ROYAL
COLLEGE
OF MIDWIVES

ISSN: 1479-4489 March 2012 Vol.10 No.1

EVIDENCE BASED MIDWIFERY

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March 2012
Volume 10 Issue 1

EVIDENCE BASED MIDWIFERY IS A STANDALONE PEER-REVIEWED JOURNAL PRODUCED BY THE ROYAL COLLEGE OF MIDWIVES

Evidence Based Midwifery
Royal College of Midwives
15 Mansfield Street
London W1G 9NH
United Kingdom

Publishers:
Redactive Media Group

CONTENTS

Artistic approaches to data collection: illustrations and collage

Key words: Artistic expression, childbirth art, collage, illustrations, evidence-based midwifery

In October 2011, archaeologists in Italy discovered fragments of ceramic pots. The excitement of the find was heightened as the world learned of the two small pictures depicting a woman giving birth. The illustrations are likely to be over 2600 years old and as such would be the earliest known artistic representation of the birthing process in Western Europe (Discovery News, 2011). Researchers from a wide range of backgrounds are already actively engaged in data analyses with expert anthropologists, archaeologists, historians, technologists and artists working collaboratively to determine its meaning for our postmodern culture. This phenomenon is a perfect example of how illustrative, artistic data can be used as evidence for historical research purposes and it is another example of occularcentrism, as previously discussed in the June editorial (Sinclair, 2011).

The sheer fact that this particular image of a mother with her long ponytail birthing the head and shoulders of her infant is highly symbolic of the culture of the people at that time. When I looked at the picture, I was struck by the graphical illustration of the woman, alone, upright and in the squatting position. The artist valued this birth and that is evident in the detailed portrayal. Having studied fine art, it is not possible to 'see' with the fetters on and as I kept looking at the image I was transfixed with a sense of the power of creativity and timeless spirituality surrounding the act of birth. This simple line drawing conveys birthing power and energy. It has withstood destructive elements and the corrosion of time and the image does not change its form, but the interpretation is fluid and will be heavily influenced by the philosophy, politics and culture of our time. The origins and history of art enrich our lives and it is important to remind ourselves that art is the earliest form of communication known to us and, as such, is priceless. Symbolism and spirituality were major concepts depicted in the visual world of early times and artists are renowned for their endeavours to depict the deeper meaning of life and this can make us feel very uncomfortable. For example, the same portrayal of the power of birth could arguably be evidenced in modern times by referral to the recent birth of baby boy in 2011 at the Microscope Art Gallery in New York. His mother, Marni Kotak, an arts performer, gave birth with the help of a midwife as part of an art installation and live exhibition. This artistic expression was designed to demonstrate that human life was and is a profound work of art (Canning, 2011). However, this particular use of art may be too abstract and philosophical for many of us to comprehend and therefore it is important to focus on the use of visual communications at a more grounded level.

The methodological home for artistic approaches is ethnography where using symbols, drawings and multimedia are part of the process. Applied and creative use of artistic techniques offers a different form of knowledge and a different way of seeing and knowing. Approaches include the use of photographs, drawings, collage, cartoons, pictures, music, poetry, storytelling, role play and using diaries. Midwives are learning to use artistic approaches to enrich research data collection in situations where words are not enough and sometimes it is too painful to talk. In other instances, language is not used because of the sensitivities, translation issues or speech impediments of the participants and these issues offer a strong rationale for the use of creative methods. I have personal experience of using artistic approaches to collect data over the past 15 years; mainly illustrations and collage although poetry is beginning to emerge. The research studies have been focused on exploring women's birth memories and perceptions of normal and technological birth (Sinclair, 1999). My doctoral students have used video, multimedia, graphical illustrations and poetry. However, collage and illustrations have been most popular and this is understandable. The main attractiveness of collage is the rapid building of the image and the fluidity of materials while the use of illustrations seems to be more popular with those who have some confidence in their drawing ability.

Key principles for the researcher include clearly articulating the rationale for artistic/creative approaches and how they are the most appropriate medium for collecting data to answer specific research questions. In addition, data analyses must be carefully planned and, if necessary, supplementation by interpretative interview, focus group or online discussion. Based on previous research, asking women to remember their birth experience and to let their mind form pictures requires considerable planning and extensive pilot work to ensure person-centeredness. Strategies for confidence building and practical use of the tools of the trade – such as paint, pencils, oils, camera, video – need to be incorporated into the project planning, if participants are to engage meaningfully. One of the most important factors to bear in mind when using creative approaches is to ensure clarity of understanding with regard to the fact that artistic ability is not required.

In conclusion, artistic approaches in the form of illustrations and collage are being used in midwifery research, but one of the most profound differences is the fact that the researcher using creative methods needs to learn to listen visually and this will require training, support and practice.

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Skilled help from the heart: the story of a midwifery research programme

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This paper is part of a series celebrating the contribution of professors to the midwifery profession.

Abstract

This paper sets out the story of one route to undertaking midwifery research. It starts with a vocational call to be a midwife, and describes a subsequent research programme that has evolved over 25 years. The key theme that characterises the programme is the understanding and promotion of physiological birth, at the macro, meso and micro level. This covers policy, how services are organised, how practice is delivered, and the nature of normal birth physiology. The work has been based on looking for what makes things go well (a salutogenic perspective) and on understanding birth as a complex, dynamic process. It involves collaborations with clinical, policy, service delivery and professional colleagues in the UK and overseas. The fundamental aim is to maximise the provision of 'skilled help from the heart' for women, their babies, and their families, through a comprehensive understanding of the nature, meaning and consequences of physiological childbirth, and of the values, contexts and policies that support the best possible maternity care provision in any given situation.

Key words: Normal birth, research, professorship, complexity, salutogenesis, physiology, values, evidence-based midwifery

Introduction

There are many ways of getting to a particular position in life. Some plan their career meticulously, working out the qualifications they need and the jobs they should get as stepping stones to that position. As this paper illustrates, in my case, most of what happened – just kind of happened. But there was always a common theme of persistent curiosity, and of wanting to make a difference. Sometimes, as they say, the journey is the destination.

Background

My interest in research started before I began my midwifery career. After school I went to the University of York where I undertook a degree in English language and literature. This introduced me to the joy of following up questions that interested and fascinated me. However, in all the excitement about and delight in learning that came with full-time undergraduate study, I was dimly aware that, at some point, I would need to get a job and earn some kind of living. I had no idea what this might be: the idea of working as a midwife had never crossed my mind. However, in 1979, as a member of the Girl Guides, I had the opportunity to work at the Girl Guide Association chalet in Switzerland over the university summer holiday. With a colleague, I was then invited over to South Africa for their jubilee event the following year. I was vaguely conscious of the effects of apartheid (which was still in operation at that time) and, in my naivety, I arranged to visit the 'real' South Africa, by way of a couple of weeks in the homeland of Bophuthatswana. Somehow, I ended up at a mission station where nuns were providing maternity care: black African rural women having babies under the care of white African nuns. I was absolutely amazed by the strength of the women, by the calmness, courage, and support of the nuns, and by the whole sense that something fundamentally creative and dynamic was happening here. It was at that point I started to think if we get childbirth right, we get the world right. And it was at that point that I got my vocation in life, and that the seeds of my research passion, physiological labour and birth, were sewn.

On my return, and on the completion of my degree, I spent some months working in Guy's Hospital as a healthcare assistant, just to see whether doing midwifery in the UK was the same as doing it in South Africa. At that time, I thought the training inevitably involved doing nursing first, so I applied to St Thomas' Hospital to do nursing. However, while I was waiting to hear back from them, I found out that Derby City Hospital ran a direct-entry midwifery programme. So, I applied there and, to my delight, was accepted. At that time, the midwifery qualification was not even at the level of diploma. Despite this, it was most difficult qualification I have obtained, because getting midwifery right fundamentally affects the lives of women, babies and families. This has made me reflect on how difficult it is for students who are now undertaking midwifery degree courses to tackle the academic level of thinking necessary to obtain their degree at the same time as gaining the in-depth clinical expertise they need to practise safely, empathically and confidently, while also (and this is often overlooked) getting to grips with the peculiar cultures of health care that predominate in many maternity settings today. I hope that the kind of casual disregard that we experienced as students and as newly qualified staff (that often led to tears in the sluice) has gone, but I am sure that the shock of crossing the boundary into the local labour ward is still profound for many students.

My first encounters in this context also taught me how powerfully transformative positive collaborative relationships can be; and this is another strand of our research programme.

When I started my midwifery training, the provision of direct-entry midwifery training was being reduced, and by the time I finished my training, Derby City Hospital was the only place still providing this route to being a midwife. I joined the Association of Radical Midwives early in my training, and in doing so also joined the pressure group that was fighting to expand the provision of direct-entry midwifery training in the UK. This was the spark for my first research study.

Starting out

My first research question was – what are the experiences of practising midwives who have been direct entrants? It resulted in a large survey of over 1000 questionnaires which, to my shame, were never fully analysed, although a column did appear in *Nursing Times* (Downe, 1986). Probably more importantly, I was asked to present the results at a meeting at the Royal Society of Medicine. Whether it's coincidence or whether the study did have some impact on the debate, as I remember it, within a year or two, decisions had been made to expand direct-entry training once more. The rest, of course, is history.

I've only just, 20 years later, destroyed these questionnaires. I always believed I would be able to analyse them, but I've concluded that, realistically, this is not going to be possible. I do empathise strongly with people who have data that are really interesting, which they cannot write up. In fact, if I could find a technique for making this happen, this would be one of the achievements of my research career.

I began thinking and writing about the nature of normal birth at about this time (Downe, 1991). The next research project was built on a desire to normalise childbirth as much as possible, especially for women who might need an intervention, such as an epidural. It formed part of a masters and then a PhD degree, and the fact that it was completed and published was, to a large degree, due to the support and encouragement of my supervisors, David Gerrett and Mary Renfrew. I'm very grateful to them both for this. It was a study of the use of the lateral position in the passive second stage for women having their first babies and using epidural anaesthetic (Downe et al, 2004). The research question was stimulated by my clinical experience of seeing women struggle to push actively once they had an epidural sited, and the observation that babies in this circumstance did not seem to negotiate rotation effectively. The study built on the theory that if the pelvic floor was anaesthetised it did not offer the usual resistance to the fetal head, but that using the lateral position (as midwives did traditionally) might offer increased lateral resistance, and so facilitate rotation more effectively.

This was the first randomised controlled (RCT) trial I had attempted, and I had a lot to learn. By the end of it I knew there were a lot of things I could have done much better, and, importantly, that it is more difficult to recruit to research studies than even the most careful and conservative pre-study planning might suggest. Later, I learned that almost every researcher feels their research could have been done better after virtually every study they ever do. Despite the shortcomings, however, the results did suggest that using the lateral position, particularly when the fetus is in the OP position at the beginning of the passive second stage of labour, might reduce the need for forceps to expedite the birth.

The questions for both of my first research studies were directly generated from personal experience, and from observing women in labour. The next large study we did was stimulated by the policy change in government thinking at the time, towards team midwifery. In response to this, the local hospital (this is pre-Trust days) set up pilot sites to run team midwifery schemes. With my colleague, Sheila McFarlane, we ran an extensive review of the scheme, incorporating questionnaires and interviews with midwives, managers and service users, and taking a longitudinal perspective as the team schemes matured. This was published in *The Practising Midwife* (McFarlane and Downe, 1999).

Again, we learnt important lessons from trying to undertake such a complex mixed methods study. One of the main frustrations was wanting to undertake specific tasks (such as complex statistical modelling of the longitudinal data) without the support of experts on hand who knew how to do them. On reflection, this experience prefigured the development, much later, of the National Institute for Health Research (NIHR) Research Design Service, that is set up to link clinical staff with good research ideas to academic methodologists who know how to make those ideas researchable. If there is anyone out there in clinical practice who feels the frustration we felt then the NIHR Research Design Service is the place to go for help.

Consolidation: moving towards a theory of physiological labour and birth

Having said that the team midwifery study was frustrating because of lack of sophisticated expertise in certain areas, one of the most important studies I have been involved in was a simple survey, that required no external funding, and that was undertaken by a group of us as clinical midwives, in collaboration with the Association for Improvements in Maternity Services (Downe et al, 2001). This was the Trent regional study of interventions that women experienced while having a so-called normal birth. It was published in the *British Journal of Midwifery*, which is not indexed on Medline, and which does not have an impact factor – but it has probably been the most influential study I have been involved in to date. Directly or indirectly, the findings have influenced the set up of the RCM Campaign for Normal Birth (and, through that, campaigns in a range of other countries, including Spain and Portugal).

Very soon after this study was published, I moved from the NHS to higher education, at the University of Central Lancashire. At this time, despite the exciting arrival of *Changing Childbirth* in 1993 (DH, 1993), the caesarean section rate was rising inexorably, and the findings of the Trent Normal Birth Survey were depressing: more than 70% of women in the survey who had a so-called 'normal birth' had at least one intervention in labour (Downe et al, 2001). I was thinking about how we could make normal physiological childbirth matter to women, midwives, managers, economists and policy-makers, but I was drawing a blank.

Then one conversation with a colleague at UCLan, Tilly Padden, provided the answer. She introduced me to the concept of salutogenesis, as one of a series of theories she was thinking about to measure capacity in parents who had babies in neonatal units. Salutogenesis is a term coined by Aaron Antonovsky (Antonovsky, 1987), professor of medical sociology.

He noticed that, contrary to expectation, some of the concentration camp survivors he was researching had a remarkably positive outlook on life. Instead of seeing these individuals as outliers, as they did not express the psychological pathology that might be expected in their situation, he began to wonder what it was that made them so resilient, despite their experience.

Salutogenesis can be roughly translated as the generation of wellbeing. The term describes an approach which focuses on factors that support and promote human health and wellbeing, rather than looking at factors that cause disease (Sinclair and Stockdale, 2011). Antonovsky uses it broadly in contrast to pathogenesis – what is it that makes things go well as opposed to making them go badly? He also developed a psychological model, based on what he termed the 'sense of coherence' concept. This model predicts that if an individual can see the world as manageable, comprehensible, and meaningful, they are more likely to be able to cope with adverse events positively, no matter how extreme their experiences might be: *'A salutogenic orientation facilitates seeing things that experts in a given pathology might well fail to see…it… pressures one to think in systems terms… it leads one to deal with (both) entropic (disorder-promoting) forces and… negentropic (order-promoting) forces'* (Antonovsky, 1993).

Antonovsky's work led me to consider the potential power of turning the usual pathological debate about pregnancy and childbirth (how can we prevent things going wrong?) towards one of saltutogensis (how can we learn from what goes right?).

My thinking was then further developed by an encounter with complexity theory. This theory holds that many aspects of the world (systems of care delivery, the weather, our heart beats, and so on) are not linear, fixed and simple, but dynamic, variable, and complex. In other words, these aspects of life respond in unexpected ways. Applying this theory to labour and birth opens up the potential of seeing each labour and birth as 'uniquely normal' where the dynamic biological systems and psychological orientation of mother and baby interact in unique and unpredictable ways with the context in which labour is happening – including the attitudes, beliefs and care practices of her birth companion and attending staff, and the setting in which she is giving birth.

Complexity also allows us to rethink the potential salutogenic effect of childbirth: maybe, rather than trying to control what might (in very few cases) go wrong by standardising care for everyone, we should understand the dynamic possibilities for each person, to maximise what might go well?

The impact of applying these two theories to childbirth was first described in a book chapter, as part of an edited book on normal childbirth (Downe and McCourt, 2004, reprinted 2008). Thinking on this topic has subsequently been extended (Downe, 2004; Downe, 2006; Downe and Walsh, 2007; Downe and McCourt, 2008; Schmidt and Downe, 2010; Downe, 2010a; Downe and Walsh, 2010). It has also been translated into a masters module on normal birth that is based on clinical story telling (Perez-Botella and Downe, 2006a, 2006b; Downe, 2010b). There are many synergies with our approach in these texts, and the new way of thinking about evidence, termed 'realist research', that has been developed by Ray Pawson and colleagues (Pawson et al, 2005). In summary, both approaches are interested in what works, for who, in what context.

From theory to practice: the current situation

Now, at UCLan, I work with a team of researchers that includes midwifery, biomedicine, alternative therapy, history, psychology, and sociology, in our Research in Childbirth and Health (ReaCH) unit. We work in synergy with Professor Fiona Dykes, who leads Maternal and Infant Nurture and Nutrition (MaINN). The MaINN group have undertaken a wide range of important work in mother and child nutrition. In collaboration with our postgraduate students, clinical colleagues and local service users, ReaCH has undertaken studies on topics that include the early urge to push (Downe et al, 2008), place of birth (Walsh and Downe, 2004; Hodnett et al, 2005, 2010), women's choice for caesarean section (Lavender and Kingdon, 2009; Kingdon et al, 2009), the nature of the 'good' midwife (Byrom and Downe, 2010), and of the 'good' midwifery leader (Downe, Simpson and Byrom, 2011), the nature of midwifery expertise in intrapartum care (Downe , Simpson and Trafford, 2007; Downe and Simpson, 2011), management of the fetal nuchal cord (Jackson et al, 2007; Melvin and Downe, 2007) what it means to women to have a positive birth after a previous traumatic experience (Thomson and Downe, 2008; Thomson and Downe, 2010), how midwives maximise physiological birth in hospital environments (O'Connell and Downe, 2009), how to build collaboration between midwives and obstetricians (Downe, Finlayson and Fleming, 2011a, 2011b), why women don't access antenatal care (Downe et al, 2009),

dealing with relationship conflict in the antenatal period (Steen et al, 2010) and fathers experiences of intrapartum care (Steen et al, 2011; Longworth and Kingdon, 2011).

With clinical colleagues and service users, we are currently undertaking studies that look at the amount and effect of record-keeping (a linear intervention in a complex environment) on the workload and options of midwives and obstetricians, an RCT where the intervention is teaching women having their first baby to self-hypnotise while they are pregnant so they can use this to minimise their need for epidurals, and on the impact of computerisation in the labour ward on staff and service users.

Our methods include systematic reviews (qualitative and quantitative) ethnography, phenomenology (Thomson et al, 2011; Downe, Thomson and Dykes, 2011), RCTs, surveys, mixed methods, and action research (Downe et al, 2007). Methodologically, we have suggested simplified tools for assessing the quality of qualitative research (Walsh and Downe, 2006; Downe, Simpson and Trafford, 2007) and new approaches to metasynthesis (Walsh and Downe, 2005; Downe, 2008).Our group has, over the last ten years, included Tina Lavender, Denis Walsh, Grace Edwards, Sheena Byrom, Anita Fleming and Mary Steen. Grace, Anita, and Sheena were all joint clinical appointments, and Mary worked on a shared contract with the RCM. These joint posts have added significant value to our work over the last ten years.

International collaborations

Since the midwifery research group was formed at UCLan, we have developed a wide range of international work. This includes studies with Hannah Dahlen and her team at the University of Western Sydney, using observational techniques to look at how women use space in different kinds of settings, including a centralised hospital, a birth centre, and at home. Collaboration with a team in Belgium involved better methods of assessing the quality of antenatal care (Beeckman et al, 2011). We are also working with a team at the University of Gotenburg, led by Marie Berg, to look at the experience of women and their partners of the first encounter on the labour ward (Nyman et al, 2011). Our international work includes a large EU study across 21 countries, (within the EU, and in China, South Africa, Australia and Israel) called *Childbirth cultures, concerns, and consequences: creating a dynamic EU framework for optimal maternity care* (Downe et al, 2010), designed to find out what works well in maternity systems, and introduce those elements into other systems across Europe.

As well as our contribution to teaching undergraduate students in our area of research expertise, we also teach and supervise postgraduate students (most, but not all of whom are midwives), from the UK, Ireland, Hong Kong, Africa, Israel, and Malta.

What use is research, anyway? Making a difference

The whole aim of our research endeavour is to provide the evidence to maximise positive childbirth for women, babies, families and maternity care staff. We are also, therefore, actively engaged in translating our academic work into action for change. At the academic level, for instance, as noted above, we run a module on normal childbirth, which has been developed to be very interactive and to be built on midwife story telling (Downe, 2010b). Along with face-to-face teaching sessions, people who access the module tell stories of seminal events relating to normal birth (when it went unexpectedly well, or unexpectedly badly, for instance). As they each tell their stories, the rest of the group start to deconstruct them, to try to unravel at each decision point what the midwife felt, what the woman/partner/other staff might have felt, and why, what the women's personal physiology/history might indicate, what the formal evidence base would suggest, what the theoretical explanations might be, and so on.

The point is to develop reflexivity in practice, so that each midwife attending the module might be able to normalise childbirth more confidently in future. The intention is to examine what might be getting in the way of physiological birth, and to share examples of situations when women who are technically high risk have managed to achieve as normal a birth as possible, with positive birth outcomes. We are particularly interested in how this works in collaboration with obstetricians and colleagues (Downe, Simpson and Fleming, 2011; Downe, Simpson and Byrom, 2011; Downe Simpson, 2011; Downe, Finlayson and Fleming, 2011).

Our work has been seminal in the setting up of the RCM Campaign for Normal Birth, and in developing the campaign to date. It has had an influence on the government definition of normal birth, and on the place of birth debate, via our Cochrane review on place of birth (Hodnett et al, 2010).

Locally, we have been involved in the design and set up of the very successful Blackburn free-standing birth centre, which is heading for nearly 1000 births in its first year of operation. I am also a member of the Board of Directors of the International Mother Baby Childbirth Organisation, which has set up demonstration sites to model ways of humanising childbirth in seven countries to date, and, for me, this work is a very exciting link between the values and beliefs we have been developing in the UK, and the potential for mutual learning with colleagues across the world.

Moving towards a values based approach

As our work has progressed, both in terms of research and of talking and meeting with midwives, other professionals, research experts, and service using women, locally, nationally, and internationally, I have begun to think about respect and disrespect and how these polar opposites link normal birth and maternal mortality. This thinking was catalysed by research with a colleague in Egypt, Amina el-Nemer, who undertook an ethnography of a busy Egyptian labour ward (el-Nemer et al, 2006). Her findings raised interesting questions about why

women in medium- or low-resource countries don't access care. As a consequence of our work in this area, I am now involved in a campaign to address disrespect and abuse in maternity care, which is being undertaken by the White Ribbon Alliance. It is becoming increasingly clear to me that all the facilities and skilled birth attendants in the world will not resolve either the persistently high rates of maternal and infant mortality in some countries, or the psychological harm associated with some routine interventions in other settings, if these are not founded in an authentically caring maternity system. These are the poetics of a knowledge-love approach to maternity care, in opposition to a knowledge-power approach.

Questions that remain

Our continuing quest to find out what makes birth go well, and what the complex, emergent, unexpected consequences of this might be, has now taken us into the fascinating but somewhat intimidating area of epigenetics. At its most basic, epigenetics is the study of changes in gene activity that do not involve alterations to the genetic code but that are still passed down to at least one successive generation.

The reason I started to become interested in this area is because there is a growing body of research that tends to suggest that the way a baby is born might affect it in a number of unexpected ways. For instance, there are reported associations between mode of birth, and specifically caesarean section, and asthma, eczema bronchiolitis, type I diabetes, and multiple sclerosis, in the child and, later, young adult. This raises some interesting questions about what birth might be doing to the fetal epigenome. A group of international inter-disciplinary colleagues from the US, Australia and the UK (the EPIgenetic Impact of Childbirth group) has recently been set up to look at these questions. This work is very new and, potentially, very exciting.

Conclusion

So, in conclusion, it's always been my belief that the whole point of research and of being a professor in a profession like midwifery, is to increase wellbeing where possible. One thing I've learned is that the issues that matter to us here in the well-resourced west of the world, are actually the same as those which matter for the under-resourced east and south of the world.

While these concerns may be expressed in different outcomes, for example, postnatal depression and dissatisfaction in the West, and maternal morbidity and mortality in the South, the factors underpinning them primarily are around respect and trust of both individuals and the physiology of their bodies. The work that we do in our team is fundamentally focused on building positive respectful relationships between colleagues, with childbearing women, and with policy-makers, so that we can maximise the capacity of women to give birth to healthy babies, to parent effectively and to build positive societies. If we get even part of the way towards this, it will be worth it.

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Midwives and the time: a theoretical discourse and analysis

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Abstract

Aim. To gain an understanding of time and its impact on midwives' working lives.
Objective. To critically discuss various theories of time and to examine the pertinence of such theories when applied to midwives' work.
Rationale. The dynamic of time is one of the most important influences upon midwifery activities, yet temporal issues have attracted very little attention in the literature regarding midwifery practice, theory and research.
Design. In the course of this paper an attempt is made, via the process of theory derivation, to clarify the meaning of 'midwifery time', and how time is valued and perceived by midwives.
Findings. Time as a key to midwifery practice is theorised. There appears to be a belief and a lack of value of midwifery time, possibly indicative of the dominance of linear models of time (such as clock and calendar time) over cyclical time, and the historical ascendancy of medicine over midwifery.
Implications. Midwives find themselves working between different ideologies of time. Understanding how time concerns impact upon midwives' working lives may open up discussion as the midwife's role and sphere of practice evolves in an ever-changing environment of care.

Key words: Time, practice development midwives, care, feminisms, medical dominance, evidence-based midwifery

Introduction

In this paper I will explore various theoretical positions about time, offering critique and application to midwifery practice. I have endeavoured to engage with multiple perspectives of time and its meanings, the aim being to move away from what have been perceived as binary opposite arguments, for example, linear versus cyclical time and work towards diverse perspectives of time. I draw on social constructionist, feminist and postmodern theory to discuss linear time, cyclical time and the notion of the extended present, as well as applications to midwives' experiences in the field. This examination of time theories arose from an action research study with a group of education and practice development midwives, following one-to-one interviews during the research activity. I offer a case study from one of the midwives involved in the study related to the use of her time as a means of application of theory to practice.

Background

Adam (1990), in her book *Timewatch: the social analysis of time*, creates opportunities for the reader to explore the notion of time within a multiplicity of ideas. She argues that, for most people, time is a taken for granted and hidden so deeply in our individual and collective consciousness that we rarely discuss it as a lived experience. However, for a concept that is so implicit in daily life, there are many and varied references in daily language. For example, time is running out, time is of the essence, overtime, in time, opening time. For Adam (1990), complexity is a key concern when analysing time and she suggests that time permeates every aspect of our lives in global and local communication, through language, in cyclical and linear processes and as a commodity that can be bought and sold. Clocks and calendars assist in the structure and measurement of our daily and yearly lives, they tell us when we should do certain things, demand how life should be organised, when to go on shift and what is acceptable to do at a certain time of day. Yet the clock cannot be applied to every aspect of our lives because, despite the clock, still we have the flow and the constant and changing rhythms of the seasons, day, night, our physiologies, health, sickness, childbirth, all synchronised in a cyclical way.

Time as a socially constructed notion: lines and cycles

The way time shapes experience and experience shapes time relates to changes in the historical period, life context and variations across different societies (Brannen and Nilsen, 2002). It is therefore socially constructed, given meaning by people in particular contexts and social settings (Davies, 1990). Nowotny (1994) suggests that in pre-industrial society, time was perceived as cyclical, related to the seasons, the demands of agriculture, reproduction, day, night and the rhythm and ageing of our bodies. According to Berger and Luckmann (1966), everyone experiences an inner flow of time related to physiological rhythms for we still feel the repetitiveness of cyclical time, for example, of the sun rising and setting every day. Berger and Luckmann (1966) call this 'inner time' and this is how time is experienced phenomenologically, through connection of experiences in the past, present and anticipation of the future. Time as seen like this is complex, repeating and of nature, and, according to Kristeva (1986), links to women's experiences of time from the perspective of reproduction and motherhood. Davies (1996) also argues from a feminist position that cyclical time, being related to women's lives, work and reproductive cycle has been made invisible by the dominance of linear and clock time because it could not be measured and, as such, was perceived as unproductive.

Helman (1992) defines cyclical time as female or polychronic time and he discusses how polychronic people manage to do many things at once in the cycle of time without imposing strict clock schedules. Kaufman-Scarborough and Lindquist (1998) investigated the concept of polychronicity defined as the extent to which people can manage two or more overlapping tasks at the same time, rather than arranging tasks longitudinally in chunks in a linear manner. They found that those with a polychronic disposition were more able to adapt to high-pressure situations because having to change a schedule of work did not affect their ability to complete work on time.

Following the introduction of clock time, time became quantified and was seen to be linear rather than cyclical; time in this way is seen as progressing along a line from past to future, a physical reality, and separate from natural rhythms of the body or seasons of life. Helman (1992) describes linear time as monochronic when the time line is divided into segments of seconds, minutes and hours, and life becomes dominated by set schedules in order to use time well. The monochronic view is exceptional in that it originates outside the person; it is imposed as a means to maintain order over chaos and is an organising principle of industrialisation. Using this view of time, we see it as a conveyor belt that moves horizontally through past, present and future. We are always in the present, the past is gone and the future is yet to happen. Using this metaphor, the conveyor belt has a series of boxes moving from past to future in which we put our activities, we can only fit so much into each box and so each full container moves into the past and is done with. Time wasted is failure to fill the boxes on the belt and we grow anxious when the boxes are limited in number or we fill them inappropriately.

Thus, linear time became the dominant western view of time due to the ascendancy of industrialisation. Innovations in technology meant that time became closely aligned with organisational processes of work and production (Hassard, 2002) and the clock was required for coordination and control of people, machines and products. Further, Hassard (2002) argues that machines became the focal point of work and the scheduling of time for activities was paramount for planning. At the beginning of the 20th century, in the US, Taylor (1911) reorganised work processes, giving a time for each one, in factories by breaking jobs down into their component parts and reassembled them so that the whole factory was synchronised to run on clock time, with no wasted minutes. Time was compressed through fragmentation and timing of tasks and separation of manual and mental jobs. The outcome of Taylor's reassembly of time per task was efficiency gains for employers in products and saving of time in the process; his strategy was named scientific management.

Parallels have been drawn from midwifery practice by Hunt and Symonds' (1995), and Bryson and Deery's (2010) analyses of midwives' occupational identity within an assembly line process whereby the midwife is captured as a dominated semi-professional (Etzioni, 1969). The women are the labourers, the production area is the labour ward, the product is the child, the line manager is the midwife and the final authority is the works manager, the obstetric consultant. Throughput of women on the conveyor belt must be achieved within the boundaries of the timed shift system to ensure the organisation is coordinated and controlled. This style of maternity care keeps control of human action through linear time constraints and thus gives rise to a conflict between the physiological processes of labour and birth, which may be viewed as cyclical time and linear institutional time that is purely functional (Pizzini, 1992).

Extended present: a postmodern view

Hassard (2002) explains the postmodern turn whereby metaphors of clock time are being superseded by the idea that time is compressed through technologies of computers, telephone and fax. Organisational time is now managed at speeds that lie beyond the capacity of human experience. Brannen and Nilsen (2002) argue that technological advance means that we experience time pluralistically – it has many aspects or facets in our lives and this is because we are more easily available to others by some means of technological communication. This further means that we are constantly interrupted in our daily tasks and routine. The experience of accelerated time is the perception that we compress many and varied activities into ever reduced time spans resulting in the feeling of being constantly busy, never able to fit everything into our hectic lives.

Nowotny (1994: 49) explores linear time and observes 'the continuous pushing out on a continuum temporally directed towards the future' is an impossible hope because sudden unexpected events push in and lead to discontinuities and breakdowns in the linear concept. She further explains the postmodern notion of the 'extended present' where planning for the future may be altered by the experience of the present. Change appears to crowd in on us so quickly so that the future seems to be thrust upon us before its time, that is, the future we planned for becomes the current state. There appears to be no time to stand back, think, plan and prioritise indeed 'the future is no longer what it used to be'.

The future becomes overshadowed by the problems arising in the present and there is little opportunity to project forward planning, as the future is no longer remote enough to absorb things that may be unwelcome. Those things are drawn into the present, so we experience life as an extended, unplanned present. Nowotny (1994) further argues that the extended present attempts to combine linear and cyclical time because we no longer accept the present as being along a line leading to some kind of future, rather we restructure as part of a cyclical flow that never ends and the future remains uncertain. Bauman (1998) suggests that those in the world of work live in an extended present, feel short of time to do the job, have a loss of control over future events and a poor connection with the past, present and future. Time to 'wait and see' becomes a luxury as the time available for the creation of the future is taking place now

Linear time

With events occurring along the line from start to ending, the new is stressed; familiar, left behind and not repeated. The

Figure 1. Linear time

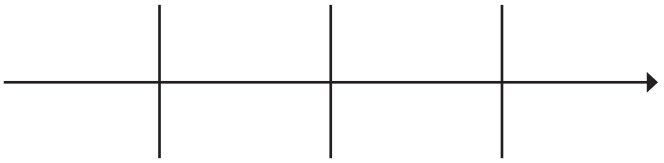


Figure 2. Cyclical time

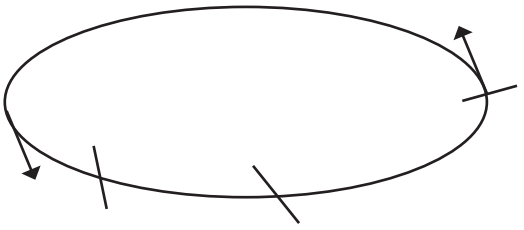
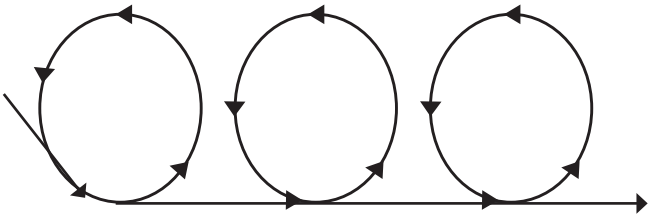


Figure 3. Extended present



future promises a wealth of possibilities but only a limited number of these can become real (see Figure 1).

Cyclical time

With recurring events of life along the continuum bound to nature's rhythms of day, night and seasons with human orientation to birth, life and death accepted in nature as reoccurring with some certainty. Davies (1996) calls this 'process time', when we think and act simultaneously and flexibly, often doing multiple tasks that take up time but may not be remembered (see Figure 2).

Considering extended present

Linear time must absorb the cyclical, the time arrow points forward but contains recurring cycles of life and activity in an attempt to diminish the uncertain future associated with linearity. Thus, according to Nowotny (1994), society tries to solve its problems with time by extending the present interpreted in both linear terms and recurring cycles (see Figure 3).

Case study of Heidi's work

Heidi was the education and practice development midwife for diabetes care and she was daunted as far as time to do the work was concerned. She tried to find a niche in the antenatal clinic, which is based on a linear model of time emphasising throughput and effectiveness of appointments. She found herself absorbed into the organisational complexity.

Heidi strove to find a way to deliver care to those women with diabetes, she defined the caseload, saw them through linear timing of regular appointments, decided upon need, and offered them care based on a cyclical model of continuity, and she saw each woman, every visit observing the cycle of their pregnancy to completion by providing care through birth. In this way, her time was spent in a variety of cycles influencing each other. She provided her innovation within an extended present that in turn avoided any adverse outcomes through poor diabetes management.

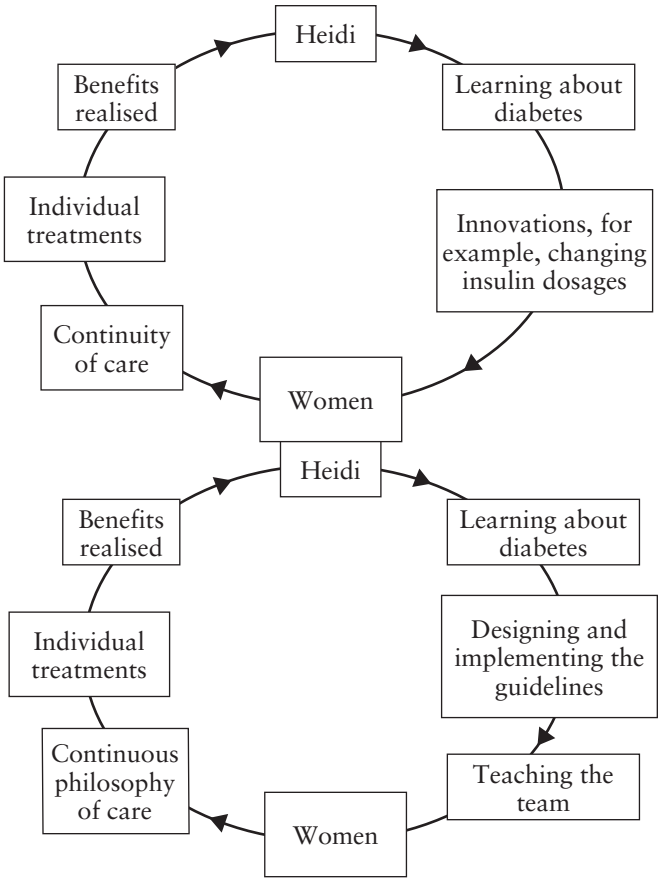
Heidi worked within the notion of the extended present, rapidly adapting to the needs of her caseload of women, changing and innovating, working linearly via appointments designed for each woman's time within a 'one stop shop' diabetes clinic, where all care was available at one clinic time for each woman. The cycle of each woman's pregnancy was accounted for. Creation and implementation of guidelines based on the Diabetes National Service Framework (Department of Health, 2003, 2010) was a linear time-consuming process due to the requirement of the key staff to be consulted. Once the staff had been taught in its use, the cyclical element for the women continues as care was delivered within a continuous philosophy underpinned with an evidence-based guideline and with expertise offered by Heidi to colleagues providing further care. Heidi's work is depicted cyclically in Figure 4.

Wealth and poverty of time

Warren (2003) asserts that poverty of time seems to exist in the life of those at work in pressured occupations with long working hours. Hochschild's (1997) research explored the detrimental effects of increased working hours on women and their families and she takes the view that time is being sucked out of the home and being pumped into work. She noted that the workplace was a 'workaholic cult' where women felt most appreciated, whereas the women viewed home as a place where they were less appreciated and so they found refuge in work to the detriment of family life at home. Hochschild (1997) takes the view that a competition exists in the currency of time between home and work and that home loses, relationships become time starved and women take up the majority of the household burden on returning home. Tronto (2003) takes up this theme when she explores gendered experiences of time in that culturally women's time has been organised cyclically at home, around processes of reproduction rather than around production. It seems that many women have now got a double burden: care and reproduction in a time efficient manner at home plus what Hochschild (1997) defines as the 'first shift' – ever more time at work.

Women in Hochschild's (1997) study had to be seen to be doing a complete job, working well past their hours, working on the computer at home and keeping in touch with work via the phone, time was seen as money – a product. Tronto (2003: 123) argues that attempting to conquer time through working to this level is to master the world of work and thus

Figure 4. Cyclical depiction of Heidi's work



production. For women it gives a paucity of time for care and nurture, 'it makes human lives of care poorer'. For the EPDG midwives, every one of them was a wife, all but one had children and they all worked on things at home. Parallels may be drawn with midwives' work, for they have expanded their roles, responsibilities and time at work partly due to reductions in doctors' hours, through specialised roles like the EPDG, and the explosion of part-time working.

Research focusing on midwives' time is sparse, however, Ball et al (2002) explored why midwives leave the midwifery profession. One of the key issues was related to the stress of working extra hours in order to cover the shifts without there being the capacity to take time back and being unable to leave work promptly. A perception of time poverty led to midwives feeling physically drained and resentful and refutes Hochschild's (1997) observations of women feeling more valued at work than at home. Indeed a category of leavers, the 'family commitments group', left because managers had little commitment to enabling family-friendly working. The two EPDG members who decided to leave the organisation for what they perceived would be a better quality of life echoed this.

Another research study, which mentions midwives' time, is an evaluation of evidence-based leaflets (Stapleton et al 2002). This study evaluated the impact of informed choices leaflets on practitioners and women. Although not explored in great depth in the study, it is clear that pressure on midwives' time affected the way in which midwives imparted information about care and choices during pregnancy to women. Midwives had to prioritise their time and listening to women's specific needs was down the list of priorities. The authors claim a lack of knowledge on the part of the midwives in giving appropriate information.

Reisch's (2001) essay on components of time wealth offers a framework to explore the notion of wealth in time. Reisch (2001) investigates the idea of individuals having sufficient time at the correct time and that one feels comfortable with the timeframes in which tasks need to be completed. Having sufficient time to do work according to one's own predilection is viewed as highly motivational. The following elements contribute to a feeling of time wealth:

- Chronometric dimension = the right amount of time
- Chronologic dimension = having time at the right time of the day, week or season
- Personal time/autonomy dimension = control over time
- Synchronisation dimension = time that fits with the time rhythms of family and friends.

The EPDG sought to manage the first three components, trying to fit in all aspects of the job, being controlled by the clock or shift patterns. Being able to apply flexible working patterns to meet the needs of client groups was a breakthrough and a satisfier as they perceived a wealth of time compared to previous time-starved roles.

Feminist perspectives: 'no down time?'

Davies (1991) takes the view that the making of clock time bears the badge of the male gender and the dominant view is of the importance in society of linear time expressed through the use of the clock. She argues that temporality viewed from this perspective means that women are not free to make choices on how they use time. According to Adams (1990), temporality is about the processes of life, living and dying and women have, because of the nature of cyclical reproductive work plus their subordinate position in society, to negotiate with others how they might use time. Davies (1990) suggests that the use of time is negotiated through gendered power positions and that we must not lose sight of time's social construction when considering how linear and clock time have gained pre-eminence in society. She notes that cyclical time is seen as less interesting than linear time maybe due to its relation to women's lives in work and reproduction. Kristeva (1981) echoes this when she observes that women are seen to be anchored in an eternal biological cycle of birth and death and that first wave feminists attempted to gain their place in linear time in order to champion equality.

It has been documented that the Church and the scientific community excluded women from the growth of science and thus time (Davies, 1991). Therefore, as the mechanistic view of the world evolved in which man sought to control nature, the clock was one tool of the control of everyday life and nature's cycles were almost defined out of existence. Felski (2000: 76) takes up the theme of everyday life as 'the essential, taken for granted continuum of mundane activities' that embeds all people in ordinary life whether they are rich or famous. She argues, however, that some groups are identified with the mundane more than others,

especially women who have traditionally toiled at home, not visible, doing caring work both in the home and at work. Felski (2000: 80) adds that, historically, women have been negated, disallowed from science and philosophy, required to be 'invisible, yet indispensable' in the doing of care work.

Sandall (1997) and Hunter (2004) have analysed the nature of emotion and caring work in midwifery, noting how midwives have become burnt out through emotional exhaustion and disillusionment with a job that is pressured, ever changing and, for many, lacks control over everyday work patterns. On the other hand, Sandall (1997) also found midwives who were able to organise their own work and caseload and offer appropriate and continuous care to 'their women'. These midwives were supported by colleagues and gained much from regular interaction with the women.

In Sandall's (1997) study, the biggest time bind was the on-call rota, which impacted greatly on the midwives' personal lives, as the timing of childbirth is unpredictable and midwives were in a constant state of readiness for the call. Frankenberg's (1992: 4) sociological critique of doctor and nurse time argues that nursing shifts proceed in linear time and when the shift is complete they go home to rest – 'private time and public time are clearly demarcated' – linear, clock time has a beginning and end. But, if we consider the cyclical nature of on-call work for midwives, Frankenberg's (1992) assertion is incorrect, time spent on-call and on shift clearly filters through into midwives' private time; they appear to become indispensable, with their everyday life disrupted.

Tronto (2003) also debates the notion of time and of doing care and agrees that, historically, women have taken the burden of care and so have experienced time differently from men, with time spent organised around reproduction rather than around production of goods. Leonard (2001) argues that no matter how many in-roads women make into careers, they continue to be primarily responsible for domestic duties, child care and reproduction and that this is transferred into working life where the 'caring professions' are, in the main, women who tend to work part-time in the aim to achieve work-life balance. Working part-time takes us back to the notion of women in caring professions being viewed as 'semi-professionals', low in status, lower in the professional hierarchy and often lower paid (Etzioni, 1969; Hunt and Symonds, 1995; Bryson and Deery, 2010). Leonard (2001) goes on to remind us that women's caring work in the home and men's relative freedom from such work means that men and women are integrated into the system of production in gender specific ways – care and reproduction are still viewed as women's work. Hochschild's (1997) 'work becomes home and home becomes work' makes this very point; women's time often becomes the time of others. Bryson and Deery (2010: 93) draw upon theories of time to critique the 'clash' between women's time and men's time: '*Women therefore experience the clash of time cultures most frequently and acutely as they strive to reconcile the physical and emotional rhythms of family life and interpersonal care with the rigid imperatives of the clock.*'

It may be argued that the external order of the clock has the effect of dehumanising an essentially human behaviour for midwives; that of providing care to women, through the implementation of tasks usually devised and devolved via obstetric dominance. Time can therefore be perceived as a means of dominating and controlling others if linear time dominates the agenda. This is clear in the reduction of junior doctors' hours whereby tasks that junior doctors had no time for, would be delegated to or 'dumped' on midwives. Devolving tasks means that skills must be learned and maintained by midwives in order that that expertise is available for practice, supervision and referral. Doctors still require training in obstetric tasks, however. One of the EPDG midwives was responsible for mandatory in-service training. Initially she devised a two-day programme, which grew into three days due to the evolving need for compliance with the Clinical Negligence Scheme for Trusts (CNST) and various initiatives aimed at managing risk. The changing NHS agenda was a political drive to make this happen. Interestingly, doctors declined to attend skills sessions – they were too busy or not available. The process of 'dumping tasks' explained by Walby et al (1994: 40), was achieved; training was implemented, but was not accessed by the dominant group.

Such non-compliance is extraordinary in the light of the NHS agenda to reduce litigation costs through strong risk management and training for competence. Helman's (1992) sociological account of monochronic time as a means of control may be helpful to gain understanding, in that flexibility of time is strongly related to power and status. It may be argued that the *Junior doctors' hours the new deal* (DH, 1997) has brought new power to doctors – they have power over their own time and partial release from some duties, whereas midwives have been left in a double time bind (Hochschild, 1997) – they must do the devolved tasks and they must do the training. Bellaby (1992: 109) observes that time discipline cannot be extricated from power, 'power is relational. It can scarcely be said to be the possession of one person or group, but flows within relations as one party seeks to control and the other resists'. This may be seen as an example of doctors resisting management strategies for change and development through creating time for themselves in the day for other tasks and of midwives complying as a lower status group. It appears that midwives' time is expendable and expandable, stretching to fit with the pressures of the politics of the day. As Walby et al (1994) concede, doctors may use resistance through closure strategies of non-attendance in order not to comply but, ultimately, management gains control because time is money, the time must be spent in being trained in order that money might be saved through lower litigation costs.

Implications for midwifery

I have theorised time from several perspectives and I have considered midwifery research to explore the impact time has on the lives and work of midwives. This is an area that has had modest clarification in the literature and as a profession we need to have awareness, in order to manage changing lives and times within the organisation of maternity services.

Midwives who attempt to provide care within the current dominant system of the hospital, may find themselves in

a culture of competing ideologies where time for care is concerned. The literature shows us that linear time continues to hold sway where time is viewed as a commodity, not to be wasted, to be used well. Within this idea is the application to midwifery time, where women must be rapidly processed through the organisational procedure in order to be effectively and efficiently dispatched home. At odds are feminist ideals of women's time where birth, life, the cycles of reproduction and care are often made invisible by the dominance of linear time. This puts midwives in a real 'time bind' (Hochschild, 1997) when in essence their role and scope of practice expects them to organise throughput linearly 'like clockwork' (Bryson and Deery, 2010: 94) and to take up the 'dumped' tasks from obstetricians, plus the provision of woman-centred and compassionate care which requires emotion work. The time to create relationships of care seems to be where 'time poverty' is experienced to the detriment of women and midwives and as Dykes (2009: 97) comments there is a 'dissonance between the much advocated low-tech, woman-centred, one-to-one focus and the reality of a medicalised, hierarchical, fragmented form of institutionalised midwifery'.

Conclusion

Time, then, is a complex and pervasive force in society that cannot be seen, heard, felt or tasted. It relates to the rhythms and flows of birth, life and death. Yet this unseen force is measured in western society by the means of clocks and calendars. The clock has become dominant and is synonymous with time, as if there is no other way of understanding it. I have discussed various perspectives to demonstrate that it is a complex entity that impacts upon midwives' everyday lives and work.

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Postnatal care across the Northern Ireland and Republic of Ireland border: a qualitative study exploring the views of mothers receiving care, and midwives and public health nurses delivering care

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Abstract

Background. In developed countries, shorter postnatal hospital stays have been reported in the literature over the last two decades. In the UK, a reduction in the number of postnatal home visits by midwives has been noted. In Northern Ireland (NI) midwives care for all mothers for a period not less than ten days and longer if necessary. In the Republic of Ireland (ROI), the public health nurse visits less often initially, but provides care for families with infants over a longer period up to, and including, the school years.
Aim. To explore whether professional home postnatal care in NI and ROI meets mothers' expectations and needs. This study was designed to explore mothers' experiences of different models of postnatal care from each side of the border to inform decision-making about universal versus targeted home visiting.
Participants. A total of 20 mothers resident in NI and 20 mothers resident in ROI took part in the study, along with five lead supervisors of midwives in NI, 12 community midwives in NI and one regional ROI service manager.
Settings. The community and hospitals in NI and the community in ROI.
Methods. Data collected using digitally recorded interviews and focus groups, and analysed using analytic induction procedures.
Findings. Four main themes emerged from the data – mothers' experiences of postnatal visits, advice given, out-of-hours help and continuity of care. ROI mothers valued home visits up to three months after the birth, but wanted more visits in the early postnatal period. More advice about maternal health and more help with infant-feeding were required. Some ROI mothers travelled across the border for home postnatal care by NI midwives. NI midwives reported routine visiting patterns.
Conclusions and implications for practice. The tension between too many or too few home visits suggests that visiting health professionals need to negotiate the visiting pattern with mothers to meet their individual needs.
Recommendation. The establishment of a dedicated, community-based, midwifery service with out-of-hours support for mothers has been recommended.

Key words: Qualitative research, analytic induction, postnatal, new mothers, Ireland, outsider, evidence-based midwifery

Background

Northern Ireland (NI) is situated in the north-east of Ireland, while the remainder of the island is governed independently as the Republic of Ireland (ROI). Two models of postnatal home visiting are explored in this cross-border study.

As far as we are aware, this is the only study to date that compares the role of the midwife and the public health nurse in home visiting after childbirth in Ireland. Debates about which health worker should be responsible for the visits are apparent globally. In China, Tao et al (2011) describe how inadequate funding, poor skills and limited human resources restrict the service. In NI, Christie and Bunting (2011) experimented with an intensive postnatal home visiting by health visitors to variable effect. Mothers in the intervention group reported higher service satisfaction. In NI, midwives care for all mothers for a period not less than ten days postnatally and most women in the UK receive about seven midwife home visits in the first ten to 14 days (MacArthur et al, 2002; NMC, 2004). Recent financial pressures in England have resulted in rationing the number of midwife visits to a maximum of three per mother (Walsh, 2011). At ten to 14 days, care is then transferred to the health visitor (Department of Health, Social Services and Public Safety (DHSSPS), 2010). In ROI, a different model of care exists whereby the public health nurse visits over a longer period in her child health promotion role (Hanafin and Cowley, 2006), but there are fewer home visits to mothers in the first postnatal week. There is a minimum standard of one visit, as soon as possible after hospital discharge, within the first 48 hours. In this visit, the public health nurse gives information about the phenylketonuria test, the baby's health and feeding (McCarthy et al, 2005). Compliance with this standard varies according to the ratio of public health nurses to the population and the effectiveness of communication between the hospital and community (O'Dwyer, 2009). The views of mothers on maternity care have been notably absent from the policy, practice and research agenda in NI and ROI. A review of the literature indicates that there are few published reports of consumer satisfaction (Magee et al, 2000; PricewaterhouseCoopers LLP, 2006; Association for Improvement of Maternity Services Ireland, 2007; Campbell and Doherty, 2007).

This research study was carried out at an opportune time as continuing peace in NI is bringing about rapid change.

However, despite equality legislation and relative political stability, women remain invisible in many areas of society (Gray and Neill, 2011). Religious segregation of neighbourhoods persist and fear, apprehension, suspicion, and distrust of others is a legacy of the conflict (Harland, 2011).

Differences are noted in data related to childbirth between the two countries. A national survey in ROI (Economic and Social Research Institute (ESRI), 2010) indicates that 45% of mothers breastfed in 2009 compared to 64% of mothers who breastfed in NI in 2010 (Health and Social Care Information Centre, 2011). Time spent in hospital after childbirth has become progressively shorter in Western countries (Brown et al, 2009; Northern Ireland Statistics and Research Agency (NISRA), 2007). The average length of hospital stay in the NI Maternal and Child Health Hospital Directorates is 2.8 days in 2006 to 2007 (NISRA, 2007). In ROI, over 90% of singleton mothers undergoing caesarean birth stayed in hospital three to five days after childbirth (ESRI, 2010).

Despite earlier discharge, there has been a trend towards a reduction of universal home visits by midwives and health visitors in the UK (House of Commons Health Committee, 2003; Robinson, 2005). Internationally, evidence suggests that home visits are restricted to specific groups of mothers. In Pennsylvania, in the US, Kishbaugh (2003) reports that health insurers pay for one visit only if the mother is discharged before 48 hours. Clearly, the impact of more time at home with earlier hospital discharge puts pressure on the community health professional team.

The objectives of the study were to identify the usual home visiting pattern; ascertain how midwives chose which mothers to visit more frequently; establish how midwives identified that the visit has met the mothers' needs; discover what were mothers' experiences of being visited at home postnatally and perceptions of their needs being met; and to compare mothers' experiences of home support after childbirth between NI and ROI.

Methods

A qualitative approach using analytic reduction principles (Taylor and Bogdan, 1998) for data analysis was chosen to provide an in-depth perspective of postnatal care. The study comprised four phases of data collection.

Phase one

Phase one involved face-to-face individual interviews with the lead supervisors of midwives for all four health boards in NI, the local ROI service manager, and the local NI midwife manager. Lead supervisors of the four NI health boards and the lead public health nurse in the ROI health board were interviewed in order to obtain a regional perspective.

In order to gain access, an initial letter of introduction about the study was sent to the five lead supervisors representing the four health boards in NI and the local ROI service manager. All those invited agreed to participate.

Phase two

The second phase involved focus groups with community midwives from NI. Information was sent to the community midwives. The team leaders in the four health centres were contacted to ask for volunteer participants. A convenient time for focus groups was agreed. A total of 12 community midwives were interviewed in four health centres in four focus groups.

Phase three

The third phase comprised individual interviews with postnatal mothers, all of whom gave birth in one hospital on the NI/ROI border. Access was granted by the study site hospital. Postnatal ward staff were orientated on the inclusion criteria for the study (both first-time mothers and mothers who already had children, half of whom resided in NI and the other half resided in ROI). The only exclusion criteria were mothers under 16, as parental consent would have been necessary. Once identified the researcher approached eligible mothers, explained the purpose of the study and left an information sheet with the new mother to read. On the sheet was a tear-off slip, which mothers could complete if consenting to participate, giving contact details for subsequent telephone follow-up. Between March 2006 and January 2007, 55 newly delivered mothers were verbally invited, when in the postnatal ward of a hospital on the NI/ROI border, to participate in the study. Subsequently, 40 mothers were interviewed. A total of 15 mothers who agreed to participate when in the postnatal ward were lost at follow-up, either being unavailable by telephone or not keeping their appointment for interview. Participants were purposively sampled to generate data about the two different models of home visiting (Green and Thorogood, 2004).

Phase four

Following analysis of the data, summaries of this and findings from the mothers interviewed were presented to the service managers and midwives as part of a rapid appraisal exercise (Annett and Rifkin, 1988) to assist in identification of further data sources, such as service users, that are not in the public domain.

Data collection

The data for this study were collected from March 2006 to January 2007. All interviews and focus groups were digitally recorded and data were collected by the first author. Data from five lead supervisors of midwives were collected in semi-structured interviews. All interviews began with: "*Tell me how you view the current community postnatal service and how it will develop in the future?*" Interview questions focused on debates around targeted versus routine home visiting, women-centred care and public health.

All focus groups were held in the community midwives' base health centres. The participants were asked to reflect on their work diaries and asked to discuss the frequency of visiting mothers, and to explain what factors were involved in making that decision. They were asked to discuss any mothers they visited for longer, particularly after the normal ten-day transfer to the health visitor; how they viewed their public health role developing; did they see a place for a postnatal clinic attendance rather than home visiting; and finally did they have any requests for telephone advice from women in ROI? At the end of each focus group, an exercise using cards was introduced. Each card named a factor that had emerged in planning the frequency of visiting and the group was asked to put the factors in order of priority.

Data from mothers were collected during semi-structured interviews. All interviews started with collection of baseline data such as age, birth experience, number of children and family support. This was followed by: "Did you spend long in hospital after the birth?" and then: "Tell me how the home visits from the midwife went?" Mothers were asked how valuable the midwives' home visits were, and what factors helped or hindered? A ranking exercise, similar to the one in the focus group described above where midwives were asked to reflect on their work patterns, was then performed to identify the perceived values of home postnatal visiting by the participant. On average, interviews lasted 28 minutes (11-53 minutes). All interviews took place in mothers' homes.

Data collection and analysis were concurrent. An experienced secretary transcribed the digital recordings verbatim. Data were managed using the computer software package NVivo 7 (QSR International Pty Ltd, 2007) during the analysis process. To enhance the accuracy of data transcription and analysis, the co-authors listened to recordings and advised on interview technique. The first author listened to all of the interviews after transcription to check for accuracy and the data were discussed in detail in the analysis process with the co-authors.

In order to complete the rapid appraisal exercise, local stakeholders were posted a summary of the findings and invited to meet either in person, or via telephone to discuss them. The midwifery service manager for the study site gave ready access to the minutes of Maternity Service Liaison Committee meetings and a recent service users' report. Access to data was permitted. Data were examined for the time period of recruitment to the study, March 2006 to January 2007. A research summary was presented to nine midwifery managers from across NI at a regional meeting; a group of NI community midwives representing several teams who had been interviewed in the study; and to the regional meeting of maternity services joint liaison groups. Information gathered has been included in the findings of this study.

Analysis

Znaniecki's (1963) classic approach of analytic induction is the development of theory through the systematic search for falsifying evidence until no further disconfirming evidence can be found. The stepwise approach of analytical induction described by Bondas (2006) has guided this study as it allows for individual differences in participants' perceptions, thereby retaining unique cases in the analysis. Comparative analysis was performed, looking for common and differing characteristics, with a view to determining a provisional list of case features, known as a taxonomy. Tentative hypotheses were then formulated and the data were studied to locate positive and negative cases. Through a process of inductive reasoning, thinking and theorising (Taylor and Bogdan, 1998), a taxonomy of categories was developed. From the taxonomy, a typology was created of the differing women's views of care in NI and ROI as they emerged from the data. A typology is a systematic method for classifying similar events, actions, people or places into discrete groupings (Berg, 2001).

The rigour of the study concerning the criteria of credibility, dependability, confirmability and transferability (Lincoln and Guba, 1985) was addressed. Credibility was enhanced by the use of an audit trail and the maintenance of journals recording reflexive analysis. Dependability was improved by the use of an assistant focus group moderator. Confirmability was achieved by the development of hypotheses grounded in the data, with linkages to categories, codes and the raw data. (Transferability was achieved by making comparisons against local evidence that emerged in the rapid appraisal exercise).

Ethical considerations

Separate ethics approval was applied for successfully from the Office for Research Ethics NI, the study hospital site, the ROI service manager and The University of Manchester research ethics committee. Time restrictions resulted in limiting the study to participants who gave birth in an NI hospital, NI midwives and one ROI public health nurse manager. At the beginning of each interview, verbal and written consent was obtained. Participants were reminded that they could withdraw at any time. All data were catalogued to maintain anonymity and confidentiality.

Results

All 40 mothers recruited to the study gave birth in hospital, and were interviewed at a minimum of three weeks after the birth to a maximum of 14 weeks after the birth. The characteristics of the participating mothers are shown in Table 1. Four focus groups were carried out involving 12 community midwives. Overall these were experienced midwives with the mean length of midwifery service being 27 years and the mode 34 years. Themes emerged from the data that are organised primarily under the objectives of the study.

Identification of the usual home visiting pattern and frequency of postnatal visits

There were differences in the pattern and frequency of home postnatal visiting in NI and ROI. One NI supervisor reported that mothers would definitely have visits on the third, fifth, ninth and the tenth day, because of tasks to perform such as weighing the baby. The pattern of frequency of visits in NI was routine and sometimes described as 'too much' by mothers. By contrast, some ROI mothers experienced only two visits. They complained that they wanted more visits, particularly in the first week:

"I thought they might have come a wee bit more often" (ROI mother 5 and 14).

"The nurse was too busy" (ROI mother 20).

The ROI manager reported that the heavy demands of the public health nurse workload rarely permitted visits on demand.

How midwives chose which mothers to visit more frequently

NI midwives identified certain groups of women who they would give priority to in their visits, and thus visit daily:

"Would visit anyone who had complicated deliveries and also including caesarean section or any women with bad tears or infected stitches" (supervisor 5).

"Teenage mothers are concerned, our visiting would be very often on a daily basis to those mothers" (supervisor 3).

"Prims (primigravidae) we're inclined to see more often, breastfeeders more often, people with infections or jaundiced babies. We prioritise six-hour discharges – we would see them more often" (focus group 1).

Supervisors and community midwives described how families

Table 1. Characteristics of mothers interviewed

Mothers	Residents in NI	Residents in ROI
Aged 17-20	2	0
Aged 21-30	6	7
Aged 31-35	5	7
Aged 36-39	4	3
Age unknown	3	3
Having first child	12	11
One previous child	4	5
Two previous children	4	4
Normal birth	7	2
Vacuum birth	2	1
Forceps birth	2	1
C-section	9	16
Breastfeeding	4	6
Formula-feeding	15	13
Mixed feeding	1	1
1-3 days in hospital after birth	10	10
4-6 days in hospital after birth	7	9
7-10 days in hospital after birth	1	0
13-14 days in hospital after birth	2	1
Baby in neonatal	3	4
Baby not in neonatal	17	16
Baby: 3-4 weeks at interview	7	4
Baby: 5-6 weeks at interview	7	10
Baby: 7-8 weeks at interview	3	2
Baby: 9-10 weeks at interview	0	2
Baby: 11-12 weeks at interview	2	1
Baby: 14 weeks at interview	1	0
Baby: age unknown at interview	0	1

identified as needing child protection were visited daily, and often the visiting was prolonged. One midwife reported:
"Well, if I could say to you at the minute for my side (area) and two of the practices I'm in, I have eight pre-birth conferences within the next three weeks, eight, and they all have previous children in care or the child, the person is in care themselves" (focus group 3).

Negotiated pattern of visiting: findings in NI
Routine daily visiting for all until six days after the birth was reported in all the focus groups. After that those mothers without problems were asked if a daily visit was needed, otherwise contact was available by phone. One supervisor reported that some midwives felt apprehensive about not visiting women more regularly. One midwife commented:
"They're at home and they've had us up to maybe day ten or whatever or longer, if necessary. Then all of a sudden, they're on their own" (community midwife focus group 2).

However, the team stated that they were in the process of developing guidelines for managing mothers who were considered 'at risk'.

Alternatives to home visits: postnatal clinics
There were diverse views about setting up postnatal clinics expressed in the focus groups with NI community midwives. Rural isolation and lack of adequate public transport for mothers were evident. Two mothers said they would prefer a home visit: "*I would never be organised to be up in a health clinic for anything… when you've had a bad bad night and there's nobody there to relieve you, how could you get organised to go anywhere in the morning and money too. You've to pay your taxi fare. Some people just don't have it"* (NI mother 8, mother of twins).

ROI mother 1 described how three days after a caesarean birth, she was told to travel to the health centre daily for a health assessment by the nurse. This caused her considerable inconvenience, as she had to find someone to drive her to the health centre, and a carer to supervise her other children. At weekends, when the health centre was closed, all the new mothers collected in one new mother's house to save the nurse visiting each individually. However, ROI mother 1 was embarrassed to have intimate examinations in someone else's house.

Meeting women's health needs during unsocial hours
Professional help by telephone was limited in ROI both in and out of office hours. One ROI mother recounted how she had phone numbers for the public health nurses, but it was sometimes a week later when the nurses returned the telephone call. One mother was concerned about her jaundiced baby:
"We decided to try and call into where the public health nurse is to ask her to look at her because she wasn't going to be calling like for another week and so we went in but she wasn't there, there was nobody there available so we went down to the doctor's surgery to see if I could get a doctor to look at her but there were no appointments available so nobody would look at her and so I had to wait then for another few days until the public health nurse came down" (ROI mother 12).

The NI midwives carried an emergency mobile phone and

gave the number to mothers:
"They would… quite often they would phone" (focus group 4).

How do midwives identify that the visit met the mother's needs?
NI midwives were asked directly as to how midwives identify that the visit has met the mothers' needs. Responses were by *"visiting at a requested time"* (focus group 3); explaining medical terminology in personal birth records and *"keeping on"* women with problems:
"You can say to her 'how are things today?' or some wee thing that she'll open up" (supervisor 1).

The midwives reported that often they just sat and listened and, as the mothers recovered their strength after the birth, their morale improved. Emotional support was described frequently by NI midwives:
"They de-brief every day of the week to us, you know, whether it be verbally or in non-verbal communication terms" (focus group 3).

This was verified in the mothers' interviews:
"Just that supportive role, definitely, was a big factor for me and someone just to talk things through with, anything that I was worried about" (NI mother 1).

Midwives described reading non-verbal cues:
"We can tell by body language if mother does not value the visit" (focus group 3).

Mothers' experiences of being visited at home postnatally and perceptions on whether their needs were met
The majority of mothers on both sides of the border valued the support for maternal and infant care. Using the cards at the end of the interviews, the top most frequently ranked value was 'support for baby care', hence midwives and public health nurses were valued for their expertise in baby care. On both sides of the border, mothers experienced uncertainty as to what to expect of visits:
"Nobody tells you what to expect, in terms of the midwives, when they're coming out, what their job is and what they can do for you" (NI mother 13).

Perspectives of women who gave birth by caesarean section
Mothers living in rural areas who had given birth by caesarean section were particularly pleased to see the public health nurses visiting, and derived emotional support. Loneliness and frustration with their isolation were often expressed. ROI mother 14 had seen her doctor to ask if she could drive:
"He said no. There was nothing, you know, that was the advice, I couldn't drive (for six weeks)" (ROI mother 14).

Comparing mothers' experiences of home professional support after childbirth between NI and ROI
Differences were reported in the advice received. Maternal health advice was limited in women interviewed in ROI. It was evident that some ROI mothers were 'border hopping' to NI for a more intensive visiting service. Mothers on both sides of the border experienced inadequate professional support in relation to formula-feeding of babies and thus depended on their wider family to learn about it, particularly those who had ceased breastfeeding. Some ROI mothers reported a lack of support for breastfeeding. In this study, only ten of the 40 mothers interviewed between three and 14 weeks after birth were breastfeeding at the time of interview. While a number of mothers reported having been told that breastfeeding support groups operated locally, only two mothers (ROI mother 12 and 19) had contacted the groups. Mothers in NI were happy, on the whole, with the general health promotion support provided, although one mother did not see its value:
"You don't really need the health promotion. I know that if anything is wrong with him to go to the doctor's but I mean you can't really promote his health because all you're giving him is milk at the end of the day" (NI mother 9).

Continuity of care
In NI, midwives were organised in small teams that were attached to health centres providing antenatal and postnatal maternity care. Continuity of carer was more commonly reported in NI:
"At least, you know, it wasn't just like a stranger and they're all very nice, so they were" (NI mother 19).

In ROI, the public health nurse was organised across the county attached to public health clinics. Mothers in this study were less likely to know the public health nurse but their 'friendliness' overcame the lack of continuity of care:
"After about two days. There was somebody else now. It just depends on the nurse schedule, you know, where they were that day and who was working and who's not working" (ROI mother 13).

The nature of engagement between mothers and NI midwives
There was a resistance to referral to breastfeeding groups and an over protectiveness of mothers expressed:
"I think we are very possessive really of our role, I'm not just trying to covet midwifery but I really do think that it's so highly specialised" (focus group 3).

Reluctance was expressed to teach about emergencies:
"I think for a lot of women, they wouldn't be fit mentally to cope with that" (focus group 3).

NI midwives expressed satisfaction with the continuity of care given. However, some NI mothers felt intimidated by midwives. Two first-time mothers complained that the midwives scared them:
"Sometimes I felt a wee bit intimidated by them, you know, sometimes just, you know, just they were more sometimes… a lecture than advice" (NI mother 18).

Discussion

This study has illustrated the different settings that postnatal home visiting midwives and nurses work in, on either side of the NI/ROI border. The study provided a unique opportunity to compare and contrast working practices and consider their impact on new mothers. Distinct typologies of women's views of the care emerged from the data.

A typology of the NI community midwife visits
Insights into the concept of health promotion in NI were gained. Mothers in NI were happy with the public health teaching, such as teaching about sudden infant death, but one mother did not see the value of it (NI mother 9, above). This mother

seemed to be dependent on attending the doctor's surgery when concerned, instead of engaging in preventative health care. A lack of self empowerment was demonstrated in other ways in the study. Only two of the 40 mothers interviewed had attended breast-feeding support groups and mothers were unenthusiastic about attending postnatal clinics instead of home visits.

Findings suggested disempowering midwifery practice. Mothers complained of too many visits, two saying that they felt intimidated. Some midwives displayed a reluctance to refer to breastfeeding support groups or teach the signs and action needed for possible emergencies. This enduring resistance to empowerment is reflected in the wider societal environment in NI where the prevailing male dominance in the home, the workplace and public life conspires to oppress female empowerment (NI Assembly, 2002). Some NI communities were still distrustful after the conflict in the society, preferring not to travel beyond their own affiliated localities (Boydell et al, 2008). The development of female empowerment, gender and equality is a worldwide challenge promoted in goal three of the millennium development goals (United Nations, 2010).

A typology of the ROI public health nurse visits

A different perspective of professional power and working patterns is evident from the data. ROI mothers wanted more visits, especially in the first week of being home. Telephone professional help was limited in ROI. The busy public health nurse was unable to return calls for days and appeared rushed when she did visit. The findings demonstrate a restriction on time and information. A lack of information helps to create consumer uncertainty and dependency on professional help (Simpson, 2004). Furthermore some ROI mothers wanted more advice about their own health, particularly contraception.

Once home, ROI mothers would have welcomed more breast-feeding advice. These findings are consistent with the work of Hanafin (2005) and McCarthy et al (2005). Ireland, north and south, compares poorly with global statistics for successful breastfeeding (Department of Health and Social Services NI (DHSSNI), 2001; Bonham, 2006). The North Western Health Board (2001) developed a policy to offer all new healthcare staff working with breastfeeding mothers appropriate education and training. In the NI study site, midwives attend a minimum of 35 hours' learning activity every three years (NMC, 2008). By comparison, the breadth of the public health nurses' work must challenge the organisation of sufficient regular updates to maintain their wide range of skills (Hanafin, 2005).

The public health nurse provides a community nursing service to families with infants and children; clients who need clinical nursing care; clients with a psychiatric illness; and clients who are intellectually and physically challenged (Hanafin et al, 2002). In an analysis of the public health nursing service to families with infants in ROI involving 539 public health nurses (Hanafin and Cowley, 2006) the concepts 'time' and 'knowledge' were found to be central to understanding the service quality.

A large workload has resulted in public health nurses being unable to have contact with mothers five times in the first year, as local policy dictates (Hanafin and Cowley, 2006). The experience of ROI mother 12, unable to access nursing or medical health care for her jaundiced newborn baby was potentially dangerous. The findings of our study sustain the argument for a specifically trained, updated workforce with 24-hour access, to meet postnatal mothers' needs in ROI.

In this study all the mothers valued the universal home visits and ROI mothers wanted more visits. A weakness across both roles in this study was the need for improved home support for infant-feeding. The NI government (DHSSPSNI, 2010) has drawn attention to the early cessation of breastfeeding in NI and the need to examine the reasons for this. A template for sustaining breastfeeding in the community has been developed by the UNICEF/WHO Baby Friendly Initiative (2011).

Limitations

We acknowledge the limitations of the study. One limitation is the age of the data collected mainly in 2006. Another limitation is that neither ROI public health nurses nor ROI mothers, who gave birth in an ROI hospital, were interviewed. Difficulties were experienced, over a period of six months, in obtaining ethical approval for the study in ROI. No organised ethics committee appeared to exist in the ROI county concerned. Delays prevented further attempts to expand the study design in ROI.

Implications for practice: recommendations for policy

The data in this study were collected after the publication of national guidelines (NICE, 2006). Negotiation of the pattern of visits with the mother is recommended in the guidelines. The data from this study indicate that some mothers wanted more visits and some wanted fewer. Guidelines need to be developed on selective visiting for the most vulnerable mothers and families (Department of Health, 2009). In NI, more use of telephone assessment may be sufficient to meet some mothers' needs. DeVore (1999) describes successful telephone triage. Our data suggest that ROI mothers wanted a choice of more home visits in the first week after the birth. Furthermore the evidence suggests that ROI mothers wanted out-of-hours access to maternity care advice. Since 2006, the preparation of the ROI public health nurse has been limited to six month's experience of maternity care. A midwifery qualification is no longer necessary (National Council for the Professional Development of Nursing and Midwifery, 2005).

Recommendations for research

It is imperative that future research should focus on an evaluation of the effectiveness of community midwifery in promoting breastfeeding. Internationally work to identify the factors that sustain longer breastfeeding in the first year of life is suggested.

Recommendations for education

Education is needed for midwives and public health nurses specifically. The paradigm of the disempowered service user should be included in pre- and post-registration midwifery and public health nursing curricula. Universities should work towards accreditation by the UNICEF Baby Friendly Initiative (2011).

Conclusion

Regardless of setting the most consistent finding in this study was the value that mothers placed on the postnatal advice provided for their baby and this needs to be borne in mind for future service delivery planning and curriculum planning.

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A qualitative exploration of women's experiences and reflections upon giving birth at home

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Abstract

Women's choice over their birth location is a subject that has come to the fore in the public's attention. There is a dearth of empirical research, which has addressed women's experiences of giving birth at home. A grounded theory method (Glaser and Strauss, 1967; Rennie, 1988) was applied to the experiences of nine women who had undergone, or had knowledge of, a home birth. The emergent theory described the overall perspective of the women on adopting a philosophy of control in planning and giving birth at home. This encompassed a dynamic relationship between the perceived three stages of having a home birth: preparing for the challenges, developing resilience strategies and the outcome of the home birth experience.

Key words: Grounded theory, holistic care, home birth, empowerment, qualitative analysis, evidence-based midwifery

Background

Historically a shift from births managed naturally by midwives at home, to hospital, occurred in the late 19th century, as a pathological perception of childbirth was promoted via some anti-home birth, medical publications and obstetric opinion (Oakley, 1984; Savage, 1986). This perspective was challenged by consumer groups in the 1970s, such as the National Childbirth Trust (NCT), who promoted natural births (Oakley, 1984).

A recent positive media contribution on the issue of home birth was Rikki Lake's (2008) documentary *The business of being born*. Nonetheless, giving birth at home remains a marginalised choice, available to privileged socio-economic groups (Edwards, 2005). According to data published on the BirthChoiceUK website, there was a decrease in the rate of home births in 2009 (2.57%) in comparison to the 2008 home birth statistic of 2.70% (BirthChoiceUK, 2011). Furthermore, the current picture of the NHS is one of over-stretched and under-funded maternity services where 'choice' is limited for women wishing to have a home birth (Dreaper, 2010).

Background literature was obtained using an Athens database search. In summary, this revealed that the detrimental effect of the technocratic model of maternity care has been a subject of continued debate in the literature (Davis-Floyd, 2001; Edwards, 2005; Stockill, 2007). In contrast, a number of researchers have demonstrated the efficacy of a humanistic model of maternity care, which aims to focus on enhancing relationships between medical practitioners and mothers (Kennell et al, 1982; Kleinman, 1988). These studies have demonstrated that having empathic, intensive one-to-one care has shortened and eased labour.

Similarly, a liberal strand of the obstetric literature focused on the beneficial experiences of an active birth (Odent, 1984). Likewise, a number of childbirth theorists have argued for non-intrusive birth conditions to create a climate that enhances a bond between mother and child (Odent, 1984; Kitzinger, 1992; Wagner, 2001). An alternative area of the literature has focused on the biological aspects of bonding at the moment of birth and the effect of natural opiates released in strengthening the mother's feelings of goodwill; in addition to extended contact with the newborn (Trevathan, 1987; Klaus and Kennell, 1976).

Some research has honed in on the specific qualitative elements of the birth space. In particular, the way in which the birth location affects a woman's sense of physical and emotional integrity (Ng and Sinclair, 2002; Parratt and Fahy, 2004; Edwards, 2005; Kornelson, 2005; Cheyney, 2008). These studies yield similar themes, namely that a home birth facilitates positive elements of the birth experience, such as retreating from the outside world to focus attention on processes that are occurring within the body, having a choice of people present, a sense of self efficacy and making an informed choice about medical interventions. These studies provide valuable information, but more research is necessary so that a more holistic perspective can be developed. Therefore this study was undertaken to add to the body of knowledge in this area.

Method

A grounded theory (GT) method was used. A distinctive strength of this approach is its capacity to look at social context and the meanings inherent in social relationships. The focus of interest was exploring a group of women who engage in the marginalised practice of home birth and the implications for this in going against cultural norms.

Rennie's (1994) version of GT was utilised in the research to analyse the data, deriving from the original GT model, which was developed in 1967 by Glaser and Strauss; this brought together three contrasting traditions of 'positivism, symbolic interactionism and pragmatism', which held opposing epistemological assumptions (Charmaz, 2006). A detached empirical stance was reflected in Glaser's proposal to apply a rigorous systematic method, which would allow for 'reality' to be discovered (Charmaz, 2006). In contrast, Strauss, who drew on the theoretical tenets of symbolic interactionism and pragmatism, proposed that interaction is dynamic as humans actively engage in processes of creating and altering social meanings via language or exchanging 'shared' symbols (Fassinger, 2005).

Sample

The criteria for selecting participants was that women had experiences giving birth in a home setting or had knowledge of

Table 1. Demographic data of participants

Age	Ethnic group	Employment status	Birth location	Education	No of children	Age of children	Birth place	Method of birth
78	Somalian	Part-time community worker	London	Not stated	6	28, 32, 38, 43, 44, 45	5 x h 1 x hb	6 x hb
35	Georgian	Part time psychologist	London	Post MSc diploma	2	1.5, 3.5	2 x h	2 x h
38	UK English	Housewife	Midlands	Degree	3	2.5, 4, 7	2 x hb 1 x h	3 x h
47	UK English	Independent midwife	Midlands	MSc	3	13, 15, 18	3 x hb	2 x hb
37	UK English	Housewife	Midlands	Degree	2	12 days, 22 months	2 x hb	2 x h
67	UK English	Part-time hairdresser	Midlands	Up to age 16	2	45, 47	1 x h 1 x hb	Not stated
30	UK English	Housewife	Midlands	MPhil	1	2	1 x h	2 x h
28	UK English	Nurse	Midlands	Degree	2	2, 4	1 x h 1 x hb	2 x h
27	UK Scottish	Not stated	Midlands	Not stated	1	4 months	1 x hb	Not stated

this topic. Selecting women for this sample was facilitated by the NCT, two independent midwives, and the Women's Health and Family Service – a voluntary organisation offering support to women from ethnic minority groups. Women were recruited following the theoretical sampling strategy recommended by Charmaz (2006). In keeping with a GT approach, questions of a general exploratory nature were developed (Fassinger, 2005). The interviews were semi-structured and the questions were open-ended. The questions became more focused as the theoretical sampling strategy was followed. After the process of saturation, the researcher began to select new cases to deepen her understanding of the research. This included using a negative case analysis to question her assumptions about the emerging theory. For example, two women who had hospital births offered a different perspective on choosing a birth space.

Interviews were undertaken in the houses of seven participants and the remaining participants chose to be interviewed within their work settings. To ensure confidentiality, a private space was chosen in these instances. Four of the inquiry sessions lasted for one hour, in two cases, the interviews were 50 minutes, and in the remaining cases, the interview duration was one and a half hours. A total of nine women volunteered to participate. Demographics of the nine women can be seen in Table 1.

Nine interviews were audio-taped and analysed. All transcribed data had a numerical line reference for ease of access (Rennie, 1988). Rennie's (1988) technique of conceptualising categories was applied, where concepts were allocated to categories and there was no limitation to the number of categories. The process described above was aimed at finding commonalities and diversities in meaning within each account and across participants in a process of constant comparison (Rennie, 1988). A theoretical sampling strategy was used where the interviews started with a few participants. The data collected from these participants were then analysed and emergent insights were used to modify the interview schedule with a view to refining hypotheses and proceed with more interviews. The aim was to construct a theory by initially generating descriptive categories that stayed close to the language of the participant, which are later connected by constructed categories demonstrating how they are related. This process of compressing categories yielded key explanatory concepts to answer the research question.

Ethical considerations

This research gained ethical approval from a university in the UK, appropriate to using a non-NHS sample of participants. A requirement of the committee was that participants would be given a briefing on the procedure of the study and written consent would be obtained. It was made clear that participants could withdraw their consent at any stage. Further, confidentiality was protected and anonymity was aided through the allocation of a transcript number to substitute personal details.

Findings

Emergent theory

Figure 1 illustrates how the core category of 'philosophy of control' acts as the umbrella term for the three main categories.

The model presents what is understood as a dynamic relationship between the perceived three stages of having a home birth: preparing for the challenges, developing resilience strategies and the outcome of the home birth experience, described as follows.

The philosophy of control

The core category 'philosophy of control' was developed as an overarching term for three main categories, as it describes the overall perspective of the pro-home birth participants on having a sense of control in planning and giving birth at home. The term 'philosophy of control' is explained here as the participants' values and wisdom in relation to having power to direct their own experience of childbirth.

Preparing for the challenges of a home birth

The first main category entitled 'preparing for the challenges of a home birth' pertains to potential obstacles that the participants encountered in planning a home birth and challenges that ensued.

Service delivery unknown

Some of the women in the study found the 'unknown' aspect of their NHS maternity care anxiety provoking. This anxiety had different manifestations – for a few participants, part of the issue was that their unique hopes for the birth could be adversely affected by the values of the allocated midwife:
"I'd never met this woman... and it could have gone horribly wrong... She might not have been a home birth person, she could have been somebody who thought I... should be in hospital."

Some women felt anxious due to not being guaranteed access to a midwife once in labour. As one participant stated:
"You'd ring up in labour and be told there were no midwives available and so you'd have to come in and that would have been my disaster scenario."

Negative judgments

This property described the negative judgements that women felt they had to contend with in planning a home birth. One participant commented:
"We were scared, you know, because it was the first and some people were trying to tell us, 'you can't have your first one at home'... and I obviously was a novice."

Similarly, another participant identified a cultural narrative that women who have a home birth are unstable for taking perceived risks in giving birth at home:
"Culturally a lot of people think that you're risking life and limb… and a bit mad, a bit crazy."

In contrast, a few women identified negative judgements imposed by maternity professionals. One stated: *"I just wanted to be at home, but I had a lot of cheek sucking from the midwife."*

Home birth viewed as unsafe

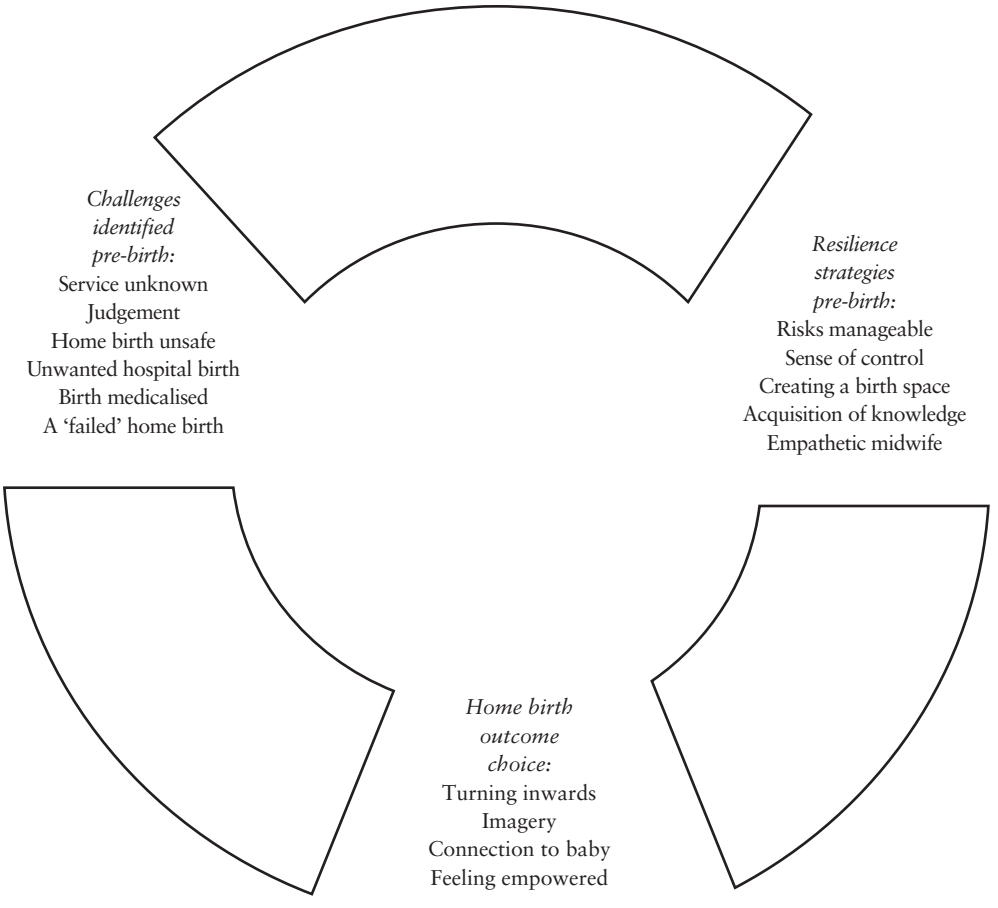
This property captures the ways in which giving birth at home was seen as an unsafe practice by a few of the participants. These women expressed views on this issue partly from their cultural perspective. One participant expressed that isolation and lack of extended family support was a risk factor for women having a home birth in the UK in the aftermath of giving birth:
"If you not got nobody, if you just had a baby... you get up, you dress up, you read this to the children... and sometimes you increase your bleeding."

However, beyond the cultural management of birth, for one participant, home birth was seen as unsafe because of the unpredictable element of labour, such as complications:
"If I chose home birth, my pregnancy was so, everything was pretty OK… They would probably have allowed me to… and it didn't turn out to be straightforward."

Unwanted hospital birth

In contrast to the above, this property captures the

Figure 1. The philosophy of control



pro-home birth participants' views on having an unwanted hospital birth. An overarching sense of anxiety was described, which seemed to relate to loss of choice in the birth setting. A few women imagined that a hospital setting would impose a restriction on allocated time during labour before applying interventions. As one described:

"I was quite scared of going into hospital because then you get interventions… they're kind of timing you, that's the impression I get."

A further issue for a couple of the participants who had unwanted hospital births was being in an 'alien environment', which meant being surrounded by strangers:

"There was always the option that someone could walk into the room by accident or... walk in and want to examine me."

Medicalisation of birth

This property refers to a collective feeling among some pro-home birth participants that birth has become a medicalised construct. These participants expressed views that women were persuaded to focus on risk and regard hospital as a place of safety. One participant described this as follows:

"Before everyone started having babies in hospital, they were giving birth at home, and because pregnant women want to do right by their baby, people, especially professionals (were) saying 'you want to be safe and you want to have doctors around you', I know that I would be swayed by that."

A few participants discussed the restriction of services faced by women using the NHS, such as the way in which labour wards dehumanised women in the level of care. As one described:

"Worst case scenario, going into hospital and not getting any personal treatment, where they come into the room and they don't even speak to you, they just speak to your partner, and poke you about and start examining you just makes me feel I don't know... it's just very invasive."

Overall the doubts expressed by some participants at the medicalisation of birth were with the political prioritising of resources over women's needs and subsequent levels of competency in the care provided by doctors:

"I don't want people to make decisions like giving me drugs… if you go into hospital, they give you a certain amount of time and I know they get worried because of litigation these days... so they'd much rather whip you in and do a c-section."

A failed home birth

A further challenge to women planning a home birth is the possibility that there are complications that require an admission to hospital. One participant stated that the effect of being unable to fulfil her hopes of a home birth led to self-critical thinking:

"My ideals of the natural birth… my body didn't seem capable of doing that."

In the aftermath of not being able to have a home birth, this participant reflected that the care provided could have been essential in making a recovery:

"I think it all does start with having a positive birth and having the right care… if I'd had... continuous care, that could have helped me... and not made me feel like I was... being silly."

Developing resilience strategies

The second main category is entitled 'developing resilience strategies'. For the purpose of clarity, the term 'resilience' will refer to the ways in which participants described being able to positively deal with stressful challenges in the context of planning for and giving birth at home.

Managing risk

This property outlines the way in which women that planned home births developed resource strategies regarding the issue of potential risks. A few participants described the importance of having a flexible approach with the acceptance that they might need to access a hospital in the event of needing emergency care:

"I… trusted her (the midwife) to make the right medical decision. So if she'd said to me, 'S it's not going as it should be going, we need to go into hospital', I would have gone to hospital."

A second strategy to contending with risk was to question the assumption that a medical setting equated with total safety. One participant stated:

"Doctors… they're just human beings and they can get things wrong and I like to think that I'm well read and well researched… I'd rather make my own choices that are not their choices."

In contrast, some women in the sample managed anticipated risks in planning their home birth through considering proximity to the hospital to have swift access to medical resources:

"I only live... ten minutes drive from the hospital so I felt if I had to go in… we'd take the decision early enough to get there."

Creating a birth space

This property describes the way in which many participants wanted to influence the relationship between the outer space of their environment and their inner psychological space in preparing for a home birth. A number of the women in the sample valued being in their own environment and having access to their personal possessions, synonymous with privacy and personal space. As one participant commented:

"I would hate to be using somebody else's bathroom... it was just very nice to be in one's own environment really."

Another participant related this to the comfort aspect of being in familiar surroundings:

"I hoped to get something therapeutic from having the baby at home, definitely… from being in my own environment, being able to have a bath in my own bath… get into my own bed."

Acquisition of knowledge

This property refers to ways in which participants acquired knowledge regarding natural childbirth and new beliefs about coping with pain. These women described using approaches such as hypnobirthing and yoga to feel physiologically calm:

"Hypnobirthing, that was really positive, and it also said that there's an attitude about, of fear… you can actually work with your body and not fight it."

A further participant described being empowered though new knowledge:

"She (the midwife) was all for home births… I felt really empowered just going to that class... she told us how to breathe, how to get through."

Further, one participant stressed the importance of

understanding the relationship between the environment and its impact on physiology during labour:
"If you don't get the environment right for birth, you are never able to release the hormones that make labour happen effectively."

Seeking empathic relationship with the midwife
Most of the women in the sample viewed the collaborative and empathic qualities of the relationship with the midwife as important in feeling resilient. One participant stated:
"She was keen on you know not interfering, she was all the things that home birth is about really… very passionate about her job and really, really cared for the mums."

Part of a collaborative relationship described by some participants was having a shared vision of the birth. One said:
"I did write a birth plan, but I didn't need to because it was all in her head… because we discussed it all… She knew exactly where I was coming from."

The outcome of the home birth experience

The main category – 'the outcome of the home birth experience' – describes the participants' perceived sense of control over their bodies as the culmation of forseeing challenges and building resources in preparing for birth at home. Broadly, there was a sense that the participants who gave birth at home experienced a freedom of expression. Moreover, this sense of control appeared to impact on how they related to others in the birth space, and how they felt about themselves in the aftermath of the experience.

Choice
This property describes the way in which many participants valued giving birth at home as they were free to choose how they occupied their physical space. One participant stated:
"I felt in control… you know on the floor being on, over a ball and being over the arm of a chair, and... just listening to my body."

Most of the pro-home birth women in the sample reported to value being able to take their time and trust their own judgement as to how they wanted to care for their baby:
"Freedom, it's the freedom of being at home you know, because you can do what you like."

Turning inwards and coping with pain
This property captures the views of the women who had a home birth on being able to turn inwards to enter an altered conscious state during labour. This seemed to be facilitated by a home setting in a number of ways. Some of the participants stated that turning inward required a process of deep relaxation:
"I was slowly internalising and you do lose your inhibitions."

One participant described noticing her instincts and feeling a sense of the body's wisdom of knowing how to give birth:
"I found that amazing really, that I knew when to push because I hadn't been examined really, so I didn't know how dilated I was, but I knew that it was the right time to push, and he came out very easily."

Alternatively, one participant stated that positive thinking as a consequence of feeling in control helped to relax with the pain:
"I think it is, it's a lot down to positive thinking on how your birth is. I think if you feel out of control, and you feel frightened, then it can only make you have more pain."

Imagery
This property captured the relationship between the imagery that women experienced and affect during labour in the birth space. In some instances the imagery was visual and, in others, it was sensory. The important thing to note was that it was strongly bound with emotion and influenced the way in which women felt able to cope with their labour.

In relation to a couple of the home birth experiences, positive images appeared to relate to pleasant affect. One participant described imagery during the transitional part of labour:
"I remember the transitional bit, you know when your contractions stop, it did happen, it really did happen. In my case the birds were singing and the sun was shining in the pool... and it was quiet… and I was like 'oh this is lovely'."

Another participant described an image of darkness and pain but this was perceived as manageable because the participant was in a warm place as she retreated into her body:
"I felt in control, dark just, just being with the pain… just listening to my body and letting my body do what was natural to it."

Connection to the baby
This property outlined how there was a sense for those who had successful home births, of feeling emotional and physical wellbeing, which enabled a strong connection between mother and child. One participant viewed a positive connection as being able to keep prolonged close proximity with her newborns:
"All the way through delivering the placenta and stuff… they were with me the whole time feeding or just nuzzling."

The confidence brought about by having a satisfying birth in a home setting led some participants to feel that they had positive associations with their babies. Some of the women attributed this partly to having agreeable perceptions of giving birth and feeling energised as a consequence of not having interventions:
"I was just like on... top of the world, which must mean that my frame of mind was such that I was positive towards my son."

Feeling empowered
This property pertains to a sense of pride and confidence that the women who had successful home births in the sample felt as a result of giving birth naturally. One participant observed:
"I just wanted to get pregnant and do it again, like the next day. I felt like I'd achieved something."

On a different note, a few women described a sense of achievement of feeling brave for coping with the pain of childbirth without needing medication. As one participant stated:
"I suppose I feel proud of myself that I've managed to give birth to two big babies."

Another participant described the empowerment that a natural birth instills:
"I think probably a normal physiological birth… actually reconfirms your body's ability to perform in that area, which I think probably gives you a lot more self confidence."

Overall, the participants who gave birth at home reported an immense sense of achievement which remained with them after the birth:
"I think it's something I carry along with me, chuffed to be able to have her at home. It was a case of being able to do everything that I'd planned."

Discussion

The emerging theory presents a dynamic relationship between the three stages of undergoing a home birth: preparing for the challenges, developing resilience strategies, and the outcome of the home birth experience. The core category 'philosophy of control' underpinned these stages of a home birth in constituting a set of values, which women in the sample developed in the process of feeling able to direct elements of this experience.

An aspect of this theory, which differentiated the home birth experience for this sample of participants from other home birth studies, was the dynamic process of reflecting upon obstacles to having a home birth. This acknowledgement of barriers constituted a catalyst for problem-solving and taking action to make the home birth experience happen; namely, expressing a belief that a natural physiological birth is possible. As such, there was a rejection of the medical model of maternity care that resonates with Cheyney's (2008) study, which proposed that participants having a home birth created new 'explanatory models' as a process of 'unlearning and relearning'.

The 'developing resilience factors' area of the model showed a process of women developing efficacious beliefs about giving birth at home, such as creating a satisfying birth and adopting a flexibility of expectations. In turn, the beliefs appeared to give the women the momentum to influence their behaviours, such as to implement the practical measures to make the home birth experience happen. This chimes with the notion that women who give birth at home acquire power through knowledge and action (Cheyney, 2008). Previous home birth literature has placed much emphasis upon the quality of the home birth experience (Parratt and Fahy, 2004; Kornelsen, 2005). In contrast to these studies, the 'outcome of the home birth experience' area of the model described elements of the home birth experience, which occurred as a culmination of women actively creating the conditions (cognitively, physiologically and behaviourally) of the desired home birth space.

As a consequence, all of the participants who achieved a successful home birth expressed a sense of choice and freedom in occupying this uniquely designed birth space. Consistent with existing home birth studies, the issue of choice in relation to the home birth space has been reported to be salient (Parratt and Fahy, 2004; Kornelsen, 2005). This suggests the importance for women of creating a birth space where there is choice over the medical interventions received to enable physical and emotional safety (Parratt and Fahy, 2004).

This study considers the psychological experience of giving birth at home with a view to providing insights to health professionals working with this group of women. The findings of this model suggest that women can adopt a number of resources to maximise their sense of actively creating a birth setting and coping with anxieties.

Conclusion

The findings suggest that women can adopt a number of resources to enhance their sense of actively creating a birth setting and coping with anxieties. Further research is needed to explore the use of imagery in internalising during the birth experience. This could usefully focus upon women who have planned for a home birth and had to deliver in hospital.

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Understanding the phenomenon of dikgaba and related health practices in pregnancy: a study among the Batswana in the rural North West Province in South Africa

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Abstract

Background. The use of traditional medicine during pregnancy and childbirth is common among the black traditional cultures of Southern Africa. A naturalistic and phenomenological approach was used to achieve the aim of the study from the perspectives of Batswana in the rural North West Province. Any pregnancy-related problem is believed to be somehow associated with dikgaba, a phenomenon that only indigenous healers are capable of managing through the use of kgaba (medicine for dikgaba). Midwives therefore need to know about traditional health practices, which can affect the mother and the baby during pregnancy and labour.
Aim. To understand the phenomenon of dikgaba and related health practices in pregnancy. In-depth individual interviews were conducted to collect data from 20 key informants who are known to be experts and familiar with the phenomenon of kgaba-related health practices.
Findings. The study revealed that understanding of dikgaba and the related healing practices in pregnancy and childbirth is common. The main categories were the description of dikgaba, management of social relationships, and management of dikgaba in practice and childbirth. Cultural beliefs and healthcare practices regarding dikgaba are entrenched among the Batswana.
Conclusions. Cultural accommodation, preservation and cultural re-patterning in rendering care to pregnant women is key. Culturally sensitive care methods must be taught in midwifery and nursing education.

Key words: Dikgaba, kgaba, traditional medicine, pregnancy, health practices, evidence-based midwifery

Introduction

South Africa is known for its diverse cultures of which the Batswanas living in the North West Province of South Africa are one of the populations and the focus of this paper. In South Africa about 70% to 85% of the population uses the services of traditional healers to manage and to prevent ill health, including pregnancy-related complications (Summerton, 2006). Consultation of healthcare practitioners and choice of healthcare options depend on the belief system of an individual. The beliefs, values and past experiences influence the pregnant woman in their selection among existing healthcare alternatives, based on socio-cultural interpretation of ill health (Chalmers, 1990). The use of traditional medicine in pregnancy has long been used by the black South African cultural groups, for example the use of isihlambezo by the Zulus (Mabina et al, 1997) and kgaba (medicine for dikgaba) by the Batswana (van der Kooi and Theobald, 2006). This practice has persisted, despite the 'modern' medicine usually prescribed by biomedical practitioners at the antenatal clinics to treat health problems identified during routine antenatal physical examinations. Indigenous healers provide a comprehensive service in the form of diagnostic, curative and preventive health care. Traditional health practices include use of medicines in the form of herbs and rituals aimed at restoring harmony and good health (Chalmers, 1990).

According to Hammond-Tooke (1993), causes of diseases can be differentiated into those with natural causes and those with supernatural causes. Those brought about by supernatural causes are referred to as 'diseases of the people'. They are often attributed to transgression of rituals and not following proper procedures expected in society, for example respect, mourning periods and appeasing of ancestors. There are also diseases caused by jealous people using sorcery or witchcraft. This phenomenon occurs throughout the lifespan of individuals, including pregnancy. There is a belief that diseases caused by supernatural powers and witchcraft can only be treated by traditional health practitioners.

In many cultural traditions, pregnancy remains a secret, as it is believed that revelation of conception, even to family members, could lead to jealousy. A study conducted by Ngomane and Mulaudzi (2010) in South Africa revealed that women attend antenatal clinic late due to fear of being bewitched, carrying a malformed fetus or giving birth to a physically or mentally impaired baby. The Batswana in the North West Province of South Africa believe that when a person is jealous of another woman's pregnancy, he or she could evoke evil spirits to harm the pregnant woman or the fetus (Chalmers, 1990; van der Kooi and Theobold, 2006). This is known as 'dikgaba' or 'kgaba'. The direct translation of kgaba is 'harm or heartache others can cause' (Ademuwagun et al, 1979). It is believed that dikgaba cause a complicated pregnancy, for example abortion, stillbirth, maternal death, prolonged or difficult labour. Some pregnant women use traditional and western medicine side by side (Banda et al, 2007) as they believe there are certain culturally explained conditions, such as dikgaba, that no western medical practitioner can cure. Indigenous healers manage dikgaba with potions or rituals (kgaba medicine/cures) aimed at 'lifting off' dikgaba (Kennett, 1976).

When an individual consults an indigenous healer, he or she diagnoses and prescribes the traditional cure (kgaba) for dikgaba. Consulting the traditional healers or herbalists usually occurs due to the belief that one is actually a victim

of covert actions of a malicious family member, neighbour, friend or colleague (Edwards, 1985). Sources of knowledge regarding pregnancy-related traditional cultural practices, such as kgaba, are herbalists and older women who have acquired the knowledge through experience, having used such health practices themselves, either as traditional birth attendants (TBAs) or as consumers during their reproductive age (Mabina et al, 1997).

Theoretical framework

Midwives and other health professionals need to know more about dikgaba and related treatments or health practices used during pregnancy in order to provide comprehensive and culturally sensitive maternity care. The transcultural theory of Leininger was used as a theoretical framework to guide this study. According to Leininger and McFarland (2006: 3), "*human care is what makes people human, gives dignity to humans and inspires people to get well and help others*". The theory identifies the following three modes of holistic care (Leininger and MacFarland, 2006).

- Culture care preservation and/or maintenance: This refers to supportive and enabling professional acts or decisions that help the cultures to keep, preserve and maintain beliefs about norms and values applicable in health and ill health. The research looked at how the Batswana preserve and maintain their norms and values regarding pregnancy-related ailments (Leininger and MacFarland, 2006)
- Culture care accommodation and/or negotiation: This implies assistive accommodating and enabling creative care actions or plans that help different cultures adapt to or negotiate with others for culturally congruent, safe and effective care for management of health, wellbeing and illness. Knowing about Dikgaba will assist nurse/midwives to make decisions on the care plan needed to assist their patients
- Culture care re-patterning or restructuring: This refers to enabling professional actions and mutual decisions that help people to change, modify or restructure their ways of life for better healthcare practices and outcomes. This research will help to evaluate if the belief system on dikgaba and health practices among the Batswana is harmful to pregnant women and enable midwives to assist women in making informed decisions (Leininger and MacFarland, 2006).

The framework served to guide the research in looking at how cultural accommodation, re-patterning and preservation can be practised to render cultural sensitive care.

Lack of research and published literature has led to a poor understanding of practices related to dikgaba in pregnancy by health professionals. Therefore, we sought to conduct a study to understand the phenomenon of dikgaba-related practices in pregnancy and childbirth.

Research design of the study

Phenomenology was used as an approach for this study. The approach focuses on perceptions and views of the participants to interpret their understanding of the phenomenon. In addition, the approach explains the way in which members of society make sense of their social environment and subjectively attach meaning to it (Holloway and Wheeler, 2002). This research project endeavoured to understand the phenomenon of dikgaba as experienced and understood by Batswana. The researcher explored the study phenomena using an interview that entails listening to, probing and observing interviewees. The focus was directed at lived experiences and meanings attached to dikgaba in pregnancy.

Population and sampling

The population used was the Batswana women and herbalists who are known to be experts in pregnancy and childbirth practices among the Tswana speaking communities of the rural district in the North West. The participants were identified from recognised birth attendants and older women who are greatly experienced in pregnancy- and childbirth-related practices, having gathered knowledge through personal observation and years of assisting pregnant and parturient women.

The snowball technique was used to reach potential participants (Rossouw, 2005) as it was not easy to identify all participants in advance. They were identified through referral by midwives in community healthcare centres. These midwives learn about these experts' services during their interaction with pregnant and parturient women. Although traditional healers and herbalists are consulted in privacy, community members learn about them through testimonies of those that believe to have been successfully treated.

The potential participants were visited in their own homes to enhance trust (Brink et al, 2012). Every participant was requested to identify another potential participant according to knowledge and recognition of the relevant traditional health practitioner's expertise and the service offered (Kennett, 1976).

The profile of the participants interviewed confirmed the notion that practices pertaining to dikgaba which belongs to indigenous knowledge systems rests with the traditional healers who are both diagnosticians and herbalists. TBAs, younger women who learned childbirth practices from their mothers (Peltzer and Mnqundaniso, 2008) and grandmothers, as well as those belonging to the interest group because of their keen interest in traditional affairs also contributed to this data. Of the 20 participants, 12 were TBAs, four traditional healers (TH), and four consumers (C) of kgaba remedies.

Data collection

Data were collected by individual in-depth interviews to ensure rich information that pertains to the topic (Brink et al, 2006). The participants were expected to give a full description of the practices while, at the same time, the researcher was observing the non-verbal cues that come across during narration of the practices as the participants give account of their experiences. Communication techniques such as minimal verbal response, clarification, reflection, encouragement, comments and listening to the interviews as described by Holloway and Wheeler (2002) were used. Field-notes were written after each interview. The main question posed was: "What is your understanding of dikgaba?" The following probing statement was used for each participant: "Tell me about the dikgaba practices used during pregnancy and labour". The setting for data collection was a private place within the participant's

home, in order to prevent disruption or restlessness on the part of the participant. As a researcher, I was trying to be positive and relaxed and approach the interaction with respect, warmth, honesty and sincerity to make the interview successful (Rossouw, 2005).

Data analysis

The data were transcribed, organised and systematised to make analysis easier. The participants' responses in the form of statements or phrases were classified into smaller, manageable units so that they could be manipulated and indexed for easy access. Related concepts were grouped together and then coded accordingly as and when they were identified. Data were then scrutinised and emerging concepts given codes and labelled for the purpose of categorisation (Burns and Grove, 2004). The whole process outlined was undertaken manually. A literature review was undertaken to gain insight from research, as well as other available literature, and research reports on the concepts identified. Key words used in the search strategy were 'dikgaba', 'kgaba', 'pregnancy' and 'health practices'.

The need to give meaning to data generated by the interviews led to the researcher continuing to reflect deeply on the data to identify the patterns or themes. All data for the same question from different participants were grouped together by coding and concepts, terminology, ideas and phrases inherent in the text were cross-checked for consistencies or connectedness.

Findings of the study

The main categories identified were the description of dikgaba, social relationships, and the management of dikgaba in pregnancy and childbirth.

Description of dikgaba

Participants gave different descriptions when asked about the understanding of dikgaba. These descriptions involved the definition, diagnosis, common suspects in dikgaba afflictions, and indicators of dikgaba in pregnancy and childbirth.

Definition of dikgaba

Participants were asked to explain their understanding of the phenomenon dikgaba. The findings revealed that dikgaba is understood by Batswana in the North West Province to be an affliction, a result of perceived act of malevolence by a family member, a neighbour or a friend directed to a victim. Lack of respect, bad behaviour or disobedience is identified as the factors necessary to evoke kgaba towards anyone exhibiting such unacceptable behavior based on cultural norms and values. The following quotes were captured regarding the participants' definition of dikgaba:

"*Kgaba is not witchcraft. Kgaba can be said to be a grudge or complaint against the person who is said to have it*" (TH 1).

"*It is not witchcraft, it is just a grudge, a favour denied, anxiety over a matter that causes kgaba to the woman*" (TBA 2).

"*The aggrieved person is capable of evoking dikgaba, the result of false utterances or insults directed to the elderly by the pregnant woman*" (C 3).

The quotes concur with what Hammond-Tooke (1993) describes as the construction of the social reality of the illness. Most participants referred to dikgaba as an affliction suffered because of the victim's failure in good social relations with her kin or due to 'the envy of some ill-disposed individual' (Hammond-Tooke, 1993: 197). Hammond-Tooke (1993) is also of the opinion that the illness can be properly comprehended and dealt with only when the meaning is imposed. The articulation of the meaning of the phenomenon by individual participants revealed the understanding they have of dikgaba, how this affects pregnancy and childbirth as well as the associated healing practices, is common:

"*When you hear someone in the company of a pregnant woman softly mumbling a wish that the pregnant woman's abdomen should rupture, the heart bewitches more than muti (the African term used for traditional medicine) can do*" (C 2).

Diagnosis of dikgaba in pregnancy

The participants indicated that dikgaba is diagnosed by traditional healers using bone throwing. One of the traditional healers said:

"Sometimes the family comes to consult… I throw the bones first, the bones will tell me that this person is… and that is kgaba, then I would be able to prescribe a remedy guided by the divining bones" (TH 3).

Through the bones the traditional healers are also able to diagnose whether the woman will experience difficult labour or not. Hammond-Tooke (1993) reports that through the guidance of the ancestors the traditional healer throws the bones to get clues about what is suspected. One of the participants explained:

"In certain instances, the problem may be diagnosed before labour starts however in most cases it is only diagnosed during labour when birth becomes difficult, traditional healers are called and they will point out the existence of dikgaba" (TH 3).

The participant also explained that when women have dikgaba, they often consult traditional healers who will diagnose the type of dikgaba that they are suffering from, including exposing the person who afflicted the woman with the dikgaba:

"*… this person consults the traditional healer who will explain that the woman is afflicted with dikgaba: 'When we have called the traditional healer to determine which type of dikgaba it is, and it is identified to be the type she trod on…'*" (C 3).

Common suspects in kgaba afflictions

The family is believed to be the significant origin of kgaba spells. The grandparents, parents, in-laws and siblings are all said to be capable of evoking kgaba spells in their individual positions in relation to the victim. A pregnant woman needs to be in a harmonious relationship with the family members at all times to avoid evoking dikgaba. The paternal aunt is singled out as the significant family member in the life of her brother's children. Conflict with her is most likely to result in kgaba (Hammond-Tooke, 1993):

"According to Setswana, we have the great aunt, who it is believed is revealed by the divining bones (Kgadi e kgolo e e ntshiwang ke ditaola). When a person is afflicted with kgaba, we confront the great aunt about this" (C 2).

"At times the pregnant woman complains of this and that, and when you go to the aunt or uncle about the child's health condition, you find their response negative" (TH 2).

The frequent reference to the aunt as the significant person mostly implicated whenever a family member experiences kgaba-related problems during pregnancy or childbirth is noted. Most participants rated the aunt as the suspect in most instances of pregnancy and childbirth complications, as these Batswana believe this to be the evidence of a kgaba spell. Divination as the means of identifying some magical play perceived to be responsible for casting the kgaba spell does not involve mentioning of names and the suspect is only referred to in terms of relationship or status. This corroborates the notion that co-operative effort between the concerned parties during divination results in all referring to their knowledge of the patient and her social relationships with her kinsmen or neighbours to decide on the suspect (Hammond-Tooke, 1993).

Indicators of dikgaba in pregnancy and childbirth

According to the cultural beliefs of Batswana, any complication occurring during pregnancy and childbirth is said to have some form of connection with dikgaba. Participants believe that the existence of kgaba is suspected whenever a pregnant woman experiences problems that make it an uncomfortable or a life-threatening experience. All problems affecting the pregnant woman are therefore referred to the experts in kgaba illness so that a problem-free pregnancy can result in a smooth childbirth experience. Classified among the kgaba-related problems in pregnancy are various minor disorders, such as sleeplessness and backache. Batswana further believe that any factor that interferes with the process of labour is somehow related to dikgaba. The problems cited are prolonged labour, abnormal position and lie of the fetus as well as delay in delivery of the placenta (Hammond-Tooke, 1993). The quotes that follow relate to the effects of dikgaba, which in essence are the signs and symptoms indicating the need for traditional interventions:

"If, after childbirth, there are problems with the delivery of the placenta, this is suspected to be due to kgaba – in the absence of dikgaba, childbirth usually occurs normally" (TBA 1).

"If a person is afflicted by dikgaba in pregnancy, this is recognised if, after the baby has been born, the placenta remains inside, it is said that the woman is afflicted with kgaba, because of her father's heartache; this is kgaba originating from the father. At times you hear it being said that it is 'breech', at times when the baby is born the cord is around the neck" (TH 2).

"When the baby is supposed to be born, it becomes a breech baby, that is, the baby is blocked from coming out, that too is kgaba" (TBA 10).

Most participants cited prolonged difficult labour as a common indication of the kgaba spell. This includes obstructed labour and retained placenta.

Management of social relations

The second category was the management of social relationships. Participants indicated that the way people manage their relationships in the family and community at large may influence the existence or affliction of dikgaba. Hammond-Tooke (1993) stated that dikgaba referred to a affliction suffered because of the victim's failure to form good social relationship with her kin or due to 'the envy of some ill-disposed individual'. Participants understand kgaba to be essentially an illness arising from broken social relationships between the afflicted and her family, friends or neighbours. They therefore believe that the cure for this is found in restoring the disturbed balance, thus ensuring a harmonious social life. The themes that emanated from this category are prevention of dikgaba, confrontation and resolution, and driving spirits away. Dikgaba is the result of disharmony between the pregnant woman and the significant person in her social relations stemming from being disrespectful, disobedient and slanderous.

Prevention

As most participants believe that dikgaba is the result of conflict between the pregnant woman and the specific individual in her circle of social relations, they also strongly believe that deliberate efforts to interact harmoniously with others is the best prevention against dikgaba. Being respectful and obedient especially to the elders in the family and among neighbours was pointed out to be a desirable conduct significant to keep kgaba at bay. A study conducted in Botswana revealed that the young generation must be taught to respect the elderly. Failure to respect the elderly may result in misfortune, which manifests through dikgaba (Livingstone, 2005):

"The greatest thing is respect. If you are a young woman with respect, there will not be any slanderous talks against you that will hurt you" (C 2).

"It means now and then the family must have respect or manners to avoid kgaba from setting in… that is kgaba, but the greatest cause is lack of respect, kgaba does not happen to a person with good manners" (TH 4).

Prevention of dikgaba lies therefore in the social relationships characterised by sustained peace and harmony borne out of the attitude of respect for all (Hammond-Tooke, 1993).

Confrontation and resolution

According to some participants, resolution is achieved by having the two conflicting parties take part in negotiations for restoration of harmony. The person believed to have cast the spell explains the extent of heartache suffered. The pregnant woman will also need to show remorse and apologise to have the kgaba spell reversed. This is also achieved by having the person blamed for the kgaba spell voice the hurt caused by the victim and apologising for her wrongdoing. The kgaba spell is then broken on verbal command by the aggrieved party. The offending spirits are set to flee by the chanting of aggressive and rebuking words by the traditional healer or the family of the victim:

"*When a person is believed to be afflicted with dikgaba, we confront the great aunt to ask what the problem is"* (TBA 9).

"…this can only be achieved by the woman confessing and apologising for the wrong doing" (TH 4).

"If I tell her, 'I have forgiven you my child', this usually lifts off kgaba" (TBA 11).

Driving the spirits away

The practice of aggressively ordering kgaba out of the victim was mentioned by some participants. It is believed that using strong language makes the spirits associated with dikgaba feel no longer comfortable abiding with the victim and would immediately flee, relieving the victim of the curse:

"We then say to her 'go give birth to the baby'. She will indeed deliver the baby thereafter, do you hear me? There is no better cure than this, Setswana, and that's my story" (TH 4).

"Yes, it is shouted at and insulted, saying your mother's this... your father's... and it then goes away" (TBA 7).

Management of dikgaba in pregnancy and childbirth

There is commonality in the herbal medicines used, the rationale behind usage and the rituals accompanying various treatment options mentioned. The procedures referred to are oral intake of herbal and non-herbal medicinal decoctions, burning of some herbal medicines to produce smoke to which the kgaba-afflicted is exposed, and boiling the herbs for inhalation of the resultant vapour by the woman undergoing treatment. Most of the traditional medicinal herbs used to manage problems of pregnancy and childbirth are chosen because of their inherent properties believed to be capable of producing the desired therapeutic effects (Kitula, 2007).

There was, however, no mention of enemas and emetics among the practices used against kgaba, even though the two are the forms of medication most commonly used by traditional healing practitioners (Kale, 1995). Although the traditional healers interviewed could easily refer to the kgaba medicinal herbs by names, they remained careful to not disclose the recipes they followed to prepare the remedies (Kale, 1995). This study confirms the fact that recipes of herbal remedies used are often kept secret, as documented in the study conducted by Kale (1995).

The frequent use of the ostrich eggshell as the kgaba remedy was identified by most participants. The finely crushed shell is mixed with water and drunk by the pregnant woman. Part of the mixture is added to the bathwater for cleansing. Some participants mentioned the mixture of water and soil collected from the junction of the footpaths as another remedy drunk, and also used for a cleansing bath. A wasp's mud house or nest removed from the wall is mixed with water and this is drunk by the pregnant woman as a kgaba remedy too. This confirms the findings by van der Kooi and Theobald (2006). Blowing forcefully into a bottle to facilitate expulsion of the baby or the placenta, when labour is prolonged as a result of dikgaba, was identified as a common practice. This is done only at the point that kgaba as the cause of the problem is believed to have been 'lifted off':

"…an ostrich egg. This is used during the first three to four months of pregnancy. You take a small piece and grind it very fine, put it in a mug and mix with a little cold water. The mixture is left for drinking, just a little bit at a time. This is a strong potion and can cause premature birth. So we put it away. When the pregnancy reaches the sixth or seventh month, you take this mixture, add to warm water and bathe the woman. Part of this mixture is left for drinking. When she reports the onset of labour pains, again you take the ostrich eggshell mixture and have her drink out of a calabash. When you often hear people saying 'when I got to the clinic, the baby simply came out', it is all because of the ostrich egg. It is painful because the pains are severe. It stretches you, that's why it is not recommended for use by anyone because others use it carelessly" (TBA 6).

"After the woman has been relieved of kgaba, you need to assist her by giving her a bottle to blow air into so that the baby may be delivered. If this does not help and delivery is still delayed, that very soil from the wasp's nest is…" (TBA 12).

Kgaba remedies are commonly used in conjunction with rituals and other practices. The practices are meant to enhance the effects of the medicines used. Another non-herbal kgaba cure is the urine of the suspect in kgaba illness. The participants explained that it is mixed with water and offered to the victim to drink. It is indicated when childbirth is believed to be prolonged due to kgaba. The use of baboon's urine was also mentioned by some participants, used to speed up the process of childbirth.

Discussion

The participants who were interviewed in this study are authority figures in the community based on the knowledge they possess of this cultural issue, including the traditional healers who render care to those patients. The participants presented their understanding of the phenomenon based on their personal experiences and knowledge of those that have earned the respect of their communities for the role they play in providing healthcare interventions that are based on the people's beliefs. The definitions of dikgaba and the understanding of the factors predisposing to affliction with dikgaba described from the understanding and perspectives of the participants, provided a logical point of entry into the focus of the study.

These findings clearly reveal that kgaba and the related healing practices will remain relevant and justifiable as long as the understanding of illness remains located and defined in the context of culture and society. Leininger's theory as a framework was used, which emphasised cultural preservation and maintenance, cultural care accommodation or negotiation and cultural re-patterning or negotiation.

The first theme focused on the description of dikgaba – the definition, diagnostic methods, common suspects and afflictions and indicators in childbirth. The sub-themes that emanated from this showed that dikgaba is a condition that is associated with jealousy and that it can be diagnosed and prevented through maintaining good social relationships in the family. These results are commensurate with the issue of cultural preservation and maintenance, which emphasise the issue of ensuring that midwives are knowledgeable of such practice to be able to render cultural safe and congruent care.

Midwives are expected to also understand the management of dikgaba, which is well articulated in theme three and which also indicated how the condition can be treated by herbal and non-herbal medicine. Cultural re-patterning and negotiation can take place to ensure that there is no harmful treatment or care rendered to the pregnant woman. The midwife must

show respect and find ways of communicating with the family and the patients using the principles described under cultural accommodation.

Recommendations

Traditional healing practices, such as those related to dikgaba, should be accepted as an integral part of client-centered midwifery care. This can be achieved by openness and mutual cooperation between the midwives, the client, her family and significant others involved in her care. Disclosure about the use of traditional medicine should be incorporated into the client's antenatal records, including naming of the responsible traditional health practitioner.

The findings also highlight the value of cultural preservation by contributing towards the preservation of black African cultures by ensuring collaboration between modern medicine with custodians of culture, for example traditional leaders in the orientation of the nursing learners towards community midwifery services. Knowledge about kgaba and the related practices could be shared with custodians of traditional medicine, such as traditional healers, herbalists and TBAs whenever opportunities arise at workshops, symposia and conferences.

In addition, concientising people about culturally safe midwifery care in order to facilitate deeper understanding and acknowledgement of the legitimacy of cultural differences and cultural accommodation in the provision of midwifery care can be achieved through health education (van der Kooi and Theobald, 2006). Cultural healing strategies that could be made accessible to pregnant women preferring traditional midwifery care over biomedical obstetrical care should be investigated and formalised by means of protocols or guidelines for use to safeguard consistency and safety (van der Kooi and Theobald, 2006).

Conclusion

In South Africa, midwifery is an important component of the comphensive curriculum for training of nurses. Therefore, findings of this study based on indigenous knowledge regarding cultural beliefs and practices, could inform midwifery and nurse educators to afford culturally safe and congruent midwifery care a place in the training curriculum.

Many of the traditional medicines commonly used in pregnancy and labour need to be investigated to determine their efficacy, safety and relevance through research. Findings of such studies would offer the rationale for further collaboration with practitioners of traditional healing systems in the management of pregnancy and childbirth. Cultural re-patterning or restructuring can be utilised by ensuring that the rights of the consumers of indigenous healing practices provided by traditional healers should be included in the *Patients' Rights Charter*.

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Information for authors

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News and resources

Apply for research scholarships

The Florence Nightingale Foundation 2012-13 research scholarships are now open for applications. The scholarships provide up to £5000 for a midwife or nurse to undertake a course in research methods, research modules or a dissertation as part of an academic course of study. The foundation will also consider post-doctoral research projects. Available to all British and Commonwealth midwives and nurses working in the UK, the research scholarships are awarded for projects that will be of direct benefit to clients and the professions. Last year the foundation awarded 31 scholarships from over 60 applications. Applications close on 18 May 2012.

Mary Seacole awards now open

Applications are now open for the Mary Seacole Awards programme for 2012-13. Midwives, health visitors and nurses are invited to apply for the awards, which provide funding for specific healthcare projects, or educational and development activity. In order to qualify, proposals must benefit and improve health outcomes for people from black and minority ethnic communities. There are two award programmes: the Mary Seacole Leadership Awards, which offer up to £12,500, and the Mary Seacole Development Awards, which offer up to £6250. Applications for the awards will close on 1 May and interviews for those who are shortlisted will take place on 26 June, 4, 5 and 17 July 2012.

Major premature birth research project trials

A new trial hoped to improve the prediction of premature birth is underway. Researchers, doctors and scientists are developing a handheld device, hoped to give midwives a better idea of whether women are likely to have a premature birth. The pencil-size electrical probe will assess a woman's cervix to establish the risk of her having a premature birth, by using electrical impulses to take measurements of the resistance of tissue in the cervix. Around 500 women are involved in the trial, which is being headed by researchers at the University of Sheffield. The Medical Research Council has allocated £620,000 to be spent over the next two years on the research and trials.

CONTENTS