RESEARCH ARTICLE

Exploring birth experience of mothers, based on comfort theory

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Abstract

Objective: To analyse the phenomenon of "giving birth" on the basis of the lived experiences of women and midwives.

Method: The qualitative study was conducted in the delivery room of a mother-friendly hospital in western Turkey from March 1 to December 30, 2019, and comprised primiparous women aged 18-35 years having a spontaneous vaginal birth, and midwives who delivered the babies. Data was collected through indepth interviews that were audio-recorded. Additionally, women's written birth stories and researcher's observation regarding the participants were used. Data was subjected to content analysis using NVIVO 12 Pro software.

Results: Of the 28 subjects 15(53.6%) were lay women with mean age 24.2±3.87 years (range: 18-30 years), and 13(46.4%) were midwives with mean age 42.61±4.50 years (range: 37-50 years). The most referred conceptual themes in Kolcaba's Theory of Comfort were "enhanced comfort", "mother-friendly hospital policy", and "midwives' comforting interventions." Under the theme of "Increasing Comfort", women cared about psychological and environmental comfort. Women had the most psychospiritual comfort and environmental comfort as well as physical and sociocultural comfort. Women cared about psychological and environmental comfort that facilitated birth.

Conclusion: The mother-friendly hospital policy increased and contributed to the support and comfort provided to women. Kolcaba's Comfort Theory was an appropriate and working theory for birth and midwifery care, indicating that women's comfort should be ensured in the psychospiritual, environmental, physical and sociocultural contexts.

Keywords: Parturition, Women, Midwives, Hospital, Patient comfort. (JPMA 74: 1623; 2024)

DOI: https://doi.org/10.47391/JPMA.10470

Introduction

Pregnancy and childbirth are natural and normal processes.[1] They are also the most beautiful and valuable life experiences for women and their families.[1] However, today, with the effect of developing technology, women are not independent in managing the birth process, as childbirth is medicalised, and unnecessary interventions are made.[2]

In order for pregnant women to have pleasant and humane births, evidence-based care guidelines were prepared by adopting the "Mother-Friendly Hospital" model in care by the Coalition for Improving Maternity Services (CIMS) in the United States in 1996, and organisations providing mother-friendly services were established in many states across the USA.[3,4] In Turkey, the first such studies were initiated in 2011,5 and mother-friendly hospital practice was launched as a pilot practice in 3 hospitals on April 17, 2015. The efforts to disseminate this practice have been continuing throughout the country.[5] The aim of the "Mother-Friendly Hospital Programme" is to ensure that childbirth is experienced as a normal, healthy and safe process, and that mothers are provided with the necessary trust, comfort and support.[6-9]

Kolcaba's Theory of Comfort has been adapted to many nursing work areas, such as internal medicine, surgery and geriatria, in the world, including Turkey, and successful results have been obtained.[10-12] However, to our knowledge, no study adapting this theory to childbirth and midwifery care has been conducted. The evaluation of women's labour comfort remains an important research topic. However, comfort is a difficult concept to evaluate objectively.[12]

The current study was planned to analyse the phenomenon of "giving birth" on the basis of the lived experiences of women and midwives in a mother-friendly hospital, using 10 comfort determinants of the Kolcaba's Theory of Comfort; "women's health care needs", "midwives' comforting interventions", "ıntervening variables", "enhanced comfort", "health-seeking behaviours", "easy birth", "perception of difficult birth", "institutional integrity", "mother-friendly hospital policy", and "best practices".[10-12]

Subjects and Methods

The qualitative study was conducted in the delivery room of a mother-friendly hospital in western Turkey from March 1 to December 30, 2019. Approval was obtained from the institutional ethics review committee, and permission was taken from the provincial directorate of health. The sample was raised using purposive sampling method. During the

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Submission complete: 08-08-2023 **Review began:** 09-09-2023

Acceptance: 24-07-2024 **Review end:** 12-06-2024

Table-1: Interview forms used for semi-structured indepth interviews with primiparous women.

1. What do you think is health? What is being healthy?
   Alternative: What did you do to protect and improve your health around birth?
   Probe: What did you do during pregnancy? (Was your birth healthy?)
   Routine control
   Pregnant class
   Vaccine
   Weight-baby tracking
   Now
2. What do you need most about your health? What do you need most to be healthy?
3. What did midwives do? Do you remember what midwives do during birth? What did they implement?
4. What do you remember when you first entered the delivery room?
   Probe: How did you feel (peace, quiet, anxiety, stress, fear)
   What was the environment like (sound, temperature, light, colour)
   Who were you with in the environment?
   What medical procedures were performed (vascular access, nutrition…..)
5. Do you remember everything from start to finish during birth? Would you tell?
6. What are your feelings and practices to make it easier during pregnancy and birth? Which of these did you apply here?
7. What are the things that make you feel important and valuable during birth? Can you explain? Can you complete the two sentences? The thing that comforted me the most during birth was ……..
   The thing that worried me the most during birth was…….. Another?
   Probe: Protection of privacy
   Feeling safe and your baby safe
8. What do you remember about women who will give birth in this hospital?
   Probe: Why would a woman give birth in this hospital?
   Reasons for choosing this hospital

Table-2: Interview forms used for semi-structured indepth interviews with midwives.

1. How long have you been working in this delivery room? What are you generally satisfied with? What are you not satisfied with? How busy do you think the hospital is?
2. In your opinion, what are the health needs of a woman giving birth? From the perspective of a woman giving birth, what do they need most?
3. As a midwife, what do you do regarding health needs such as …… you just mentioned?
   Probe: What midwifery interventions do you implement in this delivery room?
4. What are the positive or negative physical features of this delivery room compared to other hospitals?
   Probe: What do you think about this? What makes this place different from others?
   What kind of practices do you do for women during labor?
5. Have you ever come across practices that women do to facilitate birth?
   Probe: Can you give an example?
   What do you do in this situation? What other apps have you heard of? You know?
6. What do you do to ensure that the woman feels safe and has privacy during labor?
   Probe: For example, who is with you? If you say that you are doing the following, especially regarding privacy, what would they be?
7. Which women do you think give birth more easily? According to your observations and experiences, do you say that when you see a woman giving birth more easily? What kind of women?
   Probe: Pregnant class,
   Educated,
   Young women,
   Taking care of your health,
   His wife is with him
8. What do you think about your institution being mother-friendly? What did working in this institution bring to you? What does it make you experience? What are the downsides, if any?
   Alternative: Working in this institution; How do you complete the sentence ……..?
   Probe: Good practices,
   Satisfaction

sample selection, diversity was ensured by including participants with different characteristics, such as education, job, age, etc., to obtain varied type of data. Those included were primiparous women aged 18-35 years having a spontaneous vaginal birth (SVB), and were able to speak Turkish. Those outside the age range, multiparous, those who had a caesarean section (CS), were not willing to participate, and those who could not speak Turkish were excluded. The sample also enrolled midwives who delivered the babies, had been working in the delivery room for at least 6 months, were willing to participate, and could speak Turkish. Those who did not meet the criteria were excluded.

After taking written informed consent from all the participants, data was collected through indepth interviews. All data collection tools were used in Turkish in a way the participants could understand.

The women's information form consisted of questions identifying sociodemographic and marital characteristics, income status, residence, family type and educational background (Table 1). The midwives' information form consisted of questions identifying sociodemographic characteristics, job duration and satisfaction with the unit (Table 2). The interview forms were in line with literature.[12-14]

The interview forms were evaluated by five specialists; 1 obstetrics and gynaecology specialist, 1 public health nurse, and 3 midwives. Their suggestions were used to revise the forms after the experts suggested increasing the number of probes for physical, psychological, environmental and sociocultural comfort in the forms. Before collecting data, a pilot study was conducted with 3 women to ensure the form's credibility and trustworthiness. Some relevant changes were made in the light of the pilot study. When we look at the manufacturing sources of the data; Primary data production consisted of individual interview records obtained from in-depth interviews and women's birth memories. Secondary data sources are delivery room observation data.

Other than the semi-structured interviews women's written birth stories, and researchers' observation notes.

Before starting the study, the researchers made observations in the delivery room for 20 working days as part of an official assignment. The data collection process started with the observation notes. The observation notes were prepared for secondary data analysis.

The participating women were interviewed at home after

making an appointment in the hospital room at their convenience after delivery. They were given A4-sized paper and a pen to write down their birth memories, and asked to write down their feelings and experiences freely. After 2-3 days, the women submitted their written birth stories on the scheduled appointment day.

The midwives were interviewed at the hospital or in their homes, depending on the appointment time. During the interview, some women were alone at home, some were accompanied by their mothers or mother-in-law or spouses or neighbours. No one refused or dropped out because the women felt ready and had made an appointment at their own convenience. However, 2 women whose time could not be planned appropriately, could not participate in the study. There was no repeated interview. Two interviews were held with women and midwives. Participating midwives were interviewed at the hospital, an appointment was made, and they were interviewed at their homes at the appointment time. In the second interview with an appointment, in-depth interviews with women and midwives were completed.

The introductory characteristics form was filled out during indepth individual interviews. Then, face-to-face indepth interviews were conducted under the guidance of the semi-structured interview form. To facilitate the indepth interview, a quiet, calm environment was chosen, the participants' privacy was ensured, and it was made sure that the participants shared their feelings and experiences sincerely and comfortably about giving birth/delivering a baby. More information about the participants, their feelings and thoughts about giving birth/delivering a baby were obtained by asking alternative questions and probes. The interviews were recorded using a digital voice recorder (Olympus Digital Voice Recorder VN-541 PC; 1570H-Vietnam), which enabled the researcher to obtain complete and accurate participant responses. The researchers kept a journal at each interview and took observation notes.

The interviews continued until data saturation occurred. Data saturation was also used as the determinant of the sample size which is a valid tool in qualitative research.[15] After the interviews were completed, the researchers listened to the audio recordings within 24 hours, and the raw data was transferred to the computer and made ready for analysis in a Microsoft Word document. There were 10 components of Comfort Theory[12-14] used in the study. Theme tags were created with a deductive approach. However, in coding, an inductive approach was used to conduct content analysis to bring together and interpret similar data within the framework of a certain concept. Two coders coded the responses separately and a single code list was created according to coding consistency. Ten themes were created by analysing the gathered data.

For participant confirmation, feedback was ensured by interviewing 5 participants (2 midwives and 3 women) regarding the findings.

Data was analysed using the Creswell 4 steps technique. This process is carried out by pre-reading, coding qualitative data, obtaining themes, organising, interpreting, and reporting the data.[16] NVIVO 12 Pro software was used for data analysis. When presenting data, frequencies (f), and code numbers with the abbreviation of midwife (M), woman (W), story (S), master's degree (M.D.), high school degree (H.S.D.), university degree (U.D.) were used. The ages of the interviewees are also given when presenting the data. The transcripts of the interviews were given back to the midwives to validate or correct the comments. However, it was not given to women because they could not reschedule an appointment at home. For authenticity data, compatibility of observation and birth memories data with interviewers' transcripts was checked. At the end of the data analysis, the accuracy of the data was checked by the experts.

The credibility of the study was ensured by the fact that 1 researcher (obstetric nurse) collected data, while the others analysed it.[17] Open coding was done.

For data reliability, at least 10% of the total data was randomly selected, and coded by different coders, and the consistency between the coders was examined through various methods, such as Cohen's Kappa.[18-20]

To ensure intercoder reliability, 10% of the text sections was randomly selected from the encoded text after the interview (1 of a woman and 1 of a midwife) and the code list was sent to another researcher who was an expert not part of the current study. The accuracy rate of the codes was 98.06%.

Results

Of the 28 subjects 15(53.6%) were lay women with mean age 24.2±3.87 years (range: 18-30 years), and 13(46.4%) were midwives with mean age 42.61±4.50 years (range: 37-50 years). In terms of level of education, 5(33.3%) women had completed primary education, 6(40%) high school, and 4(%26.7) had completed university education. All 15(100%) were married, 13(86.7%) were housewives, and 8(53.3%) women had attended the hospital's pregnancy school 4 times or more during pregnancy.

All the 13(100%) midwives were working in the delivery room of the mother-friendly hospital. In terms of level of education, 1(7.7%) midwife had completed high school, 4(23.1$) had associate's degrees, 8(61.5%) had bachelor's

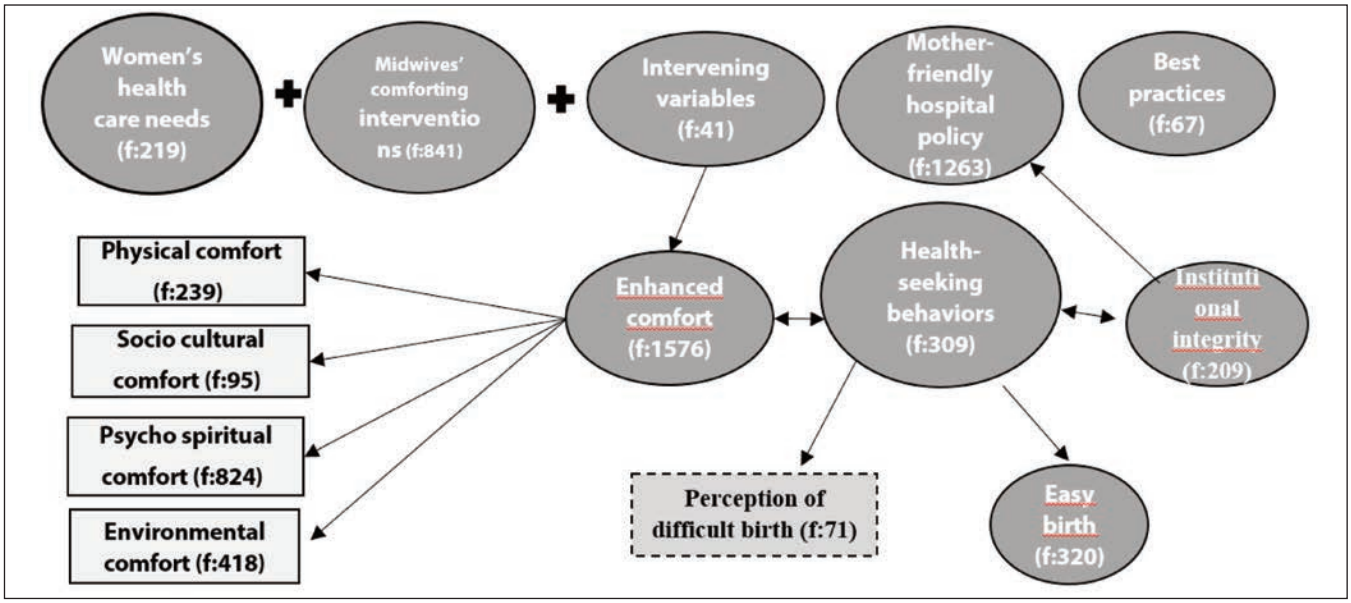

Figure: The themes obtained were "Women's healthcare needs", "Midwives' comforting interventions", "Intervening variables", "enhanced comfort", "Health-seeking behaviours", "Easy birth", "Perception of difficult birth", "Institutional integrity", "Mother-friendly hospital policy", and "Best practices".

degrees and 1(7.7%) had completed master's degree. All the 13(100%) midwives had been working as midwives for >10 years, and were associated with the delivery room for >6 months. Of the midwives, 3(23.1%) were satisfied, and 10(76.9%) were very satisfied with their work environment.

The most referred conceptual themes among the 10 identified were "enhanced comfort", "mother-friendly hospital policy", and "midwives' comforting interventions" (Figure).

Under the theme of enhanced comfort, subthemes "psychospiritual comfort," "environmental comfort," "physical comfort," and "sociocultural comfort" were described. According to 1 woman, "*I had a natural birth. I went into the water and did Pilates, and my labour was very easy. We can say that we had a lot of fun with the midwives during the birth; our midwives were very caring and friendly at the beginning. They turned on the music and sang songs. The reason why I preferred the state hospital is that I attended pregnancy school for 4 weeks. And I have overcome my fears. And I met the midwives and learned the exercises that make birth easier, and, thanks to our friendly midwives, I had an easy and beautiful birth.*" (Memoir W3, 22, H.S.D.)

One midwife explained the sociocultural comfort of pregnant women was increased. "*We also respect the patients. We allow them to do it; birth takes place when the Virgin Mary's grass is fully opened. Yes, they bring Zamzam water, we see that, and then they eat something with a prayer, you know, they eat dates-like fruit.*" (Interview M3, 50, Ü.D.)

Under the main theme of mother-friendly hospital policy, subthemes "satisfaction with policy practices", "policy practice of allowing a birth companion", "problems in practices", "evidence-based practice", "suggestions to improve the policy", "dissatisfaction", "hospital preference (service recipient)", "policy practice of single room", "professional midwifery", "pregnancy school", "midwife-pregnant meeting" and "supportive care opportunity" were described.

A woman wrote in her birth story that she was satisfied with the policy practices. "*I had a very comfortable birth, thanks to our midwives. Everything was perfect in our hospital. I would give birth in this hospital again if I could do it again for their cleanliness, care and attention. There was nothing I was dissatisfied with; everything was perfect. They also let my husband in, and I am glad they let my mother in.*" (Birth story W11, 22, H.S.D.)

One midwife described her satisfaction with the policy. "*I mean, we are a mother-friendly hospital, we already have single rooms, our workload was more before, but now our workload is less in single rooms, and then the fact that the pregnant women are satisfied with the services we provide to them allows us to get our professional satisfaction from the profession we do conscientiously. In general, I am satisfied with all of the mother-friendly hospital practices.*"(Interview M9, 38, M.D.)

Under the theme of midwives' comforting interventions, subthemes "routine practices", "mother-friendly practices", "paying attention to privacy initiative", "providing information initiative", "mother-friendly practice-service recipient", "establishing trust initiative", and "midwives'

allowing a birth companion" were described.

One midwife explained the mother-friendly practices and how they involved the father in the birth. "Of course, as soon as the baby is born and they have skin-to-skin contact, we put the baby on her lap before cutting the umbilical cord. After the beating stops, we cut the baby's cord, and we make the father cut the umbilical cord. We make the three of them hold their hands together (two seconds of silence), then we try to breastfeed the baby after the process is over." (Interview M10, 39, U.D.)

One woman described she was empowered by midwives at birth and her experience of an easy birth. "*There were 2-3 midwives. They came and went all the time. They supported me. Everything I had to do at that moment was already up to me; I mean, it ends with me, they just supported me. They told me what to do, you know. By listening to them, it was a very easy birth. It did not take very long.*" (Interview W1, 22, H.S.D)

Discussion

Based on women's experiences in the antenatal, intrapartum and postnatal periods in the mother-friendly hospital, and midwives' experiences of delivering a baby, 10 main themes emerged in line with Kolcaba's Theory of Comfort. When paired with the components of the conceptual framework of the theory, some changes emerged, and the number of themes dropped from 11 to 10. Since the theory evolved from the physiological process of birth and midwifery care, focussing on health-seeking behaviour, the theme of "peaceful death" was excluded. The two themes that changed completely were "internal behaviour" and "external behaviour." In their place, two themes were labelled as "easy birth" and "perception of difficult birth".

A mother-friendly hospital policy addresses the needs of each woman. It is known that the policy aims at implementing mother-friendly care by carefully meeting women's privacy expectations, keeping hygiene and comfort standards high, and not routinely applying non-evidence-based interventions.[7,21,22] As a result of the mother-friendly hospital policy, in addition to providing environmental comforts, such as single room, room temperature, lighting, reducing distracting noises, oral nutrition, massage, movement, position, music and non-pharmacological methods, such as water birth, have been observed to increase physical comfort. Women expressed feeling peaceful during labour and described the birth as being easy.

Providing physical comfort by meeting the physiological and physical needs of pregnant women reduces pain, increases self-efficacy in childbirth, maintains the normality of labour, facilitates delivery, and shortens the duration of labour.[7,23,24]

In addition, it is known that with an increase in psychological comfort, women feel valuable, the fear of childbirth decreases, the trust relationship between the midwife and the woman is established more easily, and the woman feels herself and her baby safe.[1,25-29]

Sociocultural comfort in childbirth is also very important. Supporting traditional practices, such as using the Virgin Mary's grass, increases sociocultural comfort. During the interviews, the midwives expressed their admiration for women's cultural practices and emphasised the assistance they provide. Studies have stated that women's ability to respond to their own emotions with cultural behaviours makes them feel cared for and accepted, and enables them to trust the midwife.[30-34] Previous studies have found that increased environmental and sociocultural comfort makes women feel at home, which makes it easier for them to focus on normal physiological delivery.[30-34] Similarly, in the current study, women and midwives reported that physical, psychological, environmental and sociocultural comfort facilitated labour and delivery in the mother-friendly hospital. The participants were generally satisfied with the changed service delivery and enhanced comfort as a result of the policy.

Based on the participants' experiences, the third main theme was the "midwives' comforting interventions". The midwives provided constant care and support, resulting in a seamless transition for women from the antenatal to postnatal period. This was achieved despite the intensity and exhaustion of the intrapartum period.

In this study, women expressed their satisfaction with the conditions in the delivery room, the care and support provided by the midwives, and the social support provided by having their husbands or other family members present. The women spoke with satisfaction about skin-to-skin contact managed by the midwives, their husbands cutting the umbilical cord, and the midwives' support for breastfeeding. The findings of the study were consistent with literature.[35-38]

It is the main responsibility of midwives to prepare the delivery room, manage the delivery, and care for the mother and newborn safely.[39] In addition to routine practices, midwives observing mother-friendly practices pay attention to privacy, passing on information, building trust, and recruitment of companions.[28,40-46] Mother-friendly practices of midwives increase comfort. The resulting model showed a relationship among enhanced comfort, health-seeking behaviour and easy birth. Mother-

friendly hospitals can be said to support a holistic care approach. With enhanced comfort, it is possible to reduce CS deliveries made at the mother's request without a medical necessity, and to improve the health of the mother and the baby.

In the current study, the midwives stated that there was institutional integrity in the mother-friendly hospital; all staff adopted mother-friendly hospital criteria, worked as a team, and the hospital management supported the delivery room team. In addition, they emphasised that they received training in line with the changing service delivery, and developed themselves professionally. In line with these findings, the mother-friendly hospital policy can be said to contribute to the professionalism of midwives.

The current study had some limitations. The findings of the study emerged from the thoughts, perceptions and experiences of the participants who gave birth and had their babies delivered in a mother-friendly hospital in Turkey. The data obtained from pregnant women was based on their recollections of their birth experiences. For this reason, those in the delivery room may have missed some details during their meetings with the researcher during the appointment. The researcher asked them to write down their birth memories to address this limitation. In addition, there were interruptions in conversations with the baby after birth and disruptions in the appointment plan.

Conclusion

Kolcaba's Theory of Comfort was found to be an appropriate and functioning theory for childbirth and midwifery care, and that comfort should be provided in the psychospiritual, environmental, physical and sociocultural contexts, which are the stages of comfort for women's empowerment and naturalisation of birth.

Acknowledgement: We are grateful to all those who participated in the study.

Disclaimer: Participants, midwives and women knew that Y.C.O. (Yonca ÇİÇEK OKUYAN, first author) was doing research for the researcher's doctoral thesis.

Conflict of İnterest: None.

Source of Funding: None.

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Author Contribution:
YCO, NB, AC: Concept, design, data acquisition, analysis, interpretation, drafting, revision, final approval and agreement to be accountable for all aspects of the work.