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Being There: Perspectives of Women Giving Birth in Zambia

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ABSTRACT

Background & aim: Women experience childbirth in a variety of contexts with different aspirations. However, the experience has far-reaching implications for women's health and that of their neonates. To explore the childbirth experiences of women giving birth in Zambia in order to better understand how they give meaning to the experience this study was conducted.

Methods: This study was carried out using an interpretive phenomenological approach. Purposive sampling was utilized to recruit 50 participants from all the 10 provinces of Zambia. The ages of the subjects ranged from 16 to 38 years. The deliveries, both home and institutional, occurred between 2005 and 2011. The data were collected through tape-recorded in-depth unstructured interviews. Data analysis was performed using van Manen's six steps of analysis.

Results: The major theme of "being there" constituted two subthemes, namely "feeling safe" and "sense of achievement" emerged from the obtained data. The major theme elucidated the physical presence of the provider, as well as feelings of safety, comfort, trust, being recognized, and respected. The subtheme of "feeling safe" explicated women's feelings of being at ease and at peace with their care providers, while the subtheme of "sense of achievement" clarified the participants' expressions of pride that came through experiencing childbirth perceived by the woman giving birth to be satisfactory.

Conclusion: By being physically and psychologically present for the woman who is giving birth, birth attendants, particularly midwives assisted in raising their confidence levels. Caring behaviours, such as showing kindness and respect, giving privacy, as well as making the cases feel comfortable made a qualitative difference of the childbirth experience.

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Introduction

The philosophy of being-with-woman acts as an anchoring force to guide, inform, and identify midwifery practice in the context of the rapidly changing modern maternity care landscapes (Bradfield et al., 2018) (1). Yet, the interrelated psychological and emotional components that women experience are often overlooked when discussing maternal health in favor of more noticeable physical elements, such as maternal mortality measures and interventions (Baker et al., 2005) (2).

The emphasis on exclusively physical measures is such that women's personal experiences of the phenomenon are often marginalized or ignored (Walsh, 2007) (3). The exclusion of women's subjective experiences and perspectives from midwifery service evaluation render an incomplete and unclear depiction of the centrality of being 'with woman' to the profession of midwifery. The Central Statistical Office (CSO) and Ministry of Health (MoH) in Zambia state that the maternal mortality ratio (MMR) in the country is 398 per 100,000 live births (CSO et al., 2014) (4). This

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ratio is very high and unacceptable. The CSO et al. (2014) (4) and a number of previous studies, such as the ones conducted by Maimbolwa et al. (2003) (5) and MacKeith et al. (2003) (6), point to the fact that homebirths are the leading cause of high MMR in Zambia.

Significant investments in resources focusing on physical aspects of pregnancy and childbirth have failed to achieve tangible results in combating high maternal mortality in Zambia, with many more women still preferring to birth at home and not health facilities, despite the reported risks of homebirths. Therefore, the need to conduct a phenomenological study was timely and necessary in order to understand how the experience of childbirth affected the way women perceived midwifery care.

The information that emerged from the interviews with participants in this phenomenological study showed that the main appeal for homebirths was the provision of maternity care. This care embraced the core values of being-with-woman through the provision of maternity care that recognized the importance of caring behaviors, such as kindness, respect, dignity, privacy, and empathetic tone of voice of the care provider. The aim of this study was to understand the centrality of the childbirth phenomenon in women's psychological health from the perspective of women giving birth in Zambia.

Materials and Methods

This qualitative study was performed over a period of three years from 2013 to 2016 using interpretive phenomenology. The selection of the methodology was driven by the fact that the researcher's focus was to understand the childbirth phenomenon from the perspective of women giving birthing. Clarity or understanding of phenomenon to Heidegger comes by 'Being-in-the-world' or 'Dasein' (Greatrex-White, 2008) (7). According to Heidegger (1998) (8), 'Dasein' involves looking at something, understanding, conceiving, and choosing access to it.

Purposive sampling was used to sample 50 women who gave birth in Zambia, not more than 10 years prior to the period of data collection. This period was chosen in cognizance of the fourth in the series of the health sector reforms that the Zambian government had been implementing since 1992. The sample size of 50 was chosen based on the diversities among women giving birthing in Zambia. For example, place of birth (home, health centre, or hospital), place of residence (rural or urban area), assistance at birth (midwife, nurse, and doctor), outcome of birth (live baby, stillbirth), type of labour (spontaneous vertex delivery, caesarean section, or Occipito-posterior position), Parity (nullipara, multipara), marital status (married, single, or divorced).

According to Smythe (2011) (9), diversity provides a platform for a deeper understanding of phenomena. According to Hein and Austin (2001) (10), the concept of saturation is not possible in deciding the number of participants in an interpretive phenomenological study, because each participant comes with their story depending on their 'Dasein'. The point is that participants were not narrating their exact birth stories per se, instead, they were verbalizing the memories of their reflections of the experience. In so being, one is always open to things, thoughts, feelings, and people that come to one's memory and unaware of all the things that were there; however, the individual did not claim one's attention.

Phenomenology accepts that not only the person cannot escape the context but also that the 'there' of 'Being' makes the experience that 'is' (Smythe, 2011) (9). This means that even though all the 50 women in the study experienced birth in Zambia, their interpretations of the phenomenon were different depending on what was presented to their consciousness during the time of data collection.

Despite the age was not an inclusion criterion, the participants' ages ranged between 16 to 38 years. Data were collected through unstructured in-depth interviews. The shortest interview lasted 30 min and 43 sec, as well as the longest lasted 1 h 20 min and 30 sec. The corresponding researcher conducted all the interviews. Each participant chose the place of the interview. One participant chose to be interviewed in her office, six chose to be interviewed at researcher's home, and the rest chose to be interviewed in their homes.

The study setting was all the ten provinces of Zambia. The inclusion criteria were a woman who had a childbirth story to tell, experienced

childbirth in Zambia not more than 10 years prior to the period of data collection and had time to tell her story. Before commencing data collection, the study proposal was passed by the University of Nottingham and ethics approval was obtained from The University of Zambia Biomedical Research Ethics Committee. In consideration of participants' human rights, each individual participant made an informed judgment on whether to participate or not after being availed comprehensive, plain and clear information well before the interview.

A copy of the information sheet was provided to each participant. To ensure that there was no mix-up of participants, each participant's demographic data sheet was completed. The participants were informed of their right to withdraw even after the process of recruitment had commenced, and they could be interviewed at any time they chose. All concerns and questions were fully answered. No participant was coerced to participate. To reaffirm participants' rights as volunteers in the study, a consent form was signed. The subjects who did not know how to write were asked to endorse left and right thumbprints.

After noticing that a participant was at ease an open-ended question: "Could you tell me how you experienced childbirth the last time you gave birth?" was asked. Many of the participants kept quiet for a brief moment before starting to narrate their accounts. This reaction signified that the question prompted participants to reflect back on how they experienced the phenomenon. Each participant was allowed to narrate her story in whichever way she wished.

The interviews were allowed to flow in a conversational manner. However, in order to stay close to the experience that was being studied, there was a need in some instances to use open-ended unstructured prompts, such as "Would you mind explaining what you mean by that?", "What happened then?", "In what way?", "How did you feel about that?", "What did you think?", and "What did this experience mean to you?". To avoid loss of information, all the interviews were audio recorded.

The data were analyzed without the aid of a computer program. Although it was laborious, the process aided the researcher to stay close to the collected data. Data analysis utilized van Manen's (2002) (11) six steps of analysis. The six steps flowed one into another, and backward in a spiral with the sixth step searching into the first step until the document was finalized.

1. Turning to a phenomenon of interest (Deciding upon the topic and the research question whose phenomenon of interest was childbirth experience)
2. Investigating experience as we live it (Exploring the lived experience of childbirth by conducting unstructured, face-to-face, and in-depth interviews with the women who had experienced the phenomenon)
3. Reflecting on the essential themes, which characterized the phenomenon (Reading and re-reading each text, listening to each interview several times, summarizing each interview, considering the interviews as a whole, and extracting and tabulating words/phrases/statements revealing the childbirth phenomenon into sections, which were grouped under keywords/statements, sub-themes, and themes)
4. Describing the phenomenon (Writing and rewriting trying to make sense of what participants said about the childbirth phenomenon)
5. Maintaining a strong and oriented relation to the phenomenon (Referring to the reflexive diary in order to ensure that the researcher's personal notions of childbirth did not side-track the interpretation)
6. Balancing the research context by considering the parts and the whole (Constant circular process involving a continual dialogue between seemingly meaningful words, phrases and concepts, as well as questioning what was really being said).

Rigor of the study

Yardley's (2008) (12) four broad principles (sensitivity to context, commitment and rigor, transparency and coherence, impact and importance) for establishing the quality of this qualitative study were used to establish the thoroughness of the study. Sensitivity to context was demonstrated by showing the socio-cultural milieu in which the study was situated. This was intended to orient readers to the context of where the study was performed so that as they

went through the text, they related and understood the 'Dasein' of the participants' reflections.

Commitment and rigor were maintained by upholding consistency in probing and noticing important cues from the participants' accounts, and checking and re-checking the memos written after each interview. Transparency was enhanced by describing how participants were selected, how the interview schedules were constructed, how the interviews were conducted, and what steps were used in the analysis. While coherence was ascertained by giving the historical background of phenomenology and the theoretical underpinning of the approach, and showing how they were utilized in the study.

Yardley (2008) (12) makes the point that however well a piece of research is conducted, a test of its real quality lies in its impact and importance. The impact and importance of this study were maintained by highlighting the reasons why the study was conducted, as well as providing background information on the phenomenon being studied. A decision trail and reflexivity were also provided in order to strengthen the rigor of the study.

Results

The theme that epitomized the philosophy of midwifery from the women's birth stories was "Being there for the woman". The theme elucidated the physical and psychological interplay of childbirth through participants' expressions of safety, comfort, trust, dignity, being recognized, and respected. These are the same attributes mentioned by Hunter (2015) (13) in her description of Being-with-woman. Hunter (2002, p615) (14) defines 'Being-with-woman' as "the provision of emotional, physical, spiritual, and psychological support by the midwife as desired by a laboring woman."

The theme defined the sympathetic care and kindness that some maternity care providers showed their clients. It did not only elucidate the importance of the interplay between physical and psychological aspects of childbirth; however, it encompassed birthing women's feelings of being recognized and accorded respect. Consequently, the feelings of being well-cared and recognized gave women giving birth courage and confidence to experience birth in a positive manner. Mrs. MB said:

"For me, I can't complain…the nurses and doctors were there for me…none of them shouted or scolded me…they smiled and asked how I was whenever they got in my room…it gave courage that they knew what they were doing…I wouldn't mind giving birth here if I happen to get pregnant…" (MB, p4)

The theme was constituted by two subthemes including "feeling safe" and "sense of achievement". The subtheme, "feeling safe" explicated the feeling of being at ease and at peace with the care provider and the birthing experience. The participants mentioned that they felt safe and at peace when they were assisted by care providers who were empathetic and kind. They pointed out that due to the way care providers talked to birthing women and their relatives the way they went about providing care, as well as the tone of their voices when interacting with clients, made birthing women feel at ease and safe with the birth experience. Mrs. LD said:

"…the midwives we found welcomed me…they pleasantly and kindly told me to sit on the bench because they were still attending to another client…I felt safe and this made me relax despite the anxiety of labor…"(LD, p3)

The subtheme of "sense of achievement" elucidated how women were proud and fulfilled of themselves for having gone through childbirth. The subjects did not associate the sense of achievement to the outcome of the experience; rather they attributed it to the whole birthing experience, which consisted of healthcare providers who were always there and ready to help. Providers of care were mentioned to have played a major role in the achievement. Thirty-eight-year-old Mrs. LD said:

"For me, I feel that the pain of labor is the pride for any woman. It is a big achievement for me... Actually, after giving birth and having undergone the pain, I am now looking forward to having another child…the midwife, who I will remember for the rest of my life played a major role in what I felt and feel about childbirth…"(LD, p4)

Discussion

The theme of "being there for the woman", which was defined by the participants as a feeling of comfort, trust, and belief in their

maternity care providers, as well as the treatment that was prescribed, expounded their not being afraid of the surroundings and establishing a trusting relationship with their care providers. The theme was mainly supported by interviews from women who had homebirths. The participants expressed the comforting and peaceful nature of birthing in an environment, which was known and comfortable to them. Therefore, many participants preferred to seek home deliveries to institutional childbirths.

The results of studies performed by Reed et al. (2016) (15), Aune et al., (2013) (16), Thorstensson et al., (2012) (17), as well as Lundgren (2010) (18), have demonstrated that women value the midwifery care concept of being-with-woman during childbirth. Although the studies by Reed et al. (2016) (15), Aune et al., (2013) (16), Thorstensson et al, (2012) (17), as well as Lundgren (2010) (18) were conducted in high-income countries, the results were similar to those of this study, which was conducted in a low-income country of Zambia.

The cases expressed the need for a provider who was there not only physically but also emotionally and mentally. The theme of "being there for the woman" explained experiences that deeply impacted women's interpretations of the childbirth experience. With yearning in their voices, the study participants expressed their desire to find healthcare workers who treated birthing women with kindness and empathy and were caring, sympathetic, and informative.

The benefits of being-with-woman through the provision of sensitive and individualized care have been well documented in maternity literature (Davis and Homer, 2016) (19); Hildingsson, 2015 (20); Hunter, 2015) (11). In this study, the theme of "being there for the woman" was expressed through subthemes that exemplified participants' feelings of safety with their providers leading to a sense of achievement.

The subtheme of "feeling safe" resonated one of the goals of midwifery care, which strives at helping women to realize that labor and childbirth are normal life processes that are safe (Power, 2015) (21). According to Larkin et al., (2010) (22), the knowledge of the ability of one's body could lead to a woman trusting her body and feeling safe with the process of childbirth. This is irrespective of influences, such as low socio-economic status and intimidating cultural practices.

Consequently, once a woman knew that her body was designed to birth she could approach childbirth with confidence. The knowledge equips her with relevant skills to address circumstances she encounters during the process (Rizvi et al., 2014) (23). This view was expressed by a few study participants who narrated having been well looked after during childbirth. They sounded confident with their future births. In some instances, the subtheme expressed formally educated participants' confidence in institutional deliveries.

This corroborated CSO et al. (2014) (4) report, which stated that educated women in Zambia have more institutional births than the ones without education. Shimamoto and Gipson (2015) (24) stated that a woman's overall status in society, including economic and social vulnerability affects her access to and utilization of health care services. The safety that study participants talked about encompassed both physical and psychological aspects of midwifery care. It was caring behaviors, such as showing women kindness and respect, giving them privacy, and making them feel comfortable irrespective of their socio-economic status that made a qualitative difference of their experience of childbirth.

Changing provider-client interactions are often more challenging than modifying clinical practices. According to Davis et al. (2011) (25), provider behaviors are often rooted in deeply held attitudes, assumptions, and prejudices about the communities they serve. For example, some study participants expressed that healthcare providers' treatments of birthing women were not always good because they knew that they were mainly serving underprivileged communities.

Therefore, if more births in Zambia are to occur in health facilities, healthcare providers should provide women with care that makes them feel physically and mentally safe. Women need to trust and feel safe that authority figures, such as midwives, can make the right decisions for them. Some participants who gave birth in health facilities expressed their desire to give

birth in their homes with people they knew and trusted. Therefore, trust was cardinal in the way women related to their care providers during childbirth. In the absence of trust, most women felt they were better giving birth at home. They prioritized social norms, such as the gender of the attendant over biological problems.

The subtheme of "sense of achievement" defined the participants' expression of pride that came through experiencing childbirth while being assisted by a caring person. It helped women feel recognized and instilled in them faith in their own abilities to birth and be able to cope with childbirth. By being present physically and psychologically for the birthing woman, birth attendants, particularly midwives, assisted in raising women's confidence levels. For women with low socio-economic status, childbirth was an achievement that raised their status through portraying to the community that they were strong.

Although some of the birth experiences were characterized by the incidences of mistreatment in reference to the achievement of birth, there was pride in the women's voices. The sense of achievement was described as an experience that redeemed women from all the difficulties they went through during their everyday lives. When asked to shed more light on what they meant, it was explained that women were not treated equally with men; therefore, childbirth became very important because it was the only phenomenon that placed them at a higher level in comparison to men.

To consolidate their recognition of being well-groomed women, some participants talked about going through childbirth in silence. Going through childbirth in silence was defined as something that was an achievement to a woman. Consequently, women were not allowed to talk about labor pain publicly. Mrs. LD explained that common statements, such as 'labor pain was the pride of a woman' were meant to encourage women not to complain about childbirth.

Women experience labor in a variety of contexts and with differing aspirations (Lindsay and Peate, 2016) (26). However, the experiences have far-reaching implications for their health and that of their babies. In the case of this study, complying with traditional expectations was perceived to be very important to birthing women. The key implication for practice pointed to a need for all maternity care stakeholders in Zambia, in particular, midwives, to have an understanding of how women birthing in Zambia experience and give meaning to the childbirth phenomenon.

This is the only way in which they can "be there" for the women as implied in the "midwife" concept. This could start by re-examining current approaches to improving reproductive health, and addressing the contextual factors and community-based issues that were brought to light in this study. In the absence of such an understanding, it is difficult to map out the interventions that do not infringe on women's beliefs and practices.

Study Limitations

This was a phenomenological study; therefore, it contains time-specific experiences of women who gave birth in public health institutions in Zambia. However, the fact that this study contained time-specific information does not mean that the findings would be inapplicable and have no meaning in other contexts, particularly in the sub-Saharan and other low-income countries.

Conclusion

The results of this study revealed the centrality of the core value of being-with-woman' in the provision of midwifery care from the women's perspective. To the women, being-with-woman lay in the recognition of the complementary role that physical and psychological aspects of childbirth play in maternity care. Overlooking this intrinsic element represents a barrier to achieving development goal number 3, and constitutes a human rights violation for women. This contribution to the body of knowledge points to the need to have women's voices heard because they are the ones who experience the phenomenon and as a result understand the meaning of being-with-woman.

Uncovering women's experiences and the meaning they attached to childbirth could be the beginning step to explore interventions that are intended to address the vision of providing each woman giving birth with a positive childbirth experience. This includes respect and dignity, a

companion of choice, clear communication by maternity staff, pain relief strategies, and mobility in labor, as well as birth position of choice (WHO, 2018) (27). Consequently, when a perspective focus on the interests of women is used, more relevant, sensitive, and culturally congruent public health programs and policies can be developed.

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Conflicts of interest

The authors declare that there is no conflict of interest.

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