences and lessons learned in the MENA countries. A main objective was to identify challenges and the required approaches to upscale midwifery education programmes, as well as strategies within the region. More than 75 participants from 20 countries attended the conference, including UNFPA staff, representatives from World Health Organization (WHO), United Nations Children’s Fund (UNICEF), and ICM delegates.

One panel, titled “The Midwife: A Professional Identity in Need to be Clarified in the Arab Region,” was moderated by Frances Day-Stirk, ICM president. The president also presented the Essential Competencies for Basic Midwifery Practice,\(^3\) which answers the questions “What is a midwife expected to know?” and “What does a midwife do?” The competencies are evidence-based and the majority are considered to be core or expected outcomes of midwifery preservice education.

This document can be used by midwives, midwifery associations, and regulatory bodies responsible for the education and practice of midwifery in their country or region. The essential competencies are guidelines for the mandatory content of midwifery education curricula and information for governments and other policy bodies that need to understand the contribution that midwives can make to the health care system. The Essential Competencies for Basic Midwifery Practice is complemented by ICM standards and guidelines related to midwifery education, regulation, and clinical practice.\(^4\)
ICM PRAGUE 2014: MIDWIVES IMPROVING WOMEN'S HEALTH GLOBALLY

ICM’s 30th Triennial Congress took place on June 1–5, 2014, in Prague, Czech Republic. It was one of the largest congresses in the history of ICM, attracting more than 3,500 participants from all around the world. The overall theme of the Congress was “Midwives: Improving Women’s Health Globally.” Key challenges facing midwives and maternity services around the world were addressed, recognizing the impact of the MDGs on the work of midwives and the health of childbearing women. Daily plenary sessions with keynote speakers, partner panels, oral presentations, workshops, and symposia, were all accommodated around the four sub-themes of the Congress:

1. Bridging midwifery and women’s health rights
2. Access: bridging the gap to improving care and outcomes for women and their families
3. Education: the bridge to midwifery and women’s autonomy
4. Midwifery bridging culture and practice

The Congress has set a new record for the highest country representation, with 1,360 abstracts received from midwives in 85 countries. The ICM Scientific Professional Programme Committee set the criteria for abstract scoring and accepted 650 abstracts for presentation at the Congress.

Another highlight of the Congress was the official appointment of Her Excellency Toyin Saraki as ICM’s Inaugural Goodwill Ambassador. In her role as the ICM Global Goodwill Ambassador, Mrs. Saraki will help raise awareness of midwives and midwifery, extending the influence of midwives, while lobbying and advocating for policy changes relating to maternal, newborn, and reproductive health care nationally and internationally. She will also promote the aims, objectives, and priorities of ICM and assist in facilitating its work with member associations, especially in the countries where maternal health is most at risk. Her Excellency Toyin Saraki presented a keynote address at the ICM Congress.

ICM organized several workshops during Congress which focused on developing and strengthening midwives associations, implementing ICM regulation standards, HMS-BAB, and Helping Babies Breathe (HBB), as well as workshops on the Twinning approach. ICM Standing Committees organized three concurrent workshops on regulation, education, and research. Plenary sessions were live streamed, which was an opportunity to follow the Congress for those unable to attend it. Daily updates on the ICM website, Tweeting, as well as a daily newsletter kept the audience informed and able to follow Congress events as they unfolded.

The ICM 30th Triennial Congress provided an excellent opportunity to share excellence in practice and knowledge, learn about the challenges facing midwifery across the continents, enjoy mutual support amongst colleagues, and celebrate midwifery as a profession in all its global diversity. It also provided an environment where midwives from around the world could draw on the skills, knowledge, and experience of colleagues for application in their own countries.

A huge success was also the launch of the State of the World’s Midwifery (SoWMy). SoWMy 2014, the second of its kind, was a joint effort coordinated by UNFPA, WHO, on behalf of the H4+ (Joint United Nations Programme on HIV/AIDS [UNAIDS], UNFPA, UNICEF, UN Women, WHO, and the World Bank), and the ICM to describe the state of the midwifery workforce, including its challenges and progresses. SoWMy 2014 shows what progress was made since the launch of the first report in 2011 in increasing the number of skilled and competent midwives; improving policies and regulations; and expanding the coverage of midwifery services and quality of care in the 75 countries that carry more than 95% of the global burden of maternal, newborn, and child deaths. It provides data on the availability, accessibility, acceptability, and quality of midwifery care. SoWMy 2014 also reveals service gaps and highlights the needs for future health workforce and health systems to ensure that all women and families have access to quality midwifery care.

NOTES

Author Guidelines

The *International Journal of Childbirth* is a quarterly, peer-reviewed publication with a global focus on childbearing. The journal invites the submission of manuscripts that address research, practice, education, and theory as well as case reports, personal narratives, and commentaries on all aspects of childbirth.

The following presentation style should be observed when submitting manuscripts:

- *Clinical and Basic Science Research* articles should include an Abstract, Introduction, Material and Methods, Case History (if applicable), Results, Discussion, Conclusion, and References.
- *Review* articles should provide a comprehensive synthesis of the available information on their chosen topic. They must include headings and reference citations.
- *Case Reports* should be brief reviews of either typical or atypical births and should include an Abstract, Introduction, Case Report data and findings, Discussion, Conclusion, and References.
- *Personal Narratives* should first-hand accounts of childbirth experiences. References are not required but may be included when needed to support data or quotations from published sources.

Manuscript Preparation

The manuscripts should be prepared in accordance with the *Publication Manual of the American Psychological Association*, which should be consulted for matter of style and formatting, including text, references, and tables.

**Length.** Submissions are generally expected to be 15 to 25 pages in length; however, the journal considers manuscripts that are longer or shorter.

**Cover Page.** A cover page separate from the main manuscript must include the article's title and the names, academic degrees, mailing addresses, and e-mail addresses of each of the contributing authors.

**Abstract.** Research articles, review articles, and case reports should include an abstract of between 125 to 200 words that concisely states the article's purpose, the study design, major findings, and main conclusion.

**Summary.** When an abstract is not appropriate for the type of article submitted, authors should include a summary of between 125 to 200 words that provides a synopsis of the article's thesis and conclusions.

**Appendices.** Instruments or large tables of data may be included as an appendix to the manuscript. The publication of appendices is at the discretion of the editors.

**Letters to the Editor.** Letters to the editor should be concise comments regarding articles published in the journal and may include references. Letters should be under 300 words. Those accepted for publication may be edited or abridged.

**Photographs, Drawings, and Graphs.** Illustrations should be submitted as individual, high resolution images in jpg, tiff, or eps graphics file formats (graphs created in Excel are also acceptable). Digital images should include the figure number in the file name. Additionally, a copy of each illustration should be embedded at the end of the manuscript after the reference list and tables.

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